North West Region Draft North West Specialised Service Committee	
Date of Meeting:	3 April 2025, 10:00am – 12:00pm
Venue:	Rothay Meeting Room, 4th Floor, 3PP, Manchester

MEETING ATTENDANCE		
Ruth Hussey	RH	Non-Executive Member, C&M ICB
Andrew Bibby	AB	Regional Director of Health & Justice and Specialised Commissioning (North West)
Clare Watson	CW	Assistant Chief Executive, C&M ICB
Fiona Lemmens	FL	Associate Medical Director for Transformation and Deputy Medical Director, C&M ICB
Steve Knight	SK	Deputy Chief Medical Officer GM ICB
Sue McGorry	SM	Director of Nursing, Direct Commissioning, NHSE NW
Ian Lythgoe	IL	Deputy Director of Commissioning Finance
Sue Bailey	SB	NED at GMNHS, lead for Quality and Performance
Lisa Spencer	LSp	Director of Strategy NCA
Louise Sinnott	LS	Head of Acute Strategy & Transformation / Place Based Lead for Greater Manchester
Jim Birrell	JB	Non-Executive Member, L&SC ICB
Fiona Simmons-Jones	FSJ	Consultant in Healthcare Public Health: Specialised Commissioning
Richard Paver	RP	Non-Exec Greater Manchester ICB
Philip Kemp	PK	Associate Director of Finance (GM Healthcare Team), GM ICB
Carole Hodgkinson	CH	Head of Commercial Management, NHSE. NW
In Attendance		
Jane Malkin	JM	Policy Officer NHSE NW
Matt Tetlow	MT	Business Coordinator

Item No.	Discussion
1	**Welcome, introductions, apologies and Declarations of interest.** Ruth Hussey chaired and welcomed the group to the meeting. Apologies were received from Katherine Sheerin, Craig Harris, Tom Rafferty, John Wareing, Simon Kendall, Janet Thompson and Stuart Moore.
2	**Minutes** The minutes from the last meeting were accepted as accurate.
3	**Action Log** Actions were updated per the action log. The action log to be circulated following the meeting. Following circulation to members, the Health Needs Assessment paper was approved by the Committee.
4	Regional Director Update AB provided an update on two ongoing pieces of local work: prioritisation and resourcing of the Women's and Children's Programme. Following several Executive meetings, decisions have now been made. Items to be paused or suspended have been identified. Regarding the Women's and Children's Programme, detailed discussions have been ongoing with ICB colleagues to address the capability gap within the team. C&M has identified someone to provide part-time support to help bridge the gap. At a national level, two Gateway Zero papers were considered by the Delegated Commissioning Group (DCG) this month: • Severe Asthma – A case for change regarding how to modify the decision-making process on prescribing biologics to ensure better availability. This proposal was broadly supported, with caveats about capacity constraints that could impact the implementation of this work. • Specialised Liver Disease – Further work is required to scope this proposal. It was noted that the Severe Asthma case for change advocated for a whole pathway approach, starting at the pre-primary care stage. During the DCG meeting, a research project examining bi-lateral cochlear implants for adults was raised. While the trial costs will be covered, ICBs may be asked to fund any excess treatment costs. For the trial to be considered by NIHR, it would require commissioner support, which raises a governance question for this group. The consensus is that each ICB will need to decide whether they are willing to cover excess treatment costs. The question raised for the group is whether this decision

should be handled within the existing governance arrangements, or if a different approach is needed at the ICB level.

The group discussed the implications of the research's excess treatment costs on ICB budgets, as well as whether ICBs have a specific mechanism for handling excess treatment costs.

While the trial will proceed, the participation of regional patients will depend on the systems' ability to fund the excess treatment costs.

RH summarised that the group would prefer NIHR to fund all trial costs. However, if this is not possible, ICBs will need to make individual decisions as commissioners particularly if it is a delegated budget.

The trial lead should be advised on how to obtain commissioner support.

AB provided an update on delegation and the transfer of staff to the hub, considering the recent announcements.

Three options were considered:

- Abandon the delegation journey entirely
- Continue with delegation but pause the transfer of staff
- Continue as planned with both delegation and staff transfer

The third option was selected, providing clarity on the direction of travel.

By the end of April, an initial outline of the principles for the new system architecture should be available, which will describe the work undertaken by the Centre, the region, and ICBs. By June, NHSE staff should have clarity on the processes for the overall reduction of the organisation.

A rewrite of the NHS Act is expected, and within the Health Bill, there will be further consideration of how Specialised Commissioning fits within the legislation. This may require additional work on the operating model, which will need to be reviewed collectively once more information becomes available.

ICBs have received a letter outlining an approach to the 50% reduction of their staff. It was noted that the Specialised Commissioning function is not a target for efficiency savings. It is hoped that this will facilitate the resumption of recruitment to fill existing vacancies, which will help alleviate fragility within the team.

It was noted that careful consideration of everyone's concerns regarding this process is necessary. Until there is clarity around the plan, it will be challenging to consider organisational design.

The group acknowledged the difficulty of this process and the uncertainty it is causing for staff. It was agreed that no assumptions can be made at this point.

Action 40: ICB leads to establish what the research excess treatment costs

	decision-making process is for their system.
5	**ICB update - Prioritisation Frameworks** CW confirmed that it has been agreed to adopt the L&SC single approach, rather than proceeding with three separate approaches. LS advised that discussions have progressed, and the NOF will be used as the clinical prioritisation framework for new schemes. However, it was noted that no new schemes will be initiated at this time. A paper later in the agenda will outline the approach taken regarding the prioritisation of these schemes. GM and C&M will take the final decision on the prioritisation approach through their respective governance processes.
6	**TOR Review** AB has reviewed the TOR and confirmed that they align with the TOR proposed for new delegation areas this year. There is an ongoing discussion within the Committee focused on the principles of decision-making, particularly regarding decisions that may impact each system differently. Once these discussions are concluded, the outcomes will need to be incorporated into the TOR. Appendix 1 may also need to be updated to reflect the new delegated services. Additionally, details for partner organisations should be revised to include updated addresses and contact information. CH commented that a process for making urgent decisions outside of the regular meeting schedule will be necessary, given the time gaps between meetings. There may be a need to delegate certain decisions to the Executive group, but an urgent meeting can be called if required. It will be important to consider the contributions of both Executive and Non-Executive members in this process. The ToR requires a Deputy Chair to be appointed, and JB was confirmed in the role as L&SC take over the Chair in April 2026. Action 41: The TOR will be formally revisited at the September meeting once the new organisational arrangements are clearer.
7	**Items for Decision/Endorsement** **NWSSC 2025/26 Work Plan** The paper outlined the approach to prioritisation for ongoing services, improvement schemes to support providers and services in their day-to-day operations, and initiatives requiring specific focus from ICBs and the Specialised Commissioning team to lead commissioner focussed work aimed at changing, reconfiguring, and improving services across the NW.

	Section 3 provided an overview of the work plan for the forthcoming year, utilising the commissioning annual planning round to inform and direct the committee's activities. This includes proposed meeting dates and suggestions for schemes to support. At each future meeting, the committee will address a care group topic, incorporating any improvement and transformation schemes as part of that programme of care. Where decisions are required within these services, they will be factored into the annual schedule. The appendix included the full list of delegated services, with categorisation and prioritisation, subject to committee approval. It was confirmed that Mental Health is currently rated amber, as it has been identified as requiring work to determine succession arrangements. This item is scheduled to be brought to the committee in September for a decision. The need to incorporate contracting into the finance plan, to be presented at the June meeting, was acknowledged. CW noted that the executive group had been asked to review the work plan, and a satisfactory position has been reached. However, some areas have had to be paused due to capacity constraints. The team believes they can deliver the work plan as outlined. It was noted that additional work is required to ensure accountability to the ICB Boards. The AAA report will provide the necessary information. Any items requiring Board decisions can be added to each ICB Chief Executive's report. The work plan was endorsed by the committee. Action 42: ICBs to review the pathway for communicating and making decisions at Board level concerning this programme of work.
8	**Quality Update** SM provided an update on progress in quality reporting. Despite current uncertainties, work will continue under the same principles; however, amendments to the RASCI model will be necessary once responsibilities and accountabilities are clearly defined. The joint escalation process has been well received nationally and has been shared for broader use. The quality work has been divided into two sections, with careful consideration of what and how information is reported to Quality and Performance Groups within ICBs. In collaboration with the BI team, consideration is now being given to how the Specialised Services Quality Dashboard can be used more effectively.

	The dashboard is now accessible to a wider audience, allowing ICBs to utilize it for their own quality assessments. Efforts are ongoing to enhance the reporting functionalities of this tool. Consideration is also being given to future reporting of serious incidents through various governance processes. An ongoing piece of work is examining the delegation of services and determining responsibility. This is subject to change in the future; therefore, the focus has shifted to the operating model for retained services, which should assist in understanding the requirements for delegated services. This is particularly important for retained highly specialised services, as there has been a lack of strong governance processes, and reporting from these services has been suboptimal. The primary principle being instilled is that any quality concerns must be raised to ensure services remain safe. It is hoped that the current work will provide a solid foundation for any future changes. SM has informed all ICB quality colleagues of the ongoing work. It was confirmed that more clarity will be available regarding regulatory functions at the intermediate tier level, with providers becoming more accountable. It was agreed to review the quality dashboard report at future meetings using the same theme as the work plan for that month. Action 43: To present the quality dashboard when undertaking a deep dive into a specific quality issue
9	**Update on 2025/26 Financial Plan** IL presented the financial plan slides, which will be circulated following the meeting. It was noted that, following the announcement regarding the removal of the Elective Recovery Fund (ERF) cap, financial remodelling will be required. Regarding the Finance and Contracting sub-group, the Month 11 position has been reviewed, alongside the forecast position for 2024/25 and the 2025/26 finance plan. It is anticipated that, once the consultation on the payment regime is received, provider contracts will be agreed. Additional work will also be required to support the transfer of staff to the ICB hub. IL provided an update on surpluses, local variables, and noted that providers have been reminded to operate within the ERF ceilings. Ongoing discussions with ICBs have focused on understanding their requirements, and a formal financial report is in development to feed into ICB financial reporting.

	The financial plans presented at the previous meeting remain unchanged. ICBs have utilised £28m of reserves to support their financial positions. While some allocations are still subject to change, these are not expected to impact the overall financial bottom line. It was highlighted that Mental Health services have not received demographic growth funding for 2025/26. Consideration is being given to adopting a population-based formula for mental health allocations, although timescales for implementation remain unclear. A Mental Health Investment Standard has been introduced as part of delegation. Within ERF, £80m was allocated in baseline funding for electives, with an additional £21m awarded for 2025/26. Providers will be expected to meet associated productivity requirements. A more detailed breakdown of reserves and commitments has been shared with ICBs. For mental health, all allocations have been directed to Lead Provider Collaboratives. Reserves are also in place for the planned perinatal service in Chester and for the GM allocation correction. Discussions are ongoing with ICBs to ensure these plans are reflected in their finance committee reports. The focus will now shift towards provider engagement and finalising contracting arrangements. While financial challenges remain, all colleagues are fully briefed on the plans, and there is a clear pathway established for each organisation
10	**Risks** CH provided an update on the recovery specialty progression. For the upcoming year, the target is to achieve an 18-week waiting time. A decision is pending regarding the monitoring approach from a Specialised Commissioning perspective. Neurosurgery and spinal services continue to be under review. Despite ongoing efforts, services remain fragile, although they have managed to stay within the required 78-week waiting time. Gynaecology services, particularly concerning severe endometriosis, continue to face capacity challenges. A cardiac services summit was held on April 2, involving the three cardiac providers, ICB colleagues, and clinical networks, to discuss potential service improvements. Modelling indicates that achieving the 18-week target by 2027 would necessitate a 20% increase over pre-pandemic levels. A series of actions have been identified for all stakeholders, including significant system-wide discussions that need to be undertaken. Work must commence promptly to advance these efforts.

	Further work is required concerning Mohs surgery service services (precise surgical technique for removing skin cancer, usually on the face), especially basal cell carcinoma and squamous cell carcinoma examine waiting times, with updates to be provided at a future meeting. CH described the process for accurately identifying specialised patients. A model has been developed that will utilize weekly waiting list submissions to determine which patients may fall into the specialised category. The risk update paper outlines five new risks proposed for inclusion in the register. Discussions continue regarding thrombectomy services, as the contract performance notice is in its final stages. There are also broader concerns about the long-term development of the service. National colleagues are closely scrutinizing this service, and continued support for the trust is essential. This situation remains highly challenging. CH confirmed that all identified risks are also issues; for instance, if the waiting list is the issue, the associated risk is that patients could be harmed at any time. These risks will persist until waiting times are reduced. Collaborative efforts with the three ICBs are ongoing to ensure that this information is incorporated into their governance processes.
11	**Delivery Reports** The report outlines the themes underpinning the current schemes being developed to address the risks and issues discussed. These schemes are reviewed in the context of the overall priorities for the upcoming year. The intention had been to progress the MFT vascular and cardiac reconfiguration proposals through Stage 2 of the service change assurance process in July. However, this has been delayed for several reasons. Additionally, the ICB-led work on neurological cancer reconfiguration has been postponed until the end of 2025. Nonetheless, plans remain in place to continue progressing this work within the system. The report will be reviewed and may be separated into delegated and retained services.
12	**Transformation Programme – ACCTS** CH provided an update on the ACCTS procurement. There is a tight timescale to award the contract, and the team has been working closely with the NECS CSU on the procurement plan and has undertaken substantial market engagement. It is hopeful that when the procurement is launched on the 8th April, that there will be bidders.

	The contract for the current interim services is due to expire March 2026 hence the need for the new services to start on the 1st April 2026. The Committee will be asked to approve the preferred provider; however, the paper will not be ready in time for the next scheduled meeting therefore the decision will need to be taken outside of the meeting. It was agreed that the provider report will be sent to committee members by the 12th June with a virtual response required by the 17th June.
13	**AAA Report** The committee approved the AAA Report from the March meeting The AAA report for the April meeting to be produced and circulated in advance of the June meeting. In future, the report will be approved by correspondence and then available for use by systems in order to be a timely update to ICBs. Action: AAA report to be prepared promptly after each meeting.
14	**AOB** SB noted that the failure to decide the site of the GM trauma service is impacting cardiac/vascular services. There should be a general principle that if one issue is having a negative impact on another, then this committee needs to have oversight. RH suggested that during the ICB updates, any major service reconfigurations should trigger conversations about the impact on other services.
15	**Next Meeting:** **5th June 2026 10:00 – 12:00 - Teams**