North West Region Draft North West Specialised Service Committee	
Date of Meeting:	5 June 2025, 10:00am – 12:00pm
Venue:	TEAMS

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
Craig Harris	CH	Chief Operating Officer, LSC 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
Carol Stubley	CS	Director of Commissioning Finance
Sue Bailey	SB	NED at GMNHS, lead for Quality and Performance
Stuart Moore	SM	Director of Strategy, MFT NHS FT
Simon Kendall	SK	Medical Director for Commissioning, NSHE
Fleur Carney	FC	Strategic Commissioner for Specialist Services, LSC 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	CHo	Head of Commercial Management, NHSE. NW
Katherine Sheerin	KS	Chief Commissioning Officer, GM ICB
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 Louise Sinnott.
2	**Minutes** The minutes from the last meeting were accepted as accurate.
3	**Action Log** Actions were updated per the action log.
4	**Regional Director Update** AB provided an update to the group. Since the last meeting of this committee, further thinking has happened nationally regarding the implications of the significant governmental announcements about the future architecture of the NHS made in late-March. As such, a decision has been made to delay the transfer of specialised commissioning staff from the 1st July to towards the end of the 25/26 financial year. This decision reflects the significant pressures on ICBs, who are currently being asked to reshape and reform as strategic commissioning organisations. Given the scale of that work, and the HR bandwidth required it was felt inappropriate to proceed with staff transfers at the same time. Further consideration has been given to the impact on plans for Directly Commissioned services in the context of abolition of NHS England and the transfer of its executive functions to a newly configured Department of Health and Social Care. These developments have prompted further reflection on the future of delegation and commissioning responsibilities. As such, work is now underway to determine who, in future, will hold responsibility and accountability for services currently described under Section 3 of the NHS Act. This includes not only specialised commissioning; but also health and justice; armed forces healthcare; community pharmacy, optometry, dental services; and primary care. A national review is being carried out to consider how these responsibilities will sit within the new system architecture which will inform a redraft of legislation. NHS England is currently reviewing the remaining services within the specialised services portfolio that haven't yet been delegated. The aim is to determine how these should be commissioned and planned in future. It's likely that ICBs will be asked to take on more responsibility, either through existing joint committee arrangements or, potentially in some cases, with one ICB acting on behalf of the whole country. As the number of commissioning organisations reduces to around 25 (larger) ICBs, there will also be a need to review whether some high-volume specialised services

still meet the criteria to remain classified as such. Some may be moved into the standard acute portfolio managed by ICBs.

This forms part of a wider portfolio review, and NHS England now has a clearer direction of travel in this area. Updates will be shared with the committee as national discussions progress.

The second theme AB updated the committee on relates to the last-minute changes in the commissioning round, specifically the shift from a block contract model to an IAP-based contract approach for acute services. This sudden change has significantly impacted the specialised commissioning team's capacity, particularly in the BI, finance, and contracting functions. As discussed previously, both BI and finance teams are already operating under business continuity arrangements due to ongoing staffing shortages, so the additional, urgent workload has been especially challenging. A key part of this work has involved ongoing discussions with Manchester Foundation Trust, the largest provider of specialised services in the Northwest. They have highlighted a perceived gap between the proposed level of income and what they believe is necessary to deliver the required services.
In meeting all the requirements of the 2025/26 planning rounds, there has been substantial work and extensive dialogue with the trust to reach a position where all parties feel able to move forward. The team has worked closely with ICB colleagues to support discussions with MFT.

One of the outcomes of this work has been the need to rapidly develop indicative activity plans for all providers. This has placed significant additional pressure on the contracting, finance, and business intelligence teams within the specialised commissioning hub, further straining already limited capacity.

Thirdly, AB provided an update from the national Delegated Commissioning Group. The group approved funding for two new drugs that have passed the clinical prioritisation process and are expected to generate cost savings for the NHS. One drug, for haemophilia A, despite a higher unit cost, results in a lower total cost per patient. The other, for angioedema, offers similar cost-saving benefits.

Additionally, there was discussion regarding a change in prophylactic treatment for infants at risk of RSV. Historically, Palivizumab has been administered as five monthly injections however, the new drug, Nirsevimab, provides protection with a single dose. While the cost per dose is higher, it offers significant patient benefits by reducing the need for repeated visits and potentially increasing uptake. The national team believes this can be managed within the existing centrally held drugs budget.

There was also discussion about the recent ministerial announcement of 30 new linear accelerators to be installed across England as part of a capital replacement programme. The North West has been fortunate to receive two of these 30 units, one at Lancashire Teaching Hospitals and another at The Christie.

Finally, AB also updated on the work around Mental Health Lead Provider Collaboratives. A paper is currently being developed for the group's September meeting, which aims to achieve two key objectives.

	First, it will explore options for configuring the adult secure provider collaborative , particularly given the absence of an active provider in the GM system. Following discussions with stakeholders, there is broad consensus that the benefit of integration outweighs the benefits of creating a larger critical mass for these LPCs. Consequently, the paper will recommend maintaining three separate LPCs for each system in the CAMHS collaborative. Second, the paper will present options regarding the perinatal lead provider collaboratives, considering the lack of an LPC in GM and the complex arrangement with Wales covering Cheshire and Mersey and North Wales. It proposes no changes to the eating disorders collaborative. Additionally, the paper will examine the pros and cons of either rolling over current contractual arrangements or re-awarding new contracts. This review is prompted by some LPCs generating significant surpluses that have not been reinvested into early pathway services. The committee's view on where such funds should be allocated from 2026/27 onwards will help determine the appropriate commercial approach. Following a query regarding GMMH, AB confirmed that Karen Howell, the Chief Exec is proposing to take a paper to their board to support keeping the staff in the short term, though the exact timeframe is not yet specified. Action 45: AB to find out the financial impact (savings or costs) of the new drugs for the Northwest and report back.
5	**ICB update** LSC: CH advised that LSC has undertaken significant work to deconstruct and reconstruct its commissioning and structural arrangements, likely going further than C&M and GM, largely due to its starting point as an organisation. Based on ongoing discussions with CW and KS, consideration is being given to how specialised commissioning fits into this work and how LSC will work with other ICBs in future. The aim is to future-proof structures in line with the move toward the £19 per head management cost, ensuring strong alignment with providers and a focus on end-to-end pathway management. As part of this, LSC has reviewed the specialised commissioning oversight group with an overall focus to streamline processes, particularly around quality oversight, and reduce duplication. SB has contributed to a number of these discussions, which have been very helpful. CH added that the team is also focusing on identifying where they can have the greatest impact and ensuring clarity over what is delivered locally to avoid duplication. There are no major ongoing issues, though LTH remains the most challenging provider, and concerns have been escalated. However, key issues are now with chief executives and chief operating officers for resolution. The process has demonstrated a strong partnership between AB's team and CH's team, with close collaborative working. Despite ongoing uncertainty and system shifts, good progress has been made, and specialised commissioning intentions have been embedded within LSC's processes.

	CH noted that LSC has just started its 26/27 commissioning intentions process, with three workshops planned. This work is also being aligned with LSC's financial sustainability plan, as part of wider recovery efforts, with a focus on identifying opportunities for greater integration with specialised commissioning. C&M: CW noted that specialised commissioning is incorporated into their future planning, however further information is expected from the transition programme regarding future arrangements. CW suggested a review of which items should be brought to local SCOGs versus this group, to avoid duplication and ensure ICBs are kept informed. This may require some reflection on methodology used. CW also noted that having a substantive discussion on lead provider collaborative, particularly mental health, at a future Spec Com Exec Leads meeting would be useful. CW suggested inviting all relevant colleagues to the discussions. GM: KS reflected on two challenging areas recently highlighted by AB, the MFT contractual issues and the adult forensic lead provider arrangements. While both have been complex to navigate, KS noted they have provided valuable insight into what the future commissioning organisation should look like, particularly the need to commission across whole pathways. Current priorities in GM include major trauma, and cardiac and vascular surgery, though these are more specific to individual ICBs. KS also referenced a recent discussion with The Christie regarding growth in patient flows, raising wider questions about cross-regional flows into and out of the Northwest for specialised services. KS emphasised the need to carefully prioritise work given the ongoing resource constraints. AB responded to KS's query on patient flows by confirming that a comprehensive piece of work was carried out recently which offers a clear picture of where patients in the Northwest travel from and to for specialised care, including services accessed outside the region. AB advised that, as clinical patterns have not significantly changed since, the existing data should be sufficient, and no further work is currently needed. CS confirmed that while a risk share arrangement was in place across the three ICBs last year, this has not been carried forward into 2025/26. The three ICBs have collectively decided not to maintain a risk share between them for the current year.
6	**Items for decision/endorsement** **Complex Termination of Pregnancy** The group agreed to introduce conflict of interest statements in future meetings. The complex terminations of pregnancy paper, updated after review by all three SCOGs, proposes a specialised procurement for complex cases involving significant co-morbidities. Basic terminations remain commissioned separately by ICBs from NHS and private providers.

The plan includes three service levels: a network lead, a provider for very late terminations, and a network of earlier-stage complex case providers. Previous procurement attempts struggled due to limited provider interest. The new approach is to first appoint a network provider who will develop and accredit the wider provider network. Ideally, this provider would also deliver very late terminations.

Two potential providers are being considered for this role, with a targeted award planned. If unsuccessful, an open procurement will follow. Phase two will focus on appointing and training the wider network. Approval is sought to proceed with this strategy and start informal discussions. It was confirmed that national funding is dedicated to this service, so there are no alternative funding options.

The paper has been shared and comments incorporated. There is general support for the procurement approach, with some clarification needed on phases. Funding use is fixed, and cost concerns around management fees will be addressed later.

The committee supported proceeding with the procurement.

Adult Critical Care Transfer Service

CHo advised that, unfortunately, despite initial indications that at least one provider was planning to submit a bid, no bids were ultimately received.

The key issues included: the complexity of the model, with a host provider needing to run a separate procurement for transport; tight timescales, which didn't allow enough time for providers to prepare bids or engage subcontractors and wider NHS pressures and workforce risk, making it an unattractive time to take on a new, complex service.

As a result, the team is now stepping back to gather more detailed feedback and reassess the approach, while proposing to extend current interim arrangements until March 2026.

It was noted that the main provider in GM and LSC, ERS Medical have gone into liquidation. Colleagues are in contact with the networks but no clinical risk has been identified.

The group noted the need to understand the impact of ERS Medical's liquidation on the current service in GM and Lancashire, particularly in relation to the proposed two-year extension of existing contracts. It's likely a further procurement will now be required. The current position is being assessed, and the proposed way forward has been shared to keep stakeholders informed. Once there is clarity on ERS Medical's situation, a formal request for approval to extend the interim contracts will be made, if that remains the appropriate course of action.

The paper was accepted by the members, noting the risks that need to be managed going forward. An update will be provided at the September meeting.

Action 46: CHo to provide a SPAR to KS by 9th June, to ensure Chief Officers are kept informed of the ERS Medical situation.

7	**Quality roles & responsibilities** SM introduced the paper to clarify governance and assurance under the de-escalation policy, using RASCI principles to define roles as responsibilities shift. It has been developed with ICB quality leads and will underpin future work. While framed around three quality domains, many elements are cross-cutting. Maintaining business as usual during ongoing change was noted as essential. A recent paper was submitted to the Executive Quality Group which outlines key risks across ICBs and NHS England, including issues around quality assurance, governance, safeguarding, IPC, unclear escalation, and workforce capacity. It provides a helpful framework for alignment and input. The position statement reinforces the need to maintain high-quality care during the transition. It links with wider work by the NQB on a quality impact assessment tool and refreshed guidance, aiming to support consistency amid structural change. It was acknowledged that while the Quality paper outlines accountability and responsibilities, there is flexibility within the framework. This presents an opportunity for more collaborative working and improved utilisation of the existing workforce across systems. It was noted that safeguarding differs from other delegated functions due to its statutory responsibilities. While NHS England remains accountable for all delegated areas, safeguarding has always been directly the responsibility of ICBs. Specialised commissioning has never had a dedicated safeguarding team, instead, it has historically worked directly with safeguarding leads embedded within ICBs, making it a long-standing, locally delivered function rather than one managed centrally. Action 47: SM will share the paper that was submitted to the Executive Quality Group by the Head of Quality and Strategy for NHS England
8	**Finance Update** CS highlighted work on agreeing Indicative Activity Plans (IAPs) with providers, noting plans will be imposed where no agreement is reached by end of June to support financial control. Initial assessments show issues with a small number of providers. The need to consider IAPs from an ICB-wide perspective was emphasised, particularly to align core and specialised commissioning. The MFT work reinforced the importance of joint activity management and improved intelligence sharing between specialised commissioning and ICBs. In addition, due to ongoing resourcing challenges, it was highlighted that the finance team is now operating with a 50% vacancy rate, up from 30%. As a result, they are in business continuity mode and unable to maintain previous levels of reporting and contract input.

	The team has had to prioritise key tasks, and this has been shared with ICB finance colleagues through the finance working group. One key impact is a shift from monthly to quarterly reporting for ICBs. While this change may have limited impact given the slower-moving nature of some areas, like activity. it does mark a significant adjustment in financial oversight and support. It was noted there is a need to consider a structured approach to managing variable contract performance. It was suggested that conversations will take place with each ICB, and a deep dive approach may be required, prioritised by materiality and risk. It was reiterated that the finance team remains in business continuity, with significant resourcing pressures impacting reporting capacity. The team is prioritising activity management and will continue exploring how to work with ICBs to collectively manage financial risk. While the situation is not new and has been shared with finance subgroups, the team hopes to exit business continuity in the near future. The challenges ahead were acknowledged, emphasizing the timing risk due to data always being received a month in arrears. They stressed the importance of managing this carefully throughout the year. PK also expressed sympathy for the team dealing with resource constraints and highlighted that this impacts ICB teams too. They called for collaborative efforts to work more efficiently and avoid overburdening any one group. There is already engagement with colleagues in LSC, and C&M to maintain core services safely despite the difficult environment. RH asked whether the ICBs three-year service and financial plans, aimed at achieving annual spend within the fair shares allocation is currently factored into the work plan given resource constraints. It was noted that spending is 6% over fair share allocation for specialised commissioning. CS responded that it is not yet included but acknowledged its importance. She explained that emerging medium-term planning will focus on contract activity costs and rebasing blocks to guide resource allocation before efficiency efforts. However, due to current capacity issues and business continuity challenges, the team can't fully address this yet. Conversations with contracting colleagues are planned, but for now, the priority is managing immediate pressures.
9	**Risks** Updates were provided on key specialties: neurosurgery remains stable though underlying issues persist and work is ongoing. Severe endometriosis in gynaecology fluctuates across providers; patient numbers have decreased but it remains a concern pending national recommendations. The recent cardiac summit was positive, with papers and action plans to support cardiac surgery shared. Skin cancer work continues with capacity reviews; Mersey and West Lancs have appointed an additional consultant to help reduce waiting times. The main waiting time challenge remains Liverpool Women's, which is under interim measures, with ongoing work alongside tier instructions and alliances. A new risk related to mental health services, specifically the delegated GMLPC financial issues scoring over 16 has been added. Additionally, some risks had changed dates as they were due to conclude by the end of April, but a detailed review

	was delayed due to ongoing contracting and planning discussions. This review has now been completed and will be included in the next report to SKOGS. Going forward, waiting list risks will be consolidated into a single risk for reporting. The paper also notes requested extensions for target dates on several risks, mainly related to staffing challenges and ongoing restructuring. Additionally, extensions have been sought for risks tied to women's and children's services and the thrombectomy project due to continued discussions. The report outlines the progress being made in these areas. CH confirmed that the agreed SOP informs the 16 risks, and it's up to the ICB teams to decide which ones to add to their risk registers. Plus, these risks are already tracked on the core NHS England register. AB explained that the introduction of a new risk for secure mental health services is essentially the movement of an existing risk onto the delegated risk-register reflecting the change for Mental Health services, with some positive signs as the situation is improving as a plan has been developed. Detailed work with ICBs will follow once more clarity emerges, likely by October, giving six months to prepare for potential new responsibilities from April 2026. The key point is ensuring regular, detailed updates for each ICB, keeping information current. It's important to align and coordinate with ICB activities, even those outside specialised commissioning, that support areas like non-surgical oncology, to ensure clear, joined-up actions and effective triangulation. AB suggested bringing an exception report to this meeting and if there aren't any risks in relation to that service then we would bring a nil report. The recommendations in the report were noted and accepted.
10	**Focus on: Women's and Children's Programme of Care** AB provided a brief introduction to the presentation, which will be shared following the meeting. There are six programmes of care, each with a scheduled deep dive at future meetings. Today's session on Women's and Children's was intended as an introductory overview. Future updates will concentrate on active areas of work, with brief summaries for the remaining services. The number of specialised services that are planned at ICB level in the Women's and Children's portfolio is relatively small, with only a few high-volume services typically covered in local SCOGs. However, at regional level, the scope is broader due to the large number of specialised children's services. Many of these are conditions that are rarer in children and require cross-boundary care across the Northwest. Children's cancer services were noted as sitting across both the Women's and Children's and the Cancer programmes of care. This overlap reflects how the services are clinically delivered and managed, involving both paediatric and cancer-specific pathways.

Delegated specialised services have been categorised into three tiers based on planned activity levels. Green services are in a maintenance phase, with no proactive work unless issues arise. Yellow services require improvements, but not major changes. Red services have active transformation plans in place, with anticipated changes in how services are delivered and experienced by patients.

Within the single ICB remit, four main areas are being focused on, including neonatal services and two other sub-services that need attention but not full-scale transformation.

The committee's wider remit includes a larger number of red-rated services, many within the children and babies' programme. These include children's cancer, teenage and young adult cancer, paediatric care, and complex termination of pregnancy (previously discussed). Specialised gynaecology is the only red-rated service not yet covered in the meeting.

In the yellow category, the services identified are those where improvement is needed, but not on a transformational scale including adult congenital heart disease, foetal medicine, children's neurosciences, children's palliative care, paediatric cardiac services, paediatric dentistry, paediatric ENT, paediatric haematology, and abnormally invasive placenta. The latter will be discussed in more detail at a future meeting, as it involves a provider selection process.

FSJ noted that the Women's and Children's Programme of Care differs from other programmes in that it is not focused on a specific body system. Instead, it is defined by sex and age, which means that prevention opportunities vary significantly across the different services within the programme, depending on the nature and purpose of each individual service.

The slides highlight broader system-level prevention opportunities, including wider determinants like housing and community injuries, as well as modifiable health risks such as smoking, hypertension, and excess weight. While these factors may not directly drive activity within all services, they still significantly affect patient outcomes.

The more targeted prevention opportunities within the Women's and Children's programme of care were described. While not broken down by individual service lines due to overlap, a more detailed analysis is being developed. This will be shared with the newly established health inequalities group and will explore each service line in greater depth.

It was highlighted that prevention opportunities in this programme of care extend beyond the child post-birth. Some conditions managed within the Women's and Children's programme can be influenced by antenatal and prenatal care, such as immunisation uptake during pregnancy which can reduce the risk of congenital disorders like rubella.

Respiratory illness shows high levels of inequality nationally and in the Northwest, with many exacerbations being preventable. Work is ongoing across the asthma pathway to improve prescribing and access to biologics. Obesity is another key area, with a focus on early identification and timely access to care, as childhood risk factors

	often shape lifelong health. Oral health was also highlighted, with the Northwest having some of the poorest outcomes, particularly linked to surgical tooth removal in children which has prompted targeted work from dental teams. In women's services, although the range of care is broad and varied, modifiable health risks significantly influence patient outcomes and add complexity, particularly in services like complex termination of pregnancy. Severe endometriosis is currently a key focus in women's health. While the condition itself may not be preventable, its impact and symptom severity can often be reduced. There's also an emphasis on improving system-wide recognition of women's health and pain, ensuring timely access to appropriate services. AB noted that children's pharmacy is a complex area, as many medications are prescribed off-label due to a lack of formal licensing for paediatric use. As a result, there's significant ongoing work around determining which drugs are appropriate and should be authorised for children. This is supported by the pharmacy team and underpinned by clinical decision support via the Blueteq system, which helps ensure safe and effective prescribing in children's services. Several risks associated with neonatal services were identified, including neonatal critical care for babies that require surgery in the Liverpool system, low activity volumes Impacting outcomes, workforce and sustainability risk at Macclesfield, lack of level 3 adult critical care services on the Crown St Hospital site and a reduction in the delivery of children's surgery at DGH level. There is significant ongoing work in the paediatric surgery recovery space to ensure that this specialty is recovering in line with other specialties across the system. Specialised gynaecology is recovering more slowly than other areas, with concerns around complex procedures, especially severe endometriosis. The slides also provide details of all the additional programmes of work in the women and children's space, including cleft lip and palette, complex termination of pregnancy and severe endometriosis. The slides also include a summary for each service, showing the relevant providers, a brief service description (including incidence or prevalence data), and key considerations around quality, equity, and value. There's also a lot of work happening around shaping new landscapes and neighbourhood models. Given the growing importance of neighbourhoods in delivering children's services, there may be a need to start thinking about how pathways are joined up to ensure alignment and integration at that local level FSJ advised that a health inequalities group has now been established for spec comm, acting as a key point of contact with each ICB via named leads, mostly from public health. This group will support the dissemination of more detailed public health work linked to the identified prevention opportunities. CW commented that work is currently ongoing to provide returns and having discussions with the region, particularly regarding progress on healthy

	neighbourhoods. Spec comm also being asked to submit a return focused on children and young people. It's important to ensure these conversations are aligned and joined up moving forward. Action 48: SM to provide the quality data dashboard that relates to the women's and children's programme presentation.
11	**Acute Specialised Service Priority Focus Areas** The paper outlined a co-produced approach to developing the priority list, involving engagement with ICB colleagues, networks, cancer alliances, and other stakeholders. The priorities have been discussed previously, including with SCOGs, and were presented for final approval. The committee was s asked to agree and support the final priority list, including awareness of the service areas not being prioritised for 2025/26. The paper was approved.
12	**Health Inequalities Update** A paper on the formation of the NW Specialised Commissioning Health Inequalities Group and proposed initial priorities, including using data to establish baseline understanding of demographics and potential inequalities in services was provided for information. A more comprehensive update will be provided at the September meeting.
13	**ICB Blueprint** The ICP blueprint was briefly discussed earlier in the meeting AB noted a workshop is planned for late June between the specialised commissioning team and the three executive leads. The aim is to review the specialised target operating model in light of the ICB blueprint and explore how to better align and integrate the different parts in the new system.
14	**AOB** No additional AOB was raised
15	**Next Meeting:** **4 Sept 2025: 10:00 – 12:00 Teams**