Date	**25th January 2022**
Time	**1.45pm – 3:50pm**
Venue	**MS TEAMS – CLICK HERE**

Meeting of the Joint Committee of the Cheshire and Merseyside CCGs

held in public (virtual meeting)

A G E N D A

Chair: Dr Andrew Wilson

QUORUM ARRANGEMENTS
The meeting will be quorate with at least one representative of each member CCG being present.

Timings	Item No	Item	Owner	Action / Approval Level	Format & Page No
1.45pm	**A**	**PRELIMINARY BUSINESS**			
	A1	Welcome, Introductions, Committee Chair Opening remarks	Chair	-	*Verbal*
	A2	Apologies for absence	Chair	-	*Verbal*
	A3	Declarations of Interest *(Committee members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Committees Register of Interests)*	Chair	*For assurance*	*Verbal*
	A4	Minutes of previous meeting	Chair	*For approval Level 1*	*Paper (Page 3)*
	A5	Committee Action and Decision Logs	Chair	*For information*	*Paper (Page 16)*
	A6	Committee Forward Plan	Chair	*For information*	*Paper (Page 20)*
	A7	Advanced notice of any other business to be raised at today's meeting	Chair	-	*Verbal*
	A8	Public Questions	Chair	-	*Verbal*
2.00pm	**B**	**HEALTH & CARE PARTNERSHIP UPDATE**			
	B1	Update from the Interim Chair of the Cheshire & Merseyside	David Flory	*For information*	*Verbal*

Timings	Item No	Item	Owner	Action / Approval Level	Format & Page No
2.10pm	**C**	**COMMITTEE BUSINESS ITEMS**			
2.10pm	C1	Transfer of haemato-oncology services from LUHFT to Clatterbridge Liverpool	Fiona Taylor	*For approval Level 1*	*Paper (Page 23)*
2.25pm	C2	Liverpool University Hospitals Clinical Services Integration Proposals	Jan Ledward	*For approval Level 1*	*Paper (Page 101)*
2.40pm	C3	Learning from Life and Death Reviews (LeDeR) – Implementation Progress Update	Simon Banks	*For Endorsement Level 1*	*Paper (Page 116)*
2.50pm	C4	Cheshire and Merseyside Core Military Veterans Service – Transfer of Coordinating Commissioner Arrangements from NHS Bury Clinical Commissioning Group to the Cheshire and Merseyside Integrated Care Board - Update	Simon Banks	*For Endorsement Level 1*	*Paper (Page 123)*
3.00pm	C5	2022/23 NHS priorities and operational planning guidance	Anthony Middleton	*For Endorsement Level 1*	*Presentation (Page 127)*
3.10pm	**D**	**SUB-COMMITTEE / GROUP REPORTS**			
3.10pm	D1	Key issues report of the Finance and Resources Sub-Committee	Martin McDowell	*For Information*	*Paper (page136)*
3.15pm	D2	Key issues report of the Quality Sub-Committee	Michelle Creed	*For Information*	*Paper (page155)*
3.20pm	D3	Key issues report of the Performance Sub-Committee	Simon Banks	*For Information*	*Verbal*
3.25pm	D4	Update from the Cheshire and Merseyside CCGs Directors of Commissioning Working Group	David Horsfield	*For Information*	*Paper (Page 167)*
3.30pm	**E**	**CHESHIRE & MERSEYSIDE SYSTEM UPDATE**			
3.35pm	E1	Update from the Executive Director of Transition of the Cheshire & Merseyside HCP	Dianne Johnson	*For assurance*	*Verbal*
3.40pm	E2	C&M System Performance Update	Anthony Middleton	*For Information*	*Verbal*
3.45pm	**AOB**	Discussion on any items raised	All		
3.50pm	**CLOSE OF MEETING**				
DATE AND TIME OF NEXT MEETING		**23 February 2022** 1.45pm – 3.30pm			

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

Draft Minutes

Meeting Name: Joint Committee (Meeting held in Public)

Meeting Date/Time: 30th November 2021 at 1.40 pm **Venue:** Microsoft Teams

Chair: Geoffrey Appleton, NHS St Helen's CCG

Attendance		
Name	**Job Title /Category of Membership**	**Organisation being Represented**
Voting Members		
Geoffrey Appleton	GB Lay Member	NHS St Helen's CCG
Simon Banks	Accountable/Chief Officer Representative	NHS Wirral CCG
Dr Sue Benbow	Secondary Care Doctor	Knowsley CCG
Dr Rob Cauldwell	Clinical Lead	NHS Southport & Formby CCG
Sylvia Cheater	GB Lay Member	NHS Wirral CCG
David Cooper	Chief Finance Officer	NHS Warrington CCG
Michelle Creed	Chief Nurse	NHS Warrington CCG
Dr Andrew Davies	Clinical Chief Officer	NHS Halton CCG
Dr Michael Ejuoneatse	GP Partner	NHS St Helen's CCG
Dr David O'Hagan	GP Director	NHS Liverpool CCG
Jan Ledward	Chief Officer	NHS Liverpool CCG and NHS Knowsley CCG
Jane Lunt	Director of Quality, Outcomes & Improvement / Chief Nurse	NHS Liverpool CCG
Paul Mavers	Healthwatch Representative	Healthwatch
Martin McDowell	Chief Finance Officer	NHS South Sefton CCG
Peter Munday	GB Lay Member	NHS Cheshire CCG
Mark Palethorpe	Accountable Officer	NHS St Helen's CCG
Dr Andrew Pryce	Governing Body Chair	NHS Knowsley CCG
Fiona Taylor	Accountable Officer	NHS Southport and Formby CCG
Clare Watson	Accountable Officer	NHS Cheshire CCG
Non-Voting Members		
Sheena Cumiskey	Cheshire & Merseyside ICS Representative (interim CEO)	Cheshire & Merseyside Health Care Partnership
Dianne Johnson	Director of Transition	Cheshire & Merseyside Health Care Partnership
Margaret Jones	Director of Public Health Representative	ChaMPs

Attendance		
Name	**Job Title /Category of Membership**	**Organisation being Represented**
Sarah O'Brien	C&M HCP Representative	Cheshire & Merseyside Health Care Partnership
In Attendance		
Nesta Hawker	Director of Commissioning and Transformation	NHS Wirral CCG
Dave Horsfield	Director of Transformation, Planning & Performance	NHS Liverpool CCG
Geraldine Murphy-Walkden	Programme Director	NHS Knowsley CCG
Matthew Cunningham	Director of Governance and Corporate Development	NHS Cheshire CCG
Emma Lloyd	Notetaker	NHS Cheshire CCG

Apologies			
Name		**Job Title /Category of Membership**	**Organisation being Represented**
Dr Andrew Wilson	AW	Clinical Chair	NHS Cheshire CCG
Ian Ashworth	IA	Director of Public Health Representative	ChaMPs
David Flory	DF	Cheshire & Merseyside ICS Representative (interim Chair)	C&M Health Care Partnership
Dr Ifeoma Onyia	IO	Director of Public Health Representative	ChaMPs
David Parr	DP	LA Chief Executive Officer Representative	Halton Borough Council

Agenda Ref:	Discussion, Actions and Outcomes	Action By
A	**Preliminary Business**	
A1	**Welcome, Introductions and Declarations of Interest:** Geoffrey Appleton welcomed everyone, including any members of the public, to the meeting of the Cheshire and Merseyside CCGs Joint Committee held in public. The Chair wished to express thanks to Sheena Cumiskey, interim Chief Officer of Cheshire & Merseyside Health and Care Partnership, as this will be her final meeting and Graham Urwin commences in the role from 1st December 2021.	
A2	**Apologies for Absence:** Apologies received are noted above along with the nominated deputies where appropriate.	
A3	**Declarations of Interests:** There were no declarations raised specific to this meeting, other than those contained in the annual register of interests.	

A4	**Minutes of the Previous Meeting:** A copy of the draft minutes from the meeting held on 26th October 2021 were circulated prior to the meeting and comments were invited. No comments were raised, and the minutes were therefore approved. **Outcome:** The minutes of the meeting held on 26th October 2021 were approved.	
A5	**Action and Decision Log:** The action and decision log were noted, and it was highlighted that there were no actions for consideration at this meeting. **Outcome:** The Cheshire and Merseyside CCGs' Joint Committee noted the action and decision logs.	
A6	**Committee Forward Planner:** The forward planner was noted by the committee.	
A7	**Advanced Notice of Any Other Business:** No AOBs were raised.	
A8	**Public Questions:** No public questions were submitted for consideration at this meeting.	
B	**Cheshire & Merseyside Health and Care Partnership Updates**	
B1	**Update from the Interim Chief Officer:** Sheena Cumiskey informed the committee that things are starting to move at pace, subject to legislative changes, as 1st April 2022 approaches. There is a lot going on and many people across all nine Clinical Commissioning Groups (CCGs) are involved in the safe closedown of the CCGs and the stand-up of the Integrated Care System. Sheena shared that it is vital that work continues to take place as close to the population as possible, to reach the objectives of improving outcomes and reducing inequalities. The current work is around ensuring that the scaffolding is in place to enable this to happen. The development of Place-based working is moving forward and a framework for each Place to assess themselves against has been established. This will be used to aid further conversations with each Place in the New Year to understand where further development is needed and how that is taken forward. The framework and logistics of how Place based leaders will be taken forward is being prepared and this will be followed up in the New Year.	

Sheena confirmed that part of the new way of working is around provider collaboratives, with the two main foci being on acute and specialist providers, and community mental health and learning disability.
The main purpose is to work together to improve quality of care and to reduce inequalities in care to the population. Just as important, is the work done at Place with provider collaboratives and integrated care, where the collaboration is not just with NHS providers but also other care providers and those within the voluntary sector. Sheena confirmed that good process is being made.

The consultation for the very senior roles started last Thursday and this is progressing. Sheena shared that it was important to recognise that this is a huge change management process that it is difficult for many people; it is therefore important to focus on wellbeing and to ensure that support is given to people going through this process. Regular staff briefing sessions have been established and recruitment for non-executive roles and other roles will commence in December. Recruitment for the substantive Chair position will be completed early in the new year.
There is a new Chief Officer in Graham Urwin and he starts his role on 1st December 2021.

The final work on the Integrated Care Board Constitution is being completed following the consultation and engagement process. This will go for submission to the region during week commencing 6th December.

Sheena confirmed that she will be handing over to Graham Urwin tomorrow and stepping back to her substantive role as Chief Executive Officer for Cheshire and Wirral Partnership. Sheena expressed thanks to everyone at the meeting today, and their teams, for their support whilst she has been carrying out the interim role. Sheena shared that she had found the role challenging, satisfying and enjoyable, and has found it a privilege to serve the people of Cheshire and Merseyside, and knows that under Graham's leadership it will go from strength to strength.

Questions were invited:-

- David O'Hagan thanked Sheena for her support in the interim role. David noted that primary care was not mentioned when talking about provider collaboratives and asked where they will fit in this.
    - Sheena confirmed that primary care is at the heart of everything as we move forward, we need to go where people live their lives and primary care do this every day. Primary care will be closely involved in integration and connected care at a Place based level, and the Integrated Care System want to see the Primary Care Forum continue. The engagement that goes through this forum is included in this. Work on developing a clinical leadership model is underway and primary care will be an integral part of this. In terms of the constitution, there will be two members from a primary care background. This is not about just having representatives; it is about members who bring knowledge and expertise to enable the Integrated Care Board to take the best decisions.

B2	**Update from the Director of Transition:** Dianne Johnson shared an update via a presentation [*link to presentation here*]. The Chair noted that the process is very important, but it was also important to note why these changes are happening and this is outlined in the presentation which is about improving outcomes and reducing inequalities. The two key questions should be asked – what is being done every day that exacerbates inequalities, or what is being done to reduce them, and how do you know. This is the bedrock of why this change is happening. No questions raised.	
C	**Committee Business Items**	
C1	**Delegation of Authority to the Cheshire & Merseyside CCGs Joint Committee:** Fiona Taylor shared that this item and C2 are interlinked and describe the same things in some parts, but each will be treated separately at this meeting. Fiona highlighted that this paper is around ensuring that CCGs work collaboratively and effectively towards a position to successfully complete the closedown of the CCGs and one way to do this is streamlining the governance arrangements. Fiona highlighted that, throughout November, this paper has been through the governing body for each CCG to consider the Terms of Reference for the joint committee and consider how the joint committee would be able to enact its functions. Three sub-committees of the Joint Committee are also proposed to cover Quality, Performance and Finance. Fiona informed the committee that these governing body conversations led to feedback, and this is contained within the paper presented at this meeting. Fiona highlighted page 40 (item 5.3) and page 41 (item 6) as examples of where updates have been incorporated following feedback from governing bodies. Fiona also highlighted page 42 and the reiteration of the inclusion of Healthwatch on the Joint Committee to acknowledge and reinforce its role as an independent voice. Fiona informed the committee that several governing bodies raised comments around further assurance being needed along with the involvement and support of Mersey Internal Audit Agency. This is included in the paper and in the recommendations for consideration. Another request for the Chair of the Joint Committee to agree and oversee the process for the appointment of members of each sub-committee. Committee workplans have been updated and continue to be fine-tuned.	

	Communication was raised by governing body and the paper now includes a direct link from the Joint Committee to governing bodies, and there is a process in place to ensure that the transition piece and Accountable Officers are interconnected. CCG governance leads are meeting weekly and are finalising the sub-committee arrangements. The group have focussed on a process that ensures governing bodies understand the work of the joint committee and its sub-committees and ensuring that they receive feedback and have access to the relevant. Fiona confirmed that this will be done through receipt of papers along with a summary from meetings and will be reported through governing body meetings. The committee is asked to note that all governing bodies have agreed to greater delegated authority to the Joint Committee, are asked to note the updated Terms of Reference, note the process to establish sub-committees, note the process for communication to governing bodies and endorse the proposal for CCG Audit Chairs to approve the Terms of Reference and scope for the review of these which will be done in conjunction with Mersey Internal Audit Agency by the end of January. The Chair thanked Fiona for the work and leadership on this item and invited any questions and comments:- • Dr Andrew Davies also thanked Fiona for the work on this paper and highlighted that, whilst the technical detail is included in this, it is important that governing bodies work with a mutual confidence, trust, and respect, with the ability to trust each other to make good decisions but to challenge issues as well. This will give the public the confidence that we are doing the job well. **Outcome:** The Cheshire & Merseyside Joint Committee noted that all Cheshire and Merseyside CCGs have agreed to delegate greater authority to the Joint Committee **Outcome:** The Cheshire & Merseyside Joint Committee noted the updated Joint Committee Terms of Reference (Appendix B) **Outcome:** The Cheshire & Merseyside Joint Committee endorsed the request for CCG Audit Chairs to consider and approve the Terms of Reference and scope of the review to be undertaken by MIAA at the end of January 2022 **Outcome:** The Cheshire & Merseyside Joint Committee noted the work underway to progress the establishment of the sub-committees. **Outcome:** The Cheshire & Merseyside Joint Committee noted the process to be followed to enable Governing Body members to be informed of the work of the Joint Committee and its sub-committees.	

C2	**Cheshire & Merseyside CCGs Joint Committee Sub-Committee Terms of Reference:** Fiona Taylor extended thanks to Matthew Cunningham who has worked alongside her for items C1 and C2 of this agenda. Fiona reminded the committee that there is some repetition within this paper but highlighted that it was important to ensure the papers represent the information required for governance purposes. The Joint Committee are being asked to approve the Terms of Reference for the Sub-Committees and note the update on the membership. Members of the Joint Committee will be aware that it was necessary to be able to exercise their oversight of relevant functions of the sub-committees, and the Terms of Reference can be seen from page 104 to 132 of the meeting papers. Fiona informed the committee that initial meeting dates have been set as this was needed to get going with the set-up of the sub-committees given the timescales. The committee were also informed that governance leads have been identified to support the committees from a subject expertise point of view. The appendices include the terms of references which incorporates cross validation from MIAA. Although there is some more fine tuning to do in terms of triangulation, if the committee agrees to the terms of reference, then Chairs will be put into place. Fiona confirmed that the governance team are working on finalising the membership of the sub-committees, including the Chairs and Vice Chairs. Matthew Cunningham confirmed that he would be emailing out to potential committee members today to confirm the agreed committee membership and the governance leads are in the process of putting together draft agendas ready to link in with the chairs and vice chairs ready for the first meetings. Matthew highlighted that whilst recognising there is only a few months of operation, there is scope to amend the terms of reference for these sub-committees, and now the Joint Committee has been given the authority to approve, it will be an easier approval process. Fiona highlighted that, as the papers have been seen several times through governing body meetings and have been fine-tuned accordingly, it was not proposed to go into further detail. The Chair expressed thanks to Fiona and Matthew, and invited questions and comments from the committee:- • Dr Andrew Davies noted the proposed quoracy and shared his view that this needs to be reviewed given that the decision-making capacity of the sub-committees. Dr Davies felt that this does not stop the committee proceeding but felt that it may be difficult to secure 75% quoracy.	

	In addition, Dr Davies asked whether there were options to delegate matters from this committee to expediate decisions that are needed quickly. o Geoffrey Appleton agreed that 75% quoracy will be a challenge and Chairs discretion may be needed, i.e. to ensure that the people around the table can make the decisions needed. o Fiona Taylor confirmed that the paper in C1 outlines the authority of the Chair of the Joint Committee and felt that it would be beneficial to have meetings of the Chairs to have a conversation around quoracy. **Action: Fiona Taylor will organise for Chairs of Committees to review sub-committee quoracy.** • David O'Hagan expressed thanks for the work done and particularly for the updates and amendments throughout the process. David noted that the MIAA report highlighted that, whilst a lot of duties had been mapped across, some duties were outstanding and most of these have now been moved into better positions within the terms of reference. However, David suggested that consideration is given to how the work of these committee can be triangulated to ensure they don't work in silos. David therefore welcomed the suggestion for a Chair's meeting and felt that these meetings were important. o Fiona Taylor confirmed that the Joint Committee will receive the formal business of the sub-committees, but some work could be done around assurance work as well as the MIAA assurance as this will ease peoples' concerns as we progress. Geoffrey Appleton expressed thanks to Dr Andrew Wilson for his work on committee membership and highlighted that it has been a challenge to balance the clinical and lay membership within the committees as well as identifying chairs and vice chairs. **Outcome:** The Joint Committee approved the Terms of Reference for the sub-committees of the Joint Committee. **Outcome:** The Joint Committee noted the update with regards to the membership of Sub-Committees subject to the further updates. **Outcome:** The Joint Committee requested that the quoracy for sub-committees is reviewed by governance leads and sub-committee chairs.	Fiona Taylor
C3	**Cheshire & Merseyside CCGs Tier 4 Bariatric Surgery Procurement Options Paper:** Nesta Hawker joined the meeting for this agenda item and highlighted that the brief report provided includes an options paper as requested at the previous Joint Committee meeting. Nesta informed the committee that South Cumbria and Lancashire ICS, which includes the lead CCG for this procurement, have opted for 2.	

	Due to the timings of meetings, the paper will be going to the Directors of Commissioning Group next week, however, Nesta confirmed that of the responses from CCG commissioning leads to date, most have replied to suggest that they would accept option 2. Nesta highlighted that, for Merseyside CCGs, this should decrease the value of bariatric surgery as they are currently paying a premium for the short-term interim contracts currently in situ. Nesta also informed the committee that, in terms of the cost of procurement, should Cheshire decide to join, this would be the same cost as it follows the national tariff. Nesta highlighted Option 2 within the paper and confirmed that Cheshire could be included as an associate and then opt in if they decided. Questions and comments were invited:- • Clare Watson confirmed that Cheshire are happy to support option 2 and, although they need to look at the quality of the service both in stoke and the proposed one, they were happy to be an associate at the moment. • Dr Andrew Davies shared that Warrington would prefer option 2 or 3 but highlighted that they are seeing a rapid turnover in pathway 2 and therefore the position is not in a stable state going into Tier 4 procurement and may impact on the need going forward. • Peter Munday highlighted that the committee needs to have an understanding around the scale in terms of finance and patient numbers involved and asked for this to be included as background information on any future reporting. • Clare Watson noted that previously Wirral has worked with Cheshire, and it would be helpful to understand their reasons for moving from that arrangement. Nesta and Clare will liaise outside the meeting. • Simon Banks confirmed that Wirral would support option 2 but would see it as an interim measure. Simon felt that the ICB may wish to look at connecting Tier 1, 2, 3 and 4 across the area in the future and, given that we are looking at preventative work and aiming to reduce inequalities, work may be undertaken with local authorities and partner organisations to prevent people getting to Tier 4 and ensure that, when they do, they are safely returned into the weight management system. **Outcome:** The Joint Committee reviewed the options within the table and agreed on Option 2 as their preferred option.	
C4	**Expansion of Cheshire & Merseyside Virtual Wards:** Geraldine Murphy-Walkden joined the meeting for this item and highlighted that there are two parts to this paper.	

	Geraldine informed the committee that the paper articulates a position and pilots the commissioning of an 'at scale' covid virtual ward offer to give enhanced support to facilitate early discharge. The other element to the paper is a virtual respiratory ward that has been tested to bring patients out of hospital early with enhanced package of care. Geraldine informed the committee that data suggests that there is a significant amount of bed days saved and significant benefit from this type of service. The ask of the committee is to continue to commission the virtual covid ward for use across Cheshire and Merseyside whilst also working to expand the current respiratory offer building on local services that exist in each Place, to accelerate early discharge for those patients that are suitable with support at home. Geraldine informed the committee that she has just taken part in a national discussion which confirmed that virtual ward expansion is expected to be part of the national guidance. The recommendation in this paper would enable Cheshire and Merseyside to be aligned with the expected direction of travel. Questions and comments were invited:- • Dr Andrew Pryce noted Section 9 about escalation which refers patients to 111 and asked what instructions have been given to 111 around this and how they would deal with this. o Geraldine confirmed that this is articulated in the SOP and highlighted that those patients will be part of a virtual ward offer. Therefore, 111 is a gateway but they aren't a 24-hour service, and the normal pathways would be followed. 111 is being used as part of the wrap around service as a central point of contact should a patient deteriorate. o Dr Pryce felt that this is fine as long as 111 are aware and know what to do. • Michelle Creed shared that she feels the covid virtual ward at scale is a good idea and asked whether this work will include current data to look at what is working well and spread this at pace. o Geraldine confirmed that the current provision for respiratory services does vary by Place and work is needed to understand what is in existence already and what can be done to enhance this. There is no expected change to the provision that is currently in place and working well, it is about an enhanced wrap around for people leaving hospital. o Geraldine also confirmed that the clinical pathways developed for respiratory step down have been developed in conjunction with respiratory leads across Cheshire and Merseyside. Therefore, whilst Liverpool Heart and Chest Hospital were commissioned to work on this, they have worked with other providers to get a common view on what these pathways should be. • David O'Hagan thanked Geraldine for the paper and the additional explanation of these two different respiratory are being proposed and how they fit in with current arrangements in Place.	

David highlighted the importance of enabling Places to develop services with local providers so that they fit better with Primary Care Networks and primary care provision.

- Dr Sue Benbow thanked Geraldine for the explanations at the meeting and highlighted that the paper is two very separate areas and felt it is much easier to deal with separately. The Covid virtual ward does have a national SOP and has already been extrapolated across Cheshire and Merseyside, whereas the respiratory aspect is really a pilot in a specific area. Dr Benbow suggested that, therefore, two possible decisions could be made regarding this paper. Dr Benbow also raised the following two questions 1) Does the paper include people that are being stepped down from hospital to care homes, and 2) Is there any outcome data for the respiratory pilot in St Helen's and Knowsley as the data presented is primarily for the covid ward step down and highlighted that it is important that clinical outcomes are looked at. Dr Benbow also raised workforce issues which are of national concern and suggested that some smaller providers may struggle with on-call provision and would hope that all providers have been involved in discussion and not just the larger acute providers.
    - Geraldine agreed that workforce is a challenge, especially for smaller trusts. Geraldine shared that during discussions with providers, it was agreed that there is flex for one provider to cover another trust and this may be needed to ensure that there is equitable provision across the area. The model will be flexed to ensure there is system cover.
    - In terms of outcomes, the data is mainly around covid as this is deeper and more available. Ongoing monitoring of outcomes from respiratory virtual ward will take place and an independent evaluation is likely to be commissioned to ensure that patients are aware of how to re-access provision if they deteriorate.

- Simon Banks confirmed that he supported the recommendations in the paper as this learns from experience and provides a standardised approach with a localised response. Simon noted table 1 in the report which outlines the various components to be provided in a collaborative way and felt that this is where local implementation is important.

- Dr Andrew Davies confirmed that he also supported the recommendations. Dr Davies noted that some work is around community nursing support and suggested that there is data from a previous pilot which could be used for this. Dr Davies agreed that there are some structures already in place and need to ensure that when endorsing this we recognise that some flex is needed to reflect local Places and workforce pressures

Outcome: The Joint Committee agreed to the continuation of the Cheshire and Merseyside Covid virtual ward and the commissioning of this service for a further six months

	Outcome: The Joint Committee agreed to the continued discussion and negotiation with providers to mobilise respiratory virtual wards across all sites with provider configuration for all three elements of respiratory virtual wards of 1. clinical in reach, 2. consultant oversight and 3.telehealth support	
C5	**Update from the Cheshire & Merseyside CCGs Directors of Commissioning:** David Horsfield joined the meeting for this item and outlined the report provided in the meeting papers, highlighting the following points from the Directors of Commissioning (DoC):- • The addition of some items discussed at the previous Joint Committee meeting around specialised commissioning transition, operational delivery networks, asylum seekers and refugee population health, health and equalities, and specialised weight management which will be added to the workplan. This ensures the group aligns to the joint committee functions and its workplans. • The group has made some amends to the work plan and aligned this more closely to the Joint Committee's plan to ensure things are not missed off. • DoC have followed up commitment to the greener NHS and this has been received. • More information on System P will follow. The DoC are linking in with System P group on this. • Work on aligning policies has been delayed and this is due to come back to the Joint Committee in January. They have followed up with each CCG to get their financial position on IVF and sub-fertility and this information has been secured and has been fed back to the team Cheshire. Other policies likely to be of high risk as we move into an Integrated Care System are being identified and the method at Cheshire looks to be the best process to do this. The group will identify all other areas that need to be addressed due to significant differences between Places. The proposal is to continue this work and use the dashboard prepared by Cheshire to review the policies. The group is also ensuring that the work on IVF and sub-fertility is progressed at pace. • Business intelligence activity is being reviewed to ensure that work is done once across the patch without duplication. • Alcohol works in the Wirral is being supported by the DOC group, and more info will follow on this issue. • The Pan-Mersey headache pathway has been referred to DOC and there were some concerns around whether the pathways are being followed across the patch. This is being followed up with all LMCs. • The next DOC meeting is focussing on monoclonal anti body works and how this work can be supported, investment in mental health services 2022/23, clinical policies, specialised commissioning services and aligning work, Tier 4 obesity procurement and how this will be taken forward, commissioning of the veteran rehab services, and specialist rehab.	

	Geoffrey Appleton thanked Dave for the update and felt it was reassuring to hear about hat the group is working collaboratively on. Comments and questions were invited:- • Jan Ledward shared that, with regard to the Bariatrics work, consistencies at Tier 2 and 3 services are critical to getting onto Tier 4 and suggested that there may need to be a review of who is on the waiting list, identify where there are inequalities to address these, and review commissioning for next year as a result. o Dave Horsfield confirmed that he would add this to the agenda for the DOC meeting. • Dr Andrew Davies referred to the IVF and Sub-fertility project and shared his understanding that the Joint Committee had agreed to scope and assess the timelines and financial implements with a view to deciding on whether to proceed and asked whether this was still the plan. o Dave Horsfield confirmed that the financial information was key as this will be important in deciding what is affordable. This information has gone back to the team at Cheshire to look at differentials. The request is that the DOC group keep this on their agenda to provide support to the team at Cheshire, and then when this is scoped it will be brought back to the Joint Committee. **Outcome:** The Joint Committee noted the contents of the report from the Directors of Commissioning. **Outcome:** The Joint Committee agreed to prioritise IVF/Subfertility clinical policy alignment and the process to identify high risk policies for review at Cheshire and Merseyside. **Outcome:** The Joint Committee agreed to the addition of the identified items to the Directors of Commissioning Group's work plan.	
D	**Any other Business**	
	N/A	

End of CMJC Meeting (Held in Public)

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

Action Log 2021-22 (Public)

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
5	**30-Nov-2021**	**Cheshire & Merseyside CCGs Joint Committee Sub-Committee Terms of Reference**	Recommended quoracy of 75% to be reviewed ih conjuction with governance leads and sub-committee chairs, and revised as felt appropriate.	Fiona Taylor	**21-Dec-2021**		NEW

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

Decision Log 2021-2022 (Public)

Decision Ref No.	Meeting Date	Topic	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	Decision Level	If Recommendation - destination for onward submission?	If a recommendation - date of subsequent consideration at approval body
1	20-Jul-2021	**Terms of Reference**	N/A	The CMJC ratified the Terms of Reference subject to minor amendments, to include an initial 3-month review and reference to virtual decision making.	1	*CCGs to take amended TOR to respective Governing body meetings for approval*	*Next meetings of each CCGs Governing Body*
2	20-Jul-2021	**Dates of Future Meetings**	N/A	The CMJC accepted the proposed meeting dates for 2021/22	1	*N/A*	*N/A*
3	20-Jul-2021	**IAPT – Common Standards for Cheshire and Merseyside**	N/A	The CMJC supported the work across Cheshire & Merseyside with regard to IAPT and noted the importance of this work. The committee also noted that the final model has yet to be finalised and that reaching the access standard is a long term plan. The committee noted that funding for the IAPT programme will be required but this will be an issue for the ICS to consider.	N/A	*NA*	*Next meetings of each CCGs Governing Body*
4	20-Jul-2021	**Update from the Directors of Commissioning Meeting**	N/A	The CMJC confirmed their support around the potential for a Cheshire & Merseyside DOC to become an operational group to the CMJC and will review recommendations, including a review of membership, prepared by this group.	N/A	*N/A*	*N/A*
5	31-Aug-2021	**Declarations of Interest**	Dr A Davies - wife is employed at a private hospital (item B4) Jan Ledward - is also the SRO for Stroke Mersey (item B2) Dr A Pryce - wife is employed by Marie Curie (item B1)	The committee considered the declarations, noting that they are included on the annual declaration, and agreed:- Jan Ledward - noted and no action/mitigation required. Dr A Davies and Dr A Pryce - it was ascertained that neither spouses worked in a decision-making capacity and therefore these declarations were sufficiently mitigated.	1	*N/A*	*N/A*
6	31-Aug-2021	**Public Questions**	N/A	2 Questions, both from Mr Chris Ingram, were put to the committee. A short verbal response/acknowledgement was provided at the meeting and it was agreed that a full written response will be sent after the meting.	N/A	*N/A*	*N/A*
7	31-Aug-2021	**Hospice Sustainability across Cheshire and Merseyside**	Dr A Pryce - see above for details	The report on Hospice Sustainability was discussed and noted by the committee, and individual CCGs were asked to take the report back to their GB's for the approval of the project plan with the support of the CMJC.	N/A	*Project Plan to be taken to individual CCGs for approval*	*Next meetings of each CCGs Governing Body*
8	31-Aug-2021	**Adoption of National Stroke Service Model Specification**	Jan Ledward - see above for details	The Cheshire & Merseyside Joint Committee considered and discussed the full report provided to them and approved the recommendation to adopt the National Stroke Service Model Specification	1	*N/A*	*N/A*
9	31-Aug-2021	**Cheshire & Merseyside ICS – Independent Sector Provision for Q.3 2021/22 onwards**	Dr A Davies - see above for details	The Cheshire & Merseyside Joint Committee noted the report and recommendations linked to the Independent Sector Provision for Q.3 2021/22 onwards.	N/A	*N/A*	*N/A*
10	31-Aug-2021	**Update from the Directors of Commissioning meeting**	N/A	The Cheshire & Merseyside Joint Committee noted the update from the Directors of Commissioning meeting.	N/A	*N/A*	*N/A*
11	28-Sep-2021	**Aligning Commissioning Policies across Cheshire and Merseyside:**	N/A	The Cheshire and Merseyside Joint Committee approved the recommendation from the Cheshire and Merseyside Directors of Commissioning (DoC's) that the Sub-fertility/Assisted Conception policies should be aligned across C&M and that a joint Consultation on this proposed alignment should be undertaken. The Cheshire and Merseyside Joint Committee agreed that the Directors of Commissioning will work on an implementation plan to include financial risk and the timeline for communications and engagement work and bring this back to the next meeting of the CMJC for further consideration.			
12	28-Sep-2021	**Cheshire and Merseyside Section 140 Protocol**	N/A	The Accountable Officers, or deputies present at the meeting approved the adoption of the Cheshire and Merseyside Section 140 Protocol	2	*N/A*	
13	28-Sep-2021	**Update from the Directors of Commissioning meeting**	N/A	The Cheshire & Merseyside Joint Committee noted the update from the Directors of Commissioning meeting.	N/A	*N/A*	*N/A*

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

Decision Log 2021-2022 (Public)

Decision Ref No.	Meeting Date	Topic	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	Decision Level	If Recommendation - destination for onward submission?	If a recommendation - date of subsequent consideration at approval body
14	26-Oct-2021	**Declarations of Interest**	•Iain Stoddard is seconded to Cheshire and Merseyside ICS for three days per week. •Leigh Thompson's husband is employed by Wirral Community Trust. •Jan Ledward has been employed as interim Chief Officer for NHS Knowsley CCG since 1st October 2021, in addition to her substantive role as Chief Officer for Liverpool CCG. •Sheena Cumiskey informed the Chair that she is seconded to the role of interim CEO for Cheshire and Merseyside Health and Care Partnership, however, her substantive role is as Chief Officer for Cheshire and Wirral Partnership.	All declarations were noted and it was agreed that these declarations did not affect discussions at the meeting. It was further agreed that the Register of Interests would be updated to include all new committee members.	1	*N/A*	*N/A*
15	26-Oct-2021	**Committee Forward Plan**	N/A	The draft plan was noted with one minor amendment.	N/A	*N/A*	*N/A*
16	26-Oct-2021	**Cheshire and Merseyside CCGs Joint Committee – Commissioning Sub-committee Draft Terms of Reference**	N/A	The Cheshire and Merseyside Joint Committee did not approve the recommendations as outlined in the papers presented and instead requested that the paper is revised (so i) they reflect that it is a working group rather than a sub-committee, ii) it is strengthened in areas such as climate change and reducing health inequalities, and iii) additional members such as local authority or provider representatives will be involved). The revisded TOR will be brought back for approval at the November meeting	N/A	*N/A*	*N/A*
17	26-Oct-2021	**Cheshire and Merseyside Core Military Veterans Service**	N/A	The content of the paper was noted and there was general support for the next steps. An updated paper, including financial information and future contracting recommendations will be brought to the next meeting for approval or recommendation to Governing Bodies, in line with the Joint Committee's delegated power at that point.	N/A	*N/A*	*N/A*
18	26-Oct-2021	**Cheshire and Merseyside Specialist Weight Management Services**	N/A	The content of the paper was noted. The Joint Committee requested that a revised paper is submitted after a review by the commissioning leads	N/A	*N/A*	*N/A*
19	26-Oct-2021	**Update from the Cheshire and Merseyside CCGs Directors of Commissioning Meeting**	N/A	The content of the paper was noted. The Joint Committee requested that the Directors of Commissioning reconsider the paper on specialist rehab at their next meeting	N/A	*N/A*	*N/A*
20	26-Oct-2021	**Cheshire and Merseyside System Updates**	N/A	The committee noted the following updates: 1) the Cheshire & Merseyside Mont 6 System Finance Update. 2) the Cheshire and Merseyside System Performance Update.			
21	30-Nov-2021	**Delegation of Authority to the Cheshire & Merseyside CCGs Joint Committee**	N/A	The Cheshire & Merseyside Joint Committee:- i) noted that all Cheshire and Merseyside CCGs have agreed to delegate greater authority to the Joint Committee; ii) noted the updated Joint Committee Terms of Reference; iii) endorsed the request for CCG Audit Chairs to consider and approve the Terms of Reference and scope of the review to be undertaken by MIAA at the end of January 2022; iv) noted the work underway to progress the establishment of the sub-committees; v) noted the process to be followed to enable Governing Body members to be informed of the work of the Joint Committee and its sub-committees.	1	*N/A*	*N/A*
22	30-Nov-2021	**Cheshire & Merseyside CCGs Joint Committee Sub-Committee Terms of Reference**	N/A	The Cheshire & Merseyside Joint Committee:- i) approved the Terms of Reference for the sub-committees of the Joint Committee; ii) noted the update with regards to the membership of Sub-Committees subject to the further updates; iii) requested that the quoracy for sub-committees is reviewed by governance leads and sub-committee chairs.	1	*N/A*	*N/A*
23	30-Nov-2021	**Cheshire & Merseyside CCGs Tier 4 Bariatric Surgery Procurement Options Paper**	N/A	The Joint Committee reviewed the options within the table and agreed on Option 2 as their preferred option. Option 2 (Preferred): Continue with the plan to commence the procurement this year (with a few weeks delay) with the intention for new tier 4 contracts to be in place covering Lancashire, Merseyside, Cumbria, and Wirral by June/July 2022. In addition, Cheshire CCG would be named in the procurement documents as an additional associate commissioner who could be added to the contract at a date to be confirmed.	1	*N/A*	*N/A*
24	30-Nov-2021	**Expansion of Cheshire & Merseyside Virtual Wards**	N/A	The Joint Committee agreed to the continuation of the Cheshire and Merseyside Covid virtual ward and the commissioning of this service for a further six months.	1	*N/A*	*N/A*
25	30-Nov-2021	**Expansion of Cheshire & Merseyside Virtual Wards**	N/A	The Joint Committee agreed to the continued discussion and negotiation with providers to mobilise respiratory virtual wards across all sites with provider configuration for all three elements of respiratory virtual wards of 1. clinical in reach, 2. consultant oversight and 3.telehealth support	1	*N/A*	*N/A*

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

Decision Log 2021-2022 (Public)

Decision Ref No.	Meeting Date	Topic	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	Decision Level	If Recommendation - destination for onward submission?	If a recommendation - date of subsequent consideration at approval body
26	30-Nov-2021	**Update from the Cheshire & Merseyside CCGs Directors of Commissioning**	N/A	The Joint Committee:- i) agreed to prioritise IVF/Subfertility clinical policy alignment and the process to identify high risk policies for review at Cheshire and Merseyside; ii) agreed to the addition of the identified items to the Directors of Commissioning Group's work plan.	1	*N/A*	*N/A*

Last updated: 18.01.22

Cheshire & Merseyside CCGs Joint Committee

Work Plan / Forward Planner 2022

Item	Frequency	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
Standing items							
Apologies	Every meeting	☑	☑	☑	☑	☑	☑
Declarations of Interest	Every meeting	☑	☑	☑	☑	☑	☑
Minutes of last meeting	Every meeting	☑	☑	☑	☑	☑	☑
Action Schedule/log	Every meeting	☑	☑	☑	☑	☑	☑
Forward Planner	Every meeting	☑	☑	☑	☑	☑	☑
Committee Risk Register	Every meeting	☑	☑	☑	☑	☑	☑
Key Issues Reports and Minutes of sub-groups/reporting committees	Every meeting	☑	☑	☑	☑	☑	☑
Cheshire and Merseyside Health and Care Partnership Update	Every meeting	☑	☑	☑	☑	☑	☑
Governance & Performance							
Review of Committee Terms of Reference	As required	☑					
Review of Sub-Committee Terms of Reference	As required						
Papers							
Mental Health 2021/22 National Funding Deployment	As required						
Aligning Commissioning Policies across Cheshire and Merseyside	As required		☑				
Cheshire and Merseyside Core Military Veterans Service	As required	☑					
Approval of Sub-Committee Terms of Reference	As required	☑					
Enhanced Supportive Care Bid (palliative care)	As required		☑				
Transfer of haemato-oncology services from LUHFT to Clatterbridge Liverpool	As required	☑					
Liverpool University Hospitals Clinical Services Integration Proposals	As required	☑				☑	
Learning from Life and Death Reviews (LeDeR) – Implementation Progress Update	As required	☑					
Cheshire and Merseyside Core Military Veterans Service	As required	☑					
2022/23 NHS priorities and operational planning guidance	As required	☑					
Enhanced supportive care bid (palliative care) Knowsley & St Helens	As required	☑					
Recurrent Papers / Updates							
C&M Health & Care Partnership Update	As required	☑	☑	☑	☑	☑	☑

Item	Frequency	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
C&M Directors of Commissioning Meeting Update	As required	☑	☑	☑	☑	☑	☑
Other							
Key national or local reports	As published						
Future areas for consideration							
C&M Plans against National Planning Guidance for 2022/23	tbc						
Implementation of national stroke service specification	tbc						
Winter Planning	tbc						

Calendar of C&M Joint Committee Meetings 2021/22 (inc through to June 2022)

Date			
2021		2022	
20 July	2:15pm – 3:15pm	**25 Jan**	1pm - 3pm
25 Aug *	1pm - 3pm	**23 Feb***	1pm - 3pm
28 Sept	1pm - 3pm	**29 March**	1pm - 3pm
26 Oct	1pm - 3pm	**26 April**	1pm – 3pm
23 Nov	1pm - 3pm	**24 May**	1pm – 3pm
21 Dec	1pm - 3pm	**28 June**	1pm – 3pm

* Note that this is not a Tuesday

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

25 January 2022

Agenda Item C1

Report Title	**Transfer of haemato-oncology services from Liverpool University Hospitals Foundation Trust to Clatterbridge Cancer Centre, Liverpool**
Report Author	Carole Hill, Director of Strategy, Communications and Integration, NHS Liverpool CCG
Committee Sponsor	Fiona Taylor, Accountable Officer, NHS South Sefton CCG and NHS Southport and Formby CCG

Purpose	**Approve**	✓	**Ratify**		**Decide**		**Endorse**		**For information**	

Decision / Authority Level	**Level One**	✓	**Level Two**		**Level Three**	

Executive Summary

Clatterbridge Cancer Centre (CCC), Liverpool University Hospital (LUHFT) and North Mersey commissioners have worked together on a proposal to create a single blood cancer (haemato oncology) service.

Treatment for blood cancers, diagnosis is becoming increasingly complex. Unlike solid tumour cancers, most treatment has historically been delivered by local hospitals rather than the tertiary cancer centre (CCC). It is now widely recognised, however, that the increasing complexity of blood cancers mean they are now best managed by subspecialist multidisciplinary teams.

As early as 2015, the Healthy Liverpool Blueprint proposed that blood cancer services should be unified across the city following overwhelming clinical consensus that the current split was unsustainable.

In 2017, the Royal Liverpool Hospital (RLBUHT) blood cancer service transferred to Clatterbridge Cancer Centre (CCC). In 2019, RLBUHT and Aintree Hospitals (AUHFT) merged to become one organisation - LUHFT. Blood cancer services are currently provided by:

- Clatterbridge Cancer Centre – Liverpool, part of The Clatterbridge Cancer Centre NHS Foundation Trust (CCC).
- Aintree University Hospital, part of Liverpool University Hospitals NHS Foundation Trust (LUHFT); and
- Southport & Ormskirk Hospital NHS Trust (S&O).

This proposal would see the creation of a single service across Aintree University Hospital (AUH) and Clatterbridge Cancer Centre – Liverpool (CCC-L), by bringing the teams together to work as one under the management of CCC.

Recommendations

The Joint Committee is asked to:

- **Note** the Business Case for the transfer of the Aintree University Hospital site Haemato-oncology Service from Liverpool University Hospitals NHS Foundation Trust to The Clatterbridge Cancer Centre NHS Foundation Trust
- **Note** the service change process undertaken to inform this proposed decision
- **Approve** this proposal to enable the transfer of haemato-oncology services to be mobilised.

Consideration for publication

Meetings of the Joint Committee will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply:

The item involves sensitive HR issues	N
The item contains commercially confidential issues	N
Some other criteria. Please outline below:	N

Committee principles supported by this report *(if applicable)*

The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services	✓
Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside	✓
Working together will achieve greater effectiveness in improving health and care outcomes	✓

Cheshire & Merseyside HCP Strategic objectives report supports:

Improve population health and healthcare	✓
Tackling health inequalities, improving outcomes and access to services	✓
Enhancing quality, productivity and value for money	✓
Helping the NHS to support broader social and economic development	

Key Risks & Implications identified within this report

Strategic	✓	Legal / Regulatory	✓
Financial	✓	Communications & Engagement	✓
Resources (other than finance)		Consultation Required	
Procurement		Decommissioning	
Equality Impact Assessment		Quality & Patient Experience	✓
Quality Impact Assessment		Governance & Assurance	✓
Privacy Impact Assessment		Staff / Workforce	✓
Safeguarding		Other – please state	

Authority to agree the recommendation:

Have you confirmed that this Committee has the necessary authority to approve the requested recommendation?	Yes
If this includes a request for funding, does this Committee have the necessary delegated financial authority to approve it?	n/a
If this includes a request for funding, have the Directors of Finance confirmed the availability of funding?	n/a

Conflicts of Interest Consideration and mitigation:	Committee members will need to raise any Conflicts of Interest at the meeting.
Link to Committee Risk Register and mitigation:	n/a
Report history:	This is the first time this report has been received by the Committee.
Next Steps:	
Responsible Officer to take forward actions:	Carol Hill
Appendices:	Business Case

TRANSFER OF HAEMATO ONCOLOGY SERVICES FROM LIVERPOOL UNIVERSITY HOSPITALS TO CLATTERBRIDGE CANCER CENTRE

1. Introduction

1.1 Clatterbridge Cancer Centre (CCC), Liverpool University Hospital (LUHFT) and North Mersey commissioners have worked together on a proposal to create a single blood cancer (haemato-oncology) service.

1.2 There are more than 100 different types of blood cancer such as leukaemia, myeloma and lymphoma. Together, blood cancers are the fifth most common form of cancer in the UK – over 40,000 people are diagnosed each year and there are more than 250,000 people living with a blood cancer (Blood cancer UK, 2020). The predicted national trend is that this will continue to increase.

1.3 The main treatments are Chemotherapy, Stem Cell Transplant (also referred to as Bone Marrow Transplant), Immunotherapy and Radiotherapy. Treatment can be intensive and require specialist multi-disciplinary team resources to be delivered safely.

1.4 Treatment for blood cancers, diagnosis is becoming increasingly complex. Unlike solid tumour cancers, most treatment has historically been delivered by local hospitals rather than the tertiary cancer centre (CCC). It is now widely recognised, however, that the increasing complexity of blood cancers mean they are now best managed by subspecialist multidisciplinary teams.

1.5 As early as 2015, the Healthy Liverpool Blueprint proposed that blood cancer services should be unified across the city following overwhelming clinical consensus that the current split was unsustainable.

1.6 In 2017, the Royal Liverpool Hospital (RLBUHT) blood cancer service transferred to Clatterbridge Cancer Centre (CCC). In 2019, RLBUHT and Aintree Hospitals (AUHFT) merged to become one organisation - LUHFT. Blood cancer services are currently provided by:

- Clatterbridge Cancer Centre – Liverpool, part of The Clatterbridge Cancer Centre NHS Foundation Trust (CCC).
- Aintree University Hospital, part of Liverpool University Hospitals NHS Foundation Trust (LUHFT); and
- Southport & Ormskirk Hospital NHS Trust (S&O).

1.7 This proposal would see the creation of a single service across Aintree University Hospital (AUH) and Clatterbridge Cancer Centre – Liverpool (CCC-L), by bringing the teams together to work as one under the management of CCC.

1.8 It is important to note that there is a separate project to address the clinical model for non-malignant haematology. The guiding principle remains that general haematology services will not be destabilised through any changes to blood cancer services.

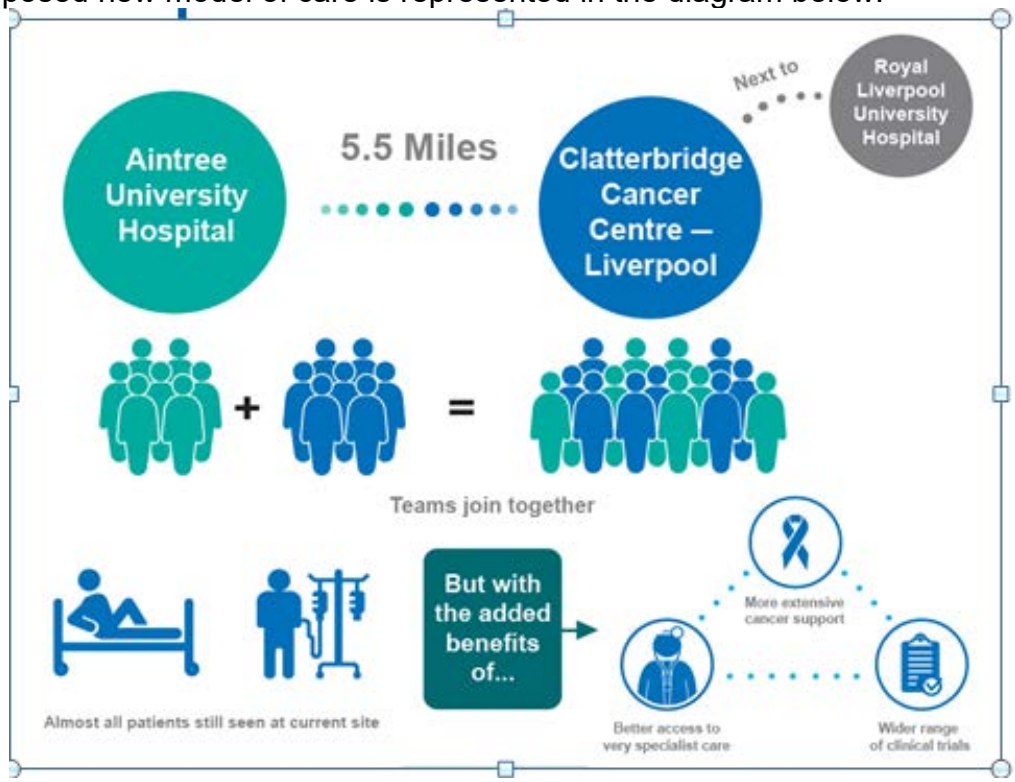
2. Model of Care

2.1 CCC-L provides the specialist regional service. It is the only provider for Teenage and Young Adult services and adult Stem Cell Transplantation in Cheshire and Merseyside. The nearest other Level Four (i.e., transplant) units are Manchester University NHS Foundation Trust and The Christie NHS Foundation Trust. Services are delivered by a multidisciplinary team that is aligned to these four subspecialties. The blood cancer service is split into four subspecialties:

- Lymphoid (treating lymphomas)
- Myeloid (treating leukaemias)
- Plasma Cell (treating myelomas)
- Stem Cell Transplantation.

2.2 At Aintree University Hospital (AUH) the haematology medical and nursing teams currently provide blood cancer care and care for non-malignant blood conditions.

2.3 The proposed new model of care is represented in the diagram below:



2.4 The new model of care would:

- Create a single service by bringing AUH and CCC-L staff together to work in subspecialist teams delivering care across both sites.

- Higher acuity inpatient pathways of care would be delivered in CCC-L. This equates to six inpatient beds worth of activity to be transferred from AUH to CCC-L*

- Complex pathways of care such as acute leukaemia and stem cell transplants would remain within CCC-L.

- Outpatient and day care would be delivered across both sites, CCC-L and AUH. The majority of patients who currently attend the AUH site would continue to do so as clinics and treatments would still be operated on that site.

- Emergency Pathways of care would be supported by CCC's 24/7 hotline service and rapid access to CCC-L.

- Shared care pathways for patients whose primary condition is not H-O, such as frailty, would continue to be clinically managed by AUH in line with the CCC/LUHFT model of care

- A wider range of clinical trials would be available locally. Patients could access trials of new treatments that can only be provided by blood cancer teams treating large numbers of patients.

- Patients would also have more extensive specialist cancer support than is available in a smaller service. This includes psychological support, practical advice and clinical therapies.

2.5 As part of a mutual aid approach to provide capacity and support infection prevention and control measures during the Covid-19 pandemic, patients usually bedded at Aintree have been using CCC-L beds. This is viewed as a temporary measure and does not pre-empt the outcome of the change assurance process.

3. Engagement Approach

3.1 This proposal would impact on a small number of patients who currently would be admitted to AUH for complex, high-intensity inpatient care. In 2019/20, there were 422 admissions (157 individual patients) to AUH for blood cancer care, the biggest number of which were South Sefton patients.

3.2 Due to the small number of patients affected by this proposed service change, it was agreed by NHS England and the three local authority Overview and Scrutiny Committees that an engagement approach was proportionate rather a formal public consultation.

3.3 Targeted engagement was carried out with patients/carers during 2020 and 2021 to seek their views on the proposals and their experience of using local blood cancer services. A range of methods were used to offer patients/carers the opportunity to be involved, and to gain qualitative and quantitative feedback.

3.4 A pre-engagement equality impact assessment (EIA) was carried out which informed the engagement process which was framed as follows:

- To seek views on the proposed relocation of some inpatient beds, its impact (e.g., travel) and any mitigations.

- Include questions on how well patients felt they were treated and whether any protected characteristics / additional needs were met.

- Include questions about protected characteristics and socioeconomic factors.

- To gain views from as people with direct experience of these services. However, reasonable steps were taken to ensure that we heard from a broad and representative group.

3.5 The engagement period ran during the Covid pandemic, from 10th May to 20th June 2021, adopting a range of methods focused on people with knowledge/experience of blood cancer, including phone interviews, online survey, online engagement groups and meetings with patient support groups.

3.6 The engagement found strong support for the proposals across all groups and channels used. Participants saw clear advantages of creating a single team that would enable greater subspecialisation among clinicians, provide a more resilient staffing model, and result in a larger patient cohort with the potential for a wider range of treatments and clinical trials in future. They also supported the proposed relocation of complex, high-intensity inpatient care from AUH to the specialist cancer centre, CCC-L. Reasons included the fact that CCC-L was the specialist cancer centre, solely focused on cancer care, and the quality of facilities provided such as single en-suite rooms. The enhanced scope for infection control was mentioned by a number of patients.

3.7 There was clear consensus that other services should be maintained on both sites. People who lived closer to AUH and supported relocation of the complex inpatient care also said they would want other services to remain local, as planned in the proposals. Patients and relatives/carers were also very complimentary about the care at both hospitals.

3.8 Finally, as expected, travel was an important factor although it did not override the clinical case for the proposals.

3.9 An Equality Impact Assessment has been completed for the proposal which has informed the final business case.

4. Haemato-Oncology Integration Business Case

4.1 A business case for this integration proposal has been approved by the Board of CCC. The business case is appended. The document sets out the economic, management and financial case. It also sets out the options appraisal process that has informed the proposed clinical model.

4.2 With regard to financial arrangements, the original financial assumption was that this was a provider-to-provider service transfer with no cost impact upon commissioners. However, it became clear in 2021 that there was an element of stranded costs/retained margin which would remain with LUHFT, to the value of £1,144k. This issue took some time to resolve, hence the delay in this proposal coming to commissioners for approval. This issue has now been resolved and an approach to risk sharing has been agreed by all organisations.

5. Governance, Scrutiny and Assurance

5.1 **Local Authority Overview and Scrutiny**. The four North Mersey CCGs presented the case for change to OSCs, each of which agreed that an engagement approach was commensurate with the scope and scale of the proposed change. The findings from the engagement were presented to the OSCs in July 2021 where endorsed the approach and the next steps in completing the process.

5.2 **NHS England Assurance Process.** A Stage 1 Strategic Sense Check panel was held with NHS England in March 2021. Support was received to proceed to the Business Case stage. Using the decision-making tool within the national 'Effective Service Change Toolkit' it was agreed that a Stage 2 assurance gateway was unlikely to be required. This approach was informed by the low numbers of patients impacted by this proposal, the relatively low impact of the proposed change and the strong strategic case.

5.3 **NHS Governance.** The four North Mersey CCGs – Knowsley, Southport and Formby, South Sefton and Liverpool, have worked collaboratively to review this proposal through the North Mersey Committees in Common. Due to the delegation of system-level programmes to the Cheshire and Merseyside Joint Commissioning Committee, the JCC is asked to make the final decision to approve this proposal.

6. Conclusion

6.1 This proposal would see the creation of a single service across Aintree University Hospital (AUH site) and Clatterbridge Cancer Centre – Liverpool (CCC-L), by bringing the teams together to work as one under the management of CCC.

6.2 The creation of a single haemato oncology service with a hub-and-spoke model of care connected to a dedicated centre (CCC-L) would bring fundamental improvements to health outcomes and the quality of service provision for patients with blood cancer.

7. Recommendations

7.1 That Joint Committee is asked to:

- Note the Business Case for the transfer of the Aintree University Hospital site Haemato-oncology Service from Liverpool University Hospitals NHS Foundation Trust to The Clatterbridge Cancer Centre NHS Foundation Trust;
- Note the service change process undertaken to inform this proposed decision;
- Approve this proposal to enable the transfer of haemato-oncology services to be mobilised.

8. Access to further information

For further information relating to this report contact:

Name	Carole Hill
Designation	Director of Strategy, Communications and Integration
Telephone	07954141447
Email	carole.hill@liverpoolccg.nhs.uk

The Clatterbridge Cancer Centre
NHS Foundation Trust

Business Case

For the Integration of the Aintree University Hospital site Haemato-oncology Service from Liverpool University Hospitals NHS Foundation Trust into The Clatterbridge Cancer Centre NHS Foundation Trust

Version 1.0

Document management

Revision history

Version	Date	Summary of changes
0.1-0.6	Jan-Sept 2021	Early drafts
0.7	Oct 2021	Late stage draft following full review
0.8	Dec 2021	Amendments following Project Executive Group meetings; updated Financial Case; inserted executive summary
0.9	Dec 2021	Updated Financial Case following commissioner discussions
1.0	Dec 2021	Final version; finalised Financial Case following agreement of risk share approach

Approved by

Name	Date	Version
CCC Trust Board	15th December 2021	0.9 (with risk share information presented separately)
LUHFT		
Lead commissioner		

Contents

1 Executive summary

The purpose of this business case is to demonstrate the rationale for integrating the haemato-oncology (H-O) services at the Aintree University Hospital site (part of Liverpool University Hospitals NHS Foundation Trust) into The Clatterbridge Cancer Centre NHS Foundation Trust. This case has been prepared using the recommended standard for business cases: the five case model.

Strategic case

The historical separation of H-O and solid tumour services within Liverpool appears unique when compared to other UK comprehensive centres such as Leeds, The Royal Marsden and The Christie where the integration of these services has benefited the delivery of excellence in cancer care and treatment.

In 2015, as part of *Healthy Liverpool: The Blueprint*, it was agreed that H-O services should be unified across the city. This followed overwhelming clinical consensus that the current split was increasingly unsustainable.

In July 2017, the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) H-O service transferred to CCC with the integration of the Aintree University Hospital NHS Foundation Trust (AUHFT) service planned to take place separately.

In October 2019, RLBUHT and AUHFT merged to become one organisation, Liverpool University Hospitals NHS Foundation Trust (LUHFT). The planned integration of the AUH site service has not yet taken place. Despite management changes since 2015, there has been no change in the clinical consensus that the best model of care for the future is a single service.

The current proposals will see the creation of a single service across Aintree University Hospital (AUH site) and Clatterbridge Cancer Centre – Liverpool (CCC-L), by bringing the teams together to work as one under the management of CCC.

The creation of a single H-O service with a hub-and-spoke model of care connected to a dedicated centre (CCC-L) will instigate fundamental improvements in the quality of service provision. There is a clear consensus amongst clinicians that this unique opportunity provides the scope to transform the future care of patients.

There are a significant number of benefits and opportunities to support the case for change. The case for change set out and agreed in 2015 still stands; in fact, developments since then, including the Covid-19 pandemic and the emergence of novel therapies, have further strengthened it.

Economic case

A number of options were determined by the clinical teams to address the issues highlighted in the strategic case.

The appraisal of these options concluded that some critical success factors, particularly those around transforming outcomes, could not be met by the do nothing option. It was therefore acknowledged that greater collaboration between - or integration of - the services would be required. The assessment considered that fully meeting the ambition set out in the critical success factors, particularly around quality of care, could only truly be achieved through integration (as has already taken place with the integration of the RLBUHT service into CCC).

The preferred option was for CCC to become the provider of H-O services on the AUH site. This will see staff, inpatients, outpatients and day care services transfer to the management of CCC.

The proposed model of care will:

1. Create a single service by bringing the AUH site and CCC-L staff together to work in subspecialist teams delivering care across both sites
2. Change some patient pathways and points of access:
    - H-O services will continue to be provided at both sites and almost all patients will continue being treated at their current site
    - No change for patients receiving outpatient and day case treatments.
    - Some patients who need to stay in hospital for complex blood cancers requiring highly-intensive treatment will be admitted to CCC-L, rather than the AUH site.

The management of the AUH site service will transfer from Liverpool University Hospitals NHS Foundation Trust to The Clatterbridge Cancer Centre NHS Foundation Trust. The inpatient changes will amount to the relocation of six inpatient H-O beds worth of activity from the AUH site to CCC-Liverpool, the specialist centre where the majority of inpatient H-O care in the region is already provided.

The proposed change to inpatient admissions – where patients will no longer be admitted to the AUH site for complex, high-intensity inpatient care – is the most significant impact for patients. In 2019/20, there were 422 admissions to the AUH site for blood cancer care. This total was made up of 157 individual patients, many of who had multiple admissions.

As part of a mutual aid approach to provide capacity and support infection prevention and control measures during the COVID-19 pandemic, blood cancer patients usually admitted to the AUH site have been using CCC-L beds. This has been a temporary measure and does not pre-empt the outcome of this business case.

The impact on patients and staff will be minimised through the delivery of a hub and spoke model of care, with clinics and treatments remaining at the AUH site. The complex inpatient activity from the AUH site will relocate to CCC-L as will aseptic pharmacy services. In the new model all staff working in the H-O service will be employed by CCC. In order to deliver this model a number of AUH site staff are eligible for transfer under TUPE regulations. This will cover a number of staff groups including medical, nursing, and administrative staff.

Financial case

The original financial assumption agreed in 2015/16 was that the integration was a provider to provider service transfer and as such that there would be no impact upon commissioners. This assumption was made was when financial arrangements were under Payment by Results (PbR). During 2020/21 and 2021/22 funding has been allocated to where costs are incurred due to current financial arrangements.

Due to the change in funding arrangements from 2021/22 there is an element of stranded costs/retained margin which remains with LUHFT. The annual value of these costs is £1,144k. Discussions have taken place with commissioners to resolve this issue and an approach to risk sharing has been agreed by all organisations.

To ensure that the risk on stranded costs is appropriately managed the following principles have been applied and agreed by relevant Directors to ensure that the services can transfer as intended. The approach includes:

- All party review of stranded cost quantum
- Commissioner financial support for stranded costs (Year 1, £0.7m)
- Residual financial risk to be equally supported by CCC and LUHFT (Year 1, £0.4m)
- Stranded costs to be reviewed in 2022/23 and then annually
- Stranded cost risk to be included in organisation and system financial planning for 2022/23 onwards, where relevant
- Integrated Care System approved process on risk sharing approach.

CCC is operating a different clinical and staffing model resulting in slightly increased pay costs when compared to LUHFT. However, it is also likely that some of the direct costs CCC has put forward as support costs (including for clinical support services) are captured within the LUHFT overhead figure.

Management case

The project has been collaboration between CCC and LUHFT working closely with NHS England and clinical commissioning groups (CCGs). The project governance

reflects a large and diverse stakeholder group covering multiple providers and commissioning organisations.

The clinical case for change in H-O is exceptionally strong. Clinicians have driven the proposals from start to finish, supported by their trusts. The combined commitment and experience of the AUH site and CCC, with clinicians leading the call for change, has ensured a strong and successful assurance and engagement processes.

Targeted engagement was carried out with patients/carers during 2020 and 2021 to seek their views on the proposals and their experience of using local blood cancer services. A range of methods were used to offer patients/carers the opportunity to be involved, and to gain qualitative and quantitative feedback.

GP groups in the Sefton area were also engaged with as half of the H-O patients admitted to the AUH site in 2019/20 were from the borough.

The engagement process found strong support for the proposals across all groups and channels used. Participants saw clear advantages of creating a single team that would enable greater subspecialisation among clinicians, provide a more resilient staffing model, and result in a larger patient cohort with the potential for a wider range of treatments and clinical trials in future. They also supported the proposed relocation of complex, high-intensity inpatient care from the AUH site to the specialist cancer centre, CCC-Liverpool.

Alongside this there was clear consensus that other non-inpatient services should be maintained on both sites. Travel was an important factor for patients although this did not override the clinical case for the proposals. This is in line with feedback from other, larger pieces of engagement and consultation that found people in North Merseyside are prepared to travel further for specialist services if it means they get the best care.

Liverpool, Sefton, Knowsley and West Lancashire OSCs have now considered the proposals set out in this business case, alongside the engagement outlined above. They were satisfied that the proposals did not constitute a substantial variation or development requiring formal consultation with OSCs, and that appropriate levels of engagement had been carried out.

Should the proposal be approved its implementation will be subject to robust governance and project management by CCC. CCC will draw on the recent experience of integrating the RLUH H-O service in 2017 and its expansion into CCC-Liverpool in 2020 when planning the transfer. A detailed operational plan has been developed outlining how the service will run following its transfer from LUHFT. This operational plan is supported by detailed workforce plans for each area of the service.

2 Introduction

2.1 Purpose

The purpose of this business case is to demonstrate the rationale for integrating the haemato-oncology services at the Aintree University Hospital site (part of Liverpool University Hospitals NHS Foundation Trust) into The Clatterbridge Cancer Centre NHS Foundation Trust.

The proposal covers the whole pathway of care for patients with blood cancers (haemato-oncology) from referral, diagnosis, treatment, follow-up and long-term care. It builds upon previous work undertaken in 2015 that demonstrated blood cancer services should be unified into a single service whilst maintaining equitable access to dedicated cancer services and specialist teams. The new clinical model is underpinned by the ethos that care is delivered centrally where necessary and local where possible.

2.2 Structure and content

This case has been prepared using the recommended standard for business cases: the five case model. The five case model comprises the following key components:

1. **Strategic case**
   The strategic case sets out the strategic context and the case for change.
2. **Economic case**
   The economic case sets out the options considered to address the case for change, the preferred option, and the benefits and impacts of the preferred option.
3. **Commercial case**
   The commercial case is used when a business case requires an associated procurement process and is therefore not required for this proposal.
4. **Financial case**
   The financial case sets out the funding arrangements and affordability and explains any impact on the organisations involved.
5. **Management case**
   The management case sets out how the project has delivered to-date and how the preferred option will be implemented, if approved.

Throughout this business case (unless stated otherwise):

- 'CCC' refers to The Clatterbridge Cancer Centre NHS Foundation Trust
- 'CCC-L' refers to Clatterbridge Cancer Centre – Liverpool
- 'LUHFT' refers to Liverpool University Hospitals NHS Foundation Trust, and
- 'AUH site' refers to Aintree University Hospital, now a site of LUHFT.

3 Strategic case

3.1 Background

Haemato-oncology (H-O) describes the diagnosis and treatment of blood cancers. H-O services in the Liverpool and North Merseyside area are provided by The Clatterbridge Cancer Centre NHS Foundation Trust (CCC) – at its Liverpool site (CCC-L) – and by Liverpool University Hospitals Foundation Trust (LUHFT) – at its Aintree site (AUH site).

In 2015, as part of Healthy Liverpool: The Blueprint*, it was agreed that blood cancer services should be unified across the city. This followed overwhelming clinical consensus that the current split was increasingly unsustainable.

This was supported at this time by the Chief Executives from Aintree University Hospital NHS Foundation Trust, The Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) and The Clatterbridge Cancer Centre NHS Foundation Trust.

A business case was developed that set out the rationale for the integration of the RLBUHT and AUH site H-O services into CCC. In July 2017, the RLBUHT blood cancer service transferred to CCC with the integration of the AUH site service planned to take place separately.

In October 2019, RLBUHT and AUHFT merged to become one organisation, Liverpool University Hospitals NHS Foundation Trust (LUHFT). While this planned integration of the AUH site service has not yet taken place, and despite management changes since 2015, there has been no change in the clinical consensus that the best model of care for the future is a 'single service'. The current proposals will see the creation of a single service across Aintree University Hospital (AUH site) and Clatterbridge Cancer Centre – Liverpool (CCC-L), by bringing the teams together to work as one under the management of CCC.

It is important to note that there is a separate project to address the clinical model for non-malignant haematology. The guiding principle remains that general haematology services will not be destabilised through any changes to blood cancer services.

3.2 The Clatterbridge Cancer Centre

CCC is one of the largest networked cancer centres in the UK. It provides specialist non-surgical oncology treatment for 2.4 million residents in Cheshire, Merseyside, North Wales and the Isle of Man.

* Healthy Liverpool: The Blueprint https://www.liverpoolccg.nhs.uk/about-us/publications/healthy-liverpool-2013-2018/

CCC has 1,575 staff and treats around 32,000 patients a year including almost 13,000 new referrals (2020/21). In total, there are more than 282,000 patient contacts a year. It delivers around 60,000 chemotherapy/SACT treatments a year, 70,000 radiotherapy treatment and planning appointments, and 175,000 outpatient consultations.

CCC provides a range of non-surgical cancer treatments and support such as acute oncology, radiotherapy, chemotherapy, palliative care, diagnostic imaging, inpatient beds, psychiatric and other holistic support.

In 2020 CCC opened its new flagship hospital, Clatterbridge Cancer Centre – Liverpool. The hospital is in the heart of the city, located next to the Royal Liverpool Hospital to support collaborative care of patients with cancer. The Trust also delivers radiotherapy and chemotherapy in its Wirral site (Clatterbridge Cancer Centre – Wirral) and on the Aintree University Hospital site: radiotherapy in Clatterbridge Cancer Centre – Aintree and chemotherapy in the Marina Dalglish Unit. It has specialist chemotherapy clinics in other Cheshire and Merseyside hospitals including Halton, Ormskirk and St Helens. The Clatterbridge in the Community service allows patients to receive their chemotherapy and other systemic anti-cancer therapies (SACT) at home or in their workplace.

3.3 Liverpool University Hospitals

LUHFT runs Aintree University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital and the Royal Liverpool University Hospital.

It serves a core population of around 630,000 people across Merseyside as well as providing a range of highly specialist services to a catchment area of more than two million people in the North West region and beyond.

The Trust has a combined workforce of over 12,000 staff, making it one of the largest employers in the region.

Between 1st October 2019 and 31st March 2020 the Trust saw: 191,434 emergency and urgent attendances, 47,258 inpatients and day cases, 40,824 day case procedures, and 487,800 outpatient appointments.

3.4 Haemato-oncology services

H-O services manage the diagnosis and treatment of blood cancers. There are more than 100 different types of blood cancer such as leukaemias, myelomas and lymphomas. Together, blood cancers are the fifth most common form of cancer in the UK – over 40,000 people are diagnosed each year and there are more than 250,000 people living with a blood cancer (Blood Cancer UK, 2020). Blood cancer is the fifth most common type of cancer in the UK and 1 in 16 men and 1 in 22 women will develop blood cancer at some point in their lives (Blood Cancer UK, 2020). The predicted national trend is that this will continue to increase.

The main treatments for blood cancer are chemotherapy, stem cell transplant (also referred to as bone marrow transplant), immunotherapy and radiotherapy. Treatment can be intensive and require specialist multi-disciplinary team resource to be delivered safely.

These services require support from a number of areas including pharmacy, clinical support services, diagnostics such as imaging, laboratory, and interventional radiology and critical care/intensive therapy unit and medical and surgical specialities.

As we learn more about blood cancers, diagnosis and treatment is becoming increasingly complex. Unlike solid tumour cancers, most treatment has historically been delivered by local hospitals rather than specialist cancer centres like CCC. It is now widely recognised, however, that the increasing complexity of blood cancers means they are best managed by subspecialist multidisciplinary teams.

Within North Mersey adult H-O services are provided by both CCC and at the AUH site. These services provide emergency and non-emergency care that may:

- Diagnose blood cancer or disorders using a wide range of diagnostics such as scans and biopsies
- Treat blood cancers or disorders with chemotherapy or medication
- Provide long term follow-up

However, the ways in which these services are delivered differ between both organisations and services.

3.4.1 Aintree University Hospital site

H-O services are delivered at the Aintree site via a consultant led General Haematology service, which also provides Clinical Haematology (non-cancer) services. The haematology medical and nursing teams at the AUH site therefore currently provide H-O care as well as care for a number of non-malignant conditions. Inpatients have historically been admitted to a general ward of 19 beds, of which six were dedicated to H-O. Due to Covid-19 throughout 2020 H-O inpatients were moved temporarily to alternative wards within the AUH site and in the autumn also to CCC-L under mutual aid arrangements.

3.4.2 The Clatterbridge Cancer Centre

CCC is a specialist regional service and is the only provider for Teenage and Young Adult services and adult Stem Cell Transplantation within Cheshire and Merseyside. The nearest other Level Four (i.e. transplant) units are Manchester University NHS Foundation Trust and The Christie NHS Foundation Trust.

The blood cancer service is split into four subspecialties:

- Lymphoid (treating lymphomas)
- Myeloid (treating leukaemias)

- Plasma Cell (treating myelomas)
- Stem Cell Transplantation

Inpatients receive care in CCC-L and the hospital has a dedicated H-O inpatient ward and a separate stem cell transplant unit. All rooms are single rooms with ensuite facilities.

3.4.3 Activity

The levels of H-O activity at the AUH site and CCC in the year 2019/20 is shown below.

Figure 1: H-O patient attendances in 2019/20

	AUH site	CCC
New outpatient	878	1,312
Follow-Up outpatient	5,551	16,869
Inpatient	422	700
Day case & systemic anti-cancer therapy	2,522	5,066

3.5 Strategic context

This business case and the associated project objectives are informed by a number of strategic elements that support the case for change.

3.5.1 National context

The number of people who are diagnosed with cancer each year is increasing. Public Health England now estimates that 1 in 2 people will have a cancer diagnosis in their lifetime. At the same time survivorship is increasing and more people are living with and beyond their cancer diagnosis. However, it is also acknowledged that nationally there are fewer doctors joining training and becoming the consultants for the future.

The historical separation of H-O and solid tumour services within Liverpool appears unique when compared to other world-class comprehensive centres such as Leeds, The Royal Marsden and The Christie where the integration of these services has benefited the delivery of providing excellence in cancer care and treatment.

3.5.2 Regional context

In 2008 the Baker Cannon report was published. Commissioned to review the provision of cancer care across Cheshire and Merseyside this report provided a number of recommendations. An offshoot from this was the agreement across the Cheshire and Merseyside network that all non-surgical oncology work should be interlinked for patient care. This played a key role in the decision to co-locate the new

CCC hospital next to the new Royal Liverpool University Hospital (RLUH), supporting collaborative care.

3.5.3 Local context

The new builds of both the RLUH and CCC-Liverpool in the heart of the city have created a catalyst for change in cancer care. They were built adjacent to each other to support patient pathways. The H-O service moved from the management of RLBUHT to CCC, aligning cancer care for this specialist team.

In 2020 the Covid pandemic saw an unprecedented impact across all areas of the NHS. H-O services were also affected and required to make changes, and this further drove a culture of collaboration between the teams.

3.6 The case for change

The creation of a single H-O service with a hub-and-spoke model of care connected to a dedicated centre (CCC-L) will instigate fundamental improvements in the quality of service provision. There is a clear consensus amongst clinicians that this unique opportunity provides the scope to transform the future care of patients.

There are a significant number of benefits and opportunities to support the case for change. The case for change set out and agreed in 2015 still stands; in fact, developments since then, including the Covid-19 pandemic and the emergence of novel therapies, have further strengthened it. The significant benefits for the integration of the AUH site H-O services at CCC are reiterated and summarised here. The case for change is set out in the following areas:

- Improving clinical outcomes
- Enhancing safety and quality
- Improving patient experience
- Enhancing community provision and patient choice
- Enhancing cancer service brand and reputation
- Addressing growth by increasing capacity and capability
- Mitigating workforce challenges

Moreover the proposal to integrate the AUH site H-O service into CCC comes following the successful integration of the RLUH H-O service into CCC in 2017. All of these subjects are expanded upon in the sections below.

3.6.1 Improving clinical outcomes

The future goal for H-O is a ‘one stop shop’ for diagnosis and staging of haematological malignancies, with the intention being that such a service has the potential to dramatically cut waiting times and improve survivorship. CCC is working with the Cheshire and Merseyside Cancer Alliance to support Rapid Diagnostic Services. An integrated service will benefit from CCC’s involvement in this project.

There is overwhelming clinical evidence (such as NICE Improving Outcomes Guidance) which demonstrates that H-O outcomes can be improved through treatment in large specialist cancer centres. This makes a compelling argument for the consolidation of the care of complex inpatients at CCC-Liverpool. Moreover, wider team working will enhance knowledge and skills in all team members.

Historically H-O outcomes locally have been poorer than the national average. While joint working has improved this, a further consolidation of the teams will continue to support these improvements. It is acknowledged that there are improved outcomes in large specialist centres.

Improving cancer outcomes in Merseyside is a challenge due to high levels of deprivation and the associated high level of late presentation and lower compliance with treatment. This notion is supported through analysis of National Cancer Intelligence Network (NCIN) data of outcomes for primary illnesses in Merseyside and Cheshire in terms of incidence, mortality and survival rates.

Local outcomes can differ significantly from the national average. For example, whilst outcomes for Non-Hodgkin's lymphoma are generally in line with the national average, leukaemia outcomes were at one stage significantly inferior in Merseyside and Cheshire, with the AML 5 year survival rate being 34.6% compared to a national average of 50.8%.

Compare this to Leeds: In 2007 the Leeds Cancer Centre opened which saw the integration of the two separate H-O units with the solid tumour service into the new build dedicated centre, which today is internationally recognised and one of the largest providers of cancer care in the UK. Subsequent to this integration, outcomes in H-O are now amongst the best nationally with 5 year survival rates for AML at 62.6%.

Whilst there may be numerous facets that explain the inferior outcomes in the region, the current confederated model of service delivery is certainly a contributory feature, particularly given the presence of data indicating better and vastly improved survival rates in large specialist centres. Such regional service inequalities are also likely to be a factor in referral direction and patient choice.

3.6.2 Enhancing safety and quality

The current H-O service lacks a streamlined admissions process which may cause delays in delivering specialist care to patients. Many patients present directly to A&E which can result in a delay to accessing a specialist oncology assessment. CCC has a dedicated 24/7 hotline and access to a Clinical Decisions Unit (CDU) for patients under the care of the centre. AUH site patients will benefit from this specialist access, reducing attendance at local A&E. The hotline is staffed by specialist cancer nurses who provide urgent care advice on a 24-hour basis to patients and other health professionals.

The CDU in CCC-L will ensure all patients are admitted into a dedicated H-O bed (CCC-L has two wards specifically for H-O). Thus patients admitted to CCC-L will benefit immediately from specialist input. This cannot be guaranteed at the AUH site, due to the acute admissions pathway in place which results in H-O patients often passing through multiple acute medical areas before reaching a specialist H-O bed. For patients who do require admission to the AUH site they will admitted to medical beds and be supported via the in reach service.

There is current fragmentation across the stem cell transplant pathways, multidisciplinary team (MDT), and access to clinical trials. Unification will reduce any risk associated with patients being managed/referred across to separate organisations. This will additionally make the system robust and further comply with NICE guidance.

H-O patients are in the highest risk category as regards infection. The Covid-19 pandemic has led to organisations across the network working together in the spirit of mutual aid to protect patients as far as possible. CCC-L has allowed H-O patients to be transferred from high risk 'hot' centres such as the AUH site, to 'cold' centres, with enhanced Covid measures. Strict infection control policies and protocols and the single ensuite patient accommodation in the new cancer centre greatly improve effective infection control.

3.6.3 Improving patient experience

Clinicians and commissioners have previously agreed that a key objective for cancer care is for services to be integrated throughout the whole patient journey. For example, currently H-O patients may attend the AUH site for their cancer treatment and be referred to CCC for stem cell transplantation or a clinical trial that would not be available to them at the AUH site. This highlights the disjointed pathways of care and the risks with fragmentation of clinical services and specialities.

Reviews of the current H-O patient pathways highlights the potential scope to reduce length of stay and improve patient experience, through transforming the current fragmented service into a more operationally efficient, all-encompassing single clinical model.

3.6.4 Enhancing community provision and patient choice

CCC provides a *Clatterbridge in the Community* service where patients can receive their treatment at home or at work. As this expands to include more H-O treatments AUH site patients could benefit from this service.

3.6.5 Enhancing cancer service brand and reputation

The integration of the AUH site H-O service within CCC will drive the research agenda forward, facilitating a centre of cancer research excellence and a research-focused team. A significant amount of H-O research is already undertaken across the city of Liverpool but more could be done with access to a greater pool of patients. This will

also provide AUH site patients with equitable access to clinical trials to that of CCC H-O patients.

The AUH site is the supra-regional centre for primary CNS lymphoma patients, has an established pathway with The Walton Centre, and regularly receives patients from Wales and the Isle of Man. It is one of only four UK centres recruiting to national and international phase three trials in this rare condition. Closer relationships between the AUH site, CCC and The Walton Centre will improve patient access to specialist transplant services and reduce delays to pathway.

3.6.6 Addressing growth by increasing capacity and capability

The H-O facility at CCC offers the flexibility for growth and the ability to flex between solid tumour and H-O beds. CCC has the added feature of 15 high-efficiency particulate air (HEPA) filtered rooms. This capacity, coupled with a dedicated clinical decision unit, will free up capacity at the AUH site.

3.6.7 Mitigating workforce challenges

The British Society for Haematology published a paper in 2019 that identified a number of issues affecting the H-O workforce. This included the number of vacancies at a time when there is an increase in incidence of this cancer type, and also an increase in the complexity of treatment required. This is further impacted by the reduced number of trainees being recruited to, with numbers having fallen over 36% in the last two years. This then impacts on the current workforce with increases in stress and sickness.

This redesign therefore helps to mitigate some of these issues by creating a larger, more resilient team that is better able to recruit and retain staff, and can ensure that patients do not face barriers to diagnostics, and novel treatments.

3.6.8 The integration of the RLUH H-O service

The case for the transfer of H-O services from the AUH site to CCC is supported by other clinical specialties, with both trusts recognising it as an immense opportunity for improving H-O through integration with H-O and the solid tumour service. This was also recognised at RLBUHT and this led to the successful integration of H-O services into CCC-L in July 2017. Benefits to date include:

- All inpatient care delivered in single ensuite room following the move into CCC-L in September 2020
- A purpose built state of the art stem cell transplant unit
- Purpose built teenage and young adult (TYA) facilities
- Enhanced access to specialist palliative care for inpatients and supporting myeloma multidisciplinary team (MDT)
- SACT e-prescribing
- Successful implementation of a fully integrated electronic patient record (EPR)
- Attracting national and international candidates to key posts within the directorate

- Access to rapid access imaging to support the cancer targets
- Additional resources to develop and transform the service

3.6.9 The case for change in summary

Due to the increasing number of speciality diagnoses and the availability of ever more complex therapies, it is widely recognised that H-O conditions should be managed by subspecialist H-O multidisciplinary teams, a model now mandated nationally and described in Improving Outcomes Guidance and NICE guidelines.

The clinical case for change sets out how H-O services across North Mersey can achieve the best care and treatment through a reconfiguration in the way in which H-O services are delivered. This proposal clearly demonstrates there is an opportunity to deliver equitable world-class care with measurable improvements in H-O care and treatments.

Without integration of the AUH site service into CCC, H-O services will become an even greater standalone sub-specialty. Moreover H-O patients will not receive equitable access to dedicated cancer services, novel therapies, clinical trials, home chemotherapy and the hub-and-spoke model of care.

4 Economic case

This section documents the options that have been considered in response to the case for change set out in within this business case. It outlines the appraisal process undertaken to assess the various options to provide H-O services across Liverpool.

4.1 Options considered

A number of options have been considered. These were determined by the clinical teams to address the issues highlighted in the strategic case. The three shortlisted options are detailed below:

Option 1 – Do nothing
Option 2 – Integration of the AUH site H-O service into CCC H-O service
Option 3 – Collaboration between trusts

4.1.1 Option 1 – Do nothing

All services would remain in their current state. There would be no changes to any element of these services.

4.1.2 Option 2 – Integration

This option proposes that the H-O services on the AUH site integrate into those of CCC. CCC would deliver all H-O care and incur all associated costs and income. This option would be delivered via a hub-and-spoke model with only inpatient services for complex blood cancers requiring highly-intensive treatment moving from their current location. This inpatient care would move to CCC-L.

4.1.3 Option 3 – Collaboration

This option proposes a more collaborative approach between the two services, but with each trust keeping the current staff and income/expenditure arrangements.

4.2 Critical success factors

To undertake the options appraisal the Critical Success Factors process was applied using the Liverpool Clinical Commissioning Group (CCG) framework as a basis. The criteria drew upon the views expressed by clinicians and management from CCC and the AUH site. This enabled the team to systematically narrow down the three options.

The critical success factors were a set of factors arranged into four domains that were used to appraise the short list of options using the available information and analysis.

Figure 2: Critical success factors

Domain	Critical success factor
Quality	The proposed option will improve the health and wellbeing of the population receiving services
	The proposed option will allow service to deliver improved clinical outcomes and standards
	The proposed option will allow services to deliver a positive patient experience and allow patients to be as involved as they wish to be in decision-making about their care and outcomes
	The proposed option will improve staff satisfaction and facilitate appropriate recruitment, retention and training
Feasibility	The proposed option is deliverable within contractual and regulatory obligations
	The proposed option appropriately recognises current and future workforce requirements
	The proposed option optimises the delivery of services on the available estate
	Delivery of general haematology services
	Is the option achievable and minimises implementation and transition risks
Financial sustainability	The proposed option helps to achieve recurrent financial sustainability for the service
	The proposed option is financially deliverable given likely funding constraints
	Aggregated project costs
Strategic fit	The proposed option aligns with the goals of the Healthier Liverpool Programme
	The proposed option supports the delivery of the national and local IT strategy
	The proposed option supports the delivery of STP [i.e. supports the aims of the integrated care system]
	The proposed option provides a platform for increased research and development
	Reputational impact

Figure 3: Assessment system used in the options appraisal

Assessment against critical success factors	
✓	Indicates limited ability to meet criterion
✓✓	Indicates the option is able to meet most elements of criterion
✓✓✓	Indicates the option is able to meet all elements of criterion
X	Indicates the option is unable to meet criterion

4.3 Preferred option

The assessment noted that both existing H-O services were safe and provided a good standard of care in line with national targets. As such the 'do nothing' option did not score poorly against the critical success factors. However it was acknowledged that some CSFs, particularly those around transforming outcomes, could not be met by the do nothing option. It was therefore acknowledged that greater collaboration between or integration of the services would be required. The assessment considered that fully meeting the ambition set out in the critical success factors, particularly around quality of care, could only truly be achieved through integration (as has already taken place with the integration of the RLBUHT service into CCC). As such, option 2 – the integration of services – scored more highly than collaboration.

The full options appraisal can be found in the appendices. In summary the options appraisal produced the following scores.

Figure 4: Summary of options appraisal scoring

Option	Score
One – Do nothing	69%
Two – Integrate with CCC	98%
Three – Collaborative approach	80%

The preferred option was for CCC to become the provider of H-O services on the AUH site. This will see staff, inpatients, outpatients and day care services transfer to the management of CCC.

4.4 Model of care

The proposed model of care has two strands:

1. Creating a single service by bringing the AUH site and CCC-L staff together to work in subspecialist teams delivering care across both sites:

    - Patients will have greater access to health professionals who specialise in their type of blood cancer and the treatments likely to work best for them.
    - A wider range of clinical trials will be available locally. Patients will be able to access trials of new treatments that can only be provided by H-O teams treating large numbers of patients.
    - Patients will also have more extensive specialist cancer support than is available in a smaller service. This includes psychological support, practical advice and clinical therapies.

2. Some changes to patient pathways and points of access:

    - H-O services will continue to be provided at both sites – almost all patients will continue being treated at their current site. There will be no change for patients receiving outpatient and day case treatments.
    - Some patients who need to stay in hospital for complex blood cancers[†] requiring highly-intensive treatment will be admitted to CCC-L, rather than the AUH site. The two hospitals are around 5.5 miles apart.
    - Other H-O patients will still be admitted to the AUH site. This includes frailer patients, those whose admission is not linked to cancer, and those who only need a short stay in hospital.

The management of the Aintree University Hospital site service will transfer from Liverpool University Hospitals NHS Foundation Trust to The Clatterbridge Cancer Centre NHS Foundation Trust. The inpatient changes will amount to the relocation of six inpatient H-O beds worth of activity from the Aintree University Hospital site to Clatterbridge Cancer Centre – Liverpool, the specialist centre where the majority of inpatient H-O care in the region is already provided.

Complex pathways of care such as acute leukaemia and stem cell transplants will remain within CCC-L. Emergency pathways of care will be supported by CCC's 24/7 hotline service and rapid access to CCC-L.

Figure 5: Summary of future delivery site for patients currently seen at the AUH site

Patient type	Site of delivery
Complex inpatients	CCC-Liverpool
Short-stay inpatients and non-cancer admissions of H-O patients	Remain at the AUH site
Outpatients	Remain at the AUH site
Day case/SACT	Remain at the AUH site

[†] As part of a mutual aid approach to provide capacity and support infection prevention and control measures during the COVID-19 pandemic, blood cancer patients usually admitted to the AUH site have been using CCC-L beds. This has been a temporary measure and does not pre-empt the outcome of this business case.

4.5 Impact of the preferred option

4.5.1 Impact on patients

As part of the options appraisal there was a section dedicated to the expected improved quality outcomes of this proposal. The preferred option delivers enhanced quality in the following ways:

- Allows the service to deliver improved clinical outcomes and standards
- Allows services to deliver a positive patient experience and allows patients to be as involved as they wish to be in decision-making about their care and outcomes
- Improves staff satisfaction and facilitates appropriate recruitment, retention and training

As the proposal is for the service to move to an established provider there is not expected detrimental impact to quality.

Patients will remain at their current place of care (where clinically appropriate) with the exception of a small number of inpatients who will be treated 5.5 miles away from the AUH site at CCC-Liverpool. They will receive their care in a state-of-the-art hospital with two dedicated H-O floors where each patient has their individual ensuite room.

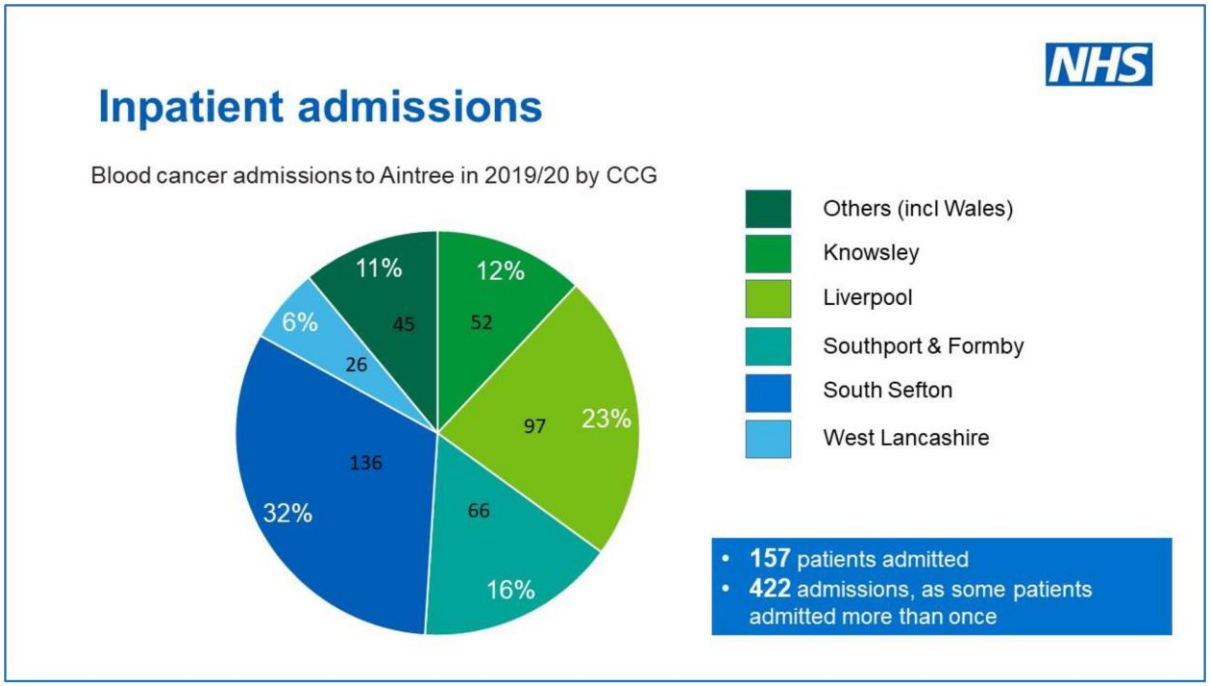
The proposed change to inpatient admissions – where patients will no longer be admitted to the Aintree University Hospital site for complex, high-intensity inpatient care – is the most significant impact. In 2019/20, there were 422 admissions to the AUH site for blood cancer care. This total was made up of 157 individual patients, many of who had multiple admissions.

Figure 6: AUH site H-O activity by type, 2019/20

Attendance type	Number
New outpatient attendances	878
Follow-up outpatient attendances	5,551
Day case procedures and SACT	2,522
Inpatient admissions	422

The largest proportion of the AUH site patients came from South Sefton (32%), followed by Liverpool (23%), Southport and Formby (16%), Knowsley (12%), and West Lancashire (6%). The remaining 11% were from other areas including Wales. South Sefton Clinical Commissioning Group (CCG) is therefore the lead commissioner for these proposals.

Figure 7: Total AUH site inpatient admissions in 2019/20 by CCG



Patients who are admitted to CCC-L after attending the AUH site will not be disadvantaged by the distance between the two hospitals as they will be transferred using patient transport.

Patients from the North Mersey area who are asked to attend directly to CCC-L (thus avoiding A&E at the AUH site) will potentially be affected. We expect in most cases patients will be brought to hospital by a friend/relative or taxi as they will be too unwell for public transport or to drive themselves. There may be some who meet the criteria for North West Ambulance Service transport.

The equality impact assessment (EIA – see the Management Case, section 6, for further information) assessed the impact on journey times from the four CCG areas that most of the 157 patients in 2019 came from. The following table shows average increased journey times by private vehicle or public transport of between zero and 16 minutes, depending on the starting point. For those travelling by public transport from Southport & Formby and Liverpool the journey times are expected to decrease.

Figure 8: Average travel times in minutes

	Journey time to AUH site by car	Journey time to AUH site by public transport	Journey time to CCC-L by car	Journey time to CCC-L by public transport	Average increase by car	Average increase by public transport
South Sefton	18	37	27	46	9	9
Southport & Formby	34	74	51	67	16	7 minutes less
Liverpool	14	25	17	26	3	1 minute less
Knowsley	14	38	29	45	13	7
West Lancashire	29	72	42	86	13	14

Based on Google Maps results for a journey at 2pm on a Tuesday from the GP practices in each CCG area

The patient engagement process (see Management Case) found that a significant majority of patients agreed the clinical benefits of providing inpatient care in the specialist cancer centre at CCC-L would outweigh the impact on journey times for patients' families and friends.

It should also be acknowledged that there are a number of mitigating factors in place, such as:

- Dedicated zones for both ambulance transfer or family/carer drop off at CCC-L with porters available for support
- Free patient parking in a dedicated car park a short distance away, with a regular free shuttle bus between the car park and CCC-L's main entrance
- Readily available public transport options for patients' family and friends at CCC-L

4.5.2 Impact on staff

The preferred option will deliver a hub and spoke model of care, with clinics and treatments remaining at the AUH site. The complex inpatient activity from the AUH site will relocate to CCC-L as will aseptic pharmacy services.

All staff working in the H-O service will be employed by CCC. In order to deliver this model a number of AUH site staff are eligible for transfer under TUPE regulations‡. This will cover a number of staff groups including medical, nursing, and administrative. For staff who would be required to move base location there is a physical difference of 5.5 miles. CCC has a staff travel and parking policy.

‡ Transfer of Undertakings (Protection of Employment) [TUPE] regulations protect employees' rights when they transfer to a new employer

Under the general principles of TUPE a staff member whose work equals 51% or more of work that is moving are expected to move employer. LUHFT has provided information on a number of staff who could be eligible for TUPE transfer to CCC. There is potential, when LUHFT formally respond under the TUPE process, that additional staff eligible for TUPE could be identified.

A full workforce plan for the delivery of the new service by CCC has been developed. A summary of the expected workforce arrangements for each key area is found below.

Consultants
Transfer of 4 consultant posts (3.43 WTE – whole time equivalent) of which 0.43 is related to the transfer of the acute leukaemia service which moved from the AUH site to CCC in 2017. Expected to include transfer of staff under TUPE regulations.

Junior doctors
Trainee medical staff who are on a 'haematology track' will move to CCC, subject to approval from Deanery/Health Education North West. This is expected to be:

- 1 specialty registrar (StR)
- 1 internal medicine trainee (IMT) and 2 foundation trainees (FT)

Senior nursing
Transfer of 3 WTE band 7 clinical nurse specialist posts (expected to include transfer of some staff under TUPE regulations).

Outpatients
Transfer of 2.8 WTE band 2 clinic clerk posts (expected to include transfer of some staff under TUPE regulations). Other clinic support staff will be provided by LUHFT via a service level agreement (SLA) which is yet to be agreed and finalised. Access to prescriptions will be via the Lloyds pharmacy, as per CCC current arrangements on the AUH site.

Day care
Transfer of some nursing, health care assistant and ward clerk posts from the day care unit at the AUH site. Expected to include transfer of staff under TUPE regulations. The H-O day care service at the AUH site will be run and managed by CCC staff. To reflect the change to the CCC nursing ratio of 1:3, additional staffing will be required.

Inpatients
The temporary transfer of H-O inpatients from the AUH site to CCC as part of the mutual aid arrangements has required CCC to absorb activity into the existing bed-base staffed by existing CCC ward nursing staff. Some inpatient posts will transfer with the service and this may include the transfer or some staff under TUPE

regulations. A revised CCC workforce plan has also identified a need for additional nursing staff.

Support staff

A number of supporting posts will transfer with the service and this is expected to include transfer of some staff under TUPE regulations:

- 2 WTE band 4 medical secretary posts and 0.8 WTE band 3 support secretary post
- 0.7 WTE band 4 MDT coordinator post
- 1 WTE band 8b principal clinical scientist (haemato-oncology)

1 WTE H-O research and innovation nurse funded by the NIHR network who will in future be allocated to CCC. Additional admin staff are aligned to the areas above where they are required. There is also a requirement for some temporary staff to prepare for the transfer of services. The temporary staffing will be required in post ahead of transfer for approximately 4 months duration. This is to move all patients across into Meditech.

Staff engagement

Staff engagement has taken place throughout the project. The proposals have been shaped by clinicians, and engagement has taken place with staff who will be directly affected. This staff engagement has been led largely by LUHFT management teams as the currently employer of these staff. CCC teams have been involved as required to answer specific questions about the future of the service at CCC, should the transfer be approved and proceed. This has included the arrangement of visits for relevant LUHFT staff to the H-O wards at CCC-L as requested.

5 Financial case

The financial case defines the activity model and planning assumptions related to income and expenditure of the H-O service.

H-O is not an independent specialty within LUHFT but forms part of a wider 'clinical haematology' department, therefore some assumptions have been applied to split these services for the financial modelling. These assumptions are based on the actual service split in the integration of the RLUH H-O service (using the known data from RLBUHT) and on the expertise of the service management, business intelligence and financial teams of LUHFT.

5.1 CCC financial performance

The trust is considered financially sound and this integration will be of no detriment to patient care for either this service or the current services delivered by CCC.

Figure 9: Summary of CCC four-year financial metrics

	2017/18 £m	2018/19 £m	2019/20 £m	2020/21 £m
Income from patient care activities	126.1	143.8	168.2	180.9
Other operating revenue	17.5	19.8	21.1	25.2
Total income	**143.7**	**163.6**	**189.4**	**206.2**
Operating expenses	(133.2)	(151.9)	(179.6)	(199.6)
Operating surplus	**10.5**	**11.7**	**9.8**	**6.6**

Overall CCC generated income totalling £206.2m in 2020/21, with £180.9m of this income received as a result of patient care activities delivered at CCC.

CCC has been able to achieve growth targets and increased total income by 43.5% over the last 4 years and the Trust achieved or exceeded all of its key financial targets in year.

The Trust is forecast to report a break even position in H1 2021/22 with expected income of £109.5m.

5.2 Current LUHFT H-O financial performance

As outlined above, H-O is not an independent specialty within LUHFT but forms part of clinical haematology. LUHFT have shared budgeted costs and establishment for the H-O service for 2019/20 as a basis for transfer, as summarised in the table below. LUHFT have also stated they wish to retain their calculated contribution from the transferring service, which they have classed as 'overhead'.

Actual income and expenditure figures have been requested through the due diligence process. It was agreed that 2020/21 would not be used as a reference year due to the uncertainty with activity and finances. The budgeted cost of the service is consistent with commissioner contract value of the transferring service.

Drugs and Junior Doctors are shown separately as they are pass through costs funded by NHSE and HEE respectively. A contract variation will be required for these items.

Figure 10: LUHFT H-O budgeted income and expenditure

LUHFT Income and Expenditure	LUHFT Budgeted Cost of Service 2019/20	LUHFT Releasble Costs	LUHFT Retained Margin	Pass through costs (NHSE/HEE)
Income				
Comissioned Contract	£7,739,516			
HEE Funded Posts	£224,025			
Total Income	**£7,963,541**			
Pay				
Pay - new model	(£1,407,941)	(£1,407,941)		
Junior Dr's	(£224,025)			(£224,025)
Non Pay				
Direct budget costs	(£150,503)	(£150,503)		
Drugs	(£4,046,600)			(£4,046,600)
Support Services Costs	(£990,900)	(£990,900)		
Overheads	(£1,143,572)		(£1,143,572)	
Total Expenditure	**(£7,963,541)**	**(£2,549,344)**	**(£1,143,572)**	**(£4,270,625)**

In order to estimate the H-O proportion of the clinical haematology income and expenditure, LUHFT undertook a clinical audit, analysing the activity related to the haematology consultants and clinicians to assess what proportion was attributable to H-O. This was validated further by the Clinical Director.

It is understood that the full value of HEE contract will form part of HEE's LDA value with CCC from the date of service transfer.

In terms of the commissioned contract for 2019/20 this is broken down in the table below, please note that this has been provided by LUHFT and has been verified with commissioners. The commissioning contract and total identified funding for the H-O

service will transfer to Clatterbridge. This will be included in the 2022/23 Clatterbridge planning round, and recent activity volumes and price increases will be applied as appropriate to arrive at a contract value.

Figure 11: AUH site H-O commissioned contract

FY 19/20 Allocation / Proxy SLAM data HO / Non HO				
Type	**HO**	**CH**	**Total**	**Notes**
Day case	£1,028,459	£178,962	£1,207,421	*allocated PDU to HO; residue CH*
Elective Admission	£212,350	£8,121	£220,471	*allocated PDU to HO; residue 95% HO; 5% CH*
Elective Excess Bed Days	£110,999	£4,877	£115,877	*allocated PDU to HO; residue 95% HO; 5% CH*
Emergency Admission	£778,083	£45,660	£823,742	*allocated PDU to HO; allocated MDU CH; residue 95% HO; 5% CH*
Emergency Excess Bed Days	£90,372	£4,756	£95,129	*proxy 95% HO; 5% CH*
Other	£4,163,074	£219,109	£4,382,183	*proxy 95% HO; 5% CH; detail => predominantly Chemo and CDF*
Outpatient First Attendance	£486,002	£162,001	£648,003	*proxy 75% HO; 25% CH*
Outpatient Follow Up	£862,773	£287,591	£1,150,363	*proxy 75% HO; 25% CH*
Outpatient Procedures	£7,404		£7,404	*allocated PDU to HO; residue CH*
Totals (£s)	£7,739,516	£911,078	£8,650,594	
Totals (%)	**89.47%**	**10.53%**		

5.3 CCC service model projected costs

The expenditure for H-O services on transfer to CCC based on the service model has been projected for a full year at 2021/22 prices as illustrated in the summary table below.

Figure 12: H-O I&E forecast 2021/22 (based on full year)

LUHFT Income and Expenditure	CCC Full Cost Model 21.22
Pay	
Pay - new model	(£1,954,041)
Junior Dr's	(£224,025)
Non Pay	
Direct budget costs	(£150,503)
Drugs	(£4,046,600)
Support Services Costs	(£990,900)
Overheads	(£757,931)
Total Expenditure	**(£8,124,000)**

5.4 Key assumptions underpinning the financial model

The key assumption underpinning this modelling is that the full contract value is made available to support the service on a recurrent basis.

No efficiency savings have been assumed and the intention is that any savings beyond provider efficiency targets will be reinvested to support delivery of outcomes prioritised through the future contracting process with commissioners.

There is no capital planned as part of the future 5-year plan for LUHFT specifically relating to H-O that will transfer with the service.

A review of the finances for research and charitable funds has been requested through the due diligence process.

5.5 Current financial arrangements and risk

The original financial assumption agreed in 2015/16 was that this was a provider to provider service transfer and so no impact upon commissioners. This was when financial arrangements were under Payment by Results (PbR). During 2020/21 and 2021/22 funding has been allocated to where costs are incurred due to current financial arrangements.

Due to the change in funding arrangements from 2021/22 there is an element of stranded costs/retained margin which remains with LUHFT. The annual value of these costs is £1,144k. Discussions have taken place with commissioners to resolve this issue and an approach to risk sharing has been agreed by all organisations.

To ensure that the risk on stranded costs is appropriately managed the following principles have been applied and agreed by relevant Directors to ensure that the services can transfer as intended. The approach includes:

- All party review of stranded cost quantum
- Commissioner financial support for stranded costs (Year 1, £0.7m)
- Residual financial risk to be equally supported by CCC and LUHFT (Year 1, £0.4m)
- Stranded costs to be reviewed in 2022/23 and then annually
- Stranded cost risk to be included in organisation and system financial planning for 2022/23 onwards, where relevant
- Integrated Care System approved process on risk sharing approach

CCC is operating a different clinical and staffing model resulting in slightly increased pay costs when compared to LUHFT. However, it is also likely that some of the direct costs CCC has put forward as support costs (including for clinical support services) are captured within the LUHFT overhead figure.

See table below reflecting cost differentials between Trusts.

Figure 13: Cost differentials between trusts

LUHFT Income and Expenditure	LUHFT Budgeted Cost of Service 2019/20	CCC Full Cost Model 21.22	CCC vs LUHFT Full Cost
Income			
Comissioned Contract	£7,739,516	£7,739,516	
HEE Funded Posts	£224,025	£224,025	
Total Income	**£7,963,541**	**£7,963,541**	
Pay			
Pay - new model	(£1,407,941)	(£1,954,041)	(£546,100)
Junior Dr's	(£224,025)	(£224,025)	£0
Non Pay			£0
Direct budget costs	(£150,503)	(£150,503)	£0
Drugs	(£4,046,600)	(£4,046,600)	£0
Support Services Costs	(£990,900)	(£990,900)	£0
Overheads	(£1,143,572)	(£757,931)	£385,641
Total Expenditure	**(£7,963,541)**	**(£8,124,000)**	**(£160,459)**

Pay has been broken down further, as per table below. This demonstrates that it is likely that some of the support service costs for CCC are included within LUHFT overall contribution to overheads:

Figure 14: Pay cost differentials between trusts

Difference by Staffing Group	CCC Staffing Model	CCC Staffing Model	LUHFT Staffing Model	LUHFT Staffing Model	Difference by Staff Group
	WTE	£	WTE	£	
Admin	10.80	£293,086	4.43	£177,442	(£115,644)
Medical	4.00	£520,000	2.71	£402,880	(£117,120)
Other Medics	0.40	£20,000	0.34	£38,270	£18,270
Nursing	18.10	£747,455	17.04	£763,442	£15,987
Support	8.40	£358,183	0.20	£10,590	(£347,593)
Difference					(£546,101)

The table below shows CCC full costing compared to LUHFT commissioned contract value at 2019/20 prices. No inflationary assumptions have been made in terms of income. Please note income assumptions have not yet been through due diligence.

Figure 15: CCC full costing compared to LUHFT commissioned contract value

LUHFT Income and Expenditure	CCC vs 19.20 Contract Value (excluding inflation)
Income	
Comissioned Contract	£7,739,516
HEE Funded Posts	£224,025
Total Income	**£7,963,541**
Pay	
Pay - new model	(£1,954,041)
Junior Dr's	(£224,025)
Non Pay	
Direct budget costs	(£150,503)
Drugs	(£4,046,600)
Support Services Costs	(£990,900)
Overheads	(£757,931)
Total Expenditure	**(£8,124,000)**
Total Income vs Expemditure	**(£160,459)**

6 Management case

This section sets out how the transformation project has been delivered so far, how the implementation of the preferred option, if approved, will be managed, and how success will be evaluated.

6.1 Governance to date

A project governance structure was detailed in the project initiation document compiled by the joint project team. This governance has been in place from the beginning with key members of staff from CCC and LUHFT working collaboratively.

Each trust has in place a mechanism to take decisions and project updates through its own governance process, through Executive Teams to Trust Boards as required.

The project has been collaboration between CCC and LUHFT working closely with NHS England and CCGs. The project governance reflects a large and diverse stakeholder group covering multiple providers and commissioning organisations.

Information has been held by the project manager to ensure consistency and audit trails. All project documentation has been held in the CCC programme management office; however all documentation has been accessible to colleagues and stakeholders on request.

6.2 Stakeholder engagement

The clinical case for change in H-O is exceptionally strong. Clinicians have driven the proposals from start to finish, supported by their trusts. The strength of clinical consensus that this is the right thing to do is perhaps unparalleled. The combined commitment and experience of the AUH site and CCC, with clinicians leading the call for change, has ensured a strong and successful assurance and engagement processes.

6.2.1 Project stakeholders

Stakeholder mapping was completed as the project commenced and has been reviewed regularly to ensure the list remains current.

Figure 16: Stakeholders

Name of stakeholder
The Clatterbridge Cancer Centre
Liverpool University Hospitals
Liverpool CCG

South Sefton CCG
Southport and Formby CCG
West Lancashire CCG
NHS England, NHS Improvement
Local Authorities and Health Overview and Scrutiny Committees
GPs (via their CCG groups)
Patients/service users (via blood cancer patient support groups, patient engagement/experience committees, targeted engagement and other groups)

6.2.2 Patient and GP engagement

Targeted engagement was carried out with patients/carers during 2020 and 2021 to seek their views on the proposals and their experience of using local blood cancer services. A range of methods were used to offer patients/carers the opportunity to be involved, and to gain qualitative and quantitative feedback.

GP groups in the Sefton area were also engaged with as half of the patients admitted to the AUH site in 2019/20 were from the borough.

Engagement aims

Our aims were to:

- Involve stakeholders affected by service change in line with best practice and our statutory duties.
- Listen and understand their views on the proposals, including any factors they thought we may have overlooked.
- Gain feedback that would help us further enhance blood cancer patient care, develop our final proposals with patients/carers in mind and ensure the maximum benefit from any changes.
- Identify and mitigate any potential issues.

Pre-engagement

The draft proposals and draft engagement approach were shared in advance with patient forums for the Sefton CCGs and Liverpool CCG, Healthwatch representatives from Sefton and Liverpool, and the region's Haematology Patient Support Group (hosted by CCC) for comment. All were happy with the proposed engagement approach. The draft engagement approach and survey questions were also shared with representatives from CCC's Patient Participation Group for comment and a patient perspective.

Equality, diversity & inclusion

A pre-engagement equality impact assessment (EIA) was carried out on the strategic outline case for the proposed service changes. The EIA report in February 2021 (provided in full in the appendices) made recommendations for the engagement process that were taken into account in the development of the methodology.

Methodology

We adopted a range of methods, all focused on people with knowledge/experience of blood cancer:

- Semi-structured phone interviews with current/recent inpatients
- Engagement survey
- Online engagement sessions
- Meetings with patient support groups
- GP meetings.

Findings

There were some clear themes that came out in the engagement. They are summarised below. The full engagement report is available at: https://www.clatterbridgecc.nhs.uk/download_file/10845/3396.

- Patients and relatives/carers were generally satisfied with the care provided by the current services. Patients who had additional needs (e.g. dietary requirements or a disability) generally felt they had been respected. There were some useful suggestions, however, on how this could be further improved.
- Engagement respondees supported the proposed changes to create a single blood cancer team. (A small number of people said this was provided that the change was for clinical reasons rather than financial reasons; this is the case.)
- There was also clear support for the proposed change to inpatient services, with the majority of patients interviewed by phone, online survey responses, and feedback from online engagement events and meetings saying it made sense for the most complex inpatient care to be provided in the specialist cancer centre.
- People who had visited or been treated in the new CCC-L were very positive about it. A number of patients commented on the advantages of having a single room, particularly during the COVID-19 pandemic. Patients who had been inpatients in CCC-L talked about the autonomy they had in their own room, the facilities and how light and airy the rooms were. Comments on hospital food were mixed, with some people preferring the AUH site food and others preferring CCC-L food.
- Although some people – particularly from Sefton and West Lancashire – said CCC-L would be harder for them to get to, they acknowledged the clinical

benefits and did not feel this should stop the proposals from going ahead. Other patients from those areas said they would not be adversely affected by travel. There was one suggestion for mitigating the impact – free parking for visitors. This is already provided at CCC-L.

- A number of the patients interviewed by phone spoke about the impact of the COVID-19 pandemic, including safety measures in hospitals such as visiting restrictions and phone/video consultations. People with blood cancer can be particularly at risk of infection and patients appreciated measures being put in place to reduce infection but also spoke honestly about some of the challenges. For example, hearing-impaired patients found it harder to understand what staff were saying while wearing facemasks or during phone consultations than in a traditional face-to-face setting. A patient who had wanted cancer advice and information (including benefits advice and psychological wellbeing) would have preferred to speak to someone in person rather than over the phone. At the time, drop-in services and face-to-face appointments for these services had been paused/reduced due to COVID-19.

Conclusions and recommendations

The engagement found strong support for the proposals across all groups and channels used. Participants saw clear advantages of creating a single team that would enable greater subspecialisation among clinicians, provide a more resilient staffing model, and result in a larger patient cohort with the potential for a wider range of treatments and clinical trials in future. They also supported the proposed relocation of complex, high-intensity inpatient care from the AUH site to the specialist cancer centre, CCC-L. Reasons included the fact that CCC-L was the specialist cancer centre, solely focused on cancer care, and the quality of facilities provided such as single ensuite rooms. The enhanced scope for infection control was mentioned by a number of patients.

Alongside this, however, there was clear consensus that other services should be maintained on both sites. People who lived closer to the AUH site and supported relocation of the complex inpatient care also said they would want other services to remain local, as planned in the proposals. A number of AUH site patients said they liked the fact that the Phoenix day case unit had been relocated due to COVID-19 and was now a separate building on the Aintree site so they didn't have to go into the main hospital. Patients and relatives/carers were also very complimentary about the care at both hospitals.

Finally, as expected, travel was an important factor although it did not override the clinical case for the proposals. This is in line with feedback from other, larger pieces of engagement and consultation that found people in North Merseyside are prepared to travel further for specialist services if it means they get the best care. One example of this is the 2017 consultation on Trauma & Orthopaedics and ENT services.

In summary the conclusions of the engagement process were:

1. There is strong support for the proposed changes: a single blood cancer service with complex, high-intensity inpatient care at CCC-L and all other care continuing to be provided at both sites.
2. If the proposals do go ahead, CCC should take the following steps:
    a. Provide people with good information about travelling to the hospital and parking arrangements.
    b. Provide social support on inpatient wards, particularly for patients in isolation (e.g. stem cell transplant)
    c. Provide an alternative way for patients to ask for help when they don't need a nurse.

6.2.3 Local authority engagement

Legislation places a statutory duty on NHS organisations to involve stakeholders when planning service improvements or changes. It does not prescribe exactly what form this engagement must take other than for proposals involving "substantial development or variation" of health services. In these cases, the NHS is required to consult local authority health overview and scrutiny committees (OSCs). There is no legal definition of "substantial development or variation" so it is good practice for NHS bodies to engage at an early stage with OSCs for areas affected by the proposals to agree whether or not the proposals met this threshold.

Where a local authority health overview and scrutiny committee decides an NHS organisation plans to make a "substantial variation or development" to health services for constituents, they are required to scrutinise the proposals; if they believe the proposals are not in the health interests of local residents, they may refer them to the Secretary of State for Health.

CCC and LUHFT have been fully committed to ensuring the proposals for H-O undergo appropriate assurance and stakeholder engagement in line with the legislation. It was considered that as this proposal will involve relocating some inpatient activity approximately five miles from the AUH site to the CCC-Liverpool the relevant OSCs might consider the relocation of inpatient beds to be a substantial variation or development for these patients. The engagement strategy has therefore aimed to mitigate this by demonstrating to OSCs that patients have been engaged with and that any concerns have been addressed.

Liverpool, Sefton, Knowsley and West Lancashire OSCs have now considered the proposals set out in this business case, alongside the engagement outlined above. They were satisfied that:

a. The proposals did not constitute a substantial variation/development requiring us to formally consult with their OSC, and
b. Appropriate levels of engagement had been carried out.

6.2.4 Trust and commissioner engagement

Since the transfer of H-O services from RLBUHT in 2017, CCC and the AUH site have engaged regularly to ensure ongoing commitment to the integration of the AUH site H-O service into CCC. Additionally, regular updates have been given to key CCG and NHSE/I commissioner colleagues. Relocating inpatient care will affect patients from the four CCGs in North Mersey and some patients from West Lancashire. We have involved the CCGs and also with Southport and Ormskirk Hospital Trust, whose patients were previously admitted to the AUH site for inpatient care, as part of the engagement strategy. (Inpatients are currently being admitted to CCC-L under Mutual Aid arrangements).

A communications, engagement and EDI working group was established to develop the communications and engagement strategy and facilitate development of the equality impact assessment (EIA). The group initially included representatives from three trusts (CCC, LUHFT and Southport & Ormskirk) and the five CCGs. This was later streamlined to include the two trusts (CCC and LUHFT) and the two Sefton CCGs and Liverpool CCG; Southport & Ormskirk Hospital and Knowsley and West Lancashire CCGs were involved/informed, as appropriate.

In addition NHS England has set out an assurance process for proposals for service reconfiguration, including assessing whether or not they meet the “four tests”: public and patient engagement; patient choice; clinical evidence base; and commissioner support.

CCC has worked with commissioners to ensure the NHSE/I assurance process is navigated successfully. While the majority of H-O services are commissioned by the CCGs, certain elements including chemotherapy are commissioned by NHS England specialised commissioning. The trusts have worked collaboratively with the CCG, specialised commissioners and those carrying out the assurance process to ensure it runs smoothly.

CCC has engaged with NHS England and submitted a strategic outline case for review. To comply with the required process a stage one assurance meeting was convened by NHS England which confirmed that the changes are of no detriment to patients and at which assurance was received that an appropriate level of patient engagement was being carried out.

6.3 Mobilisation

Should the proposal be approved its implementation will be subject to robust governance and project management by CCC. CCC will draw on the recent experience of integrating the RLUH H-O service in 2017 and its expansion into CCC-Liverpool in 2020 when planning the transfer.

A detailed operational plan has been developed outlining how the service will run following its transfer from LUHFT (subject to approval). This operational plan is supported by detailed workforce plans for each area of the service.

A full mobilisation plan is also in development outlining the necessary preparations that need to be made in each of a number of key supporting areas to allow a successful service transfer to take place once agreed. This includes mobilisation plans for areas such as imaging, digital, workforce, research and administrative services. These individual mobilisation plans will be drawn together into a single overarching plan and subject to rigorous testing and scrutiny prior to the transfer of the service.

6.4 Project risks

The delivery of the preferred option does not create risk, and indeed addresses a number of current risks. As this is a clinically led proposed model of care there is no risk to patient care, and current risks such as reduced consultant numbers will be addressed.

Project risks have been recorded on a dedicated project risk register throughout the process and have been monitored by the programme management office support from each trust, forming part of the highlight reporting process. This approach to managing the project risks will continue into the implementation phase.

The high level risks, both to the development of these proposals and their successful implementation, are summarised below.

Figure 17: Risks and mitigations

Risk category	Risk description	Mitigations
Provider	Risk of unknown consequences and impact on providers	The trusts have worked collaboratively to create the proposed model of care. There will be robust business cases for each executive team to receive assurance. There is a shared Clinical Director of the H-O services at the AUH site and CCC to reduce this risk.

Risk category	Risk description	Mitigations
Commissioner	Risk of commissioner affordability and unexpected costs in the revised clinical change model	Commissioners are represented on the project groups and each trust has strong working relations with their specific commissioning team. The risk of unexpected costs will be managed by strong engagement and transparency of the completed business cases.
Patient care	The proposed model does not deliver the enhanced care it is expected to	The model is building on that already implemented. CCGs and providers are all represented in the project. Senior clinical leadership is being delivered via a shared H-O Clinical Director who works both at the AUH site and CCC. Project delivery will have key work streams managed by clinical/nursing and allied health professional staff to ensure patient care is not compromised.
Workforce	Poorly managed transition adversely impacts morale, retention and safe staffing and is of detriment to both providers	A workforce transition plan will be developed as part of the project delivery plan. This will have input from all key stakeholders via work stream groups and also be signed off by both trusts.
Finance	Poorly managed transition creates additional costs, unrecovered income or weak expenditure controls such as “stranded costs”	Detailed financial risk assessment will be undertaken and form part of the business case process.
Ops and Performance	Poorly managed transition adversely impacts delivery of	There is dedicated project management and operational management support across the

Risk category	Risk description	Mitigations
	operational performance targets and day to day running of services – affecting both providers and commissioners	trusts. There are key work streams who will monitor delivery of each element to ensure services are not adversely affected. There is also commissioner engagement via the project steering group.
Strategic	Poorly managed transition adversely impacts clinical, managerial and board relationships between CCC and LUHFT, and also CCGs/other commissioners	Effective joint oversight of work stream at steering group and robust programme reporting and governance. All teams are working collaboratively and all stakeholders have been highly engaged.
Strategic	CCGs, Trust Board and other key external stakeholders not supportive of the project	Full engagement has been carried out with all key stakeholders throughout the process. Regular routes for communication and update are in place via governance arrangements.
Quality/safety	Poorly managed transition increases patient exposure to clinical risks e.g. lack of continuity of care	Detailed clinical risk assessment required ahead of all changes, the project is driven by lead clinicians for each area supported by nursing colleagues. There is a shared Clinical Director of H-O services at the AUH site and CCC to reduce this risk.
Reputation	Poorly managed transition adversely impacts on reputation of CCC and/or LUHFT and undermines public confidence in delivery	Effective joint oversight of work streams via the project group level and robust programme reporting and governance across all providers and commissioning organisations.

Risk category	Risk description	Mitigations
	of future major service changes There may also be a risk to commissioning organisations	

6.5 Assumptions, dependencies and constraints

6.5.1 Assumptions

It is assumed that the previous support for this project amongst clinicians, trusts and commissioners across Merseyside remains and that commitment to delivery is not compromised.

6.5.2 Dependencies

Key interdependencies have been mapped by the project team and are as follows.

Figure 18: Key interdependencies

Category	Interdependency
Trust engagement	The trusts are required to work collaboratively to deliver this work, at a time where operational pressures are unprecedented.
CCGs, Local Authorities and Patients	All these stakeholders will need to support the proposed changes and be active in delivery, ensuring the model meets all delivery points.
Clinical engagement	The model will be driven by best clinical practice and clinically driven. The proposal will be dependent on continued clinical engagement and buy in.
Patient engagement	The model will be driven by best clinical practice and clinically driven. The proposal will be dependent on patient engagement and buy in. Learning from service users what are the most important aspects in their care.

6.5.3 Constraints

It is acknowledged the unification and transfer of services is not without constraints. However, as demonstrated by the transfer of the RLUH service to CCC in 2017, this can be mitigated with planning, control and collaboration between stakeholders to enable a successful service transfer that will truly transform the way in H–O services are delivered.

The proposal is subject to the separation of clinical haematology services from H-O services at the AUH site. The intention is for the non-malignant haematology services at the AUH site to be spilt out from the malignant services at the same time as, or before, the transfer of H-O services. This is supported by an adjacent project within LUHFT to manage the merging of their two clinical haematology teams following the creation of LUHFT.

6.6 Investment evaluation

Should the integration proposed proceed, it will be reviewed and managed as part of CCC's contracts with commissioners and within its internal governance structures.

CCC will perform a post-implementation review that specifically measures the improvements to the H-O service following integration. The basis for measurement will need to be agreed in due course along with a framework for how and when the service is assessed.

7 Appendices

7.1 Glossary and abbreviations

Phrase or abbreviation	Description
AUH site	Aintree University Hospital – now the Aintree site of LUHFT
CCC	The Clatterbridge Cancer Centre NHS Foundation Trust
CCC-L	Clatterbridge Cancer Centre – Liverpool
CCG	Clinical Commissioning Group
Clinical haematology	Non blood cancer haematology services
General haematology	Same as clinical haematology, though sometimes used to refer to all haematology services as one (Clinical and H-O, cancer/non cancer)
HEE	Health Education England
H-O	Haemato-oncology – the diagnosis and treatment of blood cancers
LUHFT	Liverpool University Hospitals NHS Foundation Trust
NHSE/I	NHS England and NHS Improvement
OSC	Overview and Scrutiny Committee
RLUH	The Royal Liverpool Hospital (now part of LUHFT)
RLBUHT	Royal Liverpool Broadgreen University Hospitals Trust (now part of LUHFT)
SACT	Systemic anti-cancer therapy
TYA	Teenage and Young Adults

7.2 Options appraisal

Criteria	Critical Success Factor	Option 1 Do Nothing	Option 2 Integration	Option 3 Collaboration	Comments / conclusions
Quality	The proposed option will improve the health and wellbeing of the population receiving services	✓	✓✓✓	✓✓	The key objective for local and national cancer care is local where possible, central where necessary. Without integration the AUH site H-O service cannot fulfil its ambition to deliver services closer to home. Aligning the AUH site service with CCCs hub and spoke model is fundamental to the future success of the North Mersey H-O service. Without integration, there will continue to be disparity in access to novel therapies and clinical trials between AUH site and CCC-L. Greater collaboration between Trusts would assist but the ambition can only be fully realised with integration with other H-O / oncology services
	The proposed option will allow service to deliver improved clinical outcomes and standards	✓✓	✓✓✓	✓✓	The services currently deliver a good standard of care for patients and are meeting most required cancer targets. However, the current clinical outcomes are below those achieved within other cancer centres. Evidence suggests that outcomes are improved with dedicated sub specialist teams and access to specialist cancer care of which can be achieve within an integrated H-O services, delivered in a comprehensive cancer centre. Bringing services together in this way will create a concentration of skills and expertise that will bring benefits for both safety and quality of care.

Criteria	Critical Success Factor	Option 1 Do Nothing	Option 2 Integration	Option 3 Collaboration	Comments / conclusions
					The only option to realise benefits, unification and sub speciality care is achieving full integration
	The proposed option will allow services to deliver a positive patient experience and allow patients to be as involved as they wish to be in decision-making about their care and outcomes	✓✓	✓✓✓	✓✓	More patients will have access to dedicated state of the art H-O specialist care support / beds and services More patients will also have access to dedicated specialist cancer care and support services such as currently provided at CCC
	The proposed option will improve staff satisfaction and facilitate appropriate recruitment, retention and training	✓✓	✓✓✓	✓✓	With the loss in acute leukaemia care in AUH site staff have expressed concern about the future of H-O service and many have left the Trust. A H-O service without acute leukaemia or access to specialist cancer care will not attract consultant medical staff, thus the service will be unsustainable, With the proposed model staff would have assurances that patient care for H-O will be a key priority and focus. Staff would have access to an H-O / oncology / cancer skills escalator and development programmes that will facilitate training and development and secure retention of staff. Staff will also have opportunities for rotation across sites and services.

Criteria	Critical Success Factor	Option 1 Do Nothing	Option 2 Integration	Option 3 Collaboration	Comments / conclusions
					This could be achieved through closer collaboration but may not be feasible due to the lower number of staff within AUH site teams.
Feasibility	The proposed option is deliverable within contractual and regulatory obligations	✓✓✓	✓✓✓	✓✓✓	Activity data is available within all organisations as well as adherence to NHS standards
	The proposed option appropriately recognises current and future workforce requirements	✓✓	✓✓✓	✓✓	CCC has devised an integrated workforce plan for 2020 onwards. Several projects are also underway across a whole range of services that map current and future workforce requirements enabling planning of any gaps identified. OBC clearly demonstrates specialist centre workforce benefits realisation.
	The proposed option optimises the delivery of services on the available estate	✓	✓✓✓	✓✓✓	The proposed option would deliver an inpatient bed base for H-O and access to a dedicated CDU within CCC. Thus releasing capacity within AUH site (beds and A&E)
	Delivery of general Haematology services	✓✓✓	✓✓✓	✓✓✓	All options deliver the factor.
	Is the option achievable and minimises	✓✓✓	✓✓✓	✓✓✓	A do nothing is always easier to implement and there would be no transition risk should the service remain where is it.

Criteria	Critical Success Factor	Option 1 Do Nothing	Option 2 Integration	Option 3 Collaboration	Comments / conclusions
	implementation and transition risks				
Financial Sustainability	The proposed option helps to achieve recurrent financial sustainability for the service	✓✓	✓✓✓	✓✓✓	
	The proposed option is financially deliverable given likely funding constraints	✓✓✓	✓✓✓	✓✓✓	
	Aggregated project costs	✓✓✓	✓✓✓	✓✓	Proposed Option 2 is feasible as there is dedicated resource within CCC Closer collaboration may have less resource and would impact on the feasibility and delivery of this model
Strategic Fit	The proposed option aligns with the goals of the Healthier Liverpool Programme	✓✓	✓✓✓	✓✓	Proposed Option 2 would improve outcomes as described in the value based metrics which was developed in line with the HLP. Greater collaboration between Trusts would assist but once again the ambition can only be fully realised with integration with other H-O / oncology services
	The proposed option supports the delivery of the national and local IT strategy	✓✓	✓✓	✓✓	Ongoing works with clinical interfaces between both organisations are underway. These would support any option

Criteria	Critical Success Factor	Option 1 Do Nothing	Option 2 Integration	Option 3 Collaboration	Comments / conclusions
					This includes GDE projects such as the clinical portal
	The proposed option supports the delivery of STP [i.e. supports the aims of the integrated care system]	✓	✓✓✓	✓✓	Proposed model enables the creation of a single city-wide H-O service in line with the STP [i.e. in line with the Health Liverpool Blueprint] This factor could be realised with closer collaboration but once again will be constrained between the management and governance of services between the trusts
	The proposed option provides a platform for increased research and development	✓	✓✓✓	✓✓	H-O research across Liverpool is extensive however, site is limited by not being part of a cancer centre, having access to sub speciality trials and internationally renowned CCC H-O academics. Bringing the services together would build on the success delivered at CCC and would enable H-O patients to have equitable access to a large portfolio of trials. Again collaboration between Trusts would provide greater scope to increase R&I but this would be constrained by the inevitable fragmentation of services between Trusts that a full transfer to CCC circumvents
	Reputational impact	✓✓	✓✓✓	✓✓	Proposed Option 2 was supported by Liverpool CCG through a full Business Case and forms part of the Healthy Liverpool Blueprint.

Criteria	Critical Success Factor	Option 1 Do Nothing	Option 2 Integration	Option 3 Collaboration	Comments / conclusions
					By not integrating services this may have a reputational damage to the organisations due to the failure in the delivery of a key priority for this blueprint
	Total	**35** **69%**	**50** **98%**	**41** **80%**	(Total max score available = 51/100%)

7.3 Equality impact assessment

Equality Analysis: Final Report
Report v7

Haemato-Oncology inpatient services reconfiguration and service integration

Liverpool University Hospitals NHS FT and The Clatterbridge Cancer Centre NHS FT

Start Date:	Scoping meeting Oct 2020 Pre-engagement EA December 2020 Post- engagement EA July 2021	
Equality and Inclusion Service Signature and Date:	Jo Roberts	8th January 2021 8th February 2021 11th February 2021 12th February 2021 15th July 2021 29th July 2021
Finish Date:		29th July 2021
Sign off should be in line with the relevant NHS organisations' Operational Scheme of Delegation		
The Clatterbridge Cancer Centre Lead Officer Signature	Name:	Date of review:
The Clatterbridge Cancer Centre Committee	Committee Name:	Date considered:
Liverpool University Hospitals NHS FT Lead Officer Signature	Name:	Date of review:
Liverpool University Hospitals NHS FT Committee	Committee Name:	Date considered:
South Sefton CCG Lead Officer Signature	Name:	Date of review:
South Sefton CCG Committee	Committee Name:	Date considered:
Liverpool CCG Lead Officer Signature	Name:	Date of review:
Liverpool CCG Committee	Committee Name:	Date considered:

Document control:

Version	Type of changes	Date
V1	Original doc	08.01.2021
V2	Text edits / answer questions	01.02.2021
V3	Update patient data	08.02.2021
V4	Update patient data	11.02.2021
V5	Narrative amended specific to travel questions. Risk section updated.	12.02.2021
V6	Final analysis	15.07.2021
V7	Final edits	29.07.2021

1. Details of service / function:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.

The acute providers in North Mersey – which were the Royal Liverpool & Broadgreen University Hospitals NHS Trust (RLBUHT)[4], Aintree University Hospital NHS Foundation Trust (AUHFT) and Southport and Ormskirk Hospital NHS Trust (S&O) when this project began – have historically all provided comprehensive Haematology services, including both malignant (Haemato-Oncology) services, and non-malignant clinical haematology services. In addition, RLBUHT provided specialist services for Haemostasis and Thrombosis and also Haemoglobinopathies and Thrombotic Microangiopathy.

Following a proposal made by the haemato-oncology clinicians, the executive teams of the respective organisations agreed to explore the migration of Haemato-Oncology services from RLBUHT and AUH to The Clatterbridge Cancer Centre NHS Foundation Trust (CCC). The management integration of RLBUHT Haemato-Oncology services occurred in July 2017 and it had been originally proposed that the AUHT Haemato-Oncology services would integrate with CCC at a later date. Both trusts are now in a position to manage this move in 2021.

The clinical case for change sets out how Haemato-Oncology (H-O) services across Liverpool and North Mersey can achieve the best care and treatment through a reconfiguration in the way in which H-O services are delivered.

The proposals will significantly enhance care for people with H-O cancers by:

- Creating a single, resilient service by concentrating teams and resources to enable greater sub-specialisation for this increasingly complex group of cancers.
- Transferring management of the Aintree University Hospital site (AUH site) service from Liverpool University Hospitals NHS Foundation Trust (LUHFT) to the management of The Clatterbridge Cancer Centre NHS Foundation Trust (CCC), which already provides the majority of H-O care in Liverpool.
- Relocating six inpatient Haemato-Oncology (H-O) beds worth of activity from the AUH site to the new CCC–Liverpool, the specialist centre.
- Continuing to provide chemotherapy, day case treatments and outpatient appointments at the AUH site under the management of CCC.

This proposal involves changes to the way North Mersey H-O services are delivered.

Within North Mersey adult H-O services are provided by both CCC and AUH site. These services provide emergency and non-emergency care that may:

- Diagnose blood cancer or disorders using a wide range of diagnostics such as scans and biopsies
- Treat blood cancers or disorders with chemotherapy, other medication or radiotherapy

[4] RLBUHT and AUHFT merged on 1st October 2019 to create Liverpool University Hospitals NHS Foundation Trust (LUHFT). AUH site is used in this document to refer to the Aintree University Hospital site, not just the former trust.

- Provide long term follow-up

However, currently, the ways in which these services are delivered differ between both organisations and services. CCC is a specialist regional service and is the only provider for Teenage and Young Adult services and adult Bone Marrow Transplantation within Cheshire and Merseyside. The nearest other Level Four (i.e. transplant) units are Manchester University NHS Foundation Trust and The Christie NHS Foundation Trust.

The clinical service at CCC is spilt into four specialities which are delivered by a multi-disciplinary team that are aligned to the four H-O specialities. The haematology medical and nursing teams at the AUH site currently provide H-O care as well as care for a number of non-malignant conditions.

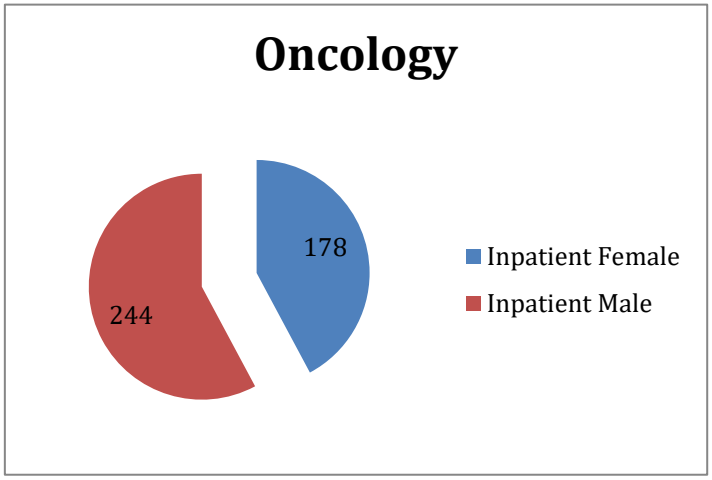
Due to the increasing number of speciality diagnoses and the availability of ever more complex therapies, it is widely recognised that H-O conditions should be managed by subspecialist H-O multidisciplinary teams, a model now mandated nationally and described in the various Improving Outcomes Guidance and NICE guidelines available.

Without integration of the AUH site service into CCC, H-O services at the AUH site would become an even greater standalone sub-specialty, with H-O clinicians becoming increasingly isolated. Moreover H-O patients will not receive equitable access to dedicated cancer services, novel therapies, clinical trials, home chemotherapy and the hub-and-spoke model of care.

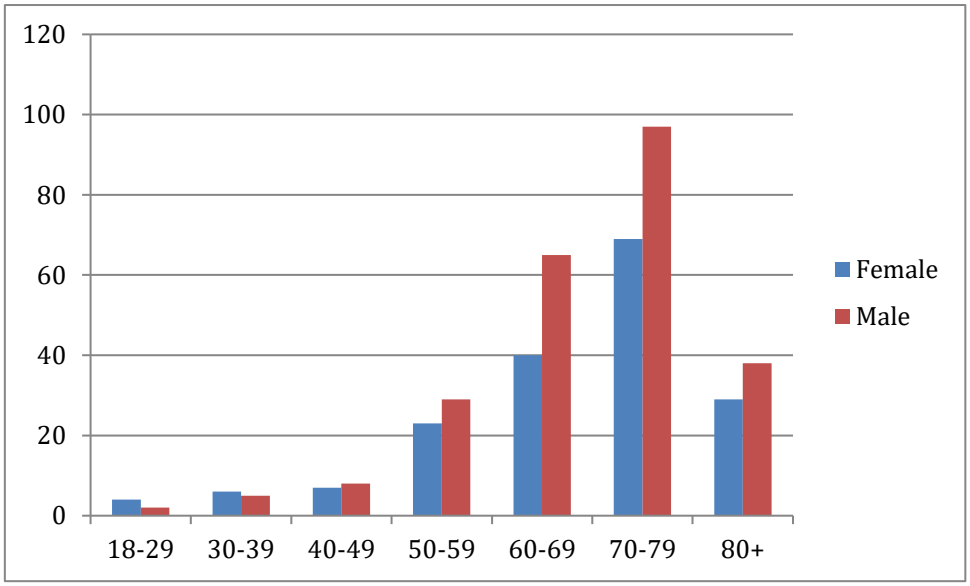
Table and chart below describes 2019 activity information for the H-O service including: outpatients, day cases and inpatient services. These figures are derived from commissioned modelling work undertaken with AUH site and CCC Business Intelligence.

	CCC	AUH site
New Outpatient Appointments	1,312	878
Follow-Up Outpatient Appointment	16,869	5,551
Inpatient admission	700	422
All patients treatment and chemotherapy	5,066	2,273

The figure below shows activity during January 2019 to December 2019 by male and female inpatient admissions at Aintree University Hospitals NHS FT. Total 422.



The chart below shows January 2019 to December 2019 inpatient admissions to the Aintree University Hospital site count by sex and age group.



Review of data indicates that the majority of patients are in the older age ranges starting from 50's. Many patients are anticipated to be retired and may already be frail with age.

Service Reconfiguration Proposal

The proposed reconfiguration of services would affect the way H-O services are delivered and the access/location of services for patients living in the North of the area. The proposal has two strands: firstly, it involves unifying both CCC and AUH site clinical teams in sub-specialist teams to deliver care across the two sites and, secondly, changes to patient pathways and points of access.

Unification of sub-specialist teams

The CCC clinical service is split into four overarching specialties and is delivered by a multi-disciplinary team aligned to the four H-O specialties. If the proposals are approved, the LUHFT Aintree site clinicians will align to this model of care within the CCC Acute Care Division and will be split as demonstrated in Figures 1 and 2.

Figure One: CCC and AUH site as it is currently structured

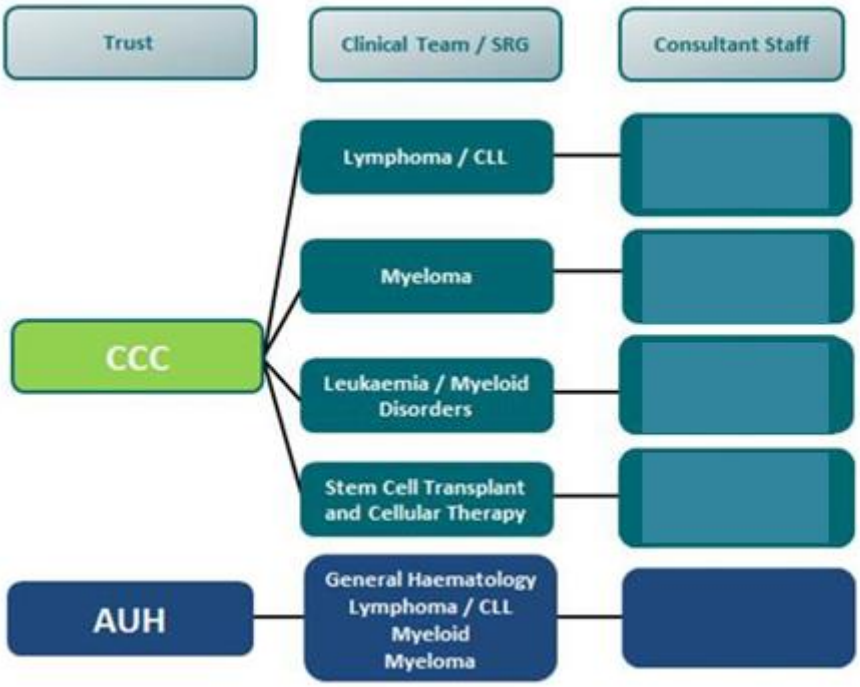
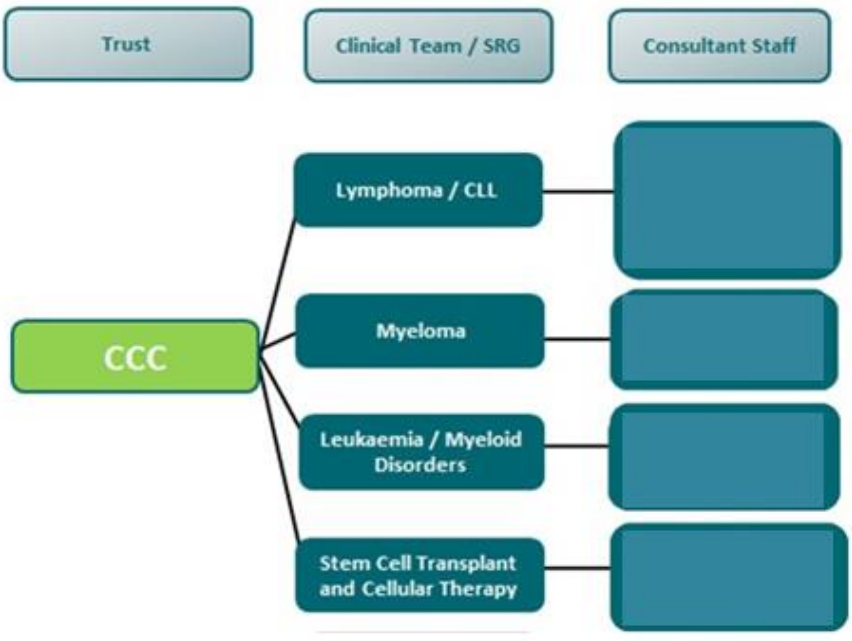


Figure Two: CCC Proposed structure



What is the **legitimate aim** of the service change / redesign

The case for change is to develop a more cohesive unit with significant benefits for the patients and staff of H-O services. These include:

- Improved clinical outcomes
- Enhanced safety and quality for patients
- Enhanced patient experience
- Improved access to specialist care for all patients with blood cancer
- Enhanced community provision and patient choice (as part of the CCC Future Clinical Model Project)
- Enhanced cancer service brand and reputation
- Addressing growth by increasing capacity and capability

2. Change to service

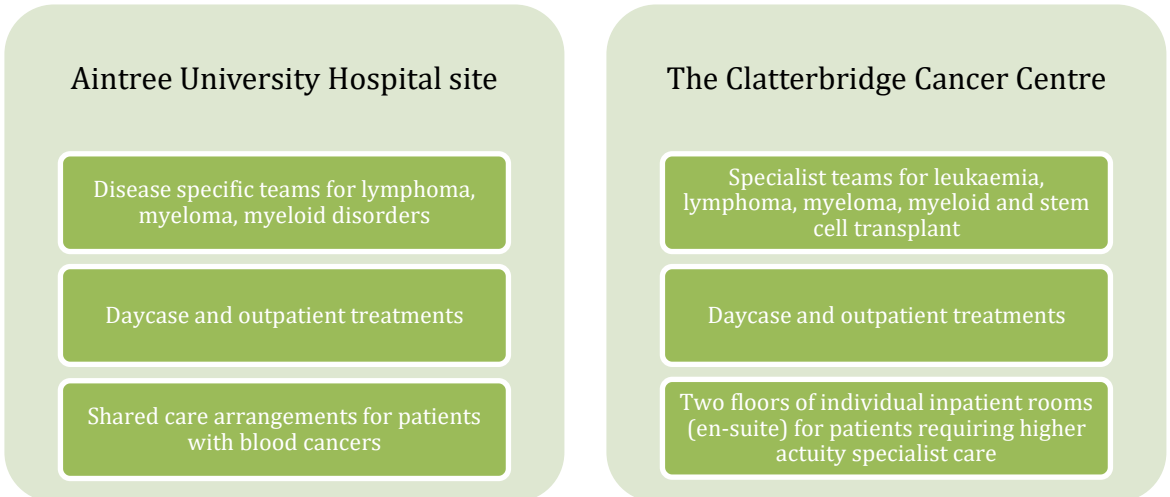
The proposed transformation would see a change in the ***patient pathway*** and ***patient access points*** as it is proposed that a hub and spoke model of care will be used, with the aim of delivering local care where possible, and centralised care where necessary. This is across both elective and non-elective model of care as described in Figures 1 and 2.

This proposal will mean that:

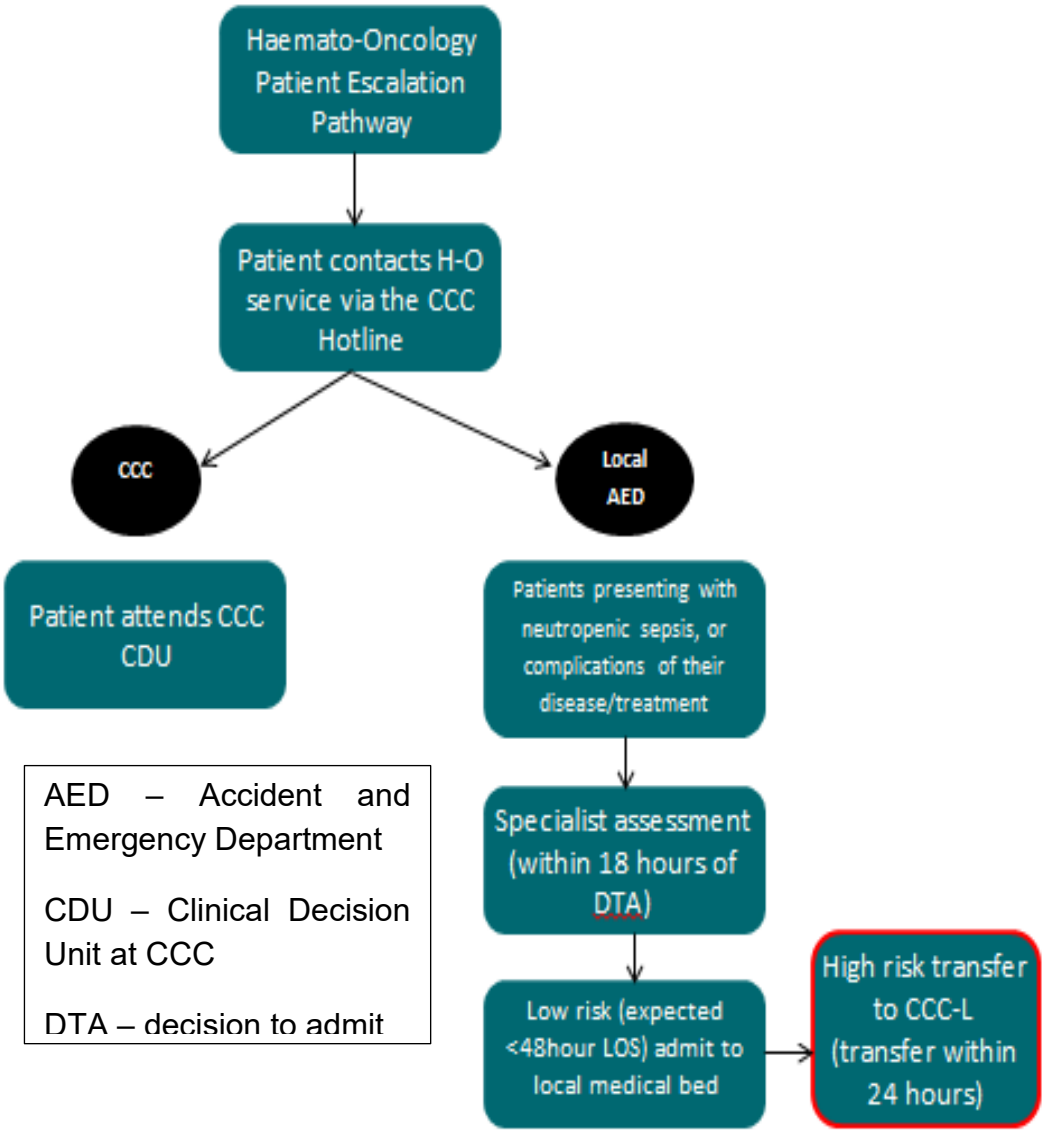
1. Higher acuity inpatient pathways of care will be delivered in CCC-L. This equates to six inpatient beds worth of activity to be transferred from AUH site to CCC-L
2. Complex pathways of care such as acute leukaemia and stem cell transplants will remain within CCC-L
3. Outpatient and day care will be delivered across both sites, CCC-L and AUH site
4. Emergency Pathways of care will be supported by CCC's 24/7 hotline service and rapid access to CCC-L
5. Shared care pathways for patients whose primary condition is not H-O, such as frailty, will continue to be clinically managed by AUH site in line with the CCC/LUHFT model of care.

Whilst the 'behind the scenes' management of the service will shift to CCC-L, from a patient perspective only points 1 and 4 above will mean a visible shift in current service supply. As such, the restructuring presents a minimal shift in service provision from a patient perspective. The biggest change, from a patient perspective, will be the transfer of beds from AUH site to CCC-L and case management from CCC-L.

Proposed Elective Inpatient and Outpatient Model of Care



Proposed Emergency Pathway Model of Care



AED – Accident and Emergency Department

CDU – Clinical Decision Unit at CCC

DTA – decision to admit

The creation of a single H-O service with a hub-and-spoke model of care connected to a dedicated centre (CCC-L) will instigate fundamental improvements in the quality of service provision.

Faster diagnosis and treatment: The future goal for H-O is a 'one stop shop' for diagnosis and staging of haematological malignancies, with the intention being that such a service has the potential to dramatically cut waiting times and improve survivorship. CCC is working with the Cheshire and Merseyside Cancer Alliance to support Rapid Diagnostic Centres. An integrated service would benefit from CCC's involvement in this project.

Reduced Length of Stay: Reviews of the current H-O patient pathways highlights the potential scope to reduce length of stay and improve patient experience, through transforming the current fragmented service into a more operationally efficient, all-encompassing single clinical model.

Improved mortality rates: There is clinical evidence (such as via NICE) which demonstrates that H-O outcomes can be improved through treatment in large specialist cancer centres, which is a compelling argument for centralisation of the care of complex inpatients from the AUH site. Wider team working will enhance knowledge and skills in all team members.

Access to CCC Clinical Decisions Unit/Helpline: The current H-O service lacks a streamlined admissions process which may cause delays in delivering specialist care to patients. Many patients present directly to A&E at both the AUH site and Southport and Ormskirk Hospitals (S&O) which can result in a delay to accessing a specialist oncology assessment. S&O has no H-O inpatient beds and those patients are currently admitted to the AUH site. CCC has a dedicated 24/7 helpline and access to a Clinical Decisions Unit (CDU) for patients under the care of the centre. AUH site patients would benefit from this specialist access, reducing attendance at local A&E. The helpline is staffed by specialist cancer nurses who provide urgent care advice on a 24 hour basis to patients and other health professionals.

COVID-19 and hospital acquired infection: H-O patients are in the highest risk category as regards infection. The pandemic has led to organisations across the network working together in the spirit of mutual aid to protect patients as far as possible. CCC-L has allowed H-O patients to be transferred from high risk 'hot' centres such as the AUH site, to a 'cold' centre, with enhanced COVID-19 measures. Strict infection control policies and protocols and the single ensuite patient accommodation in the new cancer centre greatly improves effective infection control.

Research: The inclusion of AUH site H-O within CCC will drive the research agenda forward, facilitating a centre of cancer research excellence and a focused research team. A significant amount of H-O research is already undertaken across the city of Liverpool but more could be done with access to a greater pool of patients. This would also provide AUH site patients with equitable access to clinical trials to that of CCC H-O patients.

The AUH site is the superregional centre for primary CNS lymphoma patients, and has an established pathway with the Walton Centre for Neurology and Neurosurgery (WCNN), and regularly receives patients from Wales and the Isle of Man. It is one of only four UK centres recruiting to national and international phase three trials in this rare condition. Closer relationships between the AUH site, CCC and WCNN will improve patient access to specialist transplant services and reduce delays to pathway.

Dedicated beds: The CDU in CCC-L will ensure all patients are admitted into a dedicated H-O bed. This cannot be guaranteed at the AUH site, due to the acute admissions pathway in place which results in H-O patients often passing through multiple acute medical areas before reaching a specialist H-O bed. Thus patients admitted to CCC-L will benefit immediately from specialist input.

Improved pathways: There is currently fragmentation across the stem cell transplant pathways, MDT, and access to clinical trials. Unification will reduce any risk associated with patients being managed/referred across to separate organisations. This will additionally make the system robust and further comply with NICE guidance (2016).

Community care: CCC provides a Clatterbridge in the Community service where patients can receive their treatment at home or at work. As this expands to include more H-O treatments AUH site patients could benefit from this service.

Addressing capacity constraints and releasing beds to the healthcare economy: The proposed H-O facility at CCC does not increase the current H-O bed base substantially but offers the flexibility for growth and the ability to flex between solid tumour and H-O beds. CCC has the added feature of 15 High-efficiency particulate air (HEPA) filtered rooms. This capacity, coupled with a dedicated clinical decision unit, would free up capacity across the health economy, and help support a busy acute trust, in particular when COVID-19 is a challenge.

Workforce: The British Society for Haematology published a paper in 2019 that identified a number of issues affecting the H-O workforce. This included the number of vacancies at a time when there is an increase in incidence of this cancer type, and also an increase in the complexity of treatment required. This is further impacted by the reduced number of trainees being recruited to, with numbers having fallen over 36% in the last two years. This then impacts on the current workforce with increases in stress and sickness. This redesign helps to mitigate some of these issues to ensure that patients do not face barriers to diagnostics, and novel treatments.

3. Potential barriers relevant to the protected characteristics.

H-O services, albeit over two sites, has been delivering its services already in light of statutory demands of the Public Sector Equality Duty (PSED).

Part of the engagement with patients will be to identify any negative impact that they may have experienced linked to their protected characteristics (see section 5 below)

One of the concerns that automatically stands out is the issue of (public) travel and the fact that the formation of the new service means that inpatient admissions will be to CCC-L and not the AUH site. In logistical terms this means that people from the north of the city (AUH site area) may incur additional travel times and when using public transport may have to travel across the city centre. However, patients who require admission will be supported to attend CCC-L via the local ambulance service or taxi firms (via contract). Most public transport is designed to pull people into the centre and not necessarily carry them across the centre. This may mean family and friends who wish to visit an inpatient may have to make multiple 'bus trips' as part of one journey. The impact of this will be on those that rely on public transport as their only means of travel, which includes (in more cases than not) women, older women and older men, low income families, and people with disabilities who cannot drive (e.g., partially sighted).

Families without cars or access to cars may be paying for taxis which are an unanticipated cost for families on small budgets. As such the impact of travel needs to be evaluated and mitigated as far as possible. However, it's worth noting that CCC-L is the only level 4 cancer service in the Merseyside and Cheshire regions. The next other level 4 cancer services are in Manchester. Compared to the difficulty of travelling to Manchester, travelling across the city is less daunting. CCC also has a dedicated team who work with patients and relatives to help them access benefits and charitable funds to support low income families who are experiencing additional cost due to illness.

Travel

Review of the 157 patients who could move from the AUH site to CCC-L for inpatient care has been undertaken. There is a physical distance of 5.5 miles (by road) between the two sites.

Patients who were admitted to CCC-L after attending the AUH site would not be disadvantaged by this distance as they would be transferred using patient transport.

Patients from the North Mersey area who were asked to attend directly to CCC-L (thus avoiding A&E at AUH site or S&O) will potentially be affected. It's assumed in most cases patients will be brought to hospital by a friend/relative or taxi as they will be too unwell for public transport or to drive themselves. There may be some who meet the criteria for NWAS transport.

An initial travel assessment has been carried out of the impact on journey times from the four CCG areas that most of the 157 patients in 2019 came from. The following table shows average increased journey times by private vehicle or public transport of between zero and 16 minutes, depending on the starting point. It is believed the clinical benefits of providing inpatient care in the specialist cancer centre at CCC-L outweigh the impact on journey times for patients' families and friends, but patients' views will be sought on this as part of the engagement process.

CCC-L has dedicated drop off zones for both ambulance transfer or for family/carer drop off. These are adjacent to the main entrance and porters are available to provide wheelchair support if required. Patients can access parking in a dedicated car park (This is currently at Mount Pleasant but will be at Paddington Village from autumn/September 2021.) There is a shuttle bus that operates from the car park to the CCC-L main entrance.

Visitors to CCC-L have access to a number of nearby car parks. The hospital's new car park in Paddington Village will open in 2021. The University of Liverpool has reduced parking rates after 17.30 (£3.00 max per visit) for evening visits. There is a Q Park multi storey car park adjacent to the Royal Hospital, and some smaller, privately run, car parks in the area. Parking is also available at reasonable rates in Mount Pleasant.

There are a number of public transport options for patients' family and friends. CCC-L is readily accessible by public transport as it is located next to the Royal Liverpool University Hospital and the University of Liverpool. There is a bus from the AUH site to the Royal, operating every 8 minutes and taking 20 minutes. CCC-L is also close to Lime Street station for train access. There are links to the Merseytravel journey planner from CCC's website and there will be further liaison with Merseytravel as part of this process so patients have information about the best routes for the main journeys.

Table to show average times (minutes) for travel

	Journey time to AUH by car (mins)	Journey time to AUH by public transport (mins)	Journey time to CCC-L by car (mins)	Journey time to CCC-L by public transport (mins)	Average difference by car (mins)	Average difference by public transport (mins)
Knowsley	14	38	29	45	16 mins more	7 mins more
Liverpool	14	25	17	26	3 mins more	1 min less
Southport & Formby	34	74	51	67	16 mins more	7 mins less
South Sefton	18	37	27	46	9 mins more	9 mins more
West Lancs	29	72	42	86	13 mins more	14 mins more

The chart shows that public transport travel time is usually twice that of private car, and the switch from the AUH site to CCC-L is adding around at worst 16 minutes of travel time. This was based on total journey times in Google Maps which includes waiting/transfer times in the journey.

Potential discriminatory barriers in providing the service.

The table below looks at issues highlighted by patient engagement and if they present particular discriminatory barriers and if so how can these be mitigated.

Protected Characteristic	Issue	Remedy/Mitigation
Age: Majority of service users over 50 and of this cohort the 70 year old plus make up the biggest group.	The overall consensus was that the service is warmly received. Transport/ travel were highlighted as an issue, but it was generally felt that the additional travel to get to a better service was acceptable.	Continue to put patients at the centre of the service Help with travel costs is available for patients: https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/ The Trust signpost to https://www.macmillan.org.uk/cancer-information-and-support/impacts-of-cancer/benefits-and-financial-support Free parking will be available in Paddington Village, a newly-constructed car park opening in September 2021 and therefore fully compliant with the latest accessibility standards. The car park is just a few minutes from the hospital and we will run a frequent shuttle bus, providing a door-to-door service for patients and visitors. Drop-off facilities are also available right outside Clatterbridge Cancer Centre – Liverpool to assist people with reduced mobility or other additional needs. The Trust advertises links to Merseytravel and the Cancer Information & Support Centre team in CCC-L can help anyone who may not have internet access to determine the best travel tickets for them. Consider individual patient/ family needs in the event of

		further COVID-19 waves/ variants and travel impacts.
Disability. Cancer is described as a disability under the Equality Act 2010.	Concerns were raised by some patients in relation to: - support with mental health issues. - access to psychological support - changes to consultation types e.g. virtual (which were part of the organisation's response to COVID-19) presented difficulties for patients who for example were Deaf and/ or preferred face to face appointments. Transport/ travel – **refer to Age.**	CCC has an SLA with Mersey Care NHS FT to ensure that specialist mental health support is available to assist where patients have mental health conditions. CCC to continue to promote the psychological support available to patients. Ensure staff are aware of how to support patients with sensory impairments including access to BSL interpreter provision and providing reasonable adjustments.
Gender reassignment	No issues identified, but a trans person may need specific support, especially about keeping their trans status private on the ward.	Ensure that protocols are in place to support trans patients.
Marriage and Civil Partnership	Family expressed concern over lack of visitation due to COVID-19.	Consider methods by which family could participate more in the patients care and continually review COVID-19 restrictions on ward visitation.
Pregnancy and maternity	Protocols and policy in pace as to the affect chemo may have on a foetus.	Consider wellbeing of mother and child in relation to treatment plan. Research shows that **chemotherapy** is generally safe for both the mother and the baby during the second and third trimesters, after the baby's organs have fully developed. However, radiation therapy and hormone therapy should be delayed until after a **pregnant** woman has given birth.
Race	There were no responses from other ethnic minorities.	Ensure that services are culturally sensitive. Ensure there is access to interpreter provision for people whose first language isn't English.

		Ongoing monitoring of patient experience/ feedback. Ongoing monitoring of care/outcomes across all protected characteristics.
Religion and belief	No comments were made in relation to religion from the consultation group.	Ensure patients can practice their religion as long as it is safe for them to do so.
Sex (Male /Female) Patient numbers are almost a 50% split between male/female.	Both males and females expressed how good the service was. Any criticism appeared to be non-gender specific and revolved around the general practicalities of hospital life. Transport/ travel – **refer to Age.**	Continue to provide high quality services and pick up concerns highlighted in section 5 below.
Sexual orientation	No concerns were raised on this issue.	Continue to provide quality services to all patients.
Health inequalities	H-O local outcomes historically differed significantly from the national average, and whilst joint working has improved this, a further consolidation of the teams would continue to support these improvements. It is acknowledged that there are improved survival rates in large specialist centres. **Lower socio economic** groups have a history of late presentation of illness and low compliance with treatment, which means improving mortality rates in Merseyside is even more challenging given the **high levels of deprivation** across the region. This notion is supported through analysis of National Cancer Intelligence Network (NCIN) data of outcomes for primary illnesses in Merseyside and Cheshire in terms of incidence, mortality and survival rates. Local outcomes can differ significantly from the national average. For example, whilst outcomes for non-Hodgkin's lymphoma are generally in line with the national average, leukaemia outcomes are significantly inferior in Merseyside and Cheshire, with the AML 5 year survival rate	Continue to develop inclusive services. The Trust has advisors in CCC-L who can help identify what a person and their carers may be able to claim in terms of benefits etc. Help with travel costs is available for patients: https://www.nhs.uk/nhs-services/help-with-health-costs/healthcare-travel-costs-scheme-htcs/

	being 34.6% compared to a national average of 50.8%. Compare this to Leeds: In 2007 the Leeds Cancer Centre opened which saw the integration of the two separate H-O units with the solid tumour service into the new build dedicated centre, which today is internationally recognised and one of the largest providers of cancer care in the UK. Subsequent to this integration, outcomes in H-O are now amongst the best nationally with 5 year survival rates for AML at 62.6%. Whilst there may be numerous facets that explain the inferior outcomes in the region, the current confederated model of service delivery is certainly a contributory feature, particularly given the presence of data indicating better and vastly improved survival rates in large specialist centres. Such regional service inequalities are also likely to be a factor in referral direction and patient choice.	

4. Does this service go the heart of enabling a protected characteristic to access health and wellbeing services?
Cancer treatment is essential to modern NHS service provision
5. Consultation
Targeted engagement was carried out with patients/carers during 2020 and 2021 to seek their views on the proposals and their experience of using local blood cancer services. A range of methods were used to offer patients/carers the opportunity to be involved, and to gain qualitative and quantitative feedback. The project team also engaged with GP groups in the Sefton area as half of the patients admitted to the AUH site in 2019/20 were from the borough. Due to the specialist nature of the service, engagement was very targeted and focused on people with direct experience of blood cancer as a patient or relative/carer. The Trust took steps to try and hear from a broad and representative group. The semi-structured phone interviews were with patients from a variety of ages and backgrounds, note that these were drawn from a small cohort of patients who had been inpatients in the last year and were clinically well enough to be interviewed. The online engagement was publicised across the hospital sites, via blood cancer patient groups, with patient appointment letters, and on social media. Online survey responses: • 15 were from people who currently or previously had a blood cancer

- 4 were from relatives/carers of people who currently or previously had a blood cancer
- Responses came from: Sefton (42%); West Lancashire (26%); Liverpool (21%); St Helens (5%); Wirral (5%). Although West Lancashire was over-represented in the responses, compared with the percentage of patients from the borough, this was not felt to be problematic, given the importance of hearing from people who may be adversely impacted by increased travel times.

Phone Interviews:
All of the nine inpatients interviewed were positive about the care they had received, whether at the AUH site or CCC-L. They were particularly complimentary about the staff.

Five of the patients were male; four were female. They ranged in age from their early thirties to their late seventies / early eighties and were mainly from Sefton and Liverpool, with a smaller number from West Lancashire and one person from Wirral. Their experience of inpatient care was:

- Seven had been inpatients in CCC-L.
- Four had been inpatients on the AUH site for blood cancer; two other patients had been admitted to the AUH site for other conditions.
- Three had been blood cancer inpatients both on the AUH site and at CCC-L; a fourth had received inpatient blood cancer care in CCC-L and inpatient care for another reason in AUH.

Eight of the nine inpatients said that, if they needed to be readmitted in future, they would prefer to be treated in CCC-L than on the AUH site. This wasn't because they were unhappy with the care they received at the AUH site – the reasons included preferring a single room, preferring to be in a hospital that only treated cancer, and preferring to be in the specialist cancer centre. COVID was cited by several patients who said their reduced immunity meant infection was a key concern and they would prefer to be in a single room in a hospital that did not treat people with other conditions, rather than a shared ward in an acute hospital.

Some extracts of the in-depth patient interviews are provided below:

People appreciating the service and the quality of nursing:
The treatment there was fantastic. You couldn't fault that at Clatterbridge, the nurses and everything

Clatterbridge was fantastic. I couldn't fault it. The young nurses in there are fantastic. They deserve a medal. You really get looked after in there. It's not the sort of place you want to be in but if you've got to go in that's the place to be. Even the girls when I go in for my chemo, they're good in there as well. I can't fault them at all. (At the Phoenix). I just get on with it. I can't complain about anything.

You couldn't improve on the service or the quality or the nursing or anything. It would take something to do that. The single room was great. When I first read about it when they were building the new hospital, I thought 'that would never work – how would they keep an eye on you'. But it does work. It's private, it's nice.

…the nurses were brilliant. They were so personable. Everything was explained really well. They made sure mum was all right – cups of tea, drinks, everything ['mum' is a wheelchair user and staff catered for 'mum's needs as a patient]

I had chemotherapy in Aintree. I was a day visitor every 2 weeks …. the chemotherapy care was fantastic.

The nurses are brilliant.

The facilities in room were brilliant. You've got the TV and everything. That's all you really need, isn't it? Like the shower, the bathroom is brilliant.

The nursing staff were absolutely spectacular, every single person that dealt with me. The doctors were spectacular and I appreciate at the time

[they] *made sure I was really aware of what was going to happen, so I felt informed when I was admitted*

I'm in a situation where I don't want to be in but I've always been treated courteously and everyone's always treated me with the ultimate respect

that new hospital – it was just amazing. Amazing

Patients expressing concerns: (items marked in bold have direct equality implications)

[Post treatment]…*I think they've lacked a bit in the care since. She's in remission. They told her she was in remission but that was a phone call and she got a letter but it's still not very personable.*

Traffic was our biggest problem. Aintree is 20 minutes and although the Royal is only 5 miles further, honestly, it took me nearly an hour to get there because it's city centre. That's the issue

Aintree, where the nurses were fantastic – they didn't really - nobody offered me along the way any assistance in terms of to get, you know, like counselling or psychological support or help with benefits

The meals aren't that bad but I had scouse 3 nights on the bounce and in the end on my 4th night I just said I don't want any dinner.. I got a Burger King delivered but the thing is they left it downstairs for half an hour before they brought it up. I couldn't eat it cold and it's a bit risky warming it up when you're having chemotherapy so I wasted about £16 on a Whopper, bacon double cheeseburger and everything. Then I got it and it had gone cold so I just had the Fanta.

[obtaining medication from the pharmacy] *there doesn't seem to be a lot of communication between the nurses and the staff. Even the nurses would say 'it takes you ages getting this stuff' – because of switching from the Royal, I think, because in the Royal you used to get it straight away. In Clatterbridge it's a struggle to get the medications. It's not their fault – there's something wrong in terms of the logistics of getting stuff from the Royal into Clatterbridge or vice versa. I don't know but they said in the Royal they've got no problems like they've got here, getting stuff.*

[on calling for help] *the auxiliaries come first and sometimes they could take 20 minutes or 25 minutes and you're like 'hmph, where are they' but they're busy.*

[multi-bed ward] *the first time I was in Aintree was October and I was in a multi-bed ward and it was horrendous because I was in a lot of pain and you've got other people around you and you don't want to speak to them. You just want to draw your curtains round and just – I mean, that's the way I am – so I did find it difficult being on a multi-bed ward ……. Clatterbridge is lovely and quiet because you've got your own individual room*

with Aintree, the staff need to keep their voices down at night.

communication – I feel like I've had a lot of letters which have been kind of pointless. Which is fine – you know, it doesn't do me any harm – but in terms of trying to move to a more sort of paperless and more environmentally-friendly.

Not so good, really, Aintree. I don't know how to say anything negative about it, really, because the staff were so good. Just being in an open ward and noisy and people shouting.

[patient was] ***diagnosed with bipolar …. when he went in for his first chemo, he was having a bit of a hyper moment, which I did discuss – because of how he would be, you know, on the ward. And the only thing that I kind of wish would have happened is that they could have got maybe a mental health nurse to actually come and speak to him at the time. Because obviously with his mental health as well, and having to go through the chemo, and obviously your imagination runs riot at that point, which was his first time going in. If there was any kind of little niggle, it was that. I was just a bit – and I know they're busy – but I wish – because I did bring it up and mention it, because he was extremely hyper when he was in.***

The patient is deaf in one ear so he doesn't always hear what's being said to him – I know they had masks on so it was difficult this time. Sometimes [staff] didn't really take that on board and make sure that he's understood what they've said.

The full engagement report is available here:

DRAFT Engagement report.docx

6. Have you identified any key gaps in service or potential risks that need to be mitigated
Patient feedback generally thought the service was very good – the only equality concerns that were flagged was the need for mental health support and also noting that there were no responses from people who are from ethnic minority.

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
Access to the service was not a concern from the engagement group – many spoke of how fast doctors and specialist got to them and how quickly they flowed into the service. The service is designed for all people and can cater for disabilities.
PSED Objective 2: Advance Equality of opportunity
Refer to sub-sections.
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.

The service is designed around the needs of the patient and in principle can meet all protected characteristic requirement. Patient feedback shows that high quality care was given.
PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Some patients need mental health support, whilst this was available there was a criticism that there 'wasn't enough' at the right time. A number of the patients interviewed by phone spoke about the impact of the COVID-19 pandemic, including safety measures in hospitals such as visiting restrictions and phone/video consultations. People with blood cancer can be particularly at risk of infection and patients appreciated measures being put in place to reduce infection but also spoke honestly about some of the challenges. For example, hearing-impaired patients found it harder to understand what staff were saying while wearing facemasks or during phone consultations than in a traditional face-to-face setting. A patient who had wanted cancer advice and information (including benefits advice and psychological wellbeing) would have preferred to speak to someone in person rather than over the phone. At the time, drop-in services and face-to-face appointments for these services had been paused/reduced due to COVID-19. CCC-L to ensure that patients are offered access to psychological support/ signposted to other services and to continue to increase staff awareness of the barriers for people with sensory impairments to ensure reasonable adjustments can be implemented.
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
The service is a 'needs lead' service based on A&E, GP referral or referral from other specialities. Patients without a GP can attend via A&E, however a continuous watch has to be keep to any health inequities in play which are acting as a barrier to either entering the service or carrying out the full treatment.
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (Consider whether this is engaged. If engaged, consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Objective not engaged.
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
Access to the service is via GP referral or A&E. the difficulty will be people who may be 'homeless' or marginalised' recognising that they are sick and need help.
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Not engaged at this point.
8. Recommendation to Board
Guidance Note: will PSED be met?
PSED is met, but issues around mental health support needs to be addressed to avoid it becoming an indirect discriminatory position. The service is highly thought of by patients and the issue of 'additional travel' is low down in their concerns especially when it comes to receiving better care. Mitigation that has

been put in place, regarding parking and shuttle bus that will help patients to over come any barriers here.
9. Actions that need to be taken
Refer to section 3.

7.4 References

https://bloodcancer.org.uk/understanding-blood-cancer/what-is-blood-cancer/

NHSE/I https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

Workforce report 2019, British Society for Haematology https://b-s-h.org.uk/media/18082/bsh-report-0520.pdf

NICE Improving Outcomes in Haematological Cancers, 2016

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

25 January 2022

Agenda Item C2

Report Title	**Liverpool University Hospitals Clinical Services Integration Proposals**
Report Author	Carole Hill, Director of Strategy, Communications and Integration, Liverpool CCG
Committee Sponsor	Jan Ledward, Chief Officer, NHS Liverpool CCG

Purpose	**Approve**	✓	**Ratify**		**Decide**		**Endorse**	✓	**For information**	

Decision / Authority Level	**Level One**	✓	**Level Two**		**Level Three**	

Executive Summary

This purpose of this report is to present the case for change in relation to proposals from Liverpool University Hospitals Foundation Trust (LUFHT) for the integration of a number of clinical services.

The configuration of hospital services in North Mersey is fragmented, which constrains the ability to provide care in a multi-disciplinary joined up way, sometimes resulting in sub-optimal outcomes and inequalities. The legacy of a fragmented hospital landscape also increases costs, due to duplication and inefficiencies.

The merger of Aintree University Hospital NHS FT (AUHFT) and the Royal Liverpool and Broadgreen Hospitals NHS Trust (RLBUHT) to form LUHFT took place in 2019. At the point of merger, the two trusts duplicated over 20 clinical services over three sites.

The consolidation of services within LUHFT is one component of a long-term vision for all acute and specialist services for the North Mersey population; incorporating the city's Knowledge Quarter, home to the largest cluster of science, health, education, digital and cultural expertise in the region.

The first LUHFT service integration programme established a single trauma and orthopaedics service in 2019, with the orthopaedic trauma service located at Aintree and an elective centre on the Broadgreen site. A proposal for a North Mersey comprehensive stroke centre is currently being progressed, with a public consultation underway which, subject to the findings from the consultation and commissioner approval, will see the establishment of a single hyper-acute stroke service co-located with major trauma and neurological services on the Aintree Hospital site.

Recommendations

The Joint Committee is asked to:

- Endorse the case for change for the proposals detailed in this paper
- Note the overview of the service change process, next steps and timescales for progressing these proposals;
- Endorse the proposal that Cheshire and Merseyside Joint Committee oversees the progression of these proposals in line with CCG statutory duties, best practice and in compliance with the NHS England Planning, Assuring and Delivering Service Change guidance.

Consideration for publication

Meetings of the Joint Committee will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply:

The item involves sensitive HR issues	N
The item contains commercially confidential issues	N
Some other criteria. Please outline below:	N

Committee principles supported by this report *(if applicable)*

The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services	✓
Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside	✓
Working together will achieve greater effectiveness in improving health and care outcomes	✓

Cheshire & Merseyside HCP Strategic objectives report supports:

Improve population health and healthcare	✓
Tackling health inequalities, improving outcomes and access to services	✓
Enhancing quality, productivity and value for money	✓
Helping the NHS to support broader social and economic development	✓

Key Risks & Implications identified within this report

Strategic	✓	Legal / Regulatory	✓
Financial	✓	Communications & Engagement	✓
Resources (other than finance)		Consultation Required	✓
Procurement		Decommissioning	
Equality Impact Assessment		Quality & Patient Experience	
Quality Impact Assessment		Governance & Assurance	
Privacy Impact Assessment		Staff / Workforce	✓
Safeguarding		Other – please state	

Authority to agree the recommendation:

Have you confirmed that this Committee has the necessary authority to approve the requested recommendation?	Yes
If this includes a request for funding, does this Committee have the necessary delegated financial authority to approve it?	n/a
If this includes a request for funding, have the Directors of Finance confirmed the availability of funding?	n/a

Conflicts of Interest Consideration and mitigation:	n/a
Link to Committee Risk Register and mitigation:	n/a
Report history:	This is the first time this report has come to the Joint Committee.
Next Steps:	Outline din section 5 of the paper. Further report to come to the May 2022 Committee meeting.
Responsible Officer to take forward actions:	Carol Hill
Appendices:	None

LIVERPOOL UNIVERSITY HOSPITALS CLINICAL SERVICES INTEGRATION PROPOSALS

1. Introduction

1.1 This purpose of this report is to present the case for change in relation to proposals from Liverpool University Hospitals for the integration of a number of clinical services.

1.2 People in North Mersey, which encompasses the boroughs of Liverpool, Sefton and Knowsley, experience amongst the highest levels of poor health outcomes and health inequalities, both within their places and compared to the rest of the country.

1.3 The configuration of hospital services in North Mersey is fragmented, which constrains the ability to provide care in a multi-disciplinary joined up way, sometimes resulting in sub-optimal outcomes and inequalities. The legacy of a fragmented hospital landscape also increases costs, due to duplication and inefficiencies.

1.4 The merger of Aintree University Hospital NHS FT (AUHFT) and the Royal Liverpool and Broadgreen Hospitals NHS Trust (RLBUHT) to form Liverpool University Hospitals Foundation Trust (LUHFT) took place in 2019. At the point of merger, the two trusts duplicated over 20 clinical services over three sites.

1.5 The Trust predominantly serves the populations of Liverpool, Sefton, Knowsley and, for some specialist services, extending to wider populations in Merseyside, Cheshire and North Wales.

1.6 The merger business case set out a model for single service teams delivering twenty four-hour, seven-day services, intended to improve patient experience and outcomes as well as facilitating greater opportunities for patients to participate in clinical trials, maximising research and development capability and helping attract and retain the best staff.

1.7 The Trust's integration plans are informed by the following principles: -

- Services will be delivered by teams of specialist professionals whose skill will meet the needs of patients;
- Services will be delivered by a sustainable workforce;
- Services will meet clinical standards and best practice;
- Variations in quality and standards of care will be eliminated;
- Services will be centralised whenever clinically necessary and local whenever possible.

1.8 The consolidation of services within LUHFT is one component of a long-term vision for all acute and specialist services for the North Mersey population; incorporating the city's Knowledge Quarter, home to the largest cluster of science, health, education, digital and cultural expertise in the region.

1.9 The first LUHFT service integration programme established a single trauma and orthopaedics service in 2019, with the orthopaedic trauma service located at Aintree and an elective centre on the Broadgreen site. A proposal for a North Mersey comprehensive stroke centre is currently being progressed, with a public consultation underway which, subject to the findings

from the consultation and commissioner approval, will see the establishment of a single hyper-acute stroke service co-located with major trauma and neurological services on the Aintree Hospital site.

2. Strategic Context

2.1 The local Liverpool health and care system first identified the case and provided support for acute clinical service integration between the two former acute trusts in 2013, through a Liverpool Mayoral Health Commission which reviewed health outcomes and healthcare services in the city.

2.2 The Healthy Liverpool Programme, from 2014-2017, endorsed the view of clinical leaders and set out a vision for '*single service, system-wide delivery, delivered through centres of clinical and academic excellence'*. This commitment was confirmed by the whole North Mersey health and care system in the *One Liverpool* Strategy which was published in 2019. The strategy acknowledged the number and complexity of acute and specialist centres in the city, many of which provide outstanding care but are challenged in terms of service duplication, variation in quality, experiences of care and workforce capacity.

2.3 In endorsing the *One Liverpool* strategy, all North Mersey CCG commissioners and providers supported further integration of acute services, to ensure clinical and financial sustainability and improved health outcomes. Acute clinical integration is also aligned with the Cheshire and Merseyside Integrated Care System (ICS) strategy for integrated, improved care and outcomes for acute and specialist services.

2.4 The overarching rationale for the LUHFT clinical integration programme is to co-locate services in line with whether they largely deliver planned care or urgent care. Bringing together planned services can enable capacity to be protected and enables dependent specialties to work better together. Concentrating the majority of urgent care on another site enables acute services to provide improved trauma assessment and better access to specialist urgent care, so that patients have better access to the right expertise at the right time.

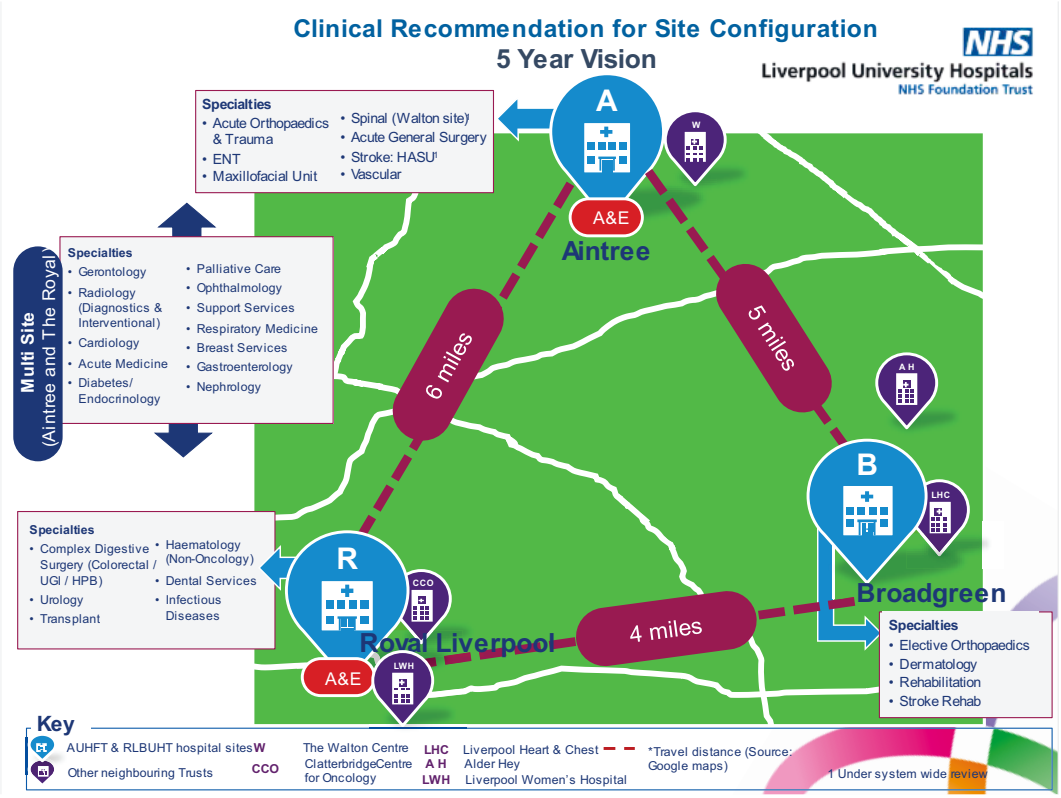
2.5 The Aintree Hospital site already brings together a critical mass of urgent and emergency care services, determined by being the Cheshire and Merseyside Major Trauma Centre and due to its co-location with the trauma-related neurology services delivered by The Walton Centre.

2.6 The new Royal Liverpool Hospital, co-located with the new Clatterbridge Cancer Centre and the city's Knowledge Quarter, provides opportunities to focus predominantly on complex planned care, including cancer care. The Royal Liverpool site would however retain an A&E service as the city requires this service across both acute sites.

2.7 Broadgreen is the predominant location for rehabilitation, as well as an elective service for orthopaedics.

2.8 Not all services will be located on just one site, although the principle of single clinical teams will be implemented across all services.

2.9 The proposed configuration of services for LUHFT across specialties is illustrated in Figure One:



3. Overview of Proposals

3.1 This case for change encompasses the next phase of clinical integration proposals, to establish single services and single teams within LUHFT for the following specialties:

- General surgery
- Vascular services
- Urology services
- Nephrology services
- Breast services.

3.2 The development of these proposals has been clinically led and they have emerged from robust option appraisal processes for each service. In developing the proposed models of care, consideration has been given to how they would support LUHFT in achieving its vision and alignment to the Trust's strategic objectives of Great Care; Great People; Great Research and Innovation; and Great Ambition. The proposed clinical model for each service is summarised below:

3.2.1 **General Surgery.**

General surgery is a specialty that focuses on surgery of the abdominal area and intestines including the gastrointestinal tract, liver, colon, pancreas and other major parts of the endocrine system of the human body. General surgery is one of the two largest surgical specialties across the UK, employing over 30% of the country's consultant surgeons.

General surgery is currently delivered at AUH and RLH sites, with both providing emergency surgical care and Broadgreen Hospital providing elective activity only. Each site

provides different models of service. Both sites provide a 7-day consultant led service for emergency surgery.

The current clinical models across sites have limitations in terms of service provision with variation in clinical pathways and standards, and inequity in patient experience and outcomes.

The proposal underpinning the integrated model for general surgery is to consolidate similar services and patients onto the same site, establishing a non-elective site at AUH where dedicated teams are in place to carry out emergency surgery, and an elective service at the new Royal Liverpool hospital.

The separation of elective and non-elective general surgical care will allow both aspects of the service to be managed efficiently, improve availability of staff for pre and post-operative reviews, allow for patients to be seen in a timely manner and treated by appropriate specialists, and ensure that trauma and other emergency demands do not impinge on the ability to deliver elective general surgical care.

3.2.2 **Vascular Services**

Liverpool Vascular and Endovascular Service (LiVES) has been an established single service for several years and serves the Merseyside region as well as a tertiary service for parts of the North England, Isle of Man and North Wales. It is based on a hub and spoke model, with the main hub based at the RLH site, and 'spoke' sites based at AUH, Whiston and Liverpool Heart and Chest Hospitals (LHCH).

The greatest challenge within this service is that of capacity, both in terms of theatres and beds, as well as challenges due to the need for inter-hospital transfers and access to Interventional Radiology services. These challenges significantly impact the service's ability to provide timely access to care, which subsequently impacts patient outcomes and experience.

The proposed clinical model would see the relocation of LiVES services to the AUH site. The proposal is to expand the service with additional theatre capacity and an optimum mix of intensive care and general acute beds, intermediate care beds, as well as access to a CT scanner, outpatient and vascular laboratory and research facilities.

3.2.3 **Urology**

Urology is another large surgical specialty and involves the treatment of conditions of the urinary tract and male genital tract. This includes some very common cancers including prostate cancer, bladder, kidney and testicular cancer and some common but debilitating conditions such as kidney stones. Urological services have been provided by two separate units based in each of the legacy trusts. The units have largely functioned as separate, duplicated services although a common leadership structure was established in 2020.

The proposed clinical model is to establish a single site inpatient urology base for both elective and non-elective care at the new RLH, with outpatient services and day case procedures to be provides at RLH and the AUH site.

3.2.4 **Breast Services**

The breast service provides diagnosis and treatment of benign breast disorders and breast cancer, currently being provided by separate units based in each of the legacy Trusts. The

Elective Care Centre at AUH accommodates the Aintree Breast Unit and the Breast Unit at RLH site is situated at the Linda McCartney Centre.

Breast cancer is the most common type of female cancer in the UK with over 55,000 women (+370 men) diagnosed each year, accounting for 15% of all new cancer cases. The current services have different clinical pathways, varying access to services as well as variation in patient experience.

The proposed model for the breast service is for all surgery, both cancer and benign, to be consolidated at the new RLH site with dedicated breast inpatient and day-case beds. Outpatients and diagnostic services would remain at both sites. The breast screening service would remain at the Broadgreen site as part of the national NHS Breast Screening Programme.

3.2.5 **Nephrology**

The LUHFT renal team provide all aspects of kidney care - acute kidney injury (AKI); chronic kidney disease (CKD); renal replacement therapy (RRT); constructive management of patients who choose not to have dialysis/transplant; and a transplantation service for Merseyside, parts of Cheshire and North Wales. The service is currently provided at AUH.

The greatest challenge within the nephrology service is prompt and equitable access to kidney services for patients. There is an increasing prevalence of renal disease in the population and demands on current services – in particular dialysis services – which will increase in the next few years.

The proposed clinical model is to establish a Mersey and Cheshire renal service, centralising nephrology services at the new RLH site while providing in-reach consultant cover at AUH to ensure appropriate care for patients with kidney disease as a co-morbidity. The proposed model will ensure that all complex renal patients in the region have equitable access to a bespoke specialist service.

3.3 Table One provides an overview of the rationale for change, the clinical model and the patient benefits of each of the five service change proposals.

Table One

Specialty		Rationale and impact of proposed change	
	Rationale for Change	**Outline Clinical Model**	**Patient Benefits**
General Surgery	**Emergency General Surgery** • **Clinical / Quality outcomes** – low consultant presence in theatre when high risk of death, consultant review within 14 hours of admissions • **Different workforce models across sites**. RL not aligned to best practice for EGS (AUGIS) **Elective subspecialties** • **Fragmentation of services** – minimum surgeon volumes not met • **Separation of HPB services** – currently liver based at AUH, Pancreas at RL site	• Acute/non acute split of Gen surgery subspecialties • RL (Elective inpatients /Complex site - Upper GI, colorectal, HPB) • AUH (non-elective/benign – enhanced ambulatory care, ERAS, day case)	• **Improved mortality rates** through dedicated emergency surgery service, specialist consultants operating through an EGSU model • **Reduce clinical variation**, timely reviews and reduced complications • **Optimised theatre capacity** through planned / unplanned split • **Reduced LoS** and release of inpatient beds • **Reduction in day case patients treated as inpatients**, bed days saved
Vascular	• **Theatre & Bed Capacity Constraints:** - **Impact on activity levels** - Currently not meeting national targets for AAA, Carotid Endarterectomy (CEA) and Critical Limb Ischaemia (CLI). - Potential to expand the bed base to meet demand. • **Interventional Radiology –** Shortage of interventional theatre capacity currently at RLH in addition to inadequate staffing levels. • **Key strategic enabler wider service reconfiguration** • **Improves patient safety** through co location with Trauma Unit	• Transfer of Vascular Services from RL to AUH site (to align to Stroke/IR and elective/ non-elective model) • Expand capacity to improve access to service • No change to outpatients	• **Enhance emergency delivery** of vascular care through co-location with the Trauma unit • **Improve timely access to care** by reducing delay in investigations • **Reduce length of stay** by reducing delays in treatment and interventions • **Reduce need for patient transfers** across sites • **Reduce rehabilitation costs** by having a lower limb prosthetic centre on site

Urology	• **Provision of timely and equitable access to care** • **Clinical workforce sustainability** – ability to meet procedure volumes with subspecialties and clinical sustainability challenges of on call rotas • **Duplication of resources** – high rental and maintenance costs	• Urology main inpatient services delivered at RL • Day surgery and Outpatient Services maintained at AUH & RL sites • Enhanced recovery programme	• **Improved access** to specialist cancer and continence services • **Improved amb ulatory assessment** of urgent problems, reducing admission • **Financial efficiencies** from reduced intensity of on call rotas and reduced duplication of equipment/maintenance costs • **Increased day case procedures** through streamlined pathways
Breast	• **Variation in practice across sites –** Different surgical pathways, different pre-op assessment • **Timely access to care –** Misalignment of capacity and demand across sites • **Inequitable access to facilities –** Radio-pharmacy service provision for breast cancer surgery patients at RL site only • **Duplication –** 2 referral points for each service leading to operational inefficiencies • **Workforce constraints** - Variations in workforce between the two sites. AUH seeing a higher volume of referrals however have a smaller consultant team	• Surgery (both cancer and benign) consolidated at the new RL site (mainly day case) • Outpatients and diagnostics unchanged at AUH and RL sites • Breast screening will remain unchanged at BGH	• **Co-location** with Clatterbridge Cancer Centre • **Improved outcomes**, patients will have a dedicated bed base at RL • **Financial efficiencies** through single on call rota • **Better utilised theatre lists** and planning • **Single site procurement efficiencies** and reduced duplication of equipment
Nephrology	• **Dialysis service provision including estate** not meeting national guidelines • **Acute Kidney Injury (AKI)** – diagnosis and treatment of AKI at RL does not meet best practice for specialist skills required and equipment • **Workforce constraints** – clinical workforce shortages impacting on quality and equity of services available to patients. This also limits the take up of home therapy	• Regional Tertiary Service with equitable access to Specialist Renal Care and Transplant for the C & M region • Nephrology main hub at RL – 56 bed tertiary unit including Transplant and Renal HDU • Medical cover provided at AUH (non-elective) • Unified Home Dialysis team and seamless flow of patients to satellite dialysis units Alignment of specialist clinics	• **Reduced mortality and improved quality of life** from more timely / equitable access • **Reduced morbidity** from early identification of AKI and access to standardised pathways • **Reduced readmissions** and length of stay • **Financial savings** from combined on call • **Procurement efficiencies** from combined Dialysis Units

3.3 Table Two sets out the impact of the service change proposals in terms of physical movements across the three sites; which of these proposals would create increased capacity and opportunities for improved models of care and elimination of unwarranted variation.

Table Two

Specialty	Outline Service Model	Main impact of proposed change		
		Transfer service to another site	Expansion/ Increase capacity	Align clinical standards to deliver single service model
Breast Services	• Complex Elective inpatients at RL (mainly day case) • Screening at both sites	✓		✓
Nephrology	• Nephrology main hub at RL • Medical cover provided at AUH (non-elective)	✓		✓
Vascular	• Transfer of Vascular Services from RL to AUH site (to align to Stroke/IR and elective/ non-elective model)	✓	✓	
Urology	• Urology main inpatient services delivered at RL • Day surgery and Outpatient Services maintained at AUH & RL sites	✓		✓
General Surgery (Acute/ Non-Acute split)	• Acute/non acute split of Gen surgery subspecialties • RL (elective /complex site). AUH (non-elective/benign)	✓	✓	✓

4. Pre-Consultation Business Case

4.1 A pre-consultation business case (PCBC) for these proposed service changes is in draft and the final version will be informed by the feedback from NHS England, commissioners and North Mersey OSC. The PCBC includes details of the clinical options appraisal process and the recommended clinical models, patient benefit case, workforce, finance, quality, equality, engagement and estates proposals have also been assessed in the context of the impact on hospital estates.

4.2 Recurrent costs for these reconfigured services were approved by the Trust Board in October 2021 and will form part of the Trust's annual financial planning process from 2022/23 onwards. A summary of costs is in Table Three.

4.3 Productivity benefits have been assessed and will largely be attributable to reductions in average length of stay. Whilst such benefits may not lead easily to 'cash out' savings - if beds can be released efficiency/productivity gains of £1.68m have been evaluated, details of which are summarised in Table Four.

Table Three

Summary Costs Clinical Services Reconfiguration					
Scheme	**Description**	**2021/22**	**2022/23**	**2023/24**	**2024/25**
		£m	**£m**	**£m**	**£m**
Nephrology	Additional x2 wte Renal Dietetics resource	-	0.04	0.08	0.08
Upper GI (elective)	Additional 0.5 WTE UGI Surgeon Nursing staff UGI Dietetics & Physio support	-	0.39	0.39	0.39
General Surgery	Additional x4 wte General Surgery consultants Staffing for additional emergency theatre capacity at AUH	-	0.72	1.03	1.32
Vascular	Staffing for additional theatre; Imaging and IR staff; support services; hybrid theatre non pay	-	0.14	1.54	1.78
TOTAL		-	**1.29**	**3.04**	**3.57**

Table Four

Reconfiguration Scheme	Description	Potential Productivity Benefits £m
Emergency General Surgery	Enhanced ambulatory care model and ERAS pathways - 6,030 bed days	1.02
Nephrology	Nurse Led approach for first-time dialysis - 306 bed days	0.06
Upper GI	Centralise routine UGI at AUH - conversion Inpatients to day case - 262 bed days. Centralise UGI Cancer Services at RLH - 840 bed days.	0.18
Urology	Improved pathways centralised inpateints at Royal site - 1,350 bed days. Day case conversion for TURBT procedures - 83 bed days	0.24
Vascular	Increased hybrid theatre capacity at AUH - 1,208 bed days	0.18
Total		**1.68**

4.4 £9.8m Vascular capital investment was approved by the Trust Board in October 2021, of which £7.5m is in the 2022/23 financial plan but awaits external approval. The Trust and North Mersey commissioners have engaged with the Cheshire and Mersey ICS regarding revenue and capital requirements.

4.5 The Joint Commissioning Committee is not being asked at this stage to endorse the pre-consultation business case. This will be presented in May 2022.

5. Governance, Scrutiny and Assurance

5.1 Local Authority Overview and Scrutiny. NHS bodies have a legal duty to consult with local authority Health Overview and Scrutiny Committees (OSC) when considering any proposal for a substantial development or variation in the way services are delivered, including in the context of access or location.

5.2 The four North Mersey CCGs, which represent the majority of patients that use services provided by LUHFT, will present the case for change for these proposals to Knowsley, Liverpool and Sefton OSCs week commencing 24 January 2022, for each to consider whether it represents a substantial variation.

If each of the three local authority OSCs consider they do represent a substantial variation, they would form a joint OSC to scrutinise the proposal development process, the detailed proposals contained in the pre-consultation business case and plans for engagement/consultation.

5.3 NHS England Assurance Process. The proposal has been reviewed by NHS England through a two-stage process, to seek assurance that commissioners are complying with their statutory duties and other responsibilities under the CCG Assurance Framework.[1] The stage 2 assurance meeting took place on 17 January 2022. Formal feedback is awaited but NHS England has stated that the pre-consultation business case is robust and that LUHFT and commissioners have satisfactorily answered their queries with regard to the clinical case, finance, quality, workforce and engagement/consultation plans. NHS England has recommended that the clinical proposals be considered by an Independent NHS Clinical Senate, which is being progressed.

5.4 NHS Governance. The four North Mersey CCGs – Knowsley, Southport and Formby, South Sefton and Liverpool, have a track record of working collaboratively on major service change proposals, as they share patient flows into acute services. Previously, such proposals would be progressed by a North Mersey Committees in Common, with formal commissioning decisions taken by each CCG Board or through the North Mersey Joint Committee which had delegated authority for specific North Mersey work programmes.

5.5 Due to the timing of this proposal, with CCGs being dis-established at the end of June 2022 and transitional governance arrangements in place until this point, it is recommended that this programme is overseen by the Cheshire and Mersey Joint Commissioning Committee (JCC) until the end of June 2022, after which accountability for final approval of these proposals will reside with the Cheshire and Merseyside Integrated Care Board (ICB).

6. Public Consultation

6.1 This a complex proposal in that it contains five separate service changes, each of which need to be considered in their own right. However, they are all informed by the same clinical objectives and an overarching vision and rationale for the delivery of services across one trust and its three hospital sites.

6.2 This would be a single consultation process, using the umbrella of hot/cold site development, but with five distinct strands to enable meaningful engagement on the proposals for each service.

6.3 The overview of the proposals does highlight that some of these service changes relate to specialist services that impact on populations beyond the North Mersey footprint. The consultation plan would incorporate activity to reflect the requirement to engage with wider populations for those elements of the proposal. The North Mersey CCGs and the Trust will work with NHS England Specialised Commissioning on these elements of the process.

6.4 The draft consultation plan will be completed by the end of February 2022, to allow time for the Joint Committee, the Joint OSC and NHS England to endorse prior to launching a consultation after the local election purdah period.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

6.5 The proposal is to run an 8-week intense public consultation. This is because these proposals are linked to the opening of the new Royal Liverpool Hospital which is planned for September 2022. The provisional dates for the consultation are 7 June to 2 August 2022. This gives enough time to analyse and report on the findings from the consultation and for the ICB to approve the business case.

7. Timeline and Milestones

7.1 Table Five below sets out the key milestones and dates for the service change process.

	Activity	Indicative Timescales
	Pre-consultation Business Case Completed	December 2021
	Individual OSCs to consider whether proposal represents a substantial variation	January 2022
	NHS England Stage 2 Assurance Process	January 2022
	Joint OSC (if agreed that this represents a substantial variation) to review the pre-consultation business case and public consultation plan	May 2022 (post-election purdah)
	Joint Commissioning Committee to approve the pre-consultation business case and consultation plan	May 2022
	Formal Public Consultation (subject to commissioner and OSC reviews)	May – July 2022
	Final business case, informed by public consultation to Joint OSC	August 2022
	Commissioners approve Final Business Case (ICB)	August 2022

8. Conclusion

8.1 This paper sets out proposals for the next phase of the clinical integration of services delivered by Liverpool University Hospitals for the populations of Knowsley, Liverpool and Sefton, and for some specialist services, across a bigger population.

8.2 The proposals align with the system vision for single service teams delivering twenty four-hour, seven-day services, to improve patient experience and health outcomes by eliminating unwarranted variation and duplication and establishing excellent clinical standards. These service reconfigurations will directly impact on the populations of Knowsley, Liverpool and Sefton and wider populations for some specialist services. As LUHFT is the largest single trust in Cheshire and Merseyside, the proposal would also have an impact on outcomes and sustainability for the whole Integrated Care System.

9. Recommendations

9.1 The Joint Committee is asked to:

- Endorse the case for change for the proposals detailed in this paper;
- Note the overview of the service change process, next steps and timescales for progressing these proposals
- Endorse the proposal that Cheshire and Merseyside Joint Committee oversees the progression of these proposals in line with CCG statutory duties, best practice and in compliance with the NHS England Planning, Assuring and Delivering Service Change guidance.

10. Access to further information

10.1 For further information relating to this report contact:

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CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

25 January 2022

Agenda Item C3

Report Title	Learning from Life and Death Reviews (LeDeR) – Implementation Progress Update
Report Author	Denise Edwards, LD Health Inequalities Senior Manager, Cheshire and Merseyside TCP
Committee Sponsor	Simon Banks, Chief Officer, NHS Wirral CCG and Wirral Health and Care Commissioning

Purpose	**Approve**		**Ratify**		**Decide**		**Endorse**	✓	**For information**	✓

Decision / Authority Level	**Level One**	✓	**Level Two**		**Level Three**	

Executive Summary

In June 2021, the new Learning from Life and Death Reviews (LeDeR) policy set out for the first time the core NHS aims and values of the LeDeR programme and the delivery expectations placed on different parts of the health and social care system. This is a mandated national policy that requires implementation at all levels of the health and care system.

This paper summarises the progress made in implementing the new approach to LeDeR in Cheshire and Merseyside in 2021/22 and plans for 2022/23 and beyond.

Recommendations

The Joint Committee is asked to:

- note this report and endorse the work being undertaken to implement the LeDeR policy in Cheshire and Merseyside.
- The Cheshire and Merseyside Integrated Care Board will become the long-term host for the combined Cheshire and Merseyside and Greater Manchester LeDeR Reviewer workforce.

Consideration for publication

Meetings of the Joint Committee will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply:

The item involves sensitive HR issues	N
The item contains commercially confidential issues	N
Some other criteria. Please outline below:	N

Committee principles supported by this report *(if applicable)*

The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services	✓
Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside	✓
Working together will achieve greater effectiveness in improving health and care outcomes	✓

Cheshire & Merseyside HCP Strategic objectives report supports:	
Improve population health and healthcare	✓
Tackling health inequalities, improving outcomes and access to services	✓
Enhancing quality, productivity and value for money	✓
Helping the NHS to support broader social and economic development	✓

Key Risks & Implications identified within this report			
Strategic	✓	Legal / Regulatory	✓
Financial	✓	Communications & Engagement	✓
Resources (other than finance)	✓	Consultation Required	
Procurement		Decommissioning	
Equality Impact Assessment		Quality & Patient Experience	✓
Quality Impact Assessment		Governance & Assurance	✓
Privacy Impact Assessment		Staff / Workforce	✓
Safeguarding		Other – please state	

Authority to agree the recommendation:	
Have you confirmed that this Committee has the necessary authority to approve the requested recommendation?	Yes
If this includes a request for funding, does this Committee have the necessary delegated financial authority to approve it?	n/a
If this includes a request for funding, have the Directors of Finance confirmed the availability of funding?	n/a

Conflicts of Interest Consideration and mitigation:	n/a
Link to Committee Risk Register and mitigation:	n/a
Report history:	This is the first time the Committee has considered the report.
Next Steps:	Continue with the implementation of LeDeR policy, governance arrangements and workforce structure, including Memorandums of Understanding (MOUs) to formalise arrangements with Greater Manchester and Merseycare. Finalise the Cheshire and Merseyside 3-Year LeDeR Strategy.
Responsible Officer to take forward actions:	Denise Edwards
Appendices:	None on this occasion

Learning from life and death reviews – People with a learning disability and autistic people (LeDeR) Policy 2021 - Implementation

1. Introduction

1.1 In June 2021, the new Learning from Life and Death Reviews (LeDeR) policy set out for the first time the core NHS aims and values of the LeDeR programme and the delivery expectations placed on different parts of the health and social care system. This is a mandated national policy that requires implementation at all levels of the health and care system.

1.2 In summary, the new approach to LeDeR sets out the following:

- when established, local Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs) will become responsible for ensuring that LeDeR reviews are completed for their local area and that actions are implemented.
- there is stronger emphasis on the delivery of the actions coming out of the reviews and holding local systems to account for that delivery, to ensure that there is evidence of service improvement locally.
- a new process for reviewers to follow has been introduced, including a new computer system ('web-based platform'), and new training for the LeDeR workforce.
- initial reviews for all notifications will be progressed to focussed reviews where necessary.
- the workforce will change and reviewers will work in teams across at least one ICS and potentially across a broader footprint.
- reviews will now include the deaths of adults who have a diagnosis of autistic spectrum disorder (ASD) but no learning disability. All reviews of people who are autistic without a learning disability will be focused reviews initially.
- all notifications of a person's death will receive an initial review including talking to their family or people who knew them well, talking to their GP or looking at the GP records, and talking to at least one other person involved in the person's care. If the reviewer feels a more detailed review is needed, a focused review will follow. Families can say if they think a focused review is needed.
- all people from Black Asian and minority ethnic (BAME) communities will get a focused review because the evidence so far shows that the health inequalities experienced by people from these communities are very significant and there is also significant under reporting of deaths from these communities.
- development of quality assurance processes to align with other existing processes including Quality Surveillance Group and ICB governance.

1.3 This paper summarises the progress made in implementing the new approach to LeDeR in Cheshire and Merseyside in 2021/22 and plans for 2022/23 and beyond.

2. Implementation Progress to date and ongoing work

2.1 The Health Inequalities Senior Manager was appointed on 5 July 2021 to take forward the LeDeR implementation work as part of the Transforming Care Programme. The Transforming Care Programme (TCP) includes LeDeR as a core area of delivery.

2.2 The new LeDeR web portal went live in June 2021 and online training is available for users, completion of which is a prerequisite to using the portal. All historical reviews were transferred to the new system. The support team continues to update the portal to enhance the operability and functionality of the system for users. Initial and focused review processes have commenced in line with the policy requirements.

2.3 In January 2022, the web portal was enabled for notifications to be received and reviews to be undertaken for those formally diagnosed with autistic spectrum disorder (ASD).

2.4 A monthly key performance indicator (KPI) assurance process has been introduced across Cheshire and Merseyside in a consistent way, new templates have been developed and started to be introduced to capture local specific, measureable, achievable, relevant and time-bound (SMART) Actions from initial reviews and emerging 'Themes' – these will be further embedded when the new workforce and governance arrangements are fully introduced.

2.5 A 3-Year LeDeR Strategy has been developed together with high level delivery action plans based upon the priorities identified from LeDeR reviews. The strategy was developed with involvement from those with lived experience. The final version of the 3-Year LeDeR Strategy will be presented to the Cheshire and Merseyside ICS Executive Team and Cheshire and Merseyside Clinical Commissioning Groups (CCGs) Joint Committee in February 2022 for approval. An easy read version will subsequently be produced.

2.6 We are exploring and developing the arrangements for how the Cheshire and Merseyside ICB, on behalf of the ICS will establish a local governance group/panel for LeDeR. A proposed structure has been drafted as well as new Terms of Reference for the group. This group/panel will sign off the quality of focused reviews and also, in discussion with the reviewer, agree actions which feed in to, and are cognisant of the strategic plan for the local area. Full membership for the group/panel is work in progress, in line with the policy a BAME Lead at a senior level needs to be identified. In the short term, existing LeDeR Steering Group Terms of Reference and members will remain unchanged until new ways of working are in place. Implementation of the new governance structure will be enabled by the appointments to Senior Reviewer and Cheshire and Merseyside Local Area Co-ordinator (LAC) roles and the establishment of ICB/ICS groups identified in the drafted governance structure.

3. LeDeR Workforce Solution

3.1 The policy sets out that the staffing arrangements must be through the commissioning or employment of a dedicated, independent, larger, multi-disciplinary team of reviewers supervised by a senior reviewer and supported by administrative staff. This is a change from the existing arrangements, currently managed by Clinical Commissioning Groups.

3.2 Working with national, regional (North West), Cheshire and Merseyside and Greater Manchester colleagues, a LeDeR workforce model and options appraisal was undertaken. On 12 October 2021, it agreed to develop a combined Cheshire and Merseyside ICS and Greater Manchester ICS Review and Improvement model. This approach has been endorsed by both ICS Executive Teams. The combined workforce ICS Model is outlined in Table One:

Reviewer & Improvement based model	
Notifications (12months) plus 10% uplift for autism	428
Initial (8hrs)/ Focused (40hrs)	285/143
Reviewers (Band 7)	5.8 WTE
Senior Reviewers (Band 8a)	1 WTE
Admin (Band 4)	1 WTE
LAC (1 identified in each ICS but part of broader nursing role not funded via LeDeR)	*Part of broader role*
Total cost of above	**£433,561**
Cheshire & Merseyside (49%)	£212,445
Greater Manchester (51%)	£221,116

Table One: LeDeR Reviewer and Improvement Model

3.4 The split of costs stated above are aligned to the proportion of the overall number of notifications expected; 49% Cheshire and Merseyside and 51% Greater Manchester. It should be noted that the LAC job description has been defined in line with the policy and is 0.6 wte, in the new structure it is not being intertwined with a broader role – this role is not funded by LeDeR cost structure, funding will be required from each ICB.

3.5 The LeDeR funding profile available for over the next 3 years; 2021-24 is as per the table below, demonstrating that additional local investment will be required to fund the LeDeR model (Table Two):

Year	GM	C&M	L&SC	Total
2021-22	£102k	£89k	£60k	£251k
2022-23	£97k	£84k	£57k	£238k
2023-24	£51k	£44k	£30	£125k

Table Two: LeDeR funding profile

3.6 Following the workforce model options appraisal, in December 2021, NHS Wirral CCG Executive Team and Cheshire and Merseyside ICS Executives agreed that NHS Wirral CCG would host the combined LeDeR Workforce in the short term, which will enable the advertising of roles. This will support the team being ready to deliver from the point of establishment of the ICS/ICB. It is proposed that the LeDeR Review Team will report into the Cheshire and Merseyside TCP Director and the LACs will report into the Chief Nurse in each ICB, maintaining independence between the two.

3.7 We are working towards new staffing arrangements with the workforce expected to be in place by end May/early June; vacant posts are planned to be advertised in February 2022.

3.8 Due to complexities of the current reviewer workforce both in Cheshire and Merseyside and in Greater Manchester further HR due diligence has been undertaken to assure Transfer of Undertakings (Protection of Employment) (TUPE) regulation compliance. Existing dedicated reviewer staff will operate under a Memorandum of Understanding (MOU) until TUPE transfer takes place. We have been advised that current staff eligible for TUPE transfer will not transfer until 1st October 2022; if possible, we would like to bring this forward and will continue to work with colleagues to reach an earlier date if practicable. Within Cheshire and Merseyside, there is one substantive reviewer post and two 0.4 whole time equivalent (wte) dedicated reviewer staff who are on Fixed Term contracts, which expire on 31st March 2022. The intention is to extend their contracts to 30th September 2022. From 1st April 2022, the funding directed to the system through the Cheshire and Merseyside Transforming Care Programme will support the Cheshire and Merseyside reviewer team. To reiterate the LAC role is outside of this funding.

3.9 Job descriptions have been developed for the new roles and were submitted to HR mid-December, these will be going through Agenda for Change by end of January 2022, vacant posts will be advertised and recruited to asap – appointments are expected to be made by End May/early June 2022; existing/shadow arrangements will remain in place until safe handover of responsibilities/allocated cases have been completed.

4. Conclusion

4.1 The implementation of the LeDeR policy in Cheshire and Merseyside is progressing well. The establishment of a core LeDeR workforce is essential to ensure that the ICB is able to discharge the functions it will inherit from CCGs. This workforce needs to be in place as soon as possible.

4.2 The review team will be initially funded from TCP programme costs. The relevant ICB will need to fund the 0.6 LAC role on a permanent recurrent basis.

4.3 Current review staff who are eligible to TUPE will operate under a Memorandum of Understanding until the TUPE transfer takes place.

5. Recommendations

5.1 The Joint Committee is asked to note this report and endorse the work being undertaken to implement the LeDeR policy in Cheshire and Merseyside.

5.2 The Cheshire and Merseyside ICB will become the long-term employer for the combined Cheshire and Merseyside ICS and Greater Manchester ICS LeDeR Reviewer workforce and work to continue to implement the policy, with shadow arrangements remaining in place until safe handover of activities / closure of ongoing LeDeR cases is completed.

5.3 The role of Local Area Co-ordinator (LAC) role for the Cheshire and Merseyside ICS will need to be part of the establishment of the Cheshire and Merseyside ICB. Funding for this is outside of the TCP resources.

6. Access to further information

6.1 For further information relating to this report contact:

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CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

25 January 2022

Agenda Item C4

Report Title	**Cheshire and Merseyside Core Military Veterans Service – Transfer of Coordinating Commissioner Arrangements from NHS Bury Clinical Commissioning Group to Cheshire and Merseyside Integrated Care Board - Update**
Report Author	Simon Banks, Chief Officer, NHS Wirral CCG
Committee Sponsor	Simon Banks, Chief Officer, NHS Wirral CCG

Purpose	**Approve**		**Ratify**		**Decide**		**Endorse**	✓	**For information**	✓

Decision / Authority Level	**Level One**	✓	**Level Two**		**Level Three**	

Executive Summary

On the meeting on 26th October 2021 the Joint Committee supported the creation of a co-ordination group to support the transfer of commissioning responsibilities for the Cheshire and Merseyside Core Military Veterans Service from NHS Bury Clinical Commissioning Group (CCG). The Joint Committee asked for an update on this work to come to a future meeting. This report provides an update of progress and recommends that the development of contract arrangements for 2022/23 are taken forward as part of the usual contracting and planning round with impacted Cheshire and Merseyside CCGs.

Recommendations

It is recommended that the Joint Committee:

- Note the contents of this report.
- Supports the proposal that the commissioning intentions, negotiation and development of the contract for 2022/23 is taken forward as part of the usual contracting and planning round with impacted Cheshire and Merseyside CCGs.

Consideration for publication

Meetings of the Joint Committee will be held in public and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply:

The item involves sensitive HR issues	N
The item contains commercially confidential issues	N
Some other criteria. Please outline below:	N

Committee principles supported by this report *(if applicable)*

The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services	✓
Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside	✓
Working together will achieve greater effectiveness in improving health and care outcomes	✓

Cheshire & Merseyside HCP Strategic objectives report supports:	
Improve population health and healthcare	✓
Tackling health inequalities, improving outcomes and access to services	✓
Enhancing quality, productivity and value for money	✓
Helping the NHS to support broader social and economic development	

Key Risks & Implications identified within this report			
Strategic	✓	Legal / Regulatory	
Financial	✓	Communications & Engagement	
Resources (other than finance)	✓	Consultation Required	
Procurement		Decommissioning	
Equality Impact Assessment		Quality & Patient Experience	✓
Quality Impact Assessment		Governance & Assurance	✓
Privacy Impact Assessment		Staff / Workforce	
Safeguarding		Other – please state	

Authority to agree the recommendation:	
Have you confirmed that this Committee has the necessary authority to approve the requested recommendation?	Yes
If this includes a request for funding, does this Committee have the necessary delegated financial authority to approve it?	Yes
If this includes a request for funding, have the Directors of Finance confirmed the availability of funding?	Yes

Conflicts of Interest Consideration and mitigation:	None.
Link to Committee Risk Register and mitigation:	n/a
Report history:	This is the first time this paper has come to the Joint Committee.
Next Steps:	The co-ordination group will continue the work with Cheshire and Merseyside CCGs to enable the safe and effective transfer of responsibilities and contractual arrangements for the Core Military Veterans Service from NHS Bury CCG.
Responsible Officer to take forward actions:	Simon Banks
Appendices:	None

Cheshire and Merseyside Core Military Veterans Service Transfer of Coordinating Commissioner Arrangements from NHS Bury Clinical Commissioning Group to Cheshire and Merseyside Integrated Care Board Update

1. Background

1.1 NHS Bury Clinical Commissioning Group (CCG) has over the years, acted in the capacity as the North West Coordinating Commissioner for the Core Military Veterans Service for Cheshire and Merseyside, Greater Manchester and Lancashire and South Cumbria. As part of the transition and closedown arrangements for CCGs and the establishment of Integrated Care Boards (ICBs), it is NHS Bury CCG's intention to hand over commissioning and contracting arrangements for Cheshire and Merseyside to NHS Wirral CCG from 1st April 2022.

1.2 There is currently an implied NHS Standard Contract with Greater Manchester Mental Health NHS Trust to provide this service, which ends on the 31st March 2022. It is implied due to the current COVID-19 contracting regime for NHS providers. A new contract needs to be established from 1st April 2022.

1.3 The Joint Committee received a report on the transfer of commissioning arrangements for the Cheshire and Merseyside Core Military Veterans Service on 26th October 2021. At this meeting the following approach was endorsed:

- A small co-ordination group will support the transfer process, which will include local authority representation.
- The co-ordination group will develop shadowing arrangements for Cheshire and Merseyside to enable the safe and effective transfer of responsibilities from 1st April 2022 to the Cheshire and Merseyside ICB.
- In relation to the forthcoming 2022/23 contracting round, the co-ordination group will confirm commissioning intentions and negotiate/develop future contract content with Cheshire and Merseyside CCGs.
- Cheshire and Merseyside should continue with the existing commissioned services model with Greater Manchester Mental Health NHS Trust and, for Liverpool, with Mersey Care NHS Foundation Trust until 2024, with a standard NHS contract in place for both services through the Cheshire and Merseyside ICB.
- Once established, the Cheshire and Merseyside ICB will explore opportunities for a single service for Cheshire and Merseyside and ensure greater integration with currently nationally commissioned specialist services.
- North West wide collaborative working will continue the through the North West Armed Forces Network.

1.4 The Joint Committee asked for an update on progress on this work to be a future meeting. This report provides the requested update.

2. Update

2.1 The co-ordination group has been working to support appropriate exit arrangements and ensure a smooth transfer of responsibilities from NHS Bury CCG to Cheshire and Merseyside from 1st April 2022. This has involved contacting each CCG for them to identify the relevant officers who will support the completion of the contract in terms of activity required and the financial consequences.

2.2 The work on the contract for the Cheshire and Merseyside Core Military Veterans Service will be progressed in line with the timetable set out in the planning guidance and standard NHS contract for 2022/23 that was published on 24th December 2021. The process of engaging with the provider will be starting shortly. This will involve the support of the relevant officers in each CCG (except NHS Liverpool CGG) and will enable the negotiation and agreement of the contract schedules that will be taken forward from 1st April 2022.

2.3 The statutory establishment of the ICB has been moved to 1st July 2022, which means that the original intention to create a contract on behalf of the Cheshire and Merseyside ICB from 1st April 2022 is no longer possible. Subject to further discussion with NHS Bury CCG, the co-ordinating group is therefore intending to create a Co-Commissioner contract for 22/23 with all C&M CCGs (except Liverpool CCG, as discussed) with NHS Wirral as Lead Commissioner, which will then transfer to the ICB alongside all other existing contracts when the ICB is formally established.

2.4 In the report to the Joint Committee on 26th October 2021 it was stated that "there will be some small contract value and specification changes, but these are not believed to be significant". Having reviewed the documentation shared by NHS Bury CCG in regard to this service, it is clear that a 'lift and shift' remains entirely feasible, subject to the appropriate changes in activity and finance. The new standard NHS contract is not significantly different to the previous iterations and the changes that have been made for 2022/23 will not have a significant impact on the existing contract schedules.

2.5 It was stated at the Joint Committee on 26th October 2021 that CCGs needed a greater understanding of the impact of any activity and finance changes. This is why the co-ordination group has asked for a named contact in each CCG to support this work. This will enable each CCG to have a clear view of their requirements for 2022/23 and support the transfer of these to the ICB as of 1st July 2022.

2.6 It is proposed that this work is now taken forward as part of the 2022/23 contract round and managed as "business as usual". NHS Wirral CCG and NHS Warrington CCG will continue to provide support to enable this to happen, engaging with each CCG and also with the officer identified by Warrington Borough Council to give a local authority view on the service.

3. Recommendations

3.1 The Joint Committee is asked to note the contents of this report.

3.2 The Joint Committee is asked to support that the commissioning intentions, negotiation and development of the contract for 2022/23 is taken forward as part of the usual contracting and planning round with impacted Cheshire and Merseyside CCGs.

4. Access to further information

4.1 For further information relating to this report contact:

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Cheshire and Merseyside
Health and Care Partnership

Cheshire & Merseyside

2022 / 23 Planning Round

2022/23 Planning Round - Introduction

Cheshire and Merseyside
Health and Care Partnership

Key points:

- This is a comprehensive planning collection, akin to pre-pandemic planning rounds
- It covers a wide range of areas across finance, workforce, activity and performance
- Planning themes include elective care, cancer, diagnostics, urgent and emergency care, mental health and community services, LD and autism, personalisation, population health management and health inequalities
- The planning collections include a significant number of new metrics and associated data collections, in particular in relation to community services
- This is further complicated by extension of CCG/ICB national timeframes

Set out below is:

- High level timeline for national deadlines and system milestones
- Draft roles and responsibilities for consideration
- Oversight framework for this planning round

High Level Timetable for Draft Submission

Cheshire and Merseyside
Health and Care Partnership

Date	National Milestone	System Milestone
14/01/2022	Technical planning guidance and non-functional templates issued for activity, performance, workforce, narrative	
w/c 17/01/2022	Functional finance templates (system and provider) and related technical guidance to be issued	
w/c 24/01/2022		Weekly 2022/23 operational planning group – initial meeting
w/c 28/02/2022	Functional templates issued and collection portal open	
w/c 28/02/2022		Sign off at provider collaborative level / JCCCG
10/03/2022		Sign off at System Oversight Board
17/03/2022 (noon)	Submission deadline (draft plans): • Activity & performance • Workforce • Finance: system and provider • Narrative	

High Level Timetable for Final Submission

Cheshire and Merseyside
Health and Care Partnership

Date	National Milestone	System Milestone
w/c 21/03/2022	Regional assurance process begins	
w/c 28/03/2022		C&M operational planning group to work through regional feedback and outstanding issues
31/03/2022	Contracts signed	
11/04/2022		Sign off at provider collaborative level / JCCCG
14/04/2022		Sign off at System Oversight Board *(may require extraordinary meeting)*
28/04/2022 (noon)	**Submission deadline (final plans):** • **Activity & performance** • **Workforce** • **MH Workforce** • **Finance: system and provider** • **Narrative**	
May 2022	NHSE/I assurance/sign off of plans	

Priority Theme Leads

Cheshire and Merseyside Health and Care Partnership

	Priority	ICB Lead	System Lead	Sign Off	Narrative Required?
A	**Invest in our workforce** – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.	Chris Samosa		CMAST and MHLDCS	**Y**
B	**Respond to COVID-19 ever more effectively** – delivering the NHS COVID-19 vaccination programme, meeting the needs of patients with COVID-19.	Sarah O'Brien	Jayne Wood		**N**
C	**Deliver significantly more elective care** to tackle the elective backlog, reduce long waits and improve cancer waiting times: • C1. Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services • C2. Complete recovery, improve performance against cancer waiting times standards. • C3. Diagnostics	Anthony Middleton	Janelle Holmes (elective) Jon Hayes (cancer) Tracey Cole (diagnostics)	Elective Recovery Board, Cancer Alliance, CMAST	**Y for C1, C2, C3**
D	**Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity** – keeping patients safe, right care, at the right time, in the right setting. Supported by creating equivalent of 5,000 additional beds, through expansion of virtual ward models. Includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays. • D1. Urgent and emergency care • D2. Transform and build community services capacity to deliver more care at home and improve hospital discharge	Anthony Middleton	James Sumner (acute) Colin Scales (community)	CMAST and MHLDCS	**Y for D1, D2**

Priority Theme Leads (continued)

	Priority	ICB Lead	System Lead	Sign Off	Narrative Required?
E	**Improve timely access to primary care** – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.	Clare Watson	Dr Jonathan Griffiths	MHLDCS	N, metrics only
F	**Improve mental health services and services or people with a learning disability and/or autistic people** – maintaining growth in mental health investment to transform and expand community health services and improve access.	Simon Banks / Claire James		MHLDCS	N, metrics only
G	**Continue to develop our approach to population health management, prevent ill health and address health inequalities** – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities, building on the Core20PLUS5 approach	Sarah O'Brien		HCP Board	**Y – in Introduction**
H	**Exploit the potential of digital technologies to transform the delivery of care and patient outcomes** – achieving a core level of digitisation in every service across systems.	Alex Chaplin			N
I	**Make the most effective use of our resources** – moving back to and beyond pre-pandemic levels of productivity when the context allows this.	Keith Griffiths			N
J	**Establish ICBs and collaborative system working** – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.	Anthony Middleton			N

Planning Outputs

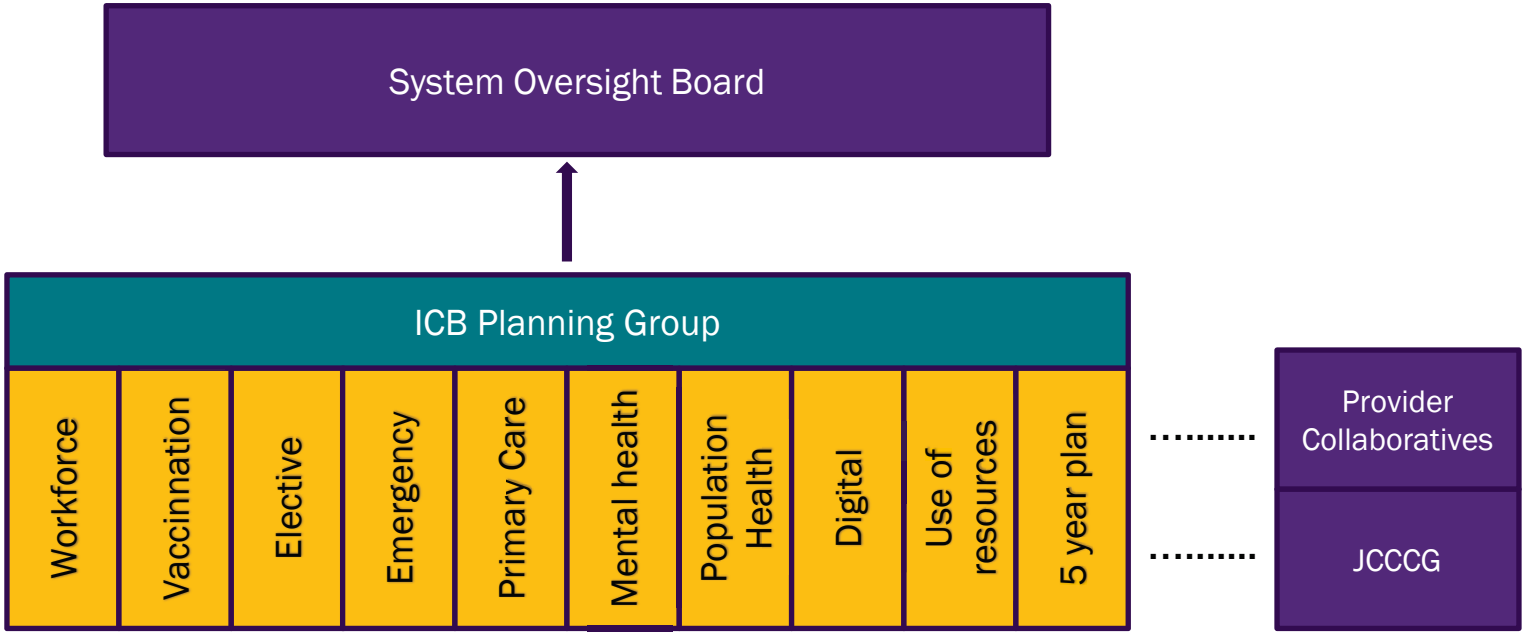
Cheshire and Merseyside
Health and Care Partnership

Product	Date	Description	Output Lead
Activity and performance	Draft 17 March Final 28 April	Single system-level collection incorporating: • provider-level breakdowns • elective recovery trajectories, including independent sector activity	Anthony Middleton
Workforce	Draft 17 March Final 28 April	System and provider-level collection across acute, ambulance, community, mental health and specialist trusts for staffing levels and KPIs. Specific tabs associated for community and primary care	Chris Samosa
Mental health workforce	Draft 28 April Final 23 June	Dedicated mental health collection at system and provider level aligned to services within the NHS Long Term Plan Mental Health Implementation Plan (MHIP)	Chris Samosa
Finance: System and provider	Draft 17 March Final 28 April	System and provider financial planning templates collecting one year revenue and three-and five-year capital plans	Keith Griffiths
Narrative	Draft 17 March Final 28 April	A single system level template covering: • the actions and assumptions that underpin the trajectories within the activity and workforce numerical submission • other critical actions that systems will take to address the priorities set out in the 2022/23 operational planning guidance, including elective recovery.	Anthony Middleton

Planning Outputs - Capital

Product	Date	Description	Output Lead
Capital: Elective Recovery Targeted Investment Fund	Ongoing	• An allocations and investment proposals template recording the distribution of the regional allocations and proposed investments by system. • The template can be submitted and iterated outside submission deadlines, but at draft and final plan stages the costs and impacts of proposed investments should be reflected across planning submissions	ICB : Anthony Middleton System : Janelle Holmes / Jenny Briggs
Capital: Diagnostics	Ongoing	• Systems should submit business cases (or equivalent requirements) as they are prepared, to commence national assurance processes. • The costs and impacts of proposed diagnostics investments should be reflected across planning submissions at draft and final plan stage • Pathology and imaging networks should refresh their digital roadmaps by the end of March, using previously issued roadmap and investment proposal templates.	ICB : Anthony Middleton System : Liz Bishop / Tracey Cole
Capital: Technology funding	Ongoing	• Systems should engage with regional teams to discuss their planned investments at an early stage, ahead of the submission of draft plans. • Approved investment proposals will be subject to letters of agreement, and business cases (or equivalent requirements) may subsequently be necessary. Systems must record how technology allocations will be shared across organisations in the financial planning template submitted in draft 17 March and final 28 April. • The costs and impacts of proposed technology investments should be reflected across planning submissions at draft and final plan stage.	ICB : Alex Chaplin System :

Oversight - Governance



Cheshire and Merseyside
Health and Care Partnership

Finance and resources sub-committee

Key issues report

Of the meeting held on 13th January 2022

NHS Cheshire Clinical Commissioning Group
NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group
NHS Wirral Clinical Commissioning Group

Key issues arising from the meeting held on 13th January 2022

ALERT (matters of concern, non-compliance or matters requiring a **response/action/decision** from the C&M Joint Committee)

Issue	Committee comments	Assurances received	Action	Timescale
F&R sub-committee terms of reference	The committee received the TORs from the C&M Joint Committee. Members have made recommendations in respect of proposed changes	N/A	C&M Joint Committee is asked to approve the proposed changes – separate paper presented to joint committee. TORs to be reviewed in March to ensure fit for purpose for April – June 2022.	February 2022 March 2022
Implications for F&R committee and other sub-committees due of the ICS delay	The committee raised a number of considerations that require a resolution in terms of agreeing what its roles and responsibilities will be in respect of *Recommending accounts for sign off by joint committee* *Recommending ICB budgets for sign off noting that not all CCGs have delegated this responsibility to the C&M joint committee* *Ensuring capacity to deliver the requirements of the contracting round (setting contracts for providers)* *Agreeing any extensions of variations to contracts to take account of the additional three month life span off CCGs* *Workforce transition and capacity*		C&M joint committee to provide guidance on what roles and responsibilities the F&R committee will have post 1st April 2022.	March 2022

HR and workforce	The committee TORs stipulate responsibilities in respect of HR and workforce – the committee would like additional clarity on what those responsibilities are. This is particularly relevant in Q1 2022-23 to support workforce transition to ICB.	N/A	ICS HR lead is to attend committee MIAA to map delegated workforce activities to the workplan. Joint committee to stipulate requirements of F&R committee to support development of the workplan	February February March 2002
Triangulation of activity between sub committees	Members were keen to ensure that committees don't operate in silo and miss the opportunity to triangulate matters that may pose risk	TORs mandate chairs to liaise across.	Key issue reports to be shared between sub-committees Sub-committee chairs to meet as per TOR mandate Development of integrated report for the C&M Joint Committee that consolidates the work of all sub-committees	February February TBC by joint committees

ADVISE (general update in respect of ongoing monitoring where an update has been provided)

Issue	Committee update	Assurances received	Action	Timescale
Patient voice	Committee concerned about patient voice being represented.	N/A	The committee chair will liaise with quality committee chair to ensure that any relevant issues are brought to F&R but would ensure there isn't any duplication.	Ongoing liaison

Report from chief finance officers on achievement of statutory duties	Committee reviewed and received the report. It was confirmed that £60.2m of £68.7m financial risk has been mitigated and that 8 out of 9 CCGs are on track to achieve breakeven. The £8.5m residual risk will continue to be managed through the agreed principles and actions described below under "assure"" Consideration of how variance and exception reporting to be undertaken.	Plans to deliver the forecast position	Continue to deliver plans	March 2022 February 2022

ASSURE (issues for which the committee has received assurances)

Issue	Committee update	Assurances received	Action	Timescale
Approach to Final Cross Cheshire and Merseyside Financial Position for the year 2021/22	The committee received the report.	Agreed set of principles under for the C&M finance community Evidence of actions being undertaken to fulfil the agreed principles Clear steps to reach agreement on the final financial positions for the CMCCGs both individually and collectively.	Implementation of agreed steps	March 2022
Risk	The committee received a report that set out the highest scoring financial risks from the respective CCGs Committee wishes to ensure consistent approach to risk assessment, mitigation and appetite for 2022-23	Risk registers and BAFs extracts with detailed mitigations	Continue to review and receive risk detail	Ongoing March 2022

Meeting of finance and resources sub-committee of the Cheshire & Merseyside CCGs Joint Committee

Minutes of the Finance and Resources Committee

9th December 2021
2-4pm
MS TEAMS

Present:

Gareth Hall (GH)	Lay Member Warrington & Halton CCG (Chair)
Mark Chidgey (MC)	CFO Wirral CCG
Debbie Fairclough (DF)	Interim Programme Lead SSCCG SFCCG (governance lead support to the F&R committee)
Alan Whittle (AW)	GB Member Wirral CCG
Paula Cowan (PC)	Chair Wirral CCG
David Cooper (DC)	CFO Warrington CCG
Janet Bliss (JB)	GB GP Liverpool
Judith Mawer (JM)	GB Member Knowsley
Gwydion Rhys (GR)	GB GP Cheshire
Martin McDowell (MM)	CFO/Deputy Chief Officer South Sefton CCG
Sally Houghton (SH)	GB Member Liverpool
Lynda Risk (LR)	CFO Cheshire CCG
Anette Metzmacher (AM)	GB GP Southport and Formby

In attendance:

Chelsea Hardman (CH)	Senior Corporate Affairs Officer Wirral CCG

REF NO	Preliminary Business	Action
A1	**Welcome and Introductions** GH welcomed members to the newly formed Finance and Resource committee and introductions were made.	
A2	**Apologies for Absence** Mark Bakewell, Alan Howgate, Iain Stoddart, Clare Watson and Mark Palethorpe.	
A3	**Quoracy** We are quorate for todays meeting, although this is not a decision making committee, it is noted in the Terms of Reference that at least 75% of members must be in attendance.	
A4	**Declarations of Interest** There are no declarations of interest.	

A5	**Conformation of Chairing Arrangements** GH has been identified through a expression of interest process to be the be the chair of this committee. ***Post meeting note:*** *It was further recommended that that Dr Paula Cowan would be vice chair and that position was confirmed by email to the committee from Gareth Hall on 10.12.21.*	
A6/A7	**Finance Committee Terms of Reference and Delegations from CCG Governing Bodies** JB asked for a few points of clarity • 2.1 workforce matters – what may these matters be as they are not included in the workplan • 2.2 financial strategy implementation – have we seen that for C&M, has it been written already? • 2.3 risk register – not had sight of this yet GH explained to members that we are asked to accept the TOR at this meeting but if anyone does have any comments or concerns these can be shared with members via email after the meeting, we can then pick up at the January meeting when they are scheduled for review. Any final changes to the terms of reference shall be submitted to the Joint Cheshire and Merseyside Committee of CCGs for approval. SH sought clarity in respect of the committee's responsibilities for HR and workforce. It was noted that there isn't currently a HR/workforce representative on the committee. It was noted that there may be a lot of matters the committee may need to cover over the next 4 months. It was noted that the Transition Committee will also help us pick up these issues. AW- commented that the terms of reference require more clarity in respect of the decision making, in 3.1 is advises not a decision-making committee and then in 6.2 and 10.3 it references voting. the committee need to have more clarity on this. JM- paragraph 9.2 refers to the performance sub-committee, is this an error? DF confirmed that the section provides a requirement of this committee to engage with other sub-committees of the C&M Joint Committee so that there is a robust approach to assurance and cross working. 10.3 says "simple majority of those voting". Need clarification on who the voting members are? We also need to have a patient voice, will this come from lay members/GP members? It was agreed that it is necessary to ensure that the patient voice is appropriately represented on the committee and further discussion is required to determine the best approach.	

	LR- 1.4 excluding BCF an S75 needs assurance that this is being looked at for the future as it's a big risk/concern. DF explained that is has been picked up through the governance leads for the Transition Committee, it will sit within the legacy items at place for the short term at least and is also included in the due diligence checklist. ***Action MC will collate and report risks, as transferred from previous committees, in the next committee's papers.*** ***Action members to submit their comments/concerns to the Chair via email.*** It was confirmed that Members are happy to accept the Terms of Reference subject to the proposed changes being incorporated and recommended to the C&M joint committee for approval.	
A8	**Advanced notice of any other business to be raised at today's meeting** There are no other items for business raised at this time.	
	Business Items	
B1	**Summary Financial positions in respect of H2 requirements and achievement of Statutory Financial Duties from all CCG's** MC presented the paper on behalf of all of the chief finance officers and asked other finance colleagues to support discussions as appropriate. Each CCG is required to deliver statutory financial targets in 2021/22. The paper summarises progress on achievements of those targets and in summary confirms:- • CCGs have worked collectively to submit breakeven plans for H2 2021/22. • Of the £68.7m of financial risk associate with these plans, £49.0m has been mitigated and a further £19.7m is to be identified • There is consistent achievement of all other statutory duties. With the exception of cash balances where the maximum balance of 1.25% was exceeded at the end of October by 5 CCGs. Chief Finance Officers met with Accountable Officers on the 8th November to consider financial risk in H2 and our collective ability to submit a breakeven position. The presentation to this meeting is attached as Appendix 2 and in summary:- • A principled approach to collective achievement was endorsed.	

	• Gross risk of £68.7m is distributed such that the range of financial challenge facing individual CCGs is between 4.2% and 16.3%. This is then mitigated by an additional C&M allocation of £37.0m. we have already identified £49m which leaves £19.7m. • The resultant net risk of £31.7m is equivalent to 3.5% and distribution of the £37.0m has been prioritised to those with the greatest gross risk such that net risk is equalised for each CCG at 3.5%. • It was subsequently agreed that allocations were then redistributed again to bring the St Helen's CCG risk below £1.0m. • CFOs are in agreement that there should be sufficient mitigations from allocation slippage and/or year-end flexibility such that breakeven is a reasonable planning assumption. MC brought members attention to the table included in appendix 1 the forecast achievement of statutory financial duties. The table is RAG rated for each of the CCGs for H2 performance at Month 7. The top 3 areas including revenue, net risk and QIPP/Mitigations. The position is consistent across all CCGs as we work collectively. The table confirms that a number of CCGs have not met their cash target. CFOs confirmed additional challenges to achieving this target where cash allocations of significant value are received late in the month with little notice. It was noted that the CCGs are in a good position to achieve financial balance but some risks remain. The focus of this group is delivery of mitigations. The committee is recommended to:- • Note that CCGs have submitted balanced plans to the ICS and the level of financial risk inherent within this. • Note the risk ratings by CCG for achievement of Statutory Financial Duties, in particular those relating to the breakeven duty and cash balances. • Require CCG CFOs to provide a monthly report as to progress and risks in achievement of collective and individual financial balance. • Request that individual financial risk registers and those risks rated 16 or above are reported to the next meeting of the committee.	

	AW thanked for the clear summary report and asked where are other areas such as provider financial performance are picked up? MC confirmed that Keith Griffiths at the HCP brings together CCG and provider reports, this can be included as an appendix for this committee but in depth discussions are picked up elsewhere. Has the allocation issue been picked up? It was confirmed that it has and there is ongoing communication regarding the issue. JM- looking at the discussion of risk share, some CCGs are more at risk than others. Is risk-sharing to equalise this? MC- confirmed that there was a wide-range of risk in opening positions. Access to the £37m system funding has then been distributed so that all CCGs have the same starting challenge of 3.5%. JM- will the public suffer due to services being affected by this unequal distribution as some CCGs have less to spend? MC- the process started with each CCG setting out the expenditure level that they needed to commission services. No allocation has been withdrawn from any CCG and therefore no services have been cut or affected because of the distribution. JW- the Mental Health Investment Standard exists to maximise access to health care. Have we missed an opportunity if it is not being met? Are we assured that the best action has been taken? MC- measurement of the target is not as strong as it should be, it measures the transfer of funding from CCGs to providers but not subsequent slippage on schemes and challenge around workforce. Therefore, we will deliver the standard but some services may not have been fully mobilised. DC- there is an issue with the target, not recurrent but confident that it will be green by the end of the year. LR- may be risk to the target, it has to be re-set and there is only a small margin on expenditure. Drug cost has gone down which has an affect also, we need to stay sighted on the risk. SH asked for some clarity on table 2 and the materiality for the CCGs, can we have the percentages included to allow comparison? The net risk for each CCG is 3.5%. We also need to remember that the data for Liverpool differs because of inclusion of HCP money. The report will change at the next meeting, there will be different sized tasks and more detail of the progress. There was similar risk to the H1 mitigations. MM- its worth reflecting on the significant figure, £20m does not seem that material in the context of CCG total allocations.	

	JM- do we have a plan B if we cannot achieve balance? MC explained that this would be discussed with ICS/ICB/HCP as to how risk may need to be managed between years. LR- we need to formalise the approach for Plan B an also how we plan on achieving plan A and increase risk appetite. JB- given last winter, do we know if this year will be as bad or worse and if so will it have an impact on current financial plans? MC explained that the plans have been set on specific assumptions, if these were to change to such a significant extent then this would be a national issue. Members confirmed acceptance of the recommendations in the paper.	
B2	**Risks** This will be a standard item as we consider/update/review at each meeting. MC requested that all CFOs arrange for their risk registers to be shared and a consolidated risk register will be developed.	
C1	**Future workplan of the committee** DF has drafted this for the committee and will take feedback to help develop further for the next committee. Mark Bakewell has raised schemes that need implementing and would need to be reviewed for finance approval before going to ICS. LR explained that we need to be careful on procurements and what is in/out of budget as it may also need to go to governing bodies. SH- in A7 MIAA paper re sickness. If HR is within scope, then we need a report on these figures at every meeting. JB- what is the remit of this group? Will this group evolve into the finance committee of the ICB? should be have the workplan longer than just 4 months. We need overview of impact on HR/Workforce to take ownership. AW presumed we would have HR dashboards to look at slot requirements as for our concerns about escalation, is it through the minutes or part of the final item on agenda for chairs note? DF explained that this will be in a key issue report and also the ratified minutes that will feed up to the Joint Committee. DF is working on a key issues reporting template for the chairs to sign of andt hen feedback will be given to CCGs via the joint committee.	

	Comms is also a vital part. Has the ICB got plans for HR comms? This is an issue which has been raised a few times, this could be flagged as a key issue for escalation. MM asked if we could invite the lead from the ICB to the next meeting and ask C&M HR what input they would like from us. This was noted for information and a further update will be at the next meeting.	
C2	**Any other business** There was no other business discussed.	
C3	**Summary of key issues and actions arising from the meeting** • Not just to focus on finance • Develop HR/organisational planning/workforce • How to pick patient voice up • Our own financial strategy – plan A and plan B • In depth mitigations to be included in the report at the next meeting • Send in suggested TOR amendments The Chair thanked everyone for attending for the first meeting and confirmed his view that it had gone very well.	
Date and Time of Next Meeting		
13th January 2022, 2pm, MS Teams		

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

25th January 2022

Agenda Item D1

Report Title	Finance and resources sub-committee terms of reference
Report Author	Debbie Fairclough – governance lead support to finance and resources sub-committee
Committee Sponsor	Mark Palethorpe – accountable officer lead for the finance and resources sub-committee

Purpose	**Approve**	✓	**Ratify**		**Decide**		**Endorse**		**For information**	

Decision / Authority Level	**Level One**	✓	**Level Two**		**Level Three**	

Executive Summary

The Cheshire and Merseyside CCGs joint committee developed a terms of reference for the finance and resources (F&R) sub-committee following consultation with the respective CCGs.

On 9th December 2021 and again on the 13th January 2022 the F&R sub-committee received the terms of reference and made recommendations for amendments to be incorporated.

The recommended amendments are highlighted in red text for ease of reference.

The committee is also asked to note that the F&R committee members will be seeking, at a future meeting, additional clarity in respect of its roles and responsibilities that will need to be updated to take account of the ICS delay.

In particular the committee will be seeking clarity with regard to any recommendations to the joint committee for the sign off the budgets for the ICB from 1st July 2022. The committee understands that its role is to provide assurances that the budgets proposed for approval will be in accordance with the relevant resource allocations and statutory guidelines. However, some CCGs have reserved the sign off of budgets to the practice membership and not delegated that authority to the joint committee so guidance will be required.

Recommendations

The Cheshire and Merseyside joint committee is asked to approve the proposed amendments to the finance and resources committee terms of reference.

Committee principles supported by this report *(if applicable)*	
The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services	
Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside	✓
Working together will achieve greater effectiveness in improving health and care outcomes	✓

Cheshire & Merseyside HCP Strategic objectives report supports:	
Improve population health and healthcare	
Tackling health inequalities, improving outcomes and access to services	
Enhancing quality, productivity and value for money	✓
Helping the NHS to support broader social and economic development	✓

Key Risks & Implications identified within this report

Strategic		Legal / Regulatory	
Financial		Communications & Engagement	
Resources (other than finance)		Consultation Required	
Procurement		Decommissioning	
Equality Impact Assessment		Quality & Patient Experience	
Quality Impact Assessment		Governance & Assurance	
Privacy Impact Assessment		Staff / Workforce	
Safeguarding		Other – please state	

Conflicts of Interest Consideration and mitigation:	N/A
Link to Committee Risk Register and mitigation:	N/A
Report history:	The terms of reference were received and reviewed by the finance and resources sub-committee on 9.12.21 and 13.1.22
Next Steps:	Terms of reference to be approved and submitted to finance and resources committee for acceptance. The terms of reference will be reviewed again in March 2022 to ensure that the roles and responsibilities of the committee are aligned to the impacts of the ICS delay.
Appendices:	Finance and resources sub-committee terms of reference

Access to further information

For further information relating to this report contact:

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Finance and Resources sub-committee of the Joint Committee of the Cheshire and Merseyside Clinical Commissioning Groups

Terms of Reference

1. Introduction

1.1 High functioning committees traditionally focus on a number of key responsibilities: setting strategy; delivery assurance and culture and establish a number of supporting sub-committees, including performance. The Cheshire and Merseyside CCGs Finance and Resources Committee has been established as a sub-committee of the Cheshire and Merseyside CCGs Joint Committee. Under the Cheshire and Merseyside Joint Committee Terms of Reference, the Joint Committee has the authority to establish and agree the Terms of Reference for sub-committees:

"The Joint Committee may appoint task and finish groups or sub-committees for any agreed purpose which, in the opinion of the Joint Committee, would be more effectively undertaken by a task and finish group or sub-committee. Any such task and finish group or sub-committee may be comprised of members of the CCGs or other relevant external partners, who are not required to be members of the Joint Committee. Minutes/reports of task and finish group or sub-committees will be promptly submitted to the Joint Committee."

1.2 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the sub-committee and shall have effect as if incorporated into the Constitution and Standing Orders of all Cheshire and Merseyside CCGs.

1.3 The sub-committee is authorised by the Cheshire and Merseyside CCGs Joint Committee to act within its terms of reference. All members and employees of the CCGs are directed to co-operate with any request made by the Committee.

1.4 The establishment of a sub-committee structure under the Cheshire and Merseyside CCGs Joint Committee will not change each of the CCG partnership arrangements for Section 75. The oversight, management and scrutiny of this item will remain within the 9 CCGs in Cheshire and Merseyside and shall continue to be governed by the relevant Section 75 agreement, signed by the respective CCG(s) and local authority. The committee is able to request updates on progress or risks from the relevant places so that the committee can be assured that matters are being effectively dealt with.

2. Role and Purpose

2.1 The overarching role and purpose of the sub-committee infrastructure is to support the Cheshire and Merseyside CCGs Joint Committee in the discharge of those CCG functions and responsibilities delegated to it until 31 March 2022.

2.2 The sub-committee will provide a focus on financial performance and delivery of financial recovery plans to ensure delivery of the Cheshire and Merseyside CCGs strategic and operational plans are achieved within financial allocations. It will provide a focus on financial performance and delivery of financial recovery plans and will support the development of reporting across a number of footprints.

2.3 In particular, the sub-committee will provide assurance to the Cheshire and Merseyside CCGs Joint Committee and the CCGs Governing Bodies on delivery of the:

- Duty as to effectiveness and efficiency.
- Workforce performance reports and dashboards for respective CCGs.

2.2 The sub-committee will support the implementation the Cheshire and Merseyside CCGs financial strategy, oversee financial development, management and deployment within the CCGs and the establishment of a whole system approach and culture to financial management and planning during the 21/22 transition period.

2.3 The sub-committee will review and monitor the shared Cheshire and Merseyside CCGs risks and provide assurance to the Joint Committee and CCG Governing Bodies in respect of Finance and Resources.

2.4 The sub-committee supports the Cheshire and Merseyside CCGs Joint Committee by providing assurance that effective use of Financial Resources underpins all services provided and commissioned on behalf of the Cheshire and Merseyside CCGs. The sub-committee will ensure that all regulatory requirements are met, and that financial information and management is continually improved to support the joint decision making of the CCGs working across Cheshire and Merseyside until the end of March 2022.

2.5 The sub-committee supports the Cheshire and Merseyside CCGs Joint Committee in ensuring that commissioning decisions are based on evidence related to financial effectiveness and influenced by patient experience, feedback and need; and in so doing, promote patient safety and a positive patient experience, in line with the principles of the NHS Constitution, the CCGs' values and the requirements of the Care Quality Commission.

2.6 The Finance and Resources sub-committee is one of three sub-committees reporting into the Cheshire and Merseyside Joint Committee as indicated in Table One. The Joint Committee will in turn continue to provide assurance reports to the Governing Body of each Cheshire and Merseyside CCG.

3. Authority of the Finance and Resources sub-committee

3.1 The Finance and Resources sub-committee is not a decision-making committee but is authorised by the Cheshire and Merseyside CCGs Joint Committee to undertake any activity within these terms of reference and act within the powers delegated to it in line with the Terms of Reference of the Cheshire and Merseyside CCGs Joint Committee.

Whilst the committee is not decision making it is required to submit relevant proposals the Cheshire and Merseyside Joint Committee for approval. Therefore, committee members are required to have a consensus view when making recommendations for matters to be approved by the Cheshire and Merseyside Joint Committee. In arriving at a consensus, it may be necessary for the Chair to request a vote on proposals. The process for voting is set out in sections 6.2 and 10.3.

3.2 The sub-committee will:

- Oversee the implementation and review of financial plans
- Oversee the delivery of these financial plans via reporting on financial performance, contract management and financial management, including detailed reporting on the financial position, variances and progress towards meeting the targets within the CCGs' financial plans, statutory financial targets and financial control totals

- Oversee the development and review of financial recovery plans
- Gain assurance on the delivery of the financial recovery plan to achieve the outcomes for the CCGs in accordance with the short- and long-term plans approved by NHS England and Improvement
- Review and provide assurance on the financial performance of the CCGs
- Review and provide assurance on financial performance across the system
- Review the CCGs budgets in line with the national planning guidance
- Review the impact of Quality, innovation, Productivity and Prevention (QIPP) plans on the financial position
- Review performance against the "finance and use of resources" elements of the NHS Oversight Framework.
- Monitor the effectiveness of the CCGs' human resources policies through overview of recruitment, retention, turnover and sickness trends.
- Monitor and ensure delivery on the requirements of the Equality Act 2010, with particular reference to monitoring and developing the diversity of the workforce
- Ensure that services provided by other organisations, notably the CSU, are being delivered as per the CCGs expectations and to advise on remedial action where necessary.

3.3 In performing its role the Finance and Resources sub-committee is:

- required to provide assurance to the Cheshire and Merseyside CCGs Joint Committee that there are appropriate systems in place which operate in order to enable the Committee to fulfil its finance and resources monitoring requirements
- required to provide regular reports to Cheshire and Merseyside CCGs Joint Committee on a timely basis and to also provide any updates that may be requested from time to time from the respective CCG governing body or committee established to retain responsibility for legacy matters
- required to produce an annual work plan to discharge its responsibilities until 31st March 2022
- required to provide assurance on any other financial and resource matters as requested by the Cheshire and Merseyside CCGs Joint Committee
- able to request further investigation or assurance on any area within its remit
- able to bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- able to make recommendations to the Cheshire and Merseyside CCGs Joint Committee
- able to escalate issues to the Cheshire and Merseyside CCGs Joint Committee and, via the Joint Committee, to CCG Governing Bodies
- able to approve the terms of reference of any sub-groups to the committee.

4. Membership

4.1 Membership of the sub-committee will be drawn from the membership of the Governing Bodies and Executive teams and officers of the Cheshire and Merseyside CCGs.

4.2 All members of the Committee are expected to represent the interests of the whole Cheshire and Merseyside population and make recommendations and decisions in the interests of all patients and residents accessing health and care services in Cheshire and Merseyside.

4.3 The Committee Membership will be composed of, as a minimum:

- Chair – Gareth Hall, lay member Warrington and Halton CCG
- At least one CCG Chair -Dr. Paula Gowan, Chair Wirral CCG and Vice Chair

- At least one Cheshire and Merseyside CCG Accountable/Chief Officer – Mark Palethorpe – AO St Helens and Clare Watson – AO Cheshire CCGs.
- Executive leads/Directors of Finance and Contracting from all Cheshire and Merseyside CCGs
- at least three Independent Governing Body Members*
- At least three Governing Body GP representatives.

** Incorporates Lay Members, Secondary Care Doctor and Registered Nurse members of a CCG Governing Body.*

4.4 The sub-committee has the authority to invite other individuals drawn from Governing Bodies and Executive teams and officers of the Cheshire and Merseyside CCGs to be members of the Committee.

4.5 All sub-committee members may appoint a deputy to represent them at meetings of the sub-committee. sub-committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

4.6 The sub-committee may also request attendance by appropriate individuals to present agenda items and/or advise the sub-committee on particular issues.

4.7 The sub-committee may invite specified individuals from within and outside of the CCG to be regular attendees (non-voting) at its meeting in order to inform its decision making and the discharge of its functions as it sees fit..

4.8 Regular attendees will receive advanced copies of the notice, agenda and papers for sub-committee meetings. They may be invited to attend any or all of the sub-committee meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting, but may not vote.

5. Chair of the sub-committee

5.1 The Chair and Vice Chair of the sub-committee will be appointed from the non-Executive members of the Governing Bodies of the Cheshire and Merseyside CCGs.

5.2 If the Chair is unable to attend a meeting, the Vice Chair will undertake the duties of Chair at that meeting. Where both the Chair and Vice Chair are unable to attend a meeting, the Chair may designate a representative from within the membership of the Committee to act as chair.

5.3 If the Chair is unable to chair an item of business due to a conflict of interest, the Vice Chair will be asked to chair that item. Where both the Chair and Vice Chair are unable to chair an item of business due to a conflict of interest the meeting, the Chair may designate a representative from within the membership of the Committee to act as chair for that item.

6. Attendance and Quorum

6.1 The meeting will be quorate with:

- 75% of the sub-committee membership in attendance
- Attendance for the purpose of quorum shall comprise the Chair or the Vice Chair.

6.2 The sub-committee will aim to make its decisions in respect of supporting proposals that require submission to the Cheshire and Merseyside Joint Committee for approval through consensus. In the event of a requirement to make a decision to support a

proposal by taking a vote, a minimum of 75% of the substantive voting sub-committee membership in attendance at the meeting in question must be in agreement for the recommendation or decision to be carried,

7. Frequency of Meetings

7.1 Meetings shall be held monthly.

7.2 Arrangements for calling meetings will be in writing to the chair of the sub-committee with a minimum of ten days' notice

8. Administrative Support

8.1 To enact the business of the sub-committee and progress the work plan dedicated administrative resource for the sub-committee will be agreed by the nine CCGs. A nominated Lead Director and a governance lead drawn from the Cheshire and Merseyside CCGs shall be responsible for supporting the sub-committee Chair in forward planning, agenda setting, follow up of actions and circulation of minutes.

8.2 Papers for each meeting will be issued to members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to members earlier if possible.

9. Accountability and Reporting Arrangements

9.1 The sub-committee will report to the Cheshire and Merseyside CCGs Joint Committee.

9.2 There will be close links between the Cheshire and Merseyside performance sub-committee, the quality sub-committee and any other sub-committees of the Cheshire and Merseyside CCGs Joint Committee that may be established with regular meetings between the Chair and Vice Chair of the Joint Committee and the Chairs of each sub-committee to ensure that there are no assurance gaps.

10. Conduct of the sub-committee

10.1 At the beginning of each meeting, the Chair will ask members whether they have any interests to declare, in accordance with the CCGs' Gifts, Hospitality and Declarations of Interests Policy.

10.2 If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the relevant CCGs' Conflicts of Interests Policy. subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

10.3 Decision making in respect of ensuring there is a consensus in respect of proposals being submitted to the Cheshire and Merseyside Joint Committee for approval will be by a simple majority vote of the present substantive members at the relevant meeting. In the event that a vote is tied, the chair will have the casting vote.

10.4 Members of the sub-committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

10.5 Finance sub-committee papers will be stored and archived by the sub-committee administrator and copies held in an accessible format. Details on location and how to access documents will be set out in the schemes of transfer.

10.6 The Finance sub-committee will apply best practice in its deliberations and in the decision-making processes. It will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

10.7 All members of the sub-committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the sub-committee.

11. Monitoring Effectiveness and Compliance with Terms of Reference

11.1 The committee will carry out a review before 31st March 2022 of its functioning and provide an outcome report of that review to the Cheshire and Merseyside CCGs Joint Committee who will in turn submit that report to the CCGs governing bodies.

12. Review of Terms of Reference

12.1 The terms of reference of the committee shall be reviewed in March 2022 to ensure they remain fit for purpose and are aligned to the additional requirements that are a consequence of the ICS delay until 1st July 2022.

12.2 Amendments to the Terms of Reference are to be approved by the Cheshire and Merseyside CCGs Joint Committee.

Version Control:
Version: 0.2

Cheshire and Merseyside
Health and Care Partnership

Quality Sub-Committee

Key issues report

7th December 2021 and 11th January 2022

NHS Cheshire Clinical Commissioning Group
NHS Halton Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group
NHS Wirral Clinical Commissioning Group

Key issues arising from the meeting held on 7th December 2021 and 11th January 2022

ALERT (matters of concern, non-compliance or matters requiring a **response/action/decision** from the C&M Joint Committee).

Issue	Committee comments	Assurances received	Action	Timescale
Quality sub-committee terms of reference (7th December 2021)	The sub-committee received these from the C&M Joint Committee. Members have made recommendations in respect of proposed changes	N/A	C&M Joint Committee is asked to approve the proposed changes. These are included at Appendix A	January 2022
Membership (7th December 2021 and 11th January 2022)	Committee proposed that a secondary care doctor would be a useful addition to the membership Amendments highlighted above include provision of a secondary care doctor	N/A	Contact has been made with the Joint Committee Chair and Quality sub-committee Chair where agreement was made to invite the one secondary care doctor C&M committee who expressed an interest to be a member. Secondary care doctor has confirmed interest as a member. C&M Joint Committee is asked to approve this.	January 2022
Workplan (7th December 2021 and 11th January 2022)	A draft workplan was considered by the sub-committee in December 2021 and it was agreed that further work was required to populate the workplan. This was undertaken following the meeting by Chief Nurse and Quality Leads and presented again for consideration by the sub-committee in January 2022.	N/A	C&M Joint Committee is asked to approve the workplan. This is included at Appendix B	January 2022

Workforce matters (11th January 2022)	Workforce issues were discussed, particularly in relation to the increases in referrals to secondary care and the shortage of workforce to manage the increase	N/A	C&M Joint Committee to consider the most appropriate forum for discussion of workforce issues with an impact on quality	January 2022
System quality assurance (11th January 2022)	Discussion took place regarding assurance via the Clinical Quality and Performance Group (CQPG) meetings	N/A	C&M Joint Committee to ascertain any updates required from CQPG meetings taking account of the different role of the CCGs to NHSE/I	January 2022

ADVISE (general update in respect of ongoing monitoring where an update has been provided)

Issue	Committee update	Assurances received	Action	Timescale
Quality surveillance (11th January 2022)	An overview of themes and trends taken from all CCG reports to the Quality Surveillance Group in December 2021 was presented. This identified key areas for consideration within the workplan and cross referenced to the risks identified by each CCG also.	All Chief Nurses/Quality Leads agreed to continue to share their reports for oversight of any ongoing themes and trends	Continue to oversee quality themes and trends	Ongoing
Risk Register (11th January 2022)	A consolidated risk register comprising all relevant quality risks was reviewed. Some of the risks reviewed were more aligned to performance matters and it was agreed that consideration was needed regarding how updates relating to performance but with an impact on quality would be managed.	All Chief Nurses/Quality Leads confirmed risks will continue to be shared	Discussion required with CM governance workstream leads to agree the risk management approach and template	January 2022

	It was also highlighted that a consistent approach was required in relation to risk and the presentation of information.			
Register of Interests (11th January 2022)	A draft register of interest was provided, and members reminded that they should review interests to ensure that any further interests should be added to the register to take into consideration the wider footprint of the sub-committee.	Interests taken from existing CCG register of interests	A template to be circulated to all members to capture any additional interests to be included	January 2022

ASSURE (issues for which the committee has received assurances)

Issue	Committee update	Assurances received	Action	Timescale
Learning from Deaths of people with a Learning Disability (LeDeR) (11th January 2022)	An update was provided on the LeDeR programme including the governance proposals. These were shared to ensure that any feedback could be incorporated into the model. The update included a status report on the implementation of the policy and workforce model, LeDeR assurance and ICS Panel preparation	Oversight and insight provided of the LeDeR programme including future arrangements	Continue with implementation, finalise the governance model and panel terms of reference and completion of current cases by reviewers	March 2022

C&M Quality Sub Committee Workplan

Quality Sub Committee Workplan	Presenter	Dec	Jan	Feb	Mar
Terms of Reference	Cathy Maddaford	✓	✓		
Workplan	Cathy Maddaford	✓	✓	✓	
Agree future meetings	Cathy Maddaford	✓		✓	
Patient Safety					
Thematic review of patient safety including SI/Never Events	Lisa Ellis			✓	
National inquiries, National Reviews (if relevant)	Michelle Creed ***(as required)***				
IPC performance, learning and feedback	**TBC**				
MAB Service (Treatment of Covid)	**TBC**				
Quality headline reports regarding all Providers (including Primary care and Independent Sector)	Michelle Creed		✓		
Learning From Deaths					
Avoidable Harm Reviews	Jane Lunt				✓
Learning from Deaths of people with Learning Disability (LeDeR)	Helen Meredith Denise Edwards		✓		
Child Death Overview Panel (CDOP)	Paula Wedd				✓
SMR/SHMI	Jane Lunt				✓
Safeguarding					
Children	Paula Wedd				✓
Looked After Children	Paula Wedd				✓
Adults	Paula Wedd				✓
Annual Reports	Paula Wedd				✓
Patient Experience					
System learning from patient engagement • Healthwatch • Patient, Public Engagement • Consultation • Complaints/PALS	Helen Meredith ***(date TBC)***				
Oversight of ongoing consultations (QIA and EIA)	Helen Meredith ***(date TBC)***				
Governance					
Risk Register	Rebecca Knight		✓	✓	✓
C&M Transformation Programmes (including personalisation agenda)					
Maternity • Continuity Care • Ockenden • Local Maternity System	Jane Lunt			✓	
Transforming Care	Helen Meredith				✓
All Age Continuing Care	Lorna Quigley		✓	✓	
Special Education Needs and Disabilities (SEND)	Lisa Ellis			✓	
Workforce	**TBC**				

Appendix A
Quality Sub Committee Terms of Reference

Quality Sub Committee of the Joint Committee of Cheshire and Merseyside Clinical Commissioning Groups
Terms of Reference

1. Introduction

1.1 High functioning Committees traditionally focus on a number of key responsibilities: setting strategy; delivery assurance and culture and establish a number of supporting sub-committees, including performance. The Cheshire and Merseyside CCGs Quality Sub Committee has been established as a sub-committee of the Cheshire and Merseyside CCGs Joint Committee. Under *section (add once Joint Committee TOR finalised)* of the Cheshire and Merseyside Joint Committee Terms of Reference, the Joint Committee has the authority to establish and agree the Terms of Reference for sub-committees:

"The Joint Committee may appoint task and finish groups or sub-committees for any agreed purpose which, in the opinion of the Joint Committee, would be more effectively undertaken by a task and finish group or sub-committee. Any such task and finish group or sub-committee may be comprised of members of the CCGs or other relevant external partners, who are not required to be members of the Joint Committee. Minutes/reports of task and finish group or sub-committees will be promptly submitted to the Joint Committee."

1.2 These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Sub Committee and shall have effect as if incorporated into the Constitution and Standing Orders of all Cheshire and Merseyside CCGs.

1.3 The Sub Committee is authorised by the Cheshire and Merseyside CCGs Joint Committee to act within its terms of reference. All Members and employees of the CCGs are directed to co-operate with any request made by the Committee.

1.4 The establishment of a sub-committee structure under the Cheshire and Merseyside CCGs Joint Committee will not change each of the CCG partnership arrangements for Section 75. The oversight, management and scrutiny of this item will remain within the 9 CCGs in Cheshire and Merseyside and shall continue to be governed by the relevant Section 75 agreement, signed by the respective CCG(s) and local authority.

2. Role and Purpose

2.1 The overarching role and purpose of the sub-committee infrastructure is to support the Cheshire and Merseyside CCGs Joint Committee in the discharge of those CCG functions and responsibilities delegated to it until 31 March 2022.

2.2 The Sub Committee will provide assurance that effective quality, safety and experience arrangements underpin all services provided and commissioned on behalf of the CCGs. The Sub Committee will ensure that all regulatory requirements are being met and patient safety is continually improved to deliver a better patient experience.

2.3 In particular, the Sub Committee will provide assurance to the Cheshire and Merseyside CCGs Joint Committee and the CCGs Governing Bodies:

- that effective quality arrangements underpin all services provided and commissioned on behalf of the CCGs. The Sub Committee will ensure that all regulatory

requirements are met and quality and patient safety is continually improved to deliver a better patient experience.

- that commissioning decisions are based on evidence of clinical effectiveness and influenced by patient experience, feedback and need; and in so doing, promote patient safety and a positive patient experience, in line with the principles of the NHS Constitution, the CCGs' values and the requirements of the Care Quality Commission.
- The CCGs will seek assurance from providers, raise formal queries and refer issues to the Joint Committee where there are significant concerns, which may compromise quality and patient safety.
- That CCGs will ensure that a clearly defined escalation process is in place for safety and quality measures, taking action as required to ensure that improvements in quality are implemented where necessary.
- That CCGs can satisfy themselves that children, Looked After Children, special educational needs and disability (SEND) requirements and adult's safeguarding duties are being met and that robust actions are taken to address concerns.

2.6 The Quality Sub Committee is one of three sub-committees and reports to the Cheshire and Merseyside Joint Committee. The Joint Committee will in turn continue to provide accountability reports to the Governing Bodies of each Cheshire and Merseyside CCG.

3. Authority of the Quality Sub Committee

3.1 The Quality Sub Committee is not a decision-making committee but is authorised by the Cheshire and Merseyside CCGs Joint Committee to undertake any activity within these terms of reference and act within the powers delegated to it in line with the Terms of Reference of the Cheshire and Merseyside CCGs Joint Committee.

3.2 The Sub Committee has the authority to:

- review the effectiveness of quality governance arrangements to ensure that the health care commissioned on behalf of the CCGs is safe and of high quality and recommending courses of action where concerns have been raised.
- Review any information, notification or advice received from NHS England and NHS Improvement, National Quality Board, CQC or any External Regulator which relates to or has a bearing on an NHS care provider's provision including the results of national clinical audit information and confidential enquiries.
- Ensure that systems to monitor the quality of commissioned services are in place and are functioning appropriately.
- Review quality information from a range of sources in accordance with the work plan.
- Provide leadership to the quality work of each organisation.
- Give direction to the development of systems and processes for managing quality governance across the local system
- Provide effective oversight and scrutiny of the quality impact assessment process for all CCGs Quality Innovation Productivity and Prevention (QIPP) programmes and being assured around the quality impact assessment processes for the cost improvement programmes of its principal providers.
- Receive and review reports on quality in respect of commissioned services to include performance against CQUINs, patient experience (including complaints and compliments) and clinical performance indicators.
- Triangulate intelligence from complaints, quality issues and patient and community experience and engagement feedback.
- Review on a rolling programme of each Place commissioning area to identify and address variation in quality and experience and to ensure that feedback on existing

services is used to inform the commissioning decisions and that patients are involved in all service redesign programmes.

- Ensure that there are robust systems and processes in place to safeguard children, special educational needs and disability (SEND) requirements, Looked After Children, and adults in line with the Mental Capacity Act (including Deprivation of Liberty Safeguards) (DoLS).
- Ensure adequate systems are in place for the governance of research in line with the Department of Health and Social Care's requirements.
- Oversee the systems and processes that are in place to ensure quality is embedded, including development of service specifications.
- Oversee work on improving clinical effectiveness.
- Consider best practice in quality and making recommendations to the Joint Committee for each local area.
- Ensure that evidence from quality assurance processes drive the quality improvement agenda and support delivery of QIPP.
- Develop and keep under review policies and procedures relevant to the role of the Sub Committee.
- Approve arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.
- Approve arrangements for supporting NHS England and NHS Improvement in discharging its responsibilities in relation to securing continuous improvement in the quality of medical services.
- Review and monitor the shared CCG risks and provide assurance to the Joint Committee and CCG Governing Bodies in respect of Quality and Safeguarding
- Review information about serious incidents including all Never Events and Serious Case Reviews (SCRs) / Safeguarding Practice Reviews (SPRs), Safeguarding Adult Reviews (SARs), and Domestic Homicide Reviews (DHRs), to identify themes/areas of risk and to ensure that actions are identified and completed to improve care delivery.

3.3 In performing its role the Quality Sub Committee is:

- required to provide assurance to the Cheshire and Merseyside CCGs Joint Committee that there are appropriate systems in place which operate in order to enable the Committee to fulfil its quality monitoring requirements
- required to provide regular reports to Cheshire and Merseyside CCGs Joint Committee on a timely basis and to also provide any updates that may be requested from time to time from the respective CCG's governing bodies or committee established to retain responsibility for legacy matters
- required to produce a~~n annual~~ work plan to discharge its responsibilities until 31st March 2022
- required to provide assurance on any other quality matters as requested by the Cheshire and Merseyside CCGs Joint Committee
- able to request further investigation or assurance on any area within its remit
- able to bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- able to make recommendations to the Cheshire and Merseyside CCGs Joint Committee
- able to escalate issues to the Cheshire and Merseyside CCGs Joint Committee and, via the Joint Committee, to CCG Governing Bodies
- able to approve the terms of reference of any sub-groups to the committee.

4. Membership

4.1 Membership of the sub-committee may be drawn from the membership of the Governing Bodies and Executive teams and officers of the Cheshire and Merseyside CCGs.

4.2 All members of the Sub Committee are expected to represent the interests of the whole Cheshire and Merseyside population and will undertake its work in the interests of all patients and residents accessing health and care services in Cheshire and Merseyside.

4.3 The Sub Committee Membership will be composed of, as a minimum:

- ~~Chair~~
- At least one Cheshire and Merseyside CCG Accountable/Chief Officer
- At least one CCG Chair
- At least one secondary care doctor
- Chief Nurses / Executive leads for ~~/Directors of~~ Quality and Safeguarding from all Cheshire and Merseyside CCGs (or nominated deputies)
- at least three Independent Governing Body Members*
- At least three Governing Body GP representatives.
- ~~Chief Nurse (or nominated deputy) for each CCG~~
- ~~Up to four Healthwatch representative~~
- ~~Up to two CCG Communications, People and Public Engagement representatives~~
- ~~Up to two Patient/Carer representatives~~

** Incorporates Lay Members, ~~Secondary Care Doctor~~ and Registered Nurse members of a CCG Governing Body.*

4.4 The Sub Committee will regularly invite the following representatives across Cheshire and Merseyside, to attend any or all of its meetings as attendees:

- Up to four Healthwatch representatives
- Up to two CCG Communications, People and Patient Engagement representatives
- Up to two Patient / Carer representatives

~~4.4~~4.5 The Sub Committee has the authority to invite other individuals drawn from Governing Bodies and Executive teams and officers of the Cheshire and Merseyside CCGs to be members of the Committee.

~~4.5~~4.6 All Sub Committee members may appoint a deputy to represent them at meetings of the committee. Sub Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

~~4.6~~4.7 The Sub Committee may also request attendance by appropriate individuals to present agenda items and/or advise the sub-committee on particular issues.

~~4.7~~4.8 The Sub Committee may invite specified individuals from within and outside of the CCGs to be regular attendees (non-voting) at its meeting in order to inform it work and the discharge of its functions as it sees fit. This could include but is not limited to Designated Nurse Safeguarding and Looked After Children (Children and Adults) as well as Heads of Quality and any other relevant representatives.

~~4.8~~4.9 Regular attendees will receive advanced copies of the notice, agenda and papers for Sub Committee meetings. They may be invited to attend any or all of the Committee meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair, to ask questions and address the meeting, but may not vote.

5. Chair of the Sub Committee

5.1 The Chair ~~and Vice Chair~~ of the Sub Committee will be appointed from the non-Executive members of the Governing Bodies of the Cheshire and Merseyside CCGs.

5.2 If the Chair is unable to attend a meeting, the Vice Chair will undertake the duties of Chair at that meeting. Where both the Chair and Vice Chair are unable to attend a meeting, the Chair may designate a representative from within the membership of the Sub Committee to act as chair.

5.3 If the Chair is unable to chair an item of business due to a conflict of interest, the Vice Chair will be asked to chair that item. Where both the Chair and Vice Chair are unable to chair an item of business due to a conflict of interest the meeting, the Chair may designate a representative from within the membership of the Sub Committee to act as chair for that item.

6. Attendance and Quorum

6.1 The meeting will be quorate with:

- 50~~75~~% of the membership in attendance
- The quorum will include the following voting members: ~~Attendees shall comprise~~ the Chair or the Vice Chair, one Lay Member, two Chief Nurses / Executive leads, and two other clinicians (including secondary care doctor and GPs)~~.~~

7. Frequency of Meetings

7.1 Meetings shall be held monthly.

7.2 Arrangements for calling meetings will be in writing to the chair of the sub-committee with a minimum of ten days' notice

8. Administrative Support

8.1 To enact the business of the Sub Committee and progress the work plan dedicated administrative resource for the Sub Committee will be agreed by the nine CCGs. A nominated Lead Director and a governance lead drawn from the Cheshire and Merseyside CCGs shall be responsible for supporting the Sub Committee Chair in forward planning, agenda setting, follow up of actions and circulation of minutes.

8.2 Papers for each meeting will be issued to Sub Committee members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting. Every effort will be made to circulate papers to members earlier if possible.

9. Accountability and Reporting Arrangements

9.1 The Sub Committee will report to the Cheshire and Merseyside CCGs Joint Committee and through the Joint Committee will provide update reports to the Governing Body of each CCG after each meeting.

9.2 There will be close links between the Quality Sub Committee and the other sub-committees of the Cheshire and Merseyside CCGs Joint Committee with regular meetings between the Chair and Vice Chair of the Joint Committee and the Chairs of each sub-committee to ensure that there are no assurance gaps.

10. Conduct of the sub-committee

10.1 At the beginning of each meeting, the Chair will ask members whether they have any interests to declare, in accordance with the CCGs' Gifts, Hospitality and Declarations of Interests Policy.

10.2 If any member has an interest, financial or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and act in accordance with the relevant CCG's Conflicts of Interests Policy. Subject to any previously agreed arrangements for managing a conflict of interest, the chair of the meeting may require the individual to withdraw from the meeting or part of it.

The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

10.3 Members of the Sub Committee have a duty to demonstrate leadership in the observation of the NHS Code of Conduct and to work to the Nolan Principles, which are selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

10.4 Quality Sub Committee papers will be stored and archived by the Sub Committee administrator and copies held in an accessible format. Details on location and how to access documents will be set out in the schemes of transfer.

10.5 The Quality Sub Committee will apply best practice in its deliberations and will conduct its business in accordance with national guidance and relevant codes of conduct and good governance practice.

10.6 All members of the Sub Committee are expected to comply with all relevant policies and procedures relating to confidentiality and information governance, noting the sensitivity of the information that will be considered by the Sub Committee.

11. Monitoring Effectiveness and Compliance with Terms of Reference

11.1 The Sub Committee will carry out a review before 31st March 2022 of its functioning and provide an outcome report of that review to the Cheshire and Merseyside CCGs Joint Committee who will in turn submit that report to the CCGs governing bodies.

12. Review of Terms of Reference

12.1 The terms of reference of the sub-committee shall be reviewed in January 2022 to ensure they remain fit for purpose.

12.2 Amendments to the Terms of Reference are to be approved by the Cheshire and Merseyside CCGs Joint Committee.

Version Control:
Version: 0.2

CHESHIRE & MERSEYSIDE CCGs
JOINT COMMITTEE MEETING

25th January 2022

Agenda Item: D4

Report Title	**Commissioning Working Group Update Report**
Report Author	Dave Horsfield, Director of Transformation, Planning & Performance, NHS Liverpool CCG
Committee Sponsor	Dianne Johnson, Executive Director of Transition, C&M HCP

Purpose	**Approve**	✓	**Ratify**		**Decide**	✓	**Endorse**		**For information**	✓

Decision / Authority Level	**Level One**	✓	**Level Two**		**Level Three**	

Executive Summary

This report provides an overview of the Directors of Commissioning Group meeting that took place on **Monday 6th December 2021** and **Monday 10th January 2022**

NB: The meeting on 10th January 2022 was curtailed to support the current pressures in the system.

Recommendations

It is recommended that the Joint Committee:

- **Note** the contents of the report.
- **Agree or amend** the timescales currently applied to the working group work plan areas and agree to the addition of Long Covid Services to the plan.
- **Approve** the development of a set of principles and communications in relation to the restriction of services .

Committee principles supported by this report *(if applicable)*	
The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services	✓
Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside	✓
Working together will achieve greater effectiveness in improving health and care outcomes	✓

Cheshire & Merseyside HCP Strategic objectives report supports:	
Improve population health and healthcare	✓
Tackling health inequalities, improving outcomes and access to services	✓
Enhancing quality, productivity and value for money	✓
Helping the NHS to support broader social and economic development	✓

Key Risks & Implications identified within this report				
Strategic	✓		Legal / Regulatory	✓
Financial	✓		Communications & Engagement	
Resources (other than finance)	✓		Consultation Required	✓
Procurement	✓		Decommissioning	✓
Equality Impact Assessment			Quality & Patient Experience	✓
Quality Impact Assessment			Governance & Assurance	✓
Privacy Impact Assessment			Staff / Workforce	
Safeguarding			Other – please state	

Conflicts of Interest Consideration and mitigation:	Joint Committee members will be required to declare any conflict of interest pertinent to this paper.
Link to Committee Risk Register and mitigation:	N/A
Report history:	Regular report updated monthly.
Next Steps:	The working group to continue activity outlined in the approved work plan and to develop recommendations to the Joint Committee based on these items.
Appendices:	N/A

Directors of Commissioning Group Update Report

1. Introduction

1.1 The Cheshire and Merseyside Commissioning Working Group met on 6th December 2021 and 10th January 2022 since the last meeting of the Joint Committee. This report provides an overview and any recommendations made to the Joint Committee on the agenda items discussed at both meetings. The January meeting was shortened with a limited agenda to reflect system pressures at the time.

2. Committee Management

2.1 Commissioning Working Group – Work Plan

The Group agreed that a structured work plan was required to ensure preparation for items and a clear indication of timing for the activities to take place. A plan has been produced with agreed leads assigned to some areas. Further leads will be assigned at the next meeting. The work plan is attached as appendix 1.

It was raised that Long Covid Service Development will be key over the coming period and should be discussed at the next meeting and added to the work plan.

Recommendation:

- The Joint Committee is asked to agree or amend the timescales currently applied to the work plan areas and the addition of Long Covid Services to the plan

3. Business

3.1 Neutralising Monoclonal Anti-bodies (nMABs)

Kate Abendstern (Programme Consultant - C&M) presented a paper summarising the position on the rollout of nMABs in the community at the December meeting. Since the paper was prepared, NHSE had delivered the instruction to stand the service up with effect from 16th December and actions were needed to progress in line with this timescale.

Commissioners were asked to:

- Note the paper and progress to date.
- Engage with their local provider to confirm the status of service mobilisation and associated costs and make arrangements to commission the service locally.
- Confirm the final requirement for the Mersey Care Covid Medicines Delivery Unit (CMDU), including prescribing costs and agree a top slice for the budget to allow the CMDU to be commissioned by Liverpool CCG.
- Ensure that the commissioning representative on the Mobilisation Group (John Webb at LCCG) was briefed on any commissioning issues that need to be addressed on a system-wide basis.

The group supported these actions to ensure delivery of the service. At the January meeting the service was discussed further and it was agreed for the following actions to remain open until further confirmation received:

- Informal MOU awaited to record contract agreement between Mersey Care and the ICS. Michelle Urwin clarified this has been sent to Sarah O'Brien.
- Michelle Urwin advised that the finance element has not been confirmed as there were insufficient funds available when K Abendstern presented to DoCs on 06-12-2021. It was agreed for this action to remain open until further information is available.

3.2 Investment in Maternal Mental Health Services from 22/23 onwards

Alison Williams (Programme Manager, NHS Liverpool CCG) provided a detailed overview of the issues surrounding of future funding for the maternal mental health programme, whilst acknowledging forthcoming changes to commissioning structures and arrangements as of 1st July 2022.

With effect from April 2022 NHSEI have advised that the programme funding will be in CCG baselines. The detail around the finance has been well established using LTP analytical tool at CCG level and how much each place should be identifying from within their baselines. The question at place level is how CCGs ensure financial planning schemes for next year and beyond for similar funding allocations to be ringfenced appropriately for the services currently provided. The original strategy and requirement to submit a bid came into existence during the Covid pandemic. Liverpool has been mobilising the service for the last three months, with the expectation to provide a wider service from April 2022.

All present agreed they would need to go back to their individual CCGs and look at commissioning intentions for next year to ensure the funding is included in the financial plans. Alison agreed to raise the funding issue with Directors of Finance.

In the January meeting an update was received on progress and the following key issues:

- There has been no response from Directors of Finance to determine how this investment can be ringfenced within baseline budgets from 1st April.
- All the C&M children's commissioners had been asked to represent this service issue with their local CCGs, however Directors of Commissioning were asked to follow up to ensure this programme featured in plans.
- The service evaluation from the pilot sites has been requested which will be shared with the group when available.

This item will remain on the group agenda until funding and programme planning issues are resolved.

3.3 Alignment of Policies

In addition to the identification of the financial variation across Cheshire and Merseyside, key to the delivery of clinical policy change is the public engagement process in order to feed the final recommendations. During the December meeting the group agreed that clarification on the engagement process during the transformation period is necessary for the programme to progress.

A Communications and Engagement handover pack has been produced the communications group setting out governance principles and the process for service change proposals. This pack has been shared with the group and programme leads at Cheshire CCG. The Chair agreed to meet with A Johnston after a brief discussion at the January meeting to follow up on any additional support required from CCGs in order to progress.

3.4 Specialist Commissioning Transition

At the December meeting, Nicola Adamson (Head of Acute Strategy and Transformation Specialised Commissioning (Northwest) referred to the approximate 150 specialised services and the decisions to be made as to where each of these services will sit in terms of national and ICS / Multi-ICS level and how joint decisions will be made with the three Northwest ICS organisations with regard to delegation. Work is being undertaken in the next coming weeks to create a summary of the national work for ICS discussions in the Northwest. A Joint Committee will need to be in place as of April 2022 for joint decision-making process, with delegation of appropriate services in April 23. Draft guidance on Joint Committees was shared at a recent national meeting and feedback was given to enable maximum flexibility at a regional level and a realistic timescale for implementation (originally suggested as Feb 22).

As an example, an outline of discussions in Lancashire and Cumbria was provided:

a) Discussions to be undertaken with ICS Executives in terms of how we will collectively manage performance, quality, contracting and other specialised commissioning functions next year
b) Engage with each of the Clinical networks at ICS level to talk about how to integrate the pathways and the benefits from integrated commissioning.
c) Meetings with the population health management leads to explore how we can reduce health inequalities for tertiary services.
d) A meeting with the Provider Collaborative – to explore their role in the future specialised services delegation and in relation to clinical networks

This was further discussed at the January meeting, whereby Roz Jones provided an overview presentation highlighting the engagement activity planned to take place between January and June 2022, for which system leads needed to be identified.

Part of the transition of specialised commissioning is being led nationally for local implementation in terms of data, service specification, tiering of the service and moving to population health management budgets etc. In regard to the tiering of services by geographical footprint, work is underway to provide a position for C&M. From April 2023, there will be a phased transition of services to the ICB.

From a regional perspective work is underway to develop the operational model for specialist commissioning. An update to the Commissioning Working Group will be provided at the meeting in February to share some of the tiering work which will provide the baseline for the work the next steps to take this work forward.

From 1st July (if not before) the focus will be on engagement and co-design with Integrated Care colleagues together with input into the proposed 5-year strategy to be developed by the ICB as outlined in planning guidance.

The group agreed that clarification of the engagement process within C&M governance structures is required. The Chair agreed to seek clarification from the ICB Executive Director of Transition on how this could be done.

3.5 Tier 4 Obesity procurement

Nesta Hawker noted the paper went forward to Joint Committee on 30 November 2021 when Option 2 was agreed. It is likely to be August before any new contracts will be awarded.

3.6 Commissioning Veterans Services from GM to CM ICS

Carl Marsh provided a detailed overview of the paper and noted the Joint Committee approved the proposal for a standard contract to be put in place for both services, as of 1st April 2022, for Cheshire & Mersey commissioned model with Great Manchester Mental Health NHS Trust and Liverpool to continue with Mersey Care NHS Foundation Trust until 2024.

Progress on this work was provided at the January meeting. A co-ordination group has been working to support appropriate exit arrangements and ensure a smooth transfer of responsibilities from NHS Bury CCG to Cheshire and Merseyside from 1st April 2022. This has involved contacting each CCG for them to identify the relevant officers who will support the completion of the contract in terms of activity required and the financial consequences.

The process of engaging with the provider will be starting shortly. As the statutory establishment of the ICB has been moved to 1st July 2022, the original intention to create a contract on behalf of the Cheshire and Merseyside ICB from 1st April 2022 is no longer possible. Subject to further discussion with NHS Bury CCG, the co-ordinating group is seeking to create a contract for 1st April 2022 involving each constituent CCG.

3.7 Spinal Services

Some clarification was received that whilst the operational transition and management of spinal cases is progressing between LUHFT and the Walton Centre (as of 1/12/21), a formal financial agreement is awaited from the Boards/Exec of both Trusts. LCCG will update the group once this agreement has been made.

3.8 Expansion of Cheshire & Merseyside Virtual Wards

Geraldine Murphy-Walkden (Programme Director) provided a detailed overview of the paper submitted to the Joint Committee to seek approval to commission covid virtual wards. The key issue arising (in December) was whether sufficient funding was in place to support the service.

The group agreed to support the request to put forward a proposal for all places to indicate a lead to join local discussion on Respiratory virtual ward development with providers and clinical leads.

Following further discussion at the January meeting as to whether the virtual wards are being utilised sufficiently, Michelle Urwin clarified she is starting to look at this and the related operational planning requirements. As such, she will seek clarification on whether the issues are financial or clinical time related and report back at the February meeting.

3.9 CMAGIC - Cheshire and Merseyside Adult Gender Identity Collaborative

Colleagues in Cheshire noted that planning is underway for local development and asked what the position was with CMAGIC across the other C&M CCGs.

Billie Dodd requested that all commissioners submit their identified lead and updates/intentions to her and the Sefton team will look to develop and circulate a proposal to the group within the next couple of weeks. The group agreed to submit responses by Friday 21st January. B Dodd agreed to provide an update at the February meeting.

3.11 **Service restriction principles**

A concern was raised in relation to restricting access to services by trusts. A recent example was dermatology waiting lists at St Helens & Knowsley with a similar approach taken in Wigan and Leigh. Other examples were given including LUHFT being forced to restrict sleep service referrals to within C&M as Lancashire Teaching Hospital has closed its service and Blackpool restricting to local patients creating significant pressure from out of area referrals.

This issue has been discussed previously and a Vulnerable Groups policy had been agreed by the group in January 2020. However, the policy was focused on local provision rather than the impact across the ICS and it was felt that it would be appropriate for a set of principles should be agreed on the management and communication process for service restrictions.

The Chair agreed to seek approval from Joint Committee to develop a set of principles and communications process in relation to restricted access to services owing to the 'domino' impact on neighbouring services.

Recommendation:

- The Joint Committee is asked to agree to the development of service restriction principles and communication process for Cheshire & Merseyside

3.12 **Haemato-oncology proposal**

B Dodd updated on progress and proposals on the Haemato-Oncology transfer from LUHFT to Clatterbridge which has now been agreed with Finance Directors (final paper to be circulated). The next steps for approval were discussed as many Governing Body meetings had been stood down. A question was raised as to whether the Joint Committee would be the appropriate body. Further discussions are required, however it was noted that the Joint Committee should be sighted on the matter.

It was agreed to reference the paper in the DoCs Report to Joint Committee subject to agreement of approval route.

5. Recommendations

5.1 It is recommended that the Joint Committee:

- **Note** the contents of the report
- **Agree** the recommendation to:
  - **approve or amend** the timescales currently applied to the work plan areas of the Commissioning Working Group
  - the development of service restriction principles and communication process for Cheshire & Merseyside

Access to further information

For further information relating to this report contact:

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Cheshire Mersey Directors of Commissioning
Work Plan: January - June 2022

Agenda Items / Issues	Lead	Comments	January	February	March	April	May	June
Specialised Commissioning Transition	Roz Jones		x	x	x	x	x	x
Operational Delivery Networks	Roz Jones			x		x		
Asylum Seekers & Refugees					x			
Population Health					x		x	
Health & Inequalities				x				
Specialist Weight Management – Tier 4 service	N Hawker	Completed						
IAPT				x				
C&YP Mental Health Services (Crisis & Eating Disorder Services)					x			
Mental Health Out of Area Placements					x			
Mental Health standards to address variation in access, provision, quality and outcomes						x		
Independent Sector Contracts	J Ashurst		x		x			x
Gender Identity							x	
Specialist Rehabilitation services (Neurodevelopment Services, Mental Health, Stroke [incl adoption of national spec], complex cases)				x				x
Spinal Services	D Horsfield		x					
Climate Change	R Burgess							x
Social Value								x
Military Veterans	C Marsh			x				
Pulmonary Rehab						x		
Clinical Policy Standardisation			x		x		x	