

Liverpool Adult Acute and Specialist Providers (LAASP)

Case for Change

January 2025

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Foreword

The Liverpool Clinical Services Review, conducted in January 2023, identified opportunities to improve health outcomes, enhance the quality and experience of care, and support financial and clinical service sustainability through systematic collaboration in Liverpool. In response to these findings, NHS Cheshire and Merseyside Integrated Care Board (C&M ICB), requested the establishment of a joint committee, the 'Liverpool Adult Acute and Specialist Providers (LAASP)'. This committee includes five acute and specialist trusts in Liverpool: Liverpool University Hospitals NHS FT (LUHFT), Liverpool Heart and Chest NHS FT (LHCH), The Clatterbridge Cancer Centre NHS FT (CCC), The Walton Centre NHS FT (TWC), and Liverpool Women's NHS FT (LWH); with the unifying aim to improve patient care and outcomes whilst creating a sustainable healthcare system.

The purpose of this document is to clearly state that, as LAASP, we must now work differently to improve patient experience, clinical outcomes and move our system to a position of financial stability. It is not a strategy or an implementation plan, but instead outlines the unprecedented scale of opportunities that lie ahead of us as LAASP with ~£2.2bn revenue and over 22,000 staff. In developing this document, we engaged with more than 40 stakeholders over six weeks and used insights from interviews, supplemented with document reviews and data analysis, to identify where change would benefit patients, staff, the city, and the wider health system.

We have a unique opportunity to reshape clinical pathways to better meet the current and increasingly complex future needs of our populations. This collaboration is not just about addressing fragmented pathways and reducing duplication in current service delivery or reducing our financial deficit; it is about working together to create a sustainable healthcare system, focused on clinical excellence that prioritises the needs of our patients rather than the limitations of the current system infrastructure. By taking collective accountability, adopting a shared approach to risk and establishing our shared electronic patient record (EPR) we can optimise resources and create a group that is both efficient and equitable.

We are committed to working collaboratively to enhance the acute care and specialist services we provide within Cheshire and Merseyside. Operating as one through LAASP will allow us to develop a common strategy, shared decision-making and simplify our contracting arrangements for acute care and specialised commissioning.

We recognise broader demand, workforce, and financial pressures impacting the quality and effectiveness of patient care, requiring a whole-system response. Challenges include patient flow in the acute system, with a significant number of LUHFT beds occupied by patients who no longer meet residency criteria. We will work with our system partners in these areas, while taking collective responsibility as LAASP for the patients under our care.

As leaders of our five hospitals, we commend the LAASP Case for Change, a document that marks the start of our collaborative journey, not its conclusion. As we move forward, we invite continued engagement and feedback as we further define the opportunities. Together we can shape the future of acute and specialist healthcare in Liverpool and the wider population we serve.

[signature here]

Kathy Doran
Chair of CCC

[signature here]

Max Steinberg
Chair of TWC

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Liz Bishop
CEO of CCC and LHCH

1. Executive Summary

1.1 Introduction and strategic context

This case for change highlights the opportunities presented by integrating five acute and specialist trusts across Liverpool under the Liverpool Adult Acute and Specialist Providers (LAASP) partnership. The participating trusts are Liverpool University Hospitals NHS FT (LUHFT), Liverpool Women's NHS FT (LWH), Liverpool Heart and Chest NHS FT (LHCH), The Clatterbridge Cancer Centre NHS FT (CCC), and The Walton Centre NHS FT (TWC).



Liverpool is the **third most deprived local authority** in England, with deepening inequalities: 1 in 4 people aged 20 and above are projected to be living with a major illness by 2040¹

As anchor institutions, our trusts play a pivotal role in the local community. The LAASP partnership aims to enhance the quality and efficiency of healthcare delivery in the city by adopting a unified approach to providing acute and specialist care that is responsive to the evolving needs of Liverpool's population.


This collective effort is driven by an understanding that the future of healthcare delivery requires innovative and collaborative solutions to meet patients at their point of need. This aligns with national priorities, such as the *2024 Darzi Report*², which advocates for better integrated care, and with the government's call to action to reshape the NHS through the *10 Year Health Plan*³.

1.2 Overview of current state

The challenges faced by our communities are significant, with rising service demand and cost pressures outpacing budgets, creating a challenging financial landscape for NHS organisations nationwide.

Diagnostic testing access

Despite these pressures, in Cheshire and Merseyside we continue to deliver improvements, including the **fastest growth in diagnostic testing access nationally**, significant progress in reducing long waits for planned care, and strong performance exceeding England and North-West averages for 31-day and 62-day cancer waiting time standards⁴.



We are making progress in Liverpool and the broader Cheshire & Merseyside region, but further improvements are needed to improve the experience of patients. Many still face challenges accessing care across the five trusts, often perceiving services as disconnected. Common concerns include a lack of coordination between trusts; long waiting times and delays; poor communication; and difficulty navigating between our Trusts for different parts of their care journey⁵. Challenges also exist within our clinical pathways, where our organisational boundaries can lead to disconnected care in areas such as

Women's Health, Cardiac Services, and Stroke Medicine. This causes unwarranted variation in the quality of care delivered to patients and in their health outcomes.

Staff satisfaction and recruitment are also significant concerns for some trusts within LAASP. Many staff members feel disconnected and under pressure, highlighting the need for a supportive environment to enable them to work at their best, with greater opportunities for professional development.

£88.7m Planned group deficit across LAASP for FY 24/25⁶

The scale of our combined planned deficit suggests our current way of operating is unsustainable and requires rethinking to achieve long-term financial sustainability and create a more resilient workforce.

Whilst there are collaborative efforts in diagnostics, and good examples of innovation within our trusts - including strong staff-led initiatives in research and development - there is still significant potential for greater achievements through a more joined-up approach.

1.3 Summary of key opportunities

Over the next three years, the LAASP Joint Committee will oversee the integration of the five trusts into the University Hospitals of Liverpool Group (UHLG). This presents multiple opportunities for patients, their families, and our staff to benefit from closer collaboration through LAASP and UHLG:

Clinical Pathways and Patient Experience

- Enhance coordination and expertise sharing between our Trusts by establishing formal pathways for joint patient care initiatives, such as the collaboration between gynaecology and surgical teams at Royal Liverpool Hospital and LWH



1. Executive Summary

1.3 Summary of key opportunities cont.

- Build upon the Liverpool Cardiology Partnership's work to optimise and align cardiology pathways. This will reduce fragmentation and variation for patients while standardising referral pathways, developing shared protocols and formalising effective informal pathways that currently exist
- Streamline thrombectomy and thrombolysis pathways by enhancing in-hospital coordination through stroke nurse-led processes, reducing unnecessary steps, and adopting integrated workforce models to improve patient flow
- Integrate digital systems across LAASP, introducing a single Electronic Patient Record (EPR) to streamline workflows and support decision-making between back-office operations and front-line workers, improving clinical safety and patient communication

Workforce

- Maintain and improve staff satisfaction by offering clear progression pathways with a focus on creating 'Liverpool Careers', attracting top national talent and investing in advanced skill development
- Harmonise bank and agency staff terms, conditions and management to support long-term financial sustainability

Clinical Support and Diagnostic Services

- Streamline diagnostic and treatment models, aligning existing pharmacy services, and expanding Medicines Optimisation programmes

Research, Development, Innovation and Commercialisation

- Scale research and commercial opportunities by leveraging a larger patient base and workforce to establish a unified research network, drive clinical innovation, and strengthen the value proposition for grants and academic recruitment

Corporate Services

- Reduce duplication by consolidating business functions, leveraging economies of scale, e.g. in procurement, and optimise use of estates by taking a strategic approach based on clinical need

1.4 Summary of financial opportunity*

Forming LAASP could unlock significant financial opportunities for our trusts through cost savings and the potential to generate additional income streams.

To estimate these, opportunities were calculated across four areas**:

- 1) Clinical Pathways
- 2) Workforce
- 3) Corporate and Shared Services

4) Research, Development, Innovation and Commercialisation

£49 – 90m

Is the estimated gross annual financial opportunity from the formulation of LAASP***

The majority are expected to arise from more efficient clinical pathways within and across our organisations (**approximately £19 - 29m**) and savings in bank spend (**approximately £13 - 28m**).

For these opportunities to be fully realised, LAASP will need to mature as group. Therefore, we assume that the total annual financial opportunity will be realised after three to five years.

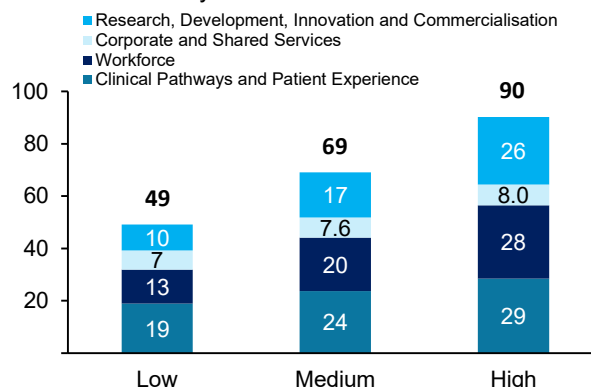


Figure 1.4.1: Annual financial opportunity associated with LAASP (£m)

1.5 Next steps

As we move forward, several **critical success factors** will guide our efforts:

- Patient and staff involvement** – including diverse perspectives in shaping the partnership and future planning
- Governance structures** – driving and delivering on a shared vision with structures that promote shared ownership and risk
- Brand identity and culture** – developing a strong brand for UHL Group whilst leveraging hospital brands that our patients recognise
- Estates and capital optimisation** – adopting a collaborative approach to capital planning, guided by need, to maximise use of our estates
- Digital enablement** – investing in our digital capabilities, such as a single EPR, to optimise workflows and communications as a group

We will now be embarking on a period of engagement with our staff and patients to develop our LAASP Strategic Case and Financial Sustainability Plan that will expand on the opportunities in this document and chart our implementation journey. By uniting our trusts, we can leverage our expertise and resources to achieve improved outcomes, financial sustainability and a better experience for our patients and their families.

Note: *More detail on how the financial opportunities were estimated can be found in the 'Financial opportunity' sub-section at the end of each section of the report. ** The financial opportunities identified here represent areas with the strongest evidence base; however, they do not encompass all potential financial benefits for LAASP. *** Financial opportunities are presented as gross rather than net benefits as they do not account for the costs associated with the formation of LAASP. As there are different scenarios and therefore costs associated with how LAASP will be established, costs have been omitted from the analysis.

2. LAASP Overview

565,000

patients served across
Liverpool

2-3.5million

patients served across a wider catchment
spanning Cheshire and Merseyside, North Wales,
Isle of Man, and the wider North-West region¹⁻⁶



**Graphic locations not exhaustive, illustrative to demonstrate geographically co-located trusts*



The Clatterbridge Cancer Centre NHS FT

Sites: Aintree, Liverpool and
Wirral Cancer Centre

Services: Inpatient cancer care,
Radiotherapy, Chemotherapy,
Gene therapy, Palliative and
Supportive care

Staff: ~1,920³

Beds: 103¹⁰

Revenue: £294.2 million³



The Walton Centre NHS FT

Sites: Aintree (The Walton Centre Main building and Sid Watkins building)

Services: Neurology, Stroke services, Rehabilitation, Neurosurgery,
Spinal Surgery, Pain Management

Staff: ~1,500⁹

Beds: 192⁹

Revenue: £198.7 million⁵



Liverpool Heart and Chest Hospital NHS FT

Sites: Liverpool Heart and
Chest Hospital

Services: Cardiothoracic Surgery,
Cardiology, Respiratory,
Diagnostic Imaging

Staff: ~1,939⁶

Beds: 181⁶

Revenue: £244.4 million⁶



Liverpool University Hospitals NHS FT

Sites: Royal Liverpool University
Hospital, Aintree University
Hospital, Broadgreen Hospital,
Liverpool University Dental
Hospital (Merged in 2019)

Services: Surgery, Anaesthetics,
Critical Care, Head and Neck,
Acute and Emergency Medicine,
Diagnostics and Support
Services, Specialist Medicine

Staff: ~15,000²

Beds: 1570¹¹

Revenue: £1.28 billion²



Liverpool Women's NHS FT

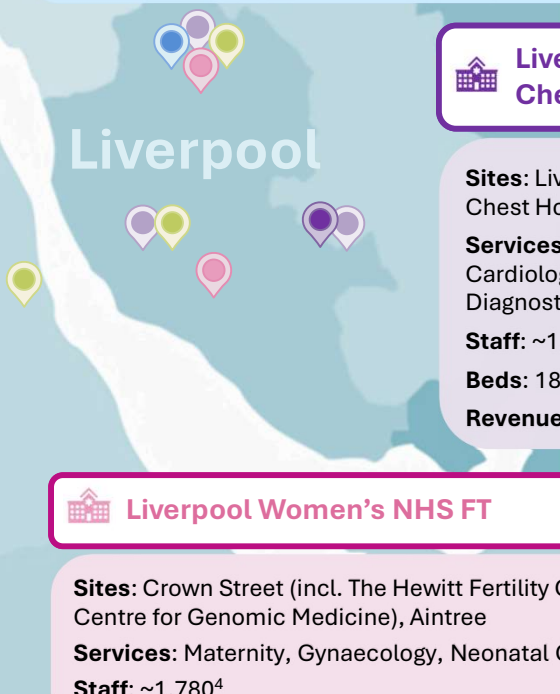
Sites: Crown Street (incl. The Hewitt Fertility Centre and Liverpool
Centre for Genomic Medicine), Aintree

Services: Maternity, Gynaecology, Neonatal Care, Fertility, Genomics

Staff: ~1,780⁴

Beds: 138^{12,13}

Revenue: £149.3 million⁴



~ £2.2 billion

total LAASP revenue



~22,139

members of LAASP staff



2,184

total beds

3/5 trusts rated
outstanding or good



LHCH voted the **TOP**
place
to work in the country⁷



Walton Centre winner of
**NHS Parliamentary
Award⁸**

2. LAASP Overview

The city of Liverpool has a unique configuration of acute and specialist trusts which stand as pillars of acute and specialist care for 565,000 residents in Liverpool and a wider population of 2.8 million across Cheshire and Merseyside (C&M). Some hospitals provide specialised services that cater to regional and national needs. For example, The Walton Centre serves a patient population of approximately 3.5 million from C&M, Lancashire, Greater Manchester, the Isle of Man, and North Wales. Together, our trusts serve a diverse and often complex population, with needs that are exacerbated by the social determinants of health. We also manage a combined annual income of approximately £2.2 billion, representing a significant resource pool to support healthcare delivery across the region.

Collectively, we employ a workforce of 22,139 dedicated staff, spanning a wide range of medical, clinical and operational roles that are essential to delivering high-quality care and the best patient experience. Our workforce also includes a mix of bank and agency staff, with 6% of total workforce expenditure allocated to bank staff and 1.1% to agency staff (year-to-date, Month 7)¹ to help support service delivery and maintain flexibility across our operations.

2.1 Our local population

In North Mersey, 53% of our population live in the top 20% most deprived areas of England. Four in every 10 children under the age of 16 live in poverty. On average, men will spend 21% of their lives in poor health, rising slightly to 24% for women¹⁵.

In Liverpool, we see the real impact of significant health challenges on the lives of our community. Many people suffer from chronic conditions, with our biggest killers being cancer, cardiovascular disease, and respiratory disease, leading to frequent hospital visits and affecting quality of life. Marked health inequalities are evident from birth in Liverpool, with people in our most deprived areas living eight years fewer than most people in affluent areas². Minority ethnic groups also experience higher rates of long-term conditions, including coronary heart disease, diabetes, and asthma³.

Long-term unemployment in our community is **7.5%**⁴ (vs the national average of **4.3%**⁵)

Liverpool is the **3rd** most deprived local authority in the UK and **63%** of Liverpool residents are living in areas ranked among the most deprived in England⁶

Looking ahead, projections indicate that by 2040, 37% of women in Liverpool will suffer from obesity⁷. The number of people with major illness (two or more long term conditions) is set to increase by between 33,000 and 38,000 people⁸, with the overall number of health conditions projected to rise by 54%⁶.

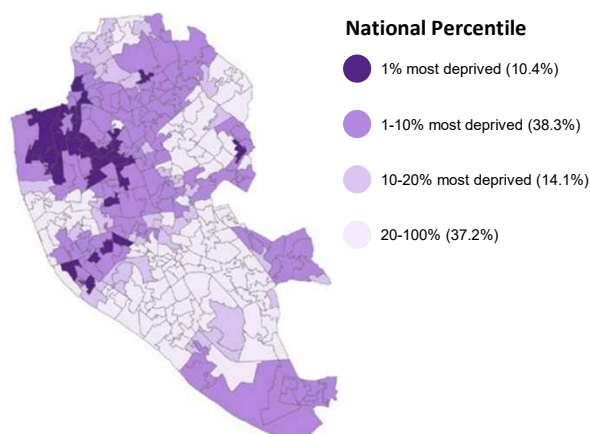


Figure 2.1.1: Heat map of deprivation in Liverpool, 2023 (using IMD 2019)³

These realities shape the lives of the people we care for, highlighting the importance of having a joined-up approach to addressing these challenges and improving health and well-being across our communities.

2.2 Strategic context

National landscape:

The NHS continues to operate under intense pressure.

Referral to treatment (RTT) figures show:

6.34m patients are awaiting treatment, of which **3.1m** have been waiting over 18 months^{8,9}

Furthermore, the demand for Emergency Department (ED) services surpasses the available capacity. In July 2024, the total number of attendances at A&E departments was more than 2.3m, which is an increase of 5.5% compared to July 2023¹⁰

2. LAASP Overview

The financial outlook for 2024/25 is pressured with NHSE's total revenue allocation only rising by 0.2% in real terms, placing demands on trusts to identify unprecedented levels of efficiency savings this year as high as 5-6%¹¹ in some cases (significantly above the efficiency target of 2.2% set by the government)¹².

This highlights the need to think differently about how healthcare is delivered to achieve longer-term financial sustainability.

Citizens and NHS staff have been called to inform the government's *10 Year Health Plan* which seeks to reshape healthcare in the UK through three shifts in care: from analogue to digital; from hospital to community; and from treatment to prevention. In alignment with the elective care reform plan, change is needed to meet the 18-week standard for RTT and transform elective care by March 2029¹⁴. This change is needed to meet the evolving holistic needs of patients and alleviate pressure on the entire system.

2.2 Strategic context cont.

As acute and specialist care providers, we have a key role to play that requires transforming how and where we deliver our services. Central to this is aligning with the priorities outlined in the *2024 Darzi Report*¹, which emphasises the urgent need for integrated care delivery models, greater collaboration between providers, and greater focus on patient-centred care. By working together, the LAASP partnership aims to sustainably realise this vision, whilst prioritising addressing health inequalities and supporting the goals of the *Core20PLUS5* framework². The *NHS Workforce Plan*, focuses on expanding and nurturing a diverse and skilled healthcare workforce. We recognise that our staff reflect the communities we serve, and in this context, we are committed to fostering a culture of support, continuous development and advanced practice.

Regional landscape

The C&M ICB vision is *"we want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer"*. Working alongside the wider integrated care partnership, C&M ICB has four key aims: (1) tackle inequalities in outcomes, experience and access; (2) improve outcomes in population health and healthcare; (3) enhance productivity and value for money; and (4) help the NHS support broader social and economic development.

In C&M, there are two provider collaboratives: 'Cheshire and Merseyside Acute and Specialist Trust (CMAST)' and 'Mental Health, Learning Disabilities and Community Collaborative (MHLDC)

These collaboratives have been formalised and encouraged by the Health and Care Act 2022, which removed barriers to collaboration that previously existed. The CMAST collaborative is home to our five LAASP trusts alongside eight further C&M trusts and has an overarching aim to support delivery and service improvement for patients across the system by reducing unwarranted variation and maximising equity of access. CMAST have agreed areas of focus and delivery with C&M ICB which also align with national priorities, including elective recovery and transformation, increasing diagnostic activity and capacity, as well as clinical pathway reviews and efficiency at scale.

2.3 Our local priorities

As individual trusts, we have been key partners in the development and delivery of the 'One Liverpool strategy' (2019-2024). Collaborating with primary care networks, the City Council, voluntary and community organisations, and other partners to improve the health and wellbeing of people living in Liverpool.

In July 2024, the LAASP Joint Committee was formed to strengthen collaboration and advance delivery recommendations from the Liverpool Clinical Services Review. The Committee aims to unify strategic activities and governance across our five trusts.

Starting in April 2025, the LAASP Joint Committee will receive formal delegation from the LAASP Trusts to lead on the development of a five-year strategy for transforming adult acute and specialist care. Its responsibilities will also include shared financial planning, the shared delivery of a LAASP EPR solution and further development of corporate and shared services. The LAASP Joint Committee will also oversee the process for the five LAASP trusts joining the University Hospitals of Liverpool Group (UHLG) over the next three years.

As LAASP Trusts, we are also full committed to supporting wider NHS Cheshire & Merseyside and priorities, including: the Women's Hospital Services in Liverpool Programme, Women's Health Hubs, Liverpool Centre for Cardiovascular Science (LCCS), and the Cheshire and Merseyside Cancer Alliance.

2. LAASP Overview

2.2 Strategic context cont.

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There are ongoing programmes of work that will continue to drive and support as LAASP, such as:

Women’s Hospital Services in Liverpool Programme³:

Led by NHS Cheshire and Merseyside, this initiative aims to develop a sustainable model for maternity and gynaecology services, focusing on quality and safety, with community feedback.

Women’s Health Hubs^{4,5}:

Established by Liverpool’s primary care networks, local NHS, and City Council, these hubs offer integrated healthcare services, improving access to reproductive health for women in Liverpool.

Liverpool Centre for Cardiovascular Science (LCCS)^{6,7}:

A research collaboration focused on improving cardiovascular health through research, education, and clinical practice in the Liverpool City Region.

Cheshire & Merseyside Cancer Alliance^{8,9}:

Aims to enhance cancer services and outcomes, including the Targeted Lung Health Checks for high-risk individuals and various cancer screening improvement projects.

LAASP Digital and Data Programme:

Initiated in December 2024, the Digital and Data Programme aims to establish LAASP as a digital exemplar within the NHS, including the delivery of flagship digital programmes e.g. a LAASP single EPR

3. Clinical Pathways and Patient Experience

Across Liverpool and the wider C&M region, there is a significant opportunity to improve patient outcomes and experiences by strengthening collaboration across clinical pathways. Operating as LAASP will provide us with the ability to take joint responsibility for the entire patient pathway for the first time. This alignment will enable us to define shared goals and work collaboratively to strategically redesign pathways where needed. By improving flow between our sites and standardising operating procedures, we can eliminate unwarranted variation in care delivery and improve equity of access to high quality care for our population. Working as one group also allows us to reimagine how we care for our patients, many of whom have complex needs. Through better coordination and fewer, better-planned interactions, we can greatly improve their overall experience of healthcare.

In this section we will explore examples of pathways: women's health; cardiac services; and stroke services / neurology, as indicators of where collaboration could further enhance care delivery and benefit our population. It should be noted that these three pathways are not exhaustive, and opportunities not exclusive, as other opportunities may exist in other specialties.

3.1 Overview of current state in women's health

As outlined in the Gynaecology and Maternity Hospital Services in Liverpool Case for Change¹, the current organisation of hospital-based gynaecology and maternity services in Liverpool does not provide women and their families with the best possible care and experience.

Unlike most other specialist centres in England, LWH's main site, Crown Street, is 'isolated' from our acute hospitals. This separation limits LWH's ability to manage acutely ill patients, patients with complex surgical needs, or patients with significant medical co-morbidities as there are limited acute and emergency hospital services available on site. In emergencies, vulnerable patients need to be transferred by ambulance to other local hospitals such as the Royal Liverpool Hospital (RLH) (1.3 miles away) or Aintree University Hospital (AUH) (6.8 miles away) at high clinical risk:

148

Clinical incidents between 2022-2024 that were caused in full or in part by women's services being provided on a separate site¹

60%

Maternity bookings each year are women with complex needs, and often require ambulance transfers (220 annually)¹

50%

Transfers are for emergency or life-threatening situations¹

Additionally, gynaecology and maternity services are not available at our acute hospital sites within Liverpool. This is despite over 2,000¹ pregnant women or those with gynaecology conditions presenting annually at the RLH or AUH A&Es. As a result, these women require transfers to LWH and unnecessary delays in treatment.

Women using gynaecology and maternity services in Liverpool versus other parts of England are at a significant disadvantage. The poor configuration of services is compounding the gender and health inequalities across North Mersey, adding to an already challenging picture to the provision of care.

75%

Maternity and emergency gynaecology patients have at least one risk factor, such as deprivation, adverse life experiences, diverse needs, or protected characteristics²

Where our patients face a higher risk of poor outcomes due to complexities associated with health inequalities, our services are less well equipped to care for them.

In 2022, NHS C&M commissioned the Liverpool Clinical Services Review, which identified resolving challenges in women's hospital services as one of three urgent priorities. To address this, the Women's Services Committee was established under the ICB to oversee the development of a safe and sustainable future care model for women's services in Liverpool.

Since this, significant progress has been made, including:



Joint operating lists for complex gynaecology care, with weekly operating sessions at RLH for patients needing critical or specialist surgical support



Joint outpatient appointments and weekly MDTs with LUHFT specialists

However significant risks remain, including the lack of co-located women's services with specialist surgical, medical and support teams, which poses a safety challenge. While staff work to manage risks in the short term, the growing complexity of patients and rising co-morbidities threaten the long-term sustainability of care and increase avoidable risks. Additionally, the pressures on staff are significant, with 25% seeking trauma-based psychological support in the past 18 months¹.

3.2 Opportunities in women's health

Operating as a group offers an exciting and unprecedented opportunity to take collective ownership of Women's Services in Liverpool. It will enable us to take a strategic approach towards the configuration of Women's Services across all our hospital sites and work towards addressing the five risks outlined in the Gynaecology and Maternity Hospital Services in Liverpool Case for Change¹.

3. Clinical Pathways and Patient Experience

3.2 Opportunities in women's health cont.

Building on successful joint initiatives

Good practice already exists within LAASP through strong informal relationships between teams across our hospitals. Operating as one group will enable us to formalise these existing relationships and scale best practices through shared learning:



Maternal medicine clinics running in partnership with specialist input from other trusts such as TWC provide coordinated, multi-specialty care for women with complex medical needs



Joint care currently provided informally at RLH, through close partnerships between gynae-oncology and surgical teams (including general surgery, urology and colorectal teams) at LUHFT

Addressing clinical safety and governance

While Crown Street remains isolated in the short term, formalised clinical risk and governance structures between sites is an effective way to enhance clinical safety and optimise care. One key area where this has been particularly impactful is the shared provision of anaesthetic cover:



At LWH, a Task and Finish Group has been established to explore a potential model for RLH to take over anaesthetic cover, highlighting how joint governance structures can address safety concerns effectively

The ability to draw on RLH's clinical staffing infrastructure makes certain that there are no gaps in anaesthetic support, even during high-demand periods, creating a safer environment for patients. Furthermore, this shared model exemplifies how challenges related to co-location can be effectively managed when resources and expertise are pooled.

Reducing risk through optimising infrastructure and co-location of services

In 2022, 70% of the standards and specifications that LWH could not meet were due to being on an isolated site.¹ 94% of these can be fully met by co-locating with adult acute services.¹ In the short term, targeted efforts to co-locate such as shared waiting lists offer an interim solution:



Weekly operating sessions have been established at the RLH for complex gynaecology patients likely to require critical care and / or surgical support from other specialities e.g. colorectal surgery and urology.

Data-driven tools can also be leveraged to enhance clinical oversight and support timely decision-making. For example, the potential use of live dashboards to monitor women presenting with gynaecological problems in ED.

Over the longer term, operating as a group will allow us to strategically assess how our collective estates landscape can be optimised to co-locate women's services with acute and emergency services. This will help us to reduce clinical risk and the associated impact this has on our workforce's wellbeing, in addition to providing more appropriate care for our patients with complex needs. It will also enable us to meet service quality standards and specifications, preventing the loss of specialised services from Liverpool and C&M more widely.



Sarah's Story

At 27 weeks pregnant, Sarah was admitted to Aintree Hospital with a broken hip. She had a mechanical heart valve and previous experiences with preterm labour.

As Aintree Hospital did not have an obstetric team, she was transferred to Arrowe Park Hospital for surgery and pregnancy monitoring. After the procedure, she needed transferring for a second time to St Mary's in Manchester because Arrowe Park lacked the required heart specialists.



3.3 Current state in cardiac services

Our current setup of cardiology services - two distinct general cardiology services within LUHFT (RLH and AUH), and specialist services at the LHCH – contributes to duplication, unwarranted variation and fragmentation across cardiac pathways, including Acute Coronary Syndrome (ACS) and arrhythmia. For patients this can introduce treatment delays and different experiences of care depending on their entry point into the system.

Moreover, C&M benchmarks poorly in some national cardiac indicators, including percutaneous coronary intervention (PCI) treatment for 100% Non-ST-elevation myocardial infarction (NSTEMI) patients within 72 hours.

26% C&M NSTEMI patients receive PCI within 72 hours vs a national median of 65%²

3. Clinical Pathways and Patient Experience

3.3 Current state in cardiac services cont.

Cardiac pathways differ in Liverpool to other parts of the country, as cardiology teams at LUHFT do not undertake certain procedures. For example, patients needing PCI must be referred by LUHFT (RLH or AUH) and transferred to LHCH. This creates more opportunity for delays at various stages throughout the pathway than at other trusts in the country, as depicted in figure 3.3.1 below:

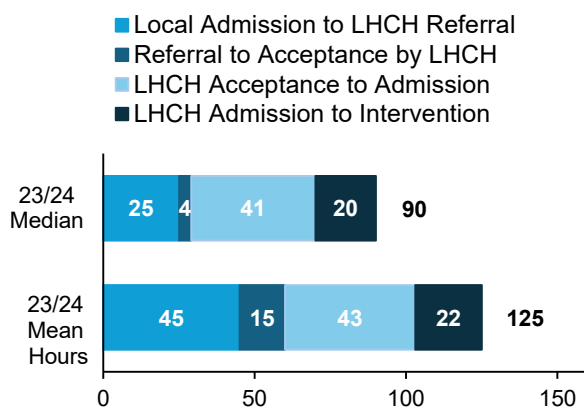


Figure 3.3.1: Median and mean hours patients receiving PCI intervention spend in each stage of the NSTEMI treatment pathway at LHCH FY23/24

The difference between the median and mean time to treatment in Figure 3.3.1 highlights how some patients experience extensive delays at each stage.

Differences in diagnostic models, referral pathways, and patient management between the cardiology teams introduces unwarranted variation in the length of time it takes for patients to receive PCI treatment as depicted in Figure 3.3.2 below.

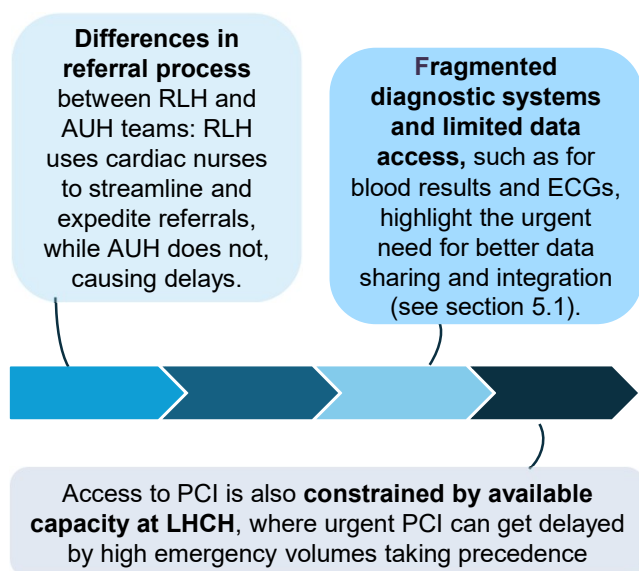


Figure 3.3.2: Challenges along each stage of the NSTEMI treatment pathway. (Stages as depicted in figure 3.3.1)

These challenges also extend beyond ACS, affecting heart failure and complex procedures, arrhythmia and pacing, and heart valve and endocarditis pathways. LHCH serves as the central provider for the management of complex devices and valve disease, and patients currently need to be transferred from acute hospitals to LHCH for these complex services.

Pacing and device implantation is currently limited to AUH, with no current plans to expand capacity at RLH. This creates variation in patient experience and delays in care depending on whether the patient presents at RLH and needs to be transferred to AUH for treatment or presents at AUH directly. This also continues to strain resources at AUH, adding to the increasing demand pressures as a major trauma centre.

LHCH frequently provides pacing support to AUH in cases of acute need, but this is through an informal pathway which creates inconsistent support. Whereas heart failure management is more distributed, with significant work happening at both AUH and RLH, however the withdrawal of funding for virtual wards has left gaps in continuity of care.

The Liverpool Cardiology Partnership



Launched in 2021, the partnership has made significant strides in enhancing cardiology care across Liverpool and the C&M region by unifying services across trusts. While UHLG plays a key role, it does not manage ACS care for the entire C&M region.

This highlights the importance of not only seizing opportunities to improve outcomes for Liverpool patients but also making sure that care is enhanced for those across the C&M region.

3.4 Opportunities in cardiac services

Single cardiology service to improve alignment and reduce duplication

Building on the foundation of the Liverpool Cardiology Partnership, establishing a single, unified cardiac service across Liverpool could further improve our collective efficiency by reducing duplication of activity across sites.

Moreover, operating as one single UHLG cardiology service will enable us to strategically optimise care pathways to cater to patient needs and demand rather than organisational boundaries.

This means making best use of our collective resources to deliver a standardised level of cardiac coverage and care to patients regardless of location.

3. Clinical Pathways and Patient Experience

3.4. Opportunities in cardiac services cont.

Standardising ACS management to reduce service variation in cardiology services across Liverpool

Becoming one unified cardiac service will serve as a platform to scale already successful initiatives and standardise service delivery by levelling up to best practice:



Successful implementation of standardised emergency department admission to referral procedure



Building on existing practices at RLH, a successful pilot of chest pain specialist nurses in AUH was rolled out



Extended criteria for direct conveyance to LHCH – previously limited to STEMI patients, this approach now includes high-risk NSTEMI patients, allowing them to be conveyed directly

Investing in the entire ACS pathway across the region is essential to facilitating timely, high quality equitable care for our patients regardless of their entry point into the system. By creating a unified approach, we can reduce variability across sites and improve the outcomes for all patients with ACS across the region.

It is important that this effort goes beyond Liverpool to include Cheshire and Merseyside. This will help create a smooth and efficient care pathway that improves results for all patients in the region.

Optimising and enhancing integration across all cardiac pathways

The potential benefits of operating as one group can also be seen across other cardiac pathways, including heart failure (HF), arrhythmias, and device management.



A shared protocol for the use of isoprenaline has been developed to optimise the medical management of arrhythmia. This protocol reduces the need for temporary wires and aims to minimise variation in care across the city

Building on best practices from existing efforts, such as shared cardiology diagnostics, standardised heart valve clinics, and the expansion of virtual heart failure wards, working within a group structure could accelerate progress.

Through shared responsibility of demand and greater alignment strategically, unwarranted variation of care

and gaps in services provision could be further reduced.



Closer collaboration between LUHFT and LHCH would streamline and formalise pacing pathways. This would enhance transparency in referrals for pacing and alleviate some of the pressure on Aintree



A shared investment in cardiac catheterisation lab capacity could address gaps in services such as emergency pacing, or elective pacemaker implantation. This would support successful implementation of the C&M catheterisation strategy

Moreover, it creates opportunities to move beyond the limitations of care provision as it currently is today to tackle more complex challenges, such as:



Implementing a single rota for 24/7 cardiology imaging



Establishing a unified EPR (electronic patient record) system, paving the way for more streamlined and efficient care.

3.5. Current state in stroke services / neurology

With the consolidation of care at the Aintree site through the Mersey Stroke Assessment Centre, our stroke services across the region have improved. However, there are still areas where we can refine pathways to enhance efficiency and patient outcomes.

With stroke incidence rising in our local population, demand for services like thrombectomy is increasing. Currently, we provide thrombectomies for approximately 6% of stroke patients presenting to Aintree, but we aim to expand this to 10%-15%¹, which would increase survival rates by providing more patients access to this life-saving procedure.

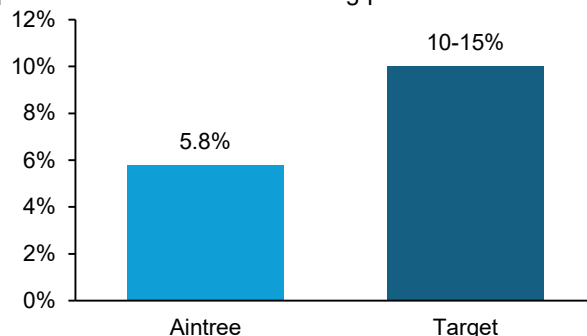


Figure 3.5.1: % of patients presenting who received thrombectomy vs national target

3. Clinical Pathways and Patient Experience



3.5. Current state in stroke services / neurology cont.

To achieve this, we need to address challenges such as reliance on phone calls to transfer patients at RLH to AUH for thrombolysis, or patients at RLH or AUH to The Walton Centre (TWC) for thrombectomy. These intermediary steps introduce delays and prevent patients from receiving timely and effective care.

Currently, the referral process for thrombectomies requires a stroke physician to contact a registrar at TWC for approval, who then coordinates with interventional neuroradiology to deliver the procedure. This creates an additional unnecessary administrative step. Furthermore, each site transfer is logged as a separate admission, inflating readmission rates. These inefficiencies present clear opportunities to streamline the process, reduce handoffs and improve overall care coordination.



By consolidating stroke care onto the Aintree site, we have transformed outcomes, with SSNAP[†] scores improving from grade Bs and Cs to consistent As¹, making our stroke service one of the best in the country.

The success of the Mersey Stroke Assessment Centre demonstrates what we can achieve through collaboration.

This has been achieved by working together to better organise services, using the same workforce in a more coordinated way. Building on this momentum, there are further opportunities to enhance pathways and support our patients to receive even better care.

3.6 Opportunities in stroke services / neurology

We have the potential to deliver enhanced stroke care by leveraging a dedicated and motivated workforce. By working together with aligned incentives we can meet growing demand for thrombectomies, streamline stroke pathways to achieve targets, and expand thrombectomy services to ultimately improve patient care, outcomes and experiences.

Streamlining the thrombectomy and thrombolysis pathways to reach local and national targets

To address out-of-hospital delays and optimise

in-hospital processes streamlining thrombectomy and thrombolysis pathways is required.



By introducing a team of specialist stroke nurses who can work across sites, perform a single assessment, and organise these interventions, we could cut unnecessary steps and improve coordination



Transitioning the coordination of A&E referrals from a neurology registrar to a stroke nurse would further streamline the process



A single workforce model comprising of stroke nurses and appropriately trained medical staff (stroke doctors or neurologists) could also enhance pathway efficiency, with interventional neuroradiologists performing the procedures

By addressing these areas, we can improve patient flow, reduce treatment delays, and enhance both efficiency and patient outcomes.

Expanding thrombectomy services to increase capacity and meet demand

Expanding thrombectomy services is another critical area where integrated approaches could address capacity constraints and support growing demand. Working in a group structure would allow for provision of the necessary infrastructure and shared resources, for example, estate expansion and recruitment of scrub nurses and operating department practitioners (ODPs), to sustain growth in case numbers.

It is also possible to enhance access and reduce treatment times while maintaining procedure delivery at TWC, which benefits from its close connection to AUH. By integrating our trusts, we can optimise care pathways, streamline resources, and uphold consistent care standards.

Addressing these needs will be critical to meeting the target of treating 10-15% of stroke patients via thrombectomies² while improving outcomes for patients presenting with other acute neurological symptoms requiring further investigation.

3. Clinical Pathways and Patient Experience

“

Anna’s Story

Anna was taken directly to Surgical Emergency Ambulatory Care (SEAC). The partnership between Aintree Hospital and The Walton Centre was excellent. She underwent three scans at Aintree before being transferred for her procedure, which was successful.

Due to the rapid response and effective treatment, Anna made a smooth recovery and was quickly able to return to her active lifestyle.

”

3.7 Further clinical opportunities

The pathways and services reflected in this section are examples of how operating as a collective could help to overcome significant challenges in our care delivery and improve the experiences of our patients. As we move forwards with the LAASP Strategic Case, we will explore these potential opportunities, which include cancer services, outpatients, and urgent and emergency care. Our existing lung cancer model, which includes the targeted lung health check programme led by C&M Cancer Alliance and LHCH, shows early data indicating increasing survival rates. This model could be replicable in other specialties and designed to minimise multiple visits.

Outpatient services across all our trusts present a significant opportunity for modernisation by making them uniformly more patient-focused. This includes transforming follow-up care for chronic diseases and ambulatory care to better meet patient needs.



Same-day care could be aligned to the national direction to shift care from hospitals to the community with LAASP clinicians providing the required oversight and expertise

Additionally, consolidating, standardising and digitising booking processes across LAASP, offers the potential to achieve operational efficiency at scale. This transformation within outpatients alone could greatly improve patient experiences of disconnection and deliver substantial financial benefits.

Having a single EPR across trusts also presents an opportunity to improve patient experience.



All information across the five trusts available on one trusted system would enable clinicians to manage patients using the latest available patient data in acute care, facilitating delivery of more holistic patient centred care

Enhanced data visibility would strengthen LAASP-wide understanding and management of demand and capacity. This improvement could create opportunities

for more effective care coordination, particularly for patients with co-morbidities. For example, it could enable the scheduling of appointments around other care they are receiving within LAASP, minimising the number of visits. It would also allow for optimisation of staff workflows, improving overall efficiency.

“

John’s Story

After being hit by a car, John was rushed to Aintree Hospital as a trauma call. He couldn’t feel or move anything from the waist down. A CT scan revealed a fracture at the top of his spine, but nothing lower down to explain his symptoms.

The doctor tried contacting the specialists at The Walton Centre repeatedly, but no one responded. Whilst John waited he became more unwell. The doctor eventually got through to The Walton Centre, but John was kept at Aintree, where his condition worsened.

”

Through collaborating, the ‘No Criteria to Reside’ challenge can continue to be addressed through admission avoidance and improved patient flow. Specialist in-reach and direct admissions could reduce unnecessary stays, while virtual wards and rapid diagnostics support timely community care.

3.8 Financial opportunity

Clinical costs

By considering the average cost of delivering similar services elsewhere in the country (utilising the 2023/24 National Cost Collection Index (NCCI))¹ we have evaluated the cost performance of LAASP trusts for inpatient services compared to other group trusts. Taking the net inpatient opportunity from LAASP having the same inpatient services NCCI as the comparators, we developed three scenarios:

- 1) **Low:** Assume LAASP achieves 50% of net opportunity
- 2) **Medium:** The average of the low and high scenario
- 3) **High:** Assume LAASP achieves 75% of net opportunity

It is estimated that the formation of LAASP, in a three-to-five-year horizon, could result in a total recurring opportunity of approximately **£19m – 28.5m**.

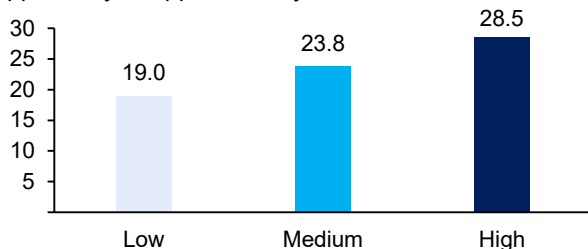


Figure 3.8.1: Potential inpatient services cost savings across LAASP with low, medium and high scenarios (£m)

4. Workforce and Staff Experience

The workforce is at the heart of delivering exceptional healthcare within the NHS. Operating as a group will provide greater consistency in staff support, foster shared learning opportunities, and enrich our workplace culture to one where everyone feels valued and empowered. By leveraging the collective strengths of our trusts and the added flexibility of group collaboration, we can address workforce challenges more effectively and create a supportive environment that benefits patients, staff, and local communities.

Our vision is to position Liverpool as a leading destination for attracting high-quality talent and providing unmatched opportunities for staff development. By reducing variations in experiences across our trusts, we aim to promote consistently high satisfaction levels for all staff, regardless of their workplace.

4.1 Overview of current state

Our clinical workforce, which represents our largest staff group, faces key challenges related to staff satisfaction and access to learning and development opportunities. At the same time, we have heard concerns about insufficient training and career development opportunities for non-clinical staff, who play an equally crucial role in the success of our services.

Whilst specialist trusts are performing well – achieving a leaver rate of **10.8%**, significantly below the national average of 16.2%¹ – there are still large variations in staff satisfaction across our other trusts

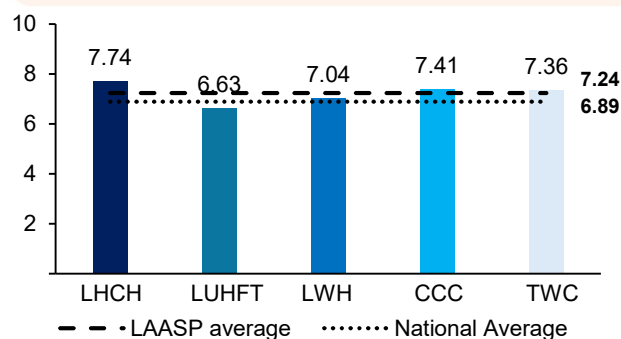


Figure 4.1.1: Staff engagement score (1-10) by trust (2023)

Disparities in engagement levels highlight the importance of addressing varying staff experiences to sustain a consistently motivated workforce. Similarly, access to training and career development remains inconsistent, with trainee feedback revealing dissatisfaction. Concerns include reluctance to recommend placements, with some considering leaving the training programme entirely.

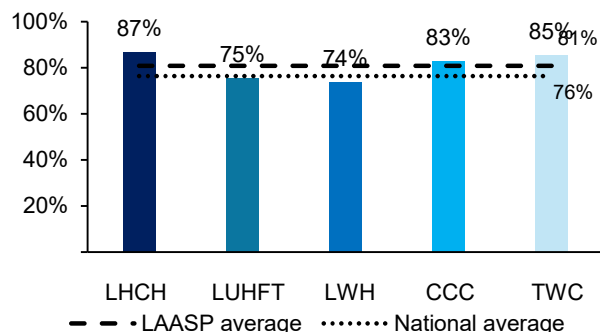


Figure 4.1.2: Trainee survey overall experience (%) by trust (2023)

Furthermore, as a group LAASP has spent an average of 6% and 1.1%² of total overall workforce spend year to date (month 7) on bank and agency staff, respectively. However, spending on bank and agency staff varies across the trusts and is suggested to be exacerbated by competition for the same staff groups. This competition has led to unwarranted pay rate escalations, and potentially greater variability between our trusts.

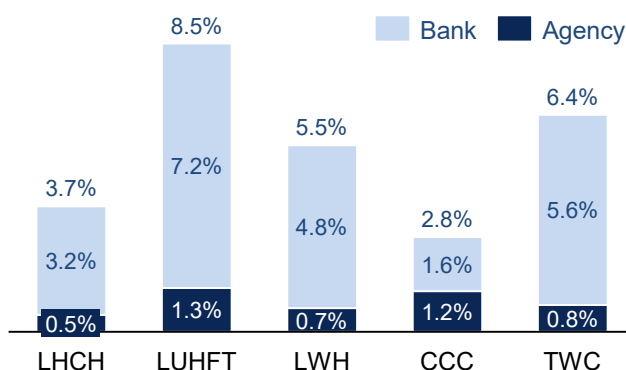


Figure 4.1.3: Difference in bank/agency spend as a proportion of total staff spend FY24/25 YTD Month 7

4.2 Key opportunities

The LAASP group will enable us to operate as one Liverpool workforce, offering unique flexibility and variety to attract and retain high quality staff. Through our collective scale, we could create new training opportunities, enhance demand and capacity management, and harmonise management of bank and agency staff.

Attracting and retaining talent

Attracting and retaining talent is essential for strengthening our workforce and ultimately delivering high quality care for our patients. Our specialist trusts have already achieved significant success in this area. By collaborating as LAASP, we can build on these strengths to offer a broader range of opportunities, making us an attractive destination for top-tier professionals. This would support staff to access all modalities across trusts rather than limiting expertise to certain modalities in individual trusts.

By establishing a 'Liverpool Careers' approach across our trusts we could break down organisational barriers and help to address workforce challenges.

4. Workforce and Staff Experience



4.2 Key opportunities cont.

For example, in response to a national shortage of sonographers, we could introduce rotational contracts across our trusts, providing flexibility and broadening opportunities for staff development.

By adopting and scaling this shared workforce vision we could implement rotational roles and shared contracts in a wide range of areas, improving staff satisfaction and increasing workforce flexibility to meet service demands more effectively.



Additionally, trusts across the country are piloting the NHS Digital Staff Passport service¹, which allows employees to move seamlessly between trusts by reducing administrative barriers and enhancing flexibility

This system streamlines onboarding, enabling staff to begin work sooner, reducing rota gaps, lowering reliance on agency workers, and simplifying rota management.

Operating together as LAASP also positions us to attract and retain ambitious professionals seeking dynamic and fulfilling career paths. We can provide more opportunities for career progression and involvement in innovative projects or research than possible as individual trusts alone. Furthermore, we have greater scope to offer flexible working arrangements and initiatives that support work-life balance, aligning with the priorities of a modern and evolving workforce.

While there is an ambition to develop a dynamic new brand for Liverpool Place, it is equally important to preserve the existing strengths that contribute to high staff satisfaction and positive patient experiences. Our unified identity should build on these strengths,

instil pride, and inspire a dedicated workforce committed to our shared success, whilst evolving to reflect our collective vision.

New training opportunities through scale

As a group we can offer trainees easier access to diverse learning and development opportunities, exposure to specialties and associated experiences that may not be available within a single trust.



This would particularly benefit Portfolio Pathway doctors by offering tailored training routes to develop expertise in targeted areas while benefiting from mentorship and diverse experiences across trusts.

By working alongside senior staff and educators from various specialties across trusts, trainees can expand their knowledge and build their portfolios with greater ease. Additionally, they can gain access to learning procedural skills unique to each of the specialist trusts, which would otherwise be unavailable without a collaborative approach.

Enhanced demand and capacity management

As one group, we can align workforce supply more effectively with population health needs, ensuring that the right resources are deployed to the right areas at the right time. This strategic alignment reduces gaps in staffing, minimising the need for costly, short-term solutions such as agency or bank staffing. Furthermore, a shared understanding of demand trends and capacity constraints across the system enables proactive workforce planning, fostering greater consistency and sustainability in staffing levels.

Demand and capacity modelling at a higher level also offers advantages over individual trust-level analysis.

4. Workforce and Staff Experience

4.2 Key opportunities cont.



Different techniques (e.g., System Dynamics, Discrete Event Simulation, and Agent Based Modelling) are typically used for modelling systems at the level of complexity seen at a system or regional level, compared to an individual trust².

These methods encourage organisations across a system to collaborate more effectively, fostering an integrated approach to addressing short- and long-term challenges¹.

Harmonising bank and agency management

A uniform approach to bank and agency management presents a significant opportunity to increase our purchasing power and negotiate the best agency rates for all. Aligning pay structures will also allow us to mitigate inflationary pressures caused by our trusts competing for the same staff groups reducing financial inefficiencies such as overpaying for agency staff, or duplicating efforts to attract the same pool of staff.

Adopting one approach to bank and agency management will also create opportunity to implement smart data systems that improve data visibility, unlocking opportunities to make both strategic and day to day data informed decisions that benefit the Group, such as easily identifying particular staff groups across the trusts where there is overreliance on bank or agency staff.

4.3 Financial opportunity

The formation of LAASP represents an opportunity to improve ways of working, boost staff satisfaction, and enhance employment opportunities across trusts - all of which serve to improve staff retention and reduce the costs associated with staff replacement.

Numerous case studies provide evidence that initiatives targeted at improving ways of working, staff engagement, and career development result in a reduction of annual leaver rates of

0.5–2.4%^{3,4}

... and evidence suggests the cost of replacing a doctor is **£297,500⁵** and the cost of replacing a nurse is **£13,600⁶** (adjusted for inflation).

Bank spend

To estimate the financial opportunity of a reduction in bank spend due to the formation of LAASP, we compared the LAASP trusts' bank spend as a proportion of staff spend to national benchmarks¹.

As shown in figure 4.3.1, the majority of LAASP trusts, except for LUHFT and TWC, are below the national lower quartile. Therefore, we developed three scenarios:



Low: Assume LUHFT bank spend proportion is reduced to national median



Medium: The average of the low and high scenario



High: Assume LUHFT and TWC bank spend proportion is reduced to the national lower quartile

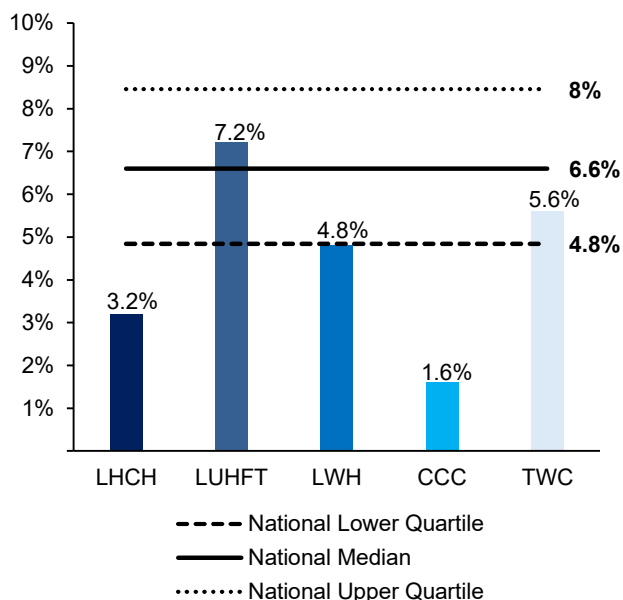


Figure 4.3.1: LAASP Bank spend as a proportion of staff spend (%)

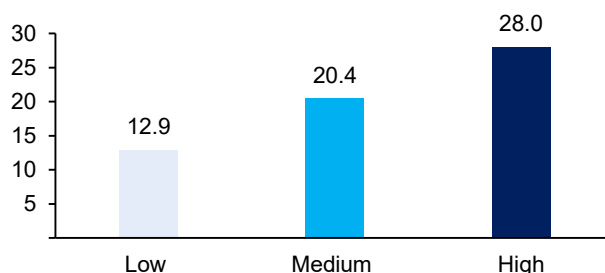


Figure 4.3.2: Low, medium and high LAASP bank spend opportunity (£m)

£13 – 28m

is the estimated bank spend opportunity from the formulation of LAASP (in a 3-5 year horizon)

5. Clinical Support and Diagnostic Services

Clinical support and diagnostic services are the backbone of our health services, providing the foundation for accurate diagnoses, effective treatments, and seamless patient journeys. While we have already made significant progress in enhancing these services, operating as a group presents an exciting opportunity to further align our efforts and reduce duplication. By working together, we can streamline pathways and optimise our resources, creating more efficient and coordinated experiences for both patients and staff.

5.1 Overview of current state

The delivery of clinical support and diagnostic services across Liverpool and the wider C&M system faces several challenges that affect operational efficiency, resource utilisation, and ultimately patient care. Significant progress has been made through collaborative efforts and integration – helping our five trusts to perform well against the national average. However, the variation across providers as shown in figure 5.1.1 highlights opportunities for improvement.*

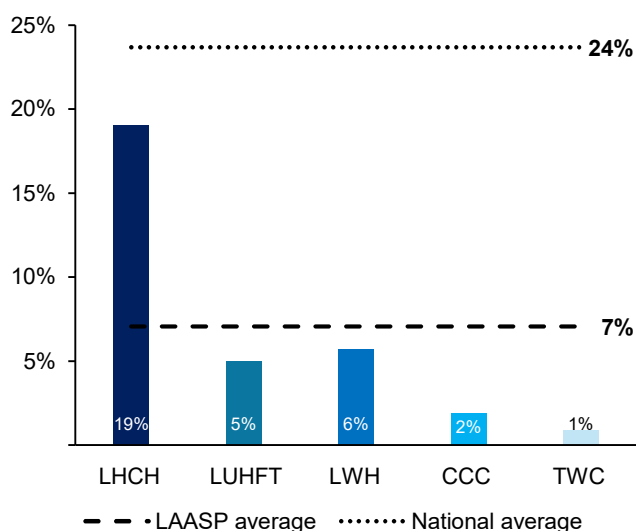


Figure 5.1.1: Average percentage of patients waiting 6+ weeks (Oct 23 - Sept 24) for diagnostic test by provider

Significant progress has been made in integrating diagnostics across sites, including the AUH-RLH merger, which has reduced fragmentation and duplication for patients. Merging processes, legislation, and waiting lists has led to reduced wait times, improved DMO1 compliance, increased accessibility, more research activity, and greater patient choice. Workforce benefits include lower turnover and vacancy rates, driven by enhanced career progression and job satisfaction.

CMAST Diagnostic Programme

Imaging and pathology networks now fall under the broader CMAST Diagnostic Programme, which unites various diagnostic networks, including endoscopy, Community Diagnostic Centres (CDCs), and primary care diagnostics. This comprehensive approach highlights the system's commitment to enhancing diagnostic services.

However, gaps remain, particularly in areas like Cardiology where greater integration could unlock further efficiencies. For instance, while both LHCH and RLH use the Integrated Clinical Environment (ICE) system for pathology, data from one trust is not visible to the other, creating gaps in patient management¹.

CAMRIN

Established in 2012, the Cheshire and Merseyside Radiology Imaging Network (CAMRIN) is a partnership of 12 NHS trusts within C&M ICS, aiming to improve services for patients and staff through large-scale change programmes. CAMRIN repurchased a single Radiology Information System (RIS) and Picture Archiving Communications System (PACS) software². This has allowed the imaging network to deploy AI solutions across the network, progressing the digital maturity of the network to 'thriving'.

However, the lack of shared access to blood results via ICE, and particularly the absence of ECGs in cardiology, continues to hinder effective patient management by leaving clinicians without a complete picture.

The benefits of collaboration are also evident within the trusts of LAASP. For example, **Liverpool Clinical Laboratories (LCL)**, established through the collaboration of LUHFT, LWH, and LHCH, has significantly improved productivity.

Similarly, closer alignment of pharmacy services could optimise resources. Currently, Broadgreen Hospital and LHCH operate separate physical pharmacy units and Electronic Prescribing and Medicines Administration (EPMA) systems, despite being in close proximity¹. Aligning these services presents an opportunity to optimise space and avoid unnecessary duplication.



Significant progress has also been made in Medicines Optimisation across several services within LAASP, such as the impactful work undertaken in LUHFT's medicines safety improvement programmes

5. Clinical Support and Diagnostic Services



5.2 Key opportunities



These initiatives focus on enhancing systems and processes to promote greater safety and quality, achieving better patient outcomes through targeted quality improvement efforts

The collaborative work fostered by CMAST and within Liverpool has demonstrated tangible benefits, yet digital systems remain a critical limitation to further progress.

Back-office systems are becoming linked, but fragmented digital systems at the front line continue to impede clinicians' ability to deliver care effectively.

By building on the strong foundations laid by CMAST and within Liverpool so far, there is significant opportunity to address current gaps and establish LAASP as a leader in integrated diagnostic and clinical support services.

Streamlined diagnostic and treatment models

Joint working across the trusts drives and streamlines pathways such as the 18-week referral to treatment (RTT) by optimising resource allocation and introducing innovative solutions.



Pooling diagnostic assets, such as imaging equipment and laboratory facilities, and designing solutions to work at scale, helps address backlogs and directs capacity where it is needed most

Coordinated efforts will enable smoother transitions between diagnostic and treatment stages while minimising delays.

Innovations like **rapid near-patient testing**, **shared diagnostic hubs** and **virtual consultations** enable faster and more accurate diagnostics, while services that can be more community-based such as phlebotomy bring essential diagnostics closer to patients, supporting the shift of care from hospitals to communities.



Aligning pharmacy services

Collaborative efforts to align pharmacy services, such as between Broadgreen and LHCH, can maximise existing resources, reduce redundancy of assets and infrastructure, and eliminate the need for duplicative investments.

Scaling best practices, such as CCC's pharmacy subsidiary PharmaC, for better contract management, could also further enhance service quality and outcomes.



Leveraging group-scale capabilities, such as having specific dispensing contracts across LUHFT, can drive efficiency and standardise high-quality care delivery

Developing and scaling Medicines Optimisation

By collaborating across trusts, we can develop streamlined and robust improvement plans for Medicines Optimisation, scaling these efforts to achieve the greatest impact across LAASP.



We can establish LAASP-wide clinical guidance and medicines management standards, e.g., ensuring uniformity in how controlled drugs are managed, administered, and delivered

5. Clinical Support and Diagnostic Services

5.2 Key opportunities cont.

Centralising these processes under a unified corporate structure will help standardise practices, driving consistency and excellence across all services. Operating as a group also allows us to pool resources, advocate for equitable funding for critical services such as radio-pharmacy, and manage these services more efficiently.

Scaling diagnostic excellence

The Cheshire and Merseyside Diagnostics Programme



Hosted by CCC since 2021¹, this programme has significantly improved diagnostic capacity and patient outcomes.

With performance increasing from **79% to 91%** against the six-week waiting time standard¹, the delivery of operational advancements such as 10 Community Diagnostics Centres (CDCs) performing over **500,000 additional tests annually**¹, and spearheading national innovations in echocardiography AI, intelligent liver function testing, and unified pathology systems, the programme has established itself as a **leader in diagnostics delivery**.

The Diagnostics Programme is set to deliver further opportunities, such as **benefits of up to £16m per annum** for a Pathology 3 Hub Target Operating Model and has secured £1.2m to revolutionise digital pathology and deliver faster biopsy turnaround times¹

Building on the strong foundation of the C&M Diagnostics Programme, we can unlock future opportunities across LAASP and the wider C&M region. For instance, by using the increased capacity of the two CDCs in Liverpool, we could collectively commit to phasing out reliance on the independent sector, except where patient choice dictates. Additionally, we could aim to see all patients within 24 hours, where appropriate, to prevent emergency admissions or attendances - shifting our focus from

sickness to prevention.



Another example is jointly bidding for the PET CT contracts, taking a Liverpool system-led approach to enhance service provision and reduce waiting times, which particularly impacts cancer performance



A combined NHS bid would support this service to be NHS-led, benefiting the wider geography and reinforcing integrated care delivery

Integrating digital systems

While ongoing collaboration has driven significant progress, a critical opportunity lies in better linking digital diagnostic systems to enhance the delivery of care and move our system from analogue to digital.

The great work of CMAST has laid a strong foundation, but by collaborating further, it allows us to implement a single laboratory information system across LAASP, revolutionising how diagnostic tests and results are requested, accessed, and utilised.

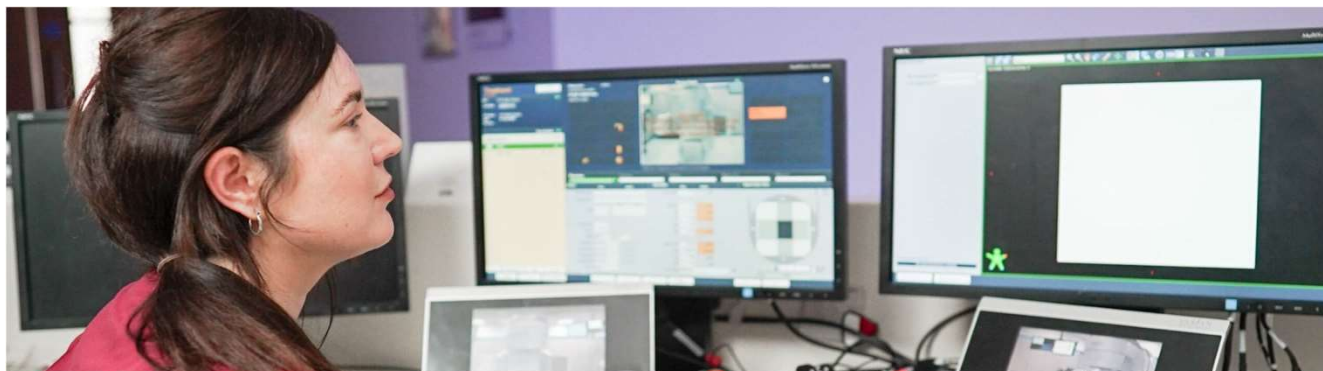
The C&M Diagnostics Programme has also found **benefits of £10m over 10 years for LIMS** (laboratory information management system) implementation¹

Through having a unified LIMS system, clinicians across the network would be able to seamlessly request and review diagnostic tests and results, regardless of their or their patient's location.



By fully integrating a unified LIMS across LAASP, we can support seamless cross-trust collaboration, empower clinicians with real-time access to data, and create a more connected, efficient, and responsive healthcare ecosystem

By investing in these areas all trusts can be digitally connected, enabling further integration among pathology labs and aligning with the strategic intent for improved collaborative care models.



6. Research, Development, Innovation and Commercialisation

Our commitment to high-quality research within each of the five trusts is beyond question, as demonstrated by our performance and strong partnerships. We believe collaborating as LAASP can enhance the impact of our research and commercial activities. Together, we can accelerate the development of innovative tools and practices by our talented staff and maximise commercial opportunities to optimise patient care.

6.1 Overview of current state

In Liverpool and the wider Cheshire and Merseyside system, we continue to have a strong research infrastructure being home to two National Institute for Health and Care Research (NIHR) funded Clinical Research Facilities (CRF).

We currently work successfully together to deliver our Liverpool CRF across LUHFT, CCC and LHCH, which was instrumental in responding to the COVID-19 pandemic. Further, LUHFT and CCC are affiliated with the Liverpool Experimental Cancer Medicine Centre (ECMC¹).

As LAASP we all bring distinct expertise and growing strengths in research and innovation.

Across our trusts, we have a **growing number of research staff**, a **diverse portfolio of clinical trials**, and **meaningful collaborations with academic institutions** both locally (The Liverpool Centre for Cardiovascular Science) and nationally (CCC's participation in a cancer specific Biomedical Research Centre (BRC) with The Royal Marsden and City University of London).

Despite investments and collaborative efforts, **participation in clinical trials within Liverpool is lower than Core City peers** per 100,000 of the population²

Increasing research participation among under-represented, socially deprived groups in Liverpool would generate findings more applicable to the local population.

Despite strong partnerships with Liverpool universities and support from Liverpool Health Partners, recruitment of academics and researchers is hampered by limited support packages.

Additionally, the largely independent nature of current research activities restricts our ability to scale initiatives and secure larger grants².

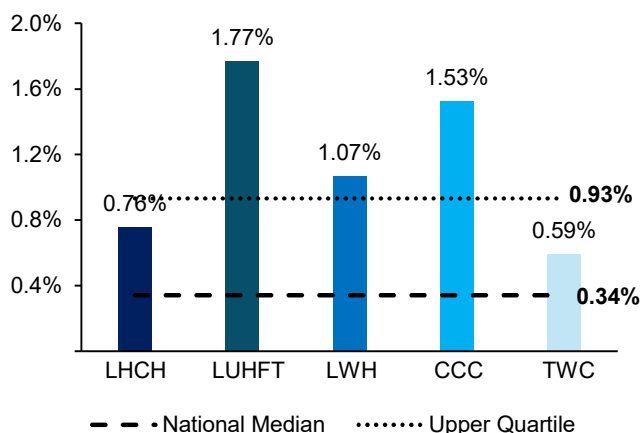


Figure 6.1.1: LAASP R&D income as a proportion of total income across trusts 2022-2023 (%)

Our trusts currently engage in varied commercial activities, but there's significant potential for expansion. Without a unified approach, leveraging a broader patient base, enhancing workforce capacity, and collaborating effectively on large-scale commercial and research opportunities remain constrained.

Commercial Research Delivery Centre (CRDC)

The new Commercial Research Delivery Centre, hosted by the University Hospitals of Liverpool Group (LUHFT and LWH combined), offers Cheshire and Merseyside communities early access to cutting-edge commercial research, alongside the indirect benefits of additional income and prestige the initiative will bring.

As one of 20 CRDCs nationwide³, the centre's establishment highlights how size, scale, and effective collaboration can attract significant NIHR grants.

6.2 Key opportunities

Scaling research and securing grants

By uniting our efforts, we can leverage a broader patient base, enhancing the scale and impact of clinical trials.

6. Research, Development, Innovation and Commercialisation

6.2 Key opportunities cont.

This would position us to attract larger funding opportunities, including NIHR grants, and allows us to compete with larger institutions.

Collaboration would also provide access to additional workforce capacity, enabling research nurses and teams to be deployed more effectively across trusts. Specialised areas such as neurosciences, cancer, and head and neck research offer avenues for targeted growth, supported by Liverpool's recognised strengths in these fields.



A unified research network can create a more compelling value proposition for fellows, professors, and academics, supported by innovative fellowship programmes and stronger ties with Liverpool's research universities

By fostering a nurturing environment that recognises individual trust contributions, we can retain the unique appeal of our trusts' brands, while benefiting from the impact of a larger group.

Aligning academic research with local population need

Creating a united interface and more standardised ways of working will enable us to deepen our relationships with Liverpool universities.



Enhanced integration with universities encourages access to better academic support and strengthens our bids for BRC status

It will also enable us to strategically align collective research priorities with our local population needs, from neurodegenerative diseases to cardiovascular medicine, fostering partnerships that are academically and clinically impactful.

Fostering clinical innovation

We have the potential to build on strong pockets of culture that support and celebrate grassroots innovation empowering clinicians to drive impactful ideas forward.

Developing a clear, standardised innovation framework will empower clinicians to bring their ideas to an innovation hub for evaluation, acceleration, and commercialisation.



Example: At CCC, a clinical director developed a groundbreaking molecular test to accurately predict mortality in palliative care patients¹.

By identifying specific metabolites that emerge before traditional diagnostic markers, this innovation enables more predictive and personalised patient care. This showcases how organic clinician-driven ideas can be transformed into impactful solutions.

Identifying and scaling commercial opportunities

As LAASP, our specialisation and scale position us to dynamically generate revenue beyond the NHS. A structured approach will help us identify and scale successful initiatives within the group.



Example: At TWC specialised spinal surgery has enabled a lucrative partnership with a leading IT services and consulting firm. By licensing long-term outcome data from their database, the trust generates £125k annually¹.

This model developed organically, demonstrating how clinical data can be effectively monetised while contributing to ongoing research and innovation.

Long-term contracts with industry leaders will allow us to secure funding, develop products collaboratively, and establish clinical programmes directly sponsored by industry partners.



Example: LHCH has established a long-term contract with a medical devices company to purchase their products over several years¹. In return for this multi-year commitment, the medical devices company provided support for capital investment.

Alongside similar agreements with other medical devices firms, the trust has been able to foster symbiotic relationships where lead clinicians can collaborate on product development and clinical programmes sponsored by the industry.



Strong relationships such as LHCH's with a medical devices company, or CCC's with a pharmaceutical company offer a strong foundation from which the group can build their commercial approach at scale.

6. Research, Development, Innovation and Commercialisation

6.3 Financial opportunity

The formation of LAASP creates an avenue for our trusts to increase income streams by leveraging our scale to consistently capitalise on commercial opportunities. This could also be beneficial for the wider Cheshire & Merseyside region. To illustrate this, we estimated the financial opportunity across three different income streams:

1) Research and Development Income (R&D)

2) Education and Training (E&T)

3) Private Patient Income (PP)

By evaluating LAASP trust income streams as a proportion of total income, we compared this against national benchmarks. Each of our trusts have variation in the levels of income from R&D, E&T and PP that each respectively drive their total income. Taking a blended view across the three income streams helps to account for the difference in how each trust operates and generates income.

To estimate the financial opportunity, unique scenarios had to be developed for each income stream (as shown in Table 6.3.1). This is due to variance in performance. For example, all LAASP trusts' income proportions for R&D are greater than the national median, whilst for PP, all income proportions are only greater than the lower quartile.

Scenario	R&D	E&T	PP
Low	Assume LAASP achieve 75% of additional income from income proportion equal to CCC (1.7%)	Assume income proportion equals national lower quartile	Assume income proportion equals national median
Medium	Average of low and high scenario	Assume income proportion equals national median	Average of low and high scenario
High	Assume LAASP achieve 75% of additional income from income proportion equal to LUHFT (1.9%)	Assume income proportion equals national upper quartile	Assume income proportion equals national upper quartile

Table 6.3.1 Financial opportunity scenarios

We estimate that the formation of LAASP could result in a total opportunity size of **£10 - 26m** in recurring annual additional income across LAASP 3-5 years after formation.

Opportunity	Low	Medium	High
R&D	3.8	4.6	5.3
E&T	4.9	8.5	13.4
PP	1.2	4.2	7.1
Total	10.0	17.2	25.8

Table 6.3.2 LAASP additional income opportunity (£m)



7. Corporate and Shared Services

To improve efficiency, productivity, and collaboration across Liverpool, we see significant opportunities in corporate and shared services within LAASP to tackle operational inefficiencies and financial challenges.

This understanding stems from the work of CMAST's efficiency at scale initiatives, like Health Procurement Liverpool and unified payroll systems. We aim to build on these efforts, enhance efficiencies at the Liverpool level, and leverage collective expertise across the acute and specialist trusts while maintaining high service quality.

7.1 Overview of current state

Of the five trusts, LWH is the only trust with costs above the national median. However, there is significant variation in the costs of the corporate functions overall and for specific functions. Within LAASP, LWH has the highest costs of c.£6m per £100m of income and LUHFT has the lowest with corporate costs of c.£4m per £100m¹ income, which are further broken down in figure 7.1.1 below.

Furthermore, there is duplication of specific fixed costs services, such as within HR, Finance, Governance and Risk functions. Through the efficiency at scale programme by CMAST, there is a specific focus on better understanding the cost drivers to improve understanding of productivity within trusts.

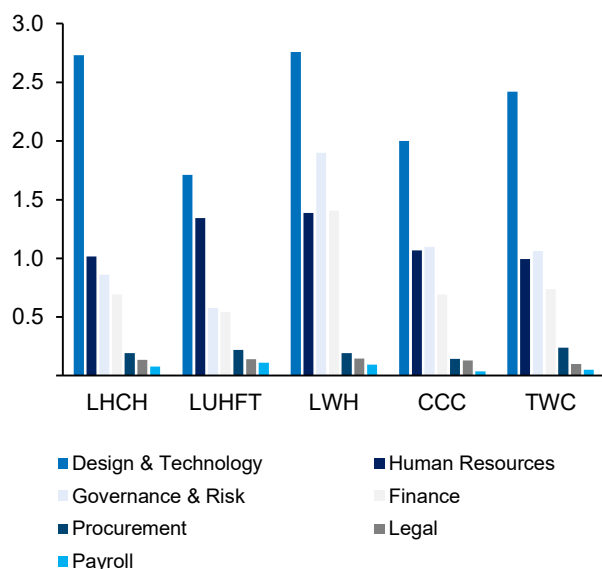


Figure 7.1.1: Corporate services total cost breakdown per £100m income by trust

7.2 Key opportunities

While we already work together to deliver many services, closer partnership can help standardise processes and reduce duplication.

Reducing unnecessary duplication

By working collectively, we can consolidate functions and processes where necessary, leading to cost savings and more efficient operations. Preliminary analysis suggests opportunities within digital services, HR processes, finance, legal services, and governance functions.



Within HR, training of Radiologists is conducted at each trust and could instead be arranged and coordinated by one department to reduce costs

Economies of scale

We can leverage our collective size to achieve economies of scale. This will enhance our purchasing power, for example allowing us to negotiate better procurement rates with suppliers for medical equipment and pharmaceuticals, thereby reducing per-unit costs.



Larger contract opportunities with service providers can lead to more favourable terms and reduced operational costs, ultimately freeing up resources to be reinvested in patient care

7.2.1 Enablers

Operating as a unified group will allow us to fully leverage three key enablers - digital, estates & facilities and finance, to drive meaningful improvements in all aspects of patient care.

Digital

We have a significant opportunity to enhance interoperability among our digital systems, currently fragmented with over ten different Patient Administration Systems (PAS) and EPR systems, hindering effective information sharing. By integrating these services, aligned with the national shift from analogue to digital, we can innovate care delivery and elevate digital capabilities across all organisations.

Shared digital platforms, such as converged EPR, referral, and EPMA systems, improve care coordination and patient management, facilitating seamless care transitions and reducing errors.

Additionally, integrated services support system-wide population health management, demand/capacity modelling, and business intelligence, providing critical insights for targeted interventions and efficient resource allocation.

Estates and facilities

Estate strategy and master planning is a key pillar within the LAASP delivery structure. By working as a group, we can make more efficient use of our joint estate, taking a strategic approach based on patient and clinical need to optimise the use of estates and

7. Corporate and Shared Services



7.2.1 Enablers cont.

capital expenditure. This also provides an opportunity to align investment with clinical pathway transformation, identifying suitable and under-utilised space across the city.

Since 2016, while the NHS estate has grown by **3%**, patient attendances have risen by **11%**¹, highlighting the need for efficient space management to meet rising demand and provide a safer and more compliant care environment for patients

The condition and functionality of NHS estates are often constraints for NHS trusts, with significant investment required to modernise and make ageing premises fit-for-purpose. However, within LAASP, most of the trusts occupy relatively modern estate with 67% of CCC estate and c.80% of RLH, within the LUHFT estate, constructed in the last 10 years². This allows for targeted investment in other areas of need and further development of the combined estate.

The C&M efficiency-at-scale programme identified significant costs in facilities like cleaning and catering, presenting opportunities for innovative approaches, such as the PropCare subsidiary established by CCC.

Recognising the critical role of estates in group operations, a dedicated project will establish a baseline assessment of estates across LAASP, providing a strong foundation for future planning.

Finance



Pooling capital resources enables us to enhance financial planning and resource allocation, allowing for strategic investments in infrastructure and technology

This approach promotes the efficient use of funds to support long-term healthcare improvements. Furthermore, collaboration enables us to better share and manage financial risks, particularly in areas where cost drivers span multiple organisations. By working collectively, we can tackle financial challenges more effectively and prioritise allocating resources where they are needed most.

7.3 Financial opportunity*

There is significant variation in corporate services costs across trusts. The formation of LAASP represents an opportunity to reduce variance and overall corporate services costs through the standardisation and sharing of services and processes. Following the Model Hospital's opportunity methodology, we estimated the cost savings opportunity across corporate functions:

- Digital and technology
- Finance
- Payroll
- HR
- Procurement
- Governance & Risk
- Legal

We developed three opportunity scenarios:

1) Low:

- If cost > National lower quartile, assume opportunity target = National lower quartile
- If cost > National median, assume opportunity target = National median
- If cost > National upper quartile, assume opportunity target = National upper quartile

2) Medium: Average of low and high scenario

3) High:

- If cost > National lower quartile, assume opportunity target = National lower quartile
- If cost > National median, assume opportunity target = National median
- If cost > National upper quartile, assume opportunity target = National median

We estimate that LAASP could have an annual recurring opportunity of approximately **£7 - 8m** in corporate services costs.

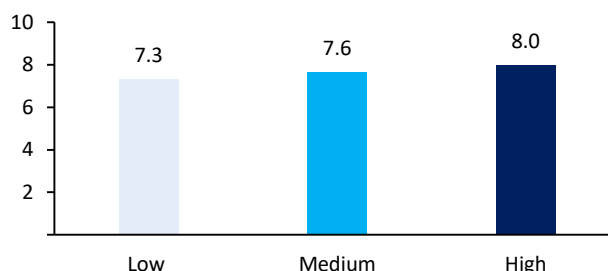


Figure 7.3.1: LAASP annual corporate and shared services financial opportunity (£m)

8. Financial Sustainability

We have a collective responsibility to design our services around the healthcare needs of the population.

As the prevalence of comorbidities continues to rise, LAASP has an opportunity to shape services to better meet the needs of our patients. Operating within a financially challenged regional and national NHS environment, we need to think differently about how to make best use of our collective resources to sustainably deliver healthcare to people in Liverpool.

8.1 Overview of current state

The five trusts within LAASP are currently operating within a significantly challenged financial environment across the NHS and Cheshire & Merseyside Integrated Care System (ICS).

As of 30th November 2024 (Month 8), the ICS is reporting a YTD deficit of £113m against a planned YTD deficit of £61.5m resulting in an adverse YTD variance of £51.5m¹.

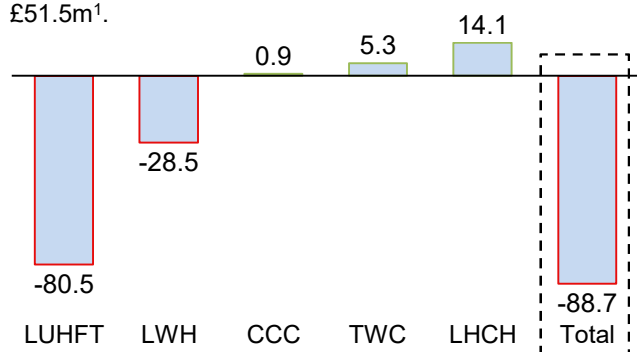


Figure 8.1.1: FY24/25 financial plans submitted by each of the 5 trusts and the total deficit (£m)

The financial picture across the trusts varies, as outlined in figure 8.1.1 above, with the majority of £88.7m planned group deficit sitting with LUHFT. At Month 6, LUHFT are also the only trust out of the 5 to have a Risk Adjusted FOT that is £18.3m worse than Plan at £98.8m¹.

In year financial performance against plan at Month 8 is also varied across the trusts, with LUHFT and LHCH £7m and 0.4m¹ behind plan respectively, CCC on plan and TWC and LWH 0.4m and 0.9m¹ ahead of plan.

8.2 Financial opportunity

Alongside opportunities to improve patient experience, clinical quality and staff experience, there are meaningful financial opportunities associated with the five hospitals working closely together within a group structure which have been explored throughout this document. These

are just an indicative sample of the true scale of opportunities that working as a group could enable.

Figure 8.2.1 shows how the LAASP financial opportunities identified within this report could bring the combined group into a more financially sustainable position, with a total estimated annual recurrent financial opportunity of **£49-90m**.

The majority of these benefits are expected to come from clinical pathway efficiencies (approximately £19-29m) and a reduction in temporary staffing costs (approximately £13-28m).

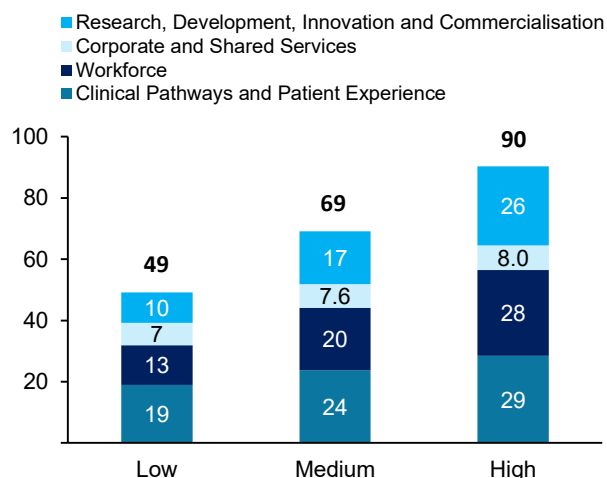


Figure 8.2.1: Cumulative financial opportunity identified with the formation of LAASP (summary of report analysis, non-exhaustive) (£m)

Our analysis into clinical pathway efficiencies focused on inpatient services so represents only a portion of the total clinical opportunity. Recent C&M ICB analysis of reference costs across all health services suggests a total financial opportunity of approximately **£160m**, indicating further opportunities in Outpatients, Emergency Care and other areas. Further work is needed to evaluate the full financial opportunity within LAASP health services.



9. Conclusion and Next Steps

This document outlines the potential opportunities of working together as five trusts within LAASP, focussing on aligning our ways of working and integrating the services we provide to ultimately improve the healthcare experiences and health outcomes of people in Liverpool.

However, we recognise that we cannot accomplish this without working more closely with our system partners, and there is more we could achieve as a group through further conversations. As we move forward, the case for change will guide our efforts to create detailed business cases that will explore how we can deliver more cohesive, efficient, and patient-centred acute and specialist care.

9.1 Further work

Following development of our Case for Change we will now be embarking on a period of engagement with our staff and patients to develop our **LAASP Strategic Case** and **Financial Sustainability Plan** that will expand on the opportunities in this document and chart our implementation journey. We will develop a financial framework that will reflect how the group could 'act as one' with a unified approach.

9.2 Critical success factors

As we design our future state and further identify the changes and improvements that will benefit our patients, staff and wider healthcare system, there are considerations that are critical to our success:



Patient and staff involvement

The voices of those we serve are central to our design and planning, as is understanding and including the diverse perspectives of our workforce.

We will create a range of opportunities to gather insights and feedback to shape our future work and provide the necessary support to guide any changes.



Our governance structures

Working collectively requires alignment at all levels - a shared vision, objectives and goals. To address the opportunities and challenges outlined in our case for change, we will establish a robust programme structure and leverage leadership from across our organisations. We will also delegate the decision-making authority and resources to the LAASP Programme to drive the success of our work.



Our brand identity and culture

It is crucial that in developing a group identity, we build on the strengths of our existing individual brands to enhance the value of LAASP as a collective.

There are strong, attractive cultures across our trusts, and our aim is to learn from and amplify what makes the trusts within LAASP a great place to work and receive care.



Estates and capital optimisation

Effective use of our collective estate is vital and depends on strategic alignment across all our trusts. We will adopt a collaborative approach to capital planning, making sure that investment is guided by patient and clinical needs, whilst identifying opportunities to maximise the efficiency and use of our estate.



Digital enablement

A unified digital approach is essential to delivering an outstanding experience for our patients and reducing complexity for our staff. We will invest in our digital capabilities such as a single EPR, convergence and greater interoperability across our organisations, to optimise our workflows and communication as a group.

9.3 Conclusion

In conclusion, the development of our Case for Change has highlighted that we can do better for the patients that we serve.

From a clinical perspective, our organisational boundaries are impacting the care we provide across several pathways, including but not limited to women's services, cardiology and stroke, while also influencing how patients experience our services.

Financially, our emerging group faces significant financial risks that require effective management. Operating at scale through LAASP offers an opportunity to mitigate these risks over the long term.

To address these challenges, we must now develop a comprehensive programme of work to simplify the delivery of our clinical and corporate services, supporting a more efficient and effective future.

Appendix A: Financial Opportunities Summary

A detailed summary of the financial opportunities* outlined in this report:

Report section	Description	Annual Opportunity Within 3 - 5 Years (£m)**		
		Low	Medium	High
Clinical Pathways & Patient Experience	Reduction in Elective, Non-Elective: Long Stay and Non-Elective: Short Stay costs	19.0	23.8	28.5
Workforce & Staff Experience	Reduction in bank spend, aligned to the median and upper quartile national spend	12.9	20.4	28.0
Research, Development & Innovation and Commercialisation	Increase in Trust income from RD&I and Commercial routes in line with the national and upper quartile medians	3.8	4.6	5.3
	Increase in trust income from Education and Training	4.9	8.5	13.4
	Increase in Private Patient income	1.2	4.2	7.1
Corporate and Shared Services	Reduction in trust spend on Corporate and Shared Services in line with the national and upper quartile medians	7.3	7.6	8.0
Total		49.2	69.1	90.3

Notes: *The financial opportunities identified here represent areas with the strongest evidence base; however, they do not encompass all potential financial benefits for LAASP. They are presented as gross rather than net benefits as they do not account for the costs associated with the formation of LAASP. As there are different scenarios and therefore costs associated with how LAASP will be established, costs have been omitted from the analysis. **Sum of opportunities and the total may differ due to rounding

Appendix B: Financial Opportunities

Methodology

The following section outlines the methodology and assumptions used to estimate the financial opportunities across the four following areas:

- 1) **Clinical Pathways**
- 2) **Workforce**
- 3) **Research, Development, Innovation, and Commercialisation**
- 4) **Corporate and Shared Services**

It is important to note across all of these areas that the financial opportunities are calculated at a high level and will require further refinement through future work as opportunity areas are developed in detail.

Financial Opportunity Assumption

The estimated financial opportunities are presented as annualised figures and represent what can be achieved once LAASP attains a suitable level of maturity, which we anticipate will occur within 3 to 5 years of all members joining LAASP (allowing for time to implement the necessary changes and initiatives to fully unlock these opportunities).

1) Clinical Pathways*

To estimate the financial opportunity within clinical pathways, we compared the weighted average of the LAASP Trusts' National Cost Collection Index (NCCI) for inpatient services (see Table B1.1) against suitable trust comparators to determine if there was variation and, therefore, an opportunity to reduce costs. Comparators were selected based on having similar sizes, structures, and specialisms to the structure of LAASP and their NCCIs are shown alongside in Table B1.2.

LAASP trusts	Elective Inpatients NCCI	Non-Elective Inpatients: Long Stay NCCI	Non-Elective Inpatients: Short Stay NCCI
LHCH	94	104	102
LUHFT	87	109	91
CCC	155	157	157
LWH	111	114	121
TWC	110	114	120
Weighted Average	96	111	99

Table B1.1: LAASP NCCI average for Inpatient Services (23/24)

Comparator trusts	Elective Inpatients NCCI	Non-Elective Inpatients: Long Stay NCCI	Non-Elective Inpatients: Short Stay NCCI
Barts Health NHS Trust	113	83	76
Guy's & St. Thomas' NHS Foundation Trust	115	138	136
Imperial College Healthcare NHS Trust	101	90	88
Manchester University Foundation Trust	105	112	111
Northern Care Alliance NHS Foundation Trust	114	93	90
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	90	87	89
Weighted Average	106	98	101

Table B1.2: Comparator trust NCCI average for Inpatient Services (23/24)

LAASP's weighted average NCCI is approximately 10% lower than the comparator for Elective Inpatients, but it is 12% higher for Non-Elective Long-Stay and 1% higher for Non-Elective Short-Stay. To estimate the opportunity, the percentage variation in NCCI was applied to the LAASP trusts' NCCIs. From this, we calculated the potential revised costs of inpatient services.

Continued on next page

Appendix B: Financial Opportunities

Methodology

1) Clinical Pathways cont.

As shown in Table B1.3, the net opportunity across LAASP trusts equalled £38 million. However, given NCCI represents a 'whole cost' measure (with a portion of overheads assigned to clinical activities), we do not believe it is appropriate to take 100% of this opportunity. To be conservative, we have therefore developed three scenarios to estimate the total LAASP opportunity:

- 1) **Low scenario:** Assume LAASP achieves 50% of the opportunity
- 2) **Medium scenario:** Assume average of low and high scenarios
- 3) **High scenario:** Assume LAASP achieves 75% of the opportunity

From this, we estimate the financial opportunity for LAASP trusts in clinical pathways to be approximately from £19 to £28.5 million.

Trust	Financial opportunity (at 100%)
LHCH	0.8
LUHFT	32.1
CCC	0.8
LWH	4.0
TWC	0.3
Total	38.0

Table B1.3: LAASP inpatient services net opportunity (£m)

Trust	Low	Medium	High
LHCH	0.4	0.5	0.6
LUHFT	16.0	20.1	24.1
CCC	0.4	0.5	0.6
LWH	2.0	2.5	3.0
TWC	0.1	0.2	0.2
Total	19.0	23.8	28.5

Table B1.4 LAASP annual financial opportunity (£m)

Appendix B: Financial Opportunities

Methodology

2) Workforce

To estimate the financial opportunity within the workforce, we compared the bank spend as a proportion of staff spend for LAASP trusts against trusts nationwide. Using data from Trust Accounts Consolidation (TAC) 22/23, we calculated the national lower quartile (4.8%), median (6.6%), and upper quartile (8.5%), as shown in Figure B2.1. When comparing LAASP trusts to the national benchmark, excluding LUHFT and TWC, the bank spend proportion for these trusts is below the national lower quartile.

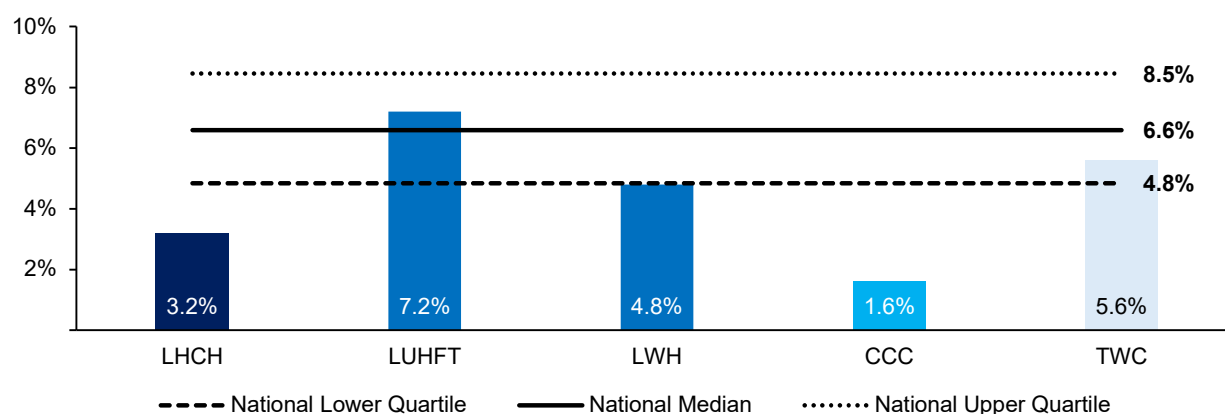


Figure B2.1 LAASP annual bank spend as a proportion of staff spend (%) (22/23)

To estimate the financial opportunity, we developed three scenarios:

- 1) Low:** Assume LUHFT's bank spend proportion is reduced to the national median.
- 2) Medium:** The average of the low and high scenarios.
- 3) High:** Assume the bank spend proportion for LUHFT and TWC is reduced to the national lower quartile.

Applying the updated bank proportion from each scenario to the total staff spend, we estimate the financial opportunity for LAASP trusts in workforce management to be approximately **£13 - 28m**.

Trust	Low	Medium	High
LHCH	0.0	0.0	0.0
LUHFT	12.9	20.4	27.9
LWH	0.0	0.0	0.1
CCC	0.0	0.0	0.0
TWC	0.0	0.01	0.03
Total	12.9	20.4	28.0

Table B2.2 LAASP bank spend savings (£m)

Appendix B: Financial Opportunities

Methodology

3) Research, Development, Innovation, and Commercialisation

To estimate the financial opportunity within Research, Development, Innovation, and Commercialisation, we estimated the potential additional income that trusts could generate from the formation of LAASP. Therefore, three income streams were chosen:

- 1) Research and Development (R&D)
- 2) Education and Training (E&T)
- 3) Private Patient (PP)

To account for the different sizes of trusts, we chose to compare income streams as a proportion of total income against trusts nationwide (See Tables B3.1 and B3.2).

Trust	R&D	E&T	PP
LHCH	0.8%	1.3%	2.0%
LUFHT	1.9%	3.9%	0.1%
LWH	0.9%	4.1%	2.9%
CCC	1.7%	1.4%	1.5%
TWC	0.6%	2.1%	0.1%

Table B3.1: LAASP commercial income as a proportion of total income (23/24)

Trust	R&D	E&T	PP
National Lower Quartile	0.2%	2.2%	0.04%
National Median	0.3%	2.7%	0.2%
National Upper Quartile	0.9%	3.4%	0.5%

Table B3.2: National benchmarks of commercial income as a proportion of total income (22/23)

As shown above, there is significant variation in income streams across trusts. LUHFT ranks highest for R&D, and LWH for E&T as well as PP. To estimate the financial opportunity across each trust, we followed a similar methodology to that used by Model Hospitals. Using national benchmarks, we estimated the additional income LAASP trusts could generate if their commercial income streams, as a proportion of income, were equal to the national benchmarks.

However, LAASP trusts' performance against the national benchmarks varies considerably for each income stream. For example, for R&D, all the LAASP Trusts have an income proportion above the national median. On the other hand, for E&T, three trusts (LHCH, CCC, and TWC) have income proportions below the national lower quartile. It was therefore necessary to develop different estimation scenarios for each income stream, as shown below in Table B3.3.

Scenario	R&D	E&T	PP
Low	Assume LAASP achieve 75% of additional income from income proportion equal to CCC (1.7%)	Assume income proportion equals national lower quartile	Assume income proportion equals national median
Medium	Average of low and high scenario	Assume income proportion equals national median	Average of low and high scenario
High	Assume LAASP achieve 75% of additional income from income proportion equal to LUHFT (1.9 %)	Assume income proportion equals national upper quartile	Assume income proportion equals national upper quartile

Table B3.3: Financial opportunity scenarios

Appendix B: Financial Opportunities

Methodology

3) Research, Development, Innovation, and Commercialisation cont.

With the developed scenarios, it was then possible to estimate the financial opportunity across trusts for each income stream (see Tables B3.5/6/7). As shown in Table B3.4, we estimate a total financial opportunity of **£10 – 26m**. The largest opportunity lies within E&T, with a total opportunity of **£5 – 13m**.

Scenario	R&D	E&T	PP	Total
Low	3.8	4.9	1.2	10.0
Medium	4.6	8.5	4.2	17.2
High	5.3	13.4	7.1	25.8

Table B3.4: LAASP additional income opportunity (£m)

Trust	R&D	E&T	PP	Total
LHCH	1.5	2.2	0.0	3.7
LUFHT	0.0	0.0	1.1	1.1
LWH	0.8	0.0	0.0	0.8
CCC	0.0	2.4	0.0	2.4
TWC	1.5	0.3	0.1	2.0
Total	3.8	4.9	1.2	10.0

Table B3.5: Low Scenario – Additional income opportunity by trust (£m)

Trust	R&D	E&T	PP	Total
LHCH	1.7	3.4	0.0	5.1
LUFHT	0.0	0.0	3.7	3.7
LWH	0.9	0.0	0.0	0.9
CCC	0.3	3.8	0.0	4.1
TWC	1.7	1.3	0.5	3.5
Total	4.6	8.5	4.2	17.2

Table B3.6: Medium Scenario – Additional income opportunity by trust (£m)

Trust	R&D	E&T	PP	Total
LHCH	1.9	5.0	0.0	6.9
LUFHT	0.0	0.0	6.2	6.2
LWH	1.1	0.0	0.0	1.1
CCC	0.5	5.8	0.0	6.3
TWC	1.9	2.6	0.9	5.4
Total	5.3	13.4	7.1	25.8

Table B3.7: High Scenario – Additional income opportunity by trust (£m)

Appendix B: Financial Opportunities

Methodology

4) Corporate and Shared Services

To estimate the financial opportunity within corporate and shared services, we followed the methodology of Model Hospitals and evaluated the variation in the cost of corporate functions across trusts and how it compared to national benchmarks. As shown in Table B4.1 below, there is significant variation in corporate function costs per £100 million income across each trust.

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll
LHCH	0.7	0.2	0.9	0.1	1.6	1.0	0.1
LUHFT	0.5	0.2	0.6	0.1	1.5	1.3	0.1
LWH	1.4	0.2	1.9	0.1	1.9	1.4	0.1
CCC	0.7	0.1	1.1	0.1	1.2	1.1	<0.1
TWC	0.7	0.2	1.1	0.1	1.7	1.0	0.1
National Lower Quartile	0.5	0.1	0.6	0.1	1.4	1.0	0.1
National Median	0.6	0.2	0.8	0.1	1.7	1.3	0.1
National Upper Quartile	0.7	0.3	1.1	0.2	2.2	1.6	0.1

Table B4.1: Corporate and shared services cost per £100m income (£m)

Exploiting the variation in cost per £100m we developed three scenarios:

1) Low:

- If cost > National lower quartile, assume opportunity target = National lower quartile
- If cost > National median, assume opportunity target = National median
- If cost > National upper quartile, assume opportunity target = National upper quartile

2) Medium: Average of low and high scenario

3) High:

- If cost > National lower quartile, assume opportunity target = National lower quartile
- If cost > National median, assume opportunity target = National median
- If cost > National upper quartile, assume opportunity target = National median*

From the scenarios, we estimated the financial opportunity across corporate functions. We estimate that the formation of LAASP could result in a reduction in Corporate and Shared Services costs of **£7 – 8m**, with the largest opportunities existing within Governance and Risk (**£2.4m**) and Finance (**£1.5 – 1.9m**). A break down of opportunity by trust can be found in Tables B4.3/4/5.

Scenario	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
Low	1.5	0.3	2.4	0.6	1.2	1.2	0.2	7.3
Medium	1.7	0.3	2.4	0.6	1.2	1.2	0.3	7.6
High	1.9	0.3	2.4	0.6	1.2	1.2	0.4	8.0

Table B4.2: LAASP corporate and shared services total opportunity (£m)

*The LWH Governance and Risk benchmark was kept as the national upper quartile. As a women's hospital, LWH faces high costs incurred by negligence claims for example. that would not likely reduce through the formation of LAASP.

Appendix B: Financial Opportunities

Methodology

4) Corporate and Shared Services cont.

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
LHCH	0.2	0.1	0.1	0.1	0.4	0.0	<0.1	0.9
LUHFT	0.1	0.1	0.0	0.5	0.6	0.9	0.1	2.2
LWH	1.0	0.1	1.2	0.0	0.2	0.2	<0.1	2.6
CCC	0.2	0.0	0.7	0.1	0.0	0.1	0.0	1.1
TWC	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.5
Total	1.5	0.3	2.4	0.6	1.2	1.2	0.2	7.3

Table B4.3: Low scenario – Corporate and shared services opportunity by trust (£m)

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
LHCH	0.2	0.1	0.1	0.1	0.4	0.0	<0.1	0.9
LUHFT	0.1	0.1	0.0	0.5	0.6	0.9	0.3	2.3
LWH	1.1	0.1	1.2	0.0	0.2	0.2	<0.1	2.7
CCC	0.2	0.0	0.7	0.1	0.0	0.1	0.0	1.1
TWC	0.1	0.0	0.4	0.0	0.0	0.0	0.0	0.6
Total	1.7	0.3	2.4	0.6	1.2	1.2	0.3	7.6

Table B4.4: Medium scenario – Corporate and shared services opportunity by trust (£m)

Trust	Finance	Procurement	Governance and Risk	Legal	Digital and Technology	HR	Payroll	Total
LHCH	0.2	0.1	0.1	0.1	0.4	0.0	<0.1	0.9
LUHFT	0.1	0.1	0.0	0.5	0.6	0.9	0.4	2.4
LWH	1.2	0.1	1.2	0.0	0.2	0.2	<0.1	2.8
CCC	0.2	0.0	0.7	0.1	0.0	0.1	0.0	1.1
TWC	0.2	0.0	0.4	0.0	0.0	0.0	0.0	0.7
Total	1.9	0.3	2.4	0.6	1.2	1.2	0.4	8.0

Table B4.5: High scenario – Corporate and shared services opportunity by trust (£m)

Appendix C: List of Abbreviations

Abbreviation	Full Description
ACS	Acute Coronary Syndrome
BRC	Biomedical Research Centre
C&M	Cheshire and Merseyside
CAMRIN	Cheshire and Merseyside Radiology Imaging Network
CCC	The Clatterbridge Cancer Centre NHS FT
CMAS	Cheshire and Merseyside Acute and Specialist Trusts
CRDC	Commercial Research Delivery Centre
CRF	Clinical Research Facilities
D&T	Digital and Technology
E&T	Education and Training
ECG	Electrocardiogram
ECMC	Experimental Cancer Medicine Centre
ED	Emergency Department
EPMA	Electronic Prescribing and Medicines Administration
EPR	Electronic Patient Record
FSP	Financial Sustainability Plan
HF	Heart Failure
ICB	Integrated Care Board
ICE	Integrated Clinical Environment
ICS	Integrated Care System
LAASP	Liverpool Adult Acute and Specialist Providers
LCCS	Liverpool Centre for Cardiovascular Science
LCL	Liverpool Clinical Laboratories
LHCH	Liverpool Heart and Chest Hospital NHS FT
LIMS	Laboratory Information Management System
LUHFT	Liverpool University Hospitals NHS FT
LWH	Liverpool Women's Hospital NHS FT
MDT	Multidisciplinary Team
MHLDC	Mental Health, Learning Disabilities and Community Collaborative
NCCI	National Cost Collection Index
NIHR	National Institute for Health and Care Research
NSTEMI	Non-ST-elevated Myocardial Infarction
PACS	Picture Archiving and Communication System
PAS	Patient Administration System
PCI	Percutaneous Coronary Intervention
PHM	Population Health Medicine
PP	Private Patient
R&D	Research and Development
RIS	Radiology Information System
RLH	Royal Liverpool Hospital
RTT	Referral to Treatment
SSNAP	Sentinel Stroke National Audit Programme
STEMI	ST Elevated Myocardial Infarction
TWC	The Walton Centre NHS FT
UHL/UHLG	University Hospitals of Liverpool Group
YTD	Year to Date