GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

DATE: Wednesday, 14 October 2015
TIME: 10:00am - 12:00noon
VENUE: Scrutiny Room
Manchester Town Hall
(Use Lloyd Street entrance
Access from the bridge on level 2 of the Old Town Hall)

AGENDA

1. APOLOGIES

2. CHAIR’S ANNOUNCEMENTS AND URGENT BUSINESS

3. DECLARATIONS OF INTEREST - attached
   To receive declarations of interest in any item for discussion at the meeting. A blank form for declaring interests has been circulated with the agenda; please ensure that this is returned to the GMIST officer at the start of the meeting.

4. MINUTES OF THE MEETING HELD ON 24th JUNE 2015 - attached
   To approve the minutes of the meeting held on 24th June 2015 as a correct record.

5. GREATER MANCHESTER HEALTH AND SOCIAL CARE DEVOLUTION – attached
   Report of Warren Heppolette, Strategic Director, Health and Social Care Reform.

6. HEALTHIER TOGETHER PROGRAMME UPDATE - attached
   Presentation of Leila Williams, Director, Greater Manchester Service Transformation.

7. REVIEW OF HEALTHIER TOGETHER BY THE JOINT HEALTH SCRUTINY COMMITTEE - attached
   Report of Councillor John O’Brien, Chair, Greater Manchester Joint Health Scrutiny Committee.

Contact Officers:
Tim Griffiths, Policy Manager, GMIST. Tel: 0161 234 3023 e-mail: tim.griffiths@agma.gov.uk
Nicola Ward, Senior Democratic Service Officer. GMIST. Tel: 0161 234 3644 e-mail: n.ward@agma.gov.uk
8. **SPECIALISED OESOPHAGO-GASTRIC & UROLOGY CANCER SURGERY SERVICE TRANSFORMATION UPDATE** - attached

Presentation of Leila Williams, Director, Greater Manchester Service Transformation.

9. **DATES OF FUTURE MEETINGS**

10:00am, Wednesday, 9 December 2015
Scrutiny Room, Manchester Town Hall
<table>
<thead>
<tr>
<th>Minute Item No. / Agenda Item No.</th>
<th>Nature of Interest</th>
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MINUTES OF THE ANNUAL MEETING OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE HELD ON 24 JUNE 2015 AT TRAFFORD TOWN HALL

Present:

Bury Council  Councillor Sarah Kerrison
Derbyshire CC  Councillor Caitlin Bisknell
Oldham Council  Councillor Brian Ames
Rochdale Council  Councillor Sara Rowbotham
Salford CC  Councillor Margaret Morris
Stockport MBC  Councillor Tom McGee
Tameside MBC  Councillor Claire Reynolds
Trafford MBC  Councillor Patricia Young
Wigan Council  Councillor John O’Brien

Advisors/Officers:

Salford Royal NHS FT  Prof Chris Brookes  (ref HSC/15/09)
GM NHS  Leila Williams
NHS England/GM  Jessica Williams
GM NHS  Jonathan Mason
The Christie NHS FT  Jackie Bird
The Christie NHS FT  Marie Hosey
Nwas  Daniel Smith
NWAS  Patrick McFadden
ANNUAL MEETING

HSC/15/01 APOLOGIES
Councillor Glyn Evans, Councillor Champak Mistry and Steven Pleasant

HSC/15/02 APPOINTMENT OF CHAIR

RESOLVED/-
That Councillor John O’Brien is appointed as Chair for 2015/16.

HSC/15/03 APPOINTMENT OF VICE CHAIR

RESOLVED/-
That Councillor Tom McGee is appointed as Vice Chair for 2015/16.

HSC/15/04 DECLARATION OF INTEREST

None declared.

HSC/15/05 MEMBERSHIP 2015-16

RESOLVED/-
To note the membership of the GM Joint Health Scrutiny Committee for 2015/16.

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<th>District</th>
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<th>Substitute Member</th>
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<tr>
<td>Bolton Council</td>
<td>Councillor Champak Mistry</td>
<td>Councillor Carol Burrows</td>
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<td>Bury Council</td>
<td>Councillor Sarah Kerrison</td>
<td>Councillor Joan Grimshaw</td>
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<td>Derbyshire CC</td>
<td>Councillor Caitlin Bisknell</td>
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<td>Councillor Angela Bruer-Morris</td>
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<td>Wigan Council</td>
<td>Councillor John O’Brien</td>
<td>Councillor Nigel Ash</td>
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MINUTES OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE HELD ON 24 JUNE 2015 AT TRAFFORD TOWN HALL

HSC/15/06 MINUTES OF THE MEETING HELD ON 11 MARCH 2015

RESOLVED-

To approve the Minutes of the meeting held on 11 March 2015 as a correct record.

HSC/15/07 THE CHRISTIE QUALITY STATEMENT

The Committee received a presentation from Jackie Bird, Director of Nursing and Quality and Marie Hosey, Head of Performance, The Christie NHS Foundation Trust providing an overview of the trust’s quality accounts for 2014/15.

Members were informed that the Trust has met the following three quality outcomes:

1. The development of an electronic business intelligence solution for sharing quality outcomes with patients and the public

2. The implementation of quality surveillance tools and delivery of focused quality improvements in:-
   i. 95% of patients with pain are comprehensively assessed by March 2015
   ii. A 10% reduction in Grade 2 hospital acquired pressure ulcers and maintenance of zero Grade 3 & 4 by March 2015
   iii. 95% of patients have a documented oral care assessment by March 2015

3. To publish patient outcome data for three cancer diagnoses; Breast, Upper Gastro-intestinal and Prostate.

The Committee welcomed the presentation and noted that the Trust served a population of 3.2m across Greater Manchester and Cheshire with 26% of patients being referred across the UK.

Comments were also made in regard to staffing levels, recruitment and training. Members were advised that there were no issues in this area with staff turnover being at just 10%.

In response to a query raised by a Member regarding complaints, the Committee was informed that these were received by the Trust at source by patient feedback.

RESOLVED-

That the GM Joint Health Scrutiny Committee welcomes the presentation and supports the work undertaken at The Christie NHS Foundation Trust.
HSC/15/08 NORTH WEST AMBULANCE SERVICE

The Committee considered a presentation from Daniel Smith, Consultant Paramedic and Patrick McFadden, Sector Manager, outlining service and performance standards of the North West Ambulance Service (NWAS).

A Member asked about support given to staff, in particular; help and sponsorship in obtaining paramedic qualifications. Daniel Smith responded by stating that applications for this qualification was gained through university application process and then placements to NWAS. That internally processes were in place for EMT2s (Emergency Medical Technicians) to again paramedic qualification within a one year conversion but that no clear pathways were currently available for EMT 1s to achieve this status.

A query was raised by a Member regarding a new pilot scheme; Community Risk Intervention Team (CRIT), led by GM Fire and Rescue (GMFRS). It was confirmed that this initiative is under the management of NWAS central as a preventative approach to help reduce demand of the three emergency services: GMFRS, NWAS and GMP(Greater Manchester Police) through three pilot areas across the conurbation.

A Member also commented on the current initiative of Cheshire Police and East Cheshire CCG whereby police constables and mental health nurses work side by side offering immediate response to situations that would benefit from the intervention of a mental health nurse, and asked if this scheme was being delivered at NWAS. It was reported that NWAS welcome this initiative with the view to developing a pilot scheme also, subject to funding and staffing availability.

RESOLVED-
To note the presentation.

HSC/15/09 HEALTHIER TOGETHER

The Committee received presentations from Leila Williams, Director of Service Transformation, Professor Chris Brookes, Executive Medical Director and Jessica Williams, Head of Transformation, Primary Care, on the Healthier Together programme overview and decision making progress.

Primary Care Progress

Members were informed that progress included:

- The launch of 6 Primary Care Demonstrator sites to test new models of care.
- The approval by the 12 CCGs of the GM Primary Care Strategy
• That Primary Care is at the heart of Healthier Together consultation including 4 Standards and representing statement of intent to GM public
• Successful Prime Minister’s Challenge Fund in Bury
• 2 further successful PMCF for City of Manchester and Wigan thereby securing investment of over £11m
• Establishment of Vanguard sites in Salford and Stockport
• The independent evaluation and published Demonstrator evaluation by National Institute for Health Research and Manchester University.

Observations/comments included:

In response to a query raised by a Member, it was noted that only some pharmacies were connected to the primary care systems and that programme work is ongoing to address this.

Future plans involved 7 day access hubs moving towards integrated specialist centres, delivering integrated health and care by end of September 2015. Plans also included same day access services for children by the end of 2016.

It was reported that an executive summary of the GM Demonstrator site evaluation was available and it was agreed that this would be circulated to Members for their information.

That the Primary Care Standards will be initially rolled out locally and then launched to a GM level.

It was noted that for the system to work more effectively information transfer and data management needed to be improved.

In-Hospital Programme

Professor Chris Brookes highlighted to the Committee proposals relating to in-hospital services and an overview of the Healthier Together Model of Care of a single service Accident & Emergency and Acute Medicine and general surgery.

The Committee noted that; as with proposals concerning provision of adult major trauma care, priorities of the programme was led by the ambition to guarantee quality care and save patients lives.

Observations/comments included:

That during the past three months the proposals had gained clarity and shape with a common theme to engage clinical leaders to achieve the best for GM residents.

That clear pathways need to be created within the programme in order to achieve repatriation of patients with focus on the interests of patients and families.

Noted that under the new proposals, the aim is that a patient should receive a senior clinical decision within 30 minutes as compared to the current time frame of up to 12 hours.
That under the proposals, every Accident and Emergency unit will have a consultant there 12 hours a day, increasing to 16 hours a day in the acute sector. In addition a senior consultant will always be available within the system.

**Joined Up Care Programme**

Leila Williams gave a presentation outlining the Joined Up Care programme and feedback received from the Healthier Together consultation and what actions had been taken.

Members were reminded that a number of key decisions have already been agreed:

1. Confirmation of the Case for Change (confirmed by the CiC on 21 January 2015);
2. Support for the proposed Model of Care (confirmed by the CiC on 21 January 2015);
3. Alternative options (on 21 January 2015 the CiC reconfirmed that only options with 4 or 5 specialist sites would be considered);
4. The criteria to be used to select options for implementation (agreed by the CiC on 18 February 2015).
5. 4 Single Services (confirmed by the CiC on 17 July 2015).

That the final decision remaining:

6. Which option should be implemented? That this decision is due to be confirmed at CiC on 15 July 2015.

The presentation also outlined specific asks from the Committee during the scrutiny process of Healthier Together and what actions had been taken to address these.

The Chair suggested that as the option decision would be taken on 15th July, that the provisional meeting on 22 July be cancelled and a report from the Healthier Together team be circulated electronically for Members consideration.

**RESOLVED**-

1. That the presentations be noted.
2. That Jessica Williams provides electronic copy of the summary evaluation of the GM Demonstrators to Julie Gaskell for circulation to Committee Members.
3. That Councillors McGee and Morris to explore what can be done to improve information sharing across the health system.
RESOLVED:-

1. That the provisional meeting date of 22 July 2015 is to be cancelled.

2. That the following meeting dates be noted:

   Wednesday, 23 September 2015 – Trafford Council, Trafford Town Hall.
   Wednesday, 14 October 2015 - venue tbc
   Wednesday, 9 December 2015 - venue tbc

   All meetings will commence at 10am.

Chair……………..
GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

Date: 14th October 2015

Subject: Greater Manchester Health and Social Care Devolution

Report of: Warren Heppolette, Strategic Director, Health and Social Care Reform

PURPOSE OF REPORT

The purpose of this report is to update the Greater Manchester Joint Health and Scrutiny Committee on work to date on the Greater Manchester Health and Social Care Devolution Programme.

RECOMMENDATIONS:

The GM Joint Health and Scrutiny Committee is asked to note the report.

CONTACT OFFICER:

Warren Heppolette
Strategic Director, Health and Social Care Reform

warrenheppolette@nhs.net
1. **Introduction**

1.1 The purpose of this paper is to update the GM Joint Health and Scrutiny Committee (JHSC) on the work to date on the Greater Manchester (GM) Health and Social Care Devolution Programme.

2. **Background and context**

2.1 The Greater Manchester Devolution Agreement, settled with Government in November 2014, created the platform for greater freedoms and flexibilities in GM. The Agreement proposed the devolution of powers to Greater Manchester (GM) including transport, planning and housing. Some of those powers can be exercised now, some require new legislation.

2.2 Following the Agreement, NHS England invited the GMCA, GM’s Clinical Commissioning Groups and NHS Trusts and Foundation Trusts to develop a plan for further joined up and integrated health and social care. The NHS Five Year Forward View, published in late 2014 articulated why changes to the way health and social care services are delivered are needed urgently. It described various models of care that could be provided in the future and the actions required at local and national level to support delivery.

2.3 In February 2015, the 10 AGMA Local Authorities, 12 Clinical Commissioning Groups, and NHS England entered into a formal Memorandum of Understanding (MoU) that committed the parties to develop a broad framework that would see all health and social care funding devolved and or delegated to GM. In addition to the parties identified, the MoU was supported by the 15 NHS Trusts and Foundation Trusts that are located across GM.

2.4 The primary objectives that underpin the MoU are:

- Improving the health and well-being of all of the residents of Greater Manchester from early age to elderly, recognising that this will only be achieved with a focus on the prevention of ill health and the promotion of well-being.
- Moving from having some of the worst health outcomes to having some of the best.
- Closing the health inequalities gap within GM and between GM and the rest of the UK faster.

2.5 There are a number of key principles:

- GM will remain firmly within the NHS and social care system, uphold the standards set out in national guidance and continue to meet statutory duties including those of the NHS Constitution and Mandate and those that underpin the delivery of social care and public health services.
- Decisions will be focused on the interests and outcomes of patients and people in GM and organisations will collaborate to prioritise those interests.
- Decision making will be underpinned by transparency and the open sharing of information.
- There will be a principle that ‘all decisions about GM will be taken with GM’ subject to the national statutory framework from 1st April 2015.
GM will work collaboratively with local non GM bodies and take into account the impact of GM decisions on non GM bodies and their communities.

3. **Greater Manchester Health and Social Care Devolution Programme**

3.1 In order to deliver the objectives of the MoU, a GM Health and Social Care Devolution programme was established. The programme will be completed by April 2016, when health and social care funding is devolved / delegated to GM.

3.2 The programme, which is being overseen by a Programme Board chaired by Sir Howard Bernstein and Simon Stevens (Chief Executive NHS England), has been split into the following key work streams:
   - Strategic plan (for clinical and financial sustainability);
   - Establishing leadership, governance and accountability;
   - Devolving responsibilities and resources;
   - Partnerships, engagement and communications;
   - Early implementation priorities.

3.3 Due to the scale of the programme that is being delivered, each of the work streams identified above has a number of discreet work packages.

4. **Strategic Plan**

4.1 The development of a GM Strategic Plan is underway and will be complete by December 2015. A Strategic Plan Leadership Group comprising of representatives from across health and social care meets monthly to oversee the delivery of a cohesive strategic plan owned by the health and social care system.

4.2 The GM Strategic Plan will describe a population health based model of care for the people of GM and will be built from 10 locality place-based plans (the Local Authority footprints), existing and emerging GM-wide work and strategies, a number of GM level transformation initiatives and a set of key enabling work packages.

4.3 The bulk of the content in the strategic plan will be informed by the 10 locality plans developed by health and social care stakeholders in each of the GM districts. Each locality has identified a Senior Responsible Officer (SRO) who is responsible for overseeing the delivery of each locality plan and engaging with local stakeholders. The ten SROs meet on a weekly basis with support from the Programme team to ensure timely delivery. The ambition to integrate health and social care across GM has developed significantly over the last couple of months, with a combined intent to pool £2.7bn of health and social care funding across GM to improve outcomes for the population of GM.

4.4 A number of additional work streams are progressing strategies which will feed into the overall GM strategy. These are:
   - Mental Health (including Learning Disabilities, CAMHS, dementia and mental health and work)
   - Primary and social care transformation
   - Early Intervention and Prevention
• Public Service Reform
• Asset based change
• The role of the acute sector.

4.5 GM intends to commission and develop four or five GM wide transformation programmes to inform the development of the GM Strategic Plan and expressions of interest have been received from the health and social care system to develop transformation initiatives in the following areas:
• Standardisation at scale
• Integrated care coordination and commissioning
• Payment innovation to align incentives
• Place-based approach to health and social care estate.

Successful expressions of interest will be worked up into full business cases and pursued as pilots with the potential to scale up initiatives at a GM level.

4.6 There are a number of enabling work streams that will facilitate the delivery of the GM Strategic Plan and the 10 Locality Plans:
• Public Estate
• IM&T
• Workforce and Organisational Development
• Shared Services
• Contracting and procurement

4.7 The GM Strategic Plan will be supported by a Strategic Financial Framework (StFF). The first iteration at a GM level of this has been completed and informed the GM health and social care submission to the Comprehensive Spending Review (CSR) process. The StFF continues to be developed to inform the GM Strategic Plan and the 10 Locality plans and this work continues to progress at pace with the support of the GM Finance Working Group.

4.8 The GM Devolution Programme Team will work with Locality SROs to ensure that the GM Strategic Plan is aligned to the 10 Locality plans and delivers the objectives described within the CSR submission.

5. Leadership, Governance and Accountability

5.1 Shadow governance arrangements went live on 1st October following agreement by the GM Standing Conference. The GM Standing Conference membership is drawn from all GM organisations. A Strategic Partnership Board with representatives from the 37 health and social care organisations in GM will be convened quarterly, with a smaller Executive meeting monthly. A Joint Commissioning Board is also in the process of being established.

5.2 The 15 NHS trusts in GM have formed a Provider Federation to aid collaborative working. This is the first of its kind in the country.

5.3 Discussions with national Arms-Length regulatory Bodies (ALBs) to determine their relationship with a devolved GM health and social care system are ongoing. Parties involved to date include Monitor, the TDA, CQC, NICE, Health
Education England (HEE), Public Health England (PHE) and NHS England (NHSE).

5.4 An MoU has been signed between GM, PHE and NHSE and an MoU with HEE is in development.

5.5 The Cities and Devolution Bill has been published and further consideration is being given on how the Bill interacts with the NHS.

6. Devolving Responsibilities and Resources

6.1 A Chief Finance Officer (CFO) and deputy CFO have been appointed to oversee this work stream. They are supported by Council Treasurers, CCG CFOs and NHS Provider Finance Directors to draw on expertise across the system.

6.2 To date, focus has been on completing the programme’s submission to the CSR process and baseline modelling to identify a health and social care financial gap of £2bn. Further work is now underway to model in more detail at locality level. This dovetails with the development of the GM Strategic Plan and the 10 Locality Plans.

6.3 This work stream also includes oversight of the devolution of primary care and specialised services and a number of enablers, including IM&T, estates, contracting and procurement and support services.

7. Partnerships, Communications and Engagement

7.1 A Communications and Engagement Working Group has been established which includes representatives from local authorities, providers, CCGs, Healthwatch and the third sector. The group has produced a number of resources for GM staff and the public, including an engagement toolkit.

7.2 The GM health and social care devolution website is regularly updated and a resource area is developing at pace. A monthly E-bulletin is uploaded to the website and circulated to a growing mailing list. There is a strong Twitter presence which the public have started to engage with.

7.3 The Health and Social Care Devolution Programme continues to receive a significant amount of press coverage, both locally and nationally. Most recently this has focused on the announcement of the shadow governance arrangements and the launch of Health Innovation Manchester. Press enquiries are managed through a dedicated team of press officers who liaise with relevant individuals.

7.4 Proposals for engagement with the public are being finalised to enable wide-reaching conversations with the public to begin as soon as possible. This will be aligned to engagement activities planned by the wider GM Devolution programme.
8. **Early Implementation Priorities**

8.1 In order to demonstrate and test how the emerging GM governance would operate and the ability of the GM health and social care system to deliver system-level change, a number of early implementation priorities to be delivered during the build-up year were agreed by the GM Health and Social Care Programme Board in May.

8.2 **Primary care 7 day access** – The delivery of seven day access to Primary Care from December 2015 for everyone living in Greater Manchester who needs medical help was launched at the GM Primary Care Summit in June. This is one of the Healthier Together standards. The GM 7 day access plans received positive press coverage at NHS Expo in September.

8.3 **Public health MoU** – An MoU between Public Health England, NHS England and GM was signed in July at the first meeting of the GM Public Health Prevention and Early Implementation Board. Wendy Meredith has been appointed as the GM Director of Population Health Transformation to oversee the public health aspects of the devolution programme.

8.4 **Healthier Together decision** – the Healthier Together Committee in Common has made the decision regarding the geography of the four single services. Further work is being undertaken with stakeholders to aid the transition into the implementation phase.

8.5 **Academic Health Science System** – Leading healthcare research, academia and industry organisations in GM launched the Health Innovation Manchester Partnership at the NHS Expo on 2nd September 2015. Health Innovation will aim to speed up the discovery, development and delivery of innovative solutions to help improve the health of the people in Greater Manchester, and beyond. It will build on the existing expertise and assets in the area and harness the partner organisations’ collective expertise to develop the infrastructure needed for clinical trials and health informatics.

8.6 **Dementia pilot** – A GM dementia stakeholder group has been established to define the early implementation work, which will include: the development of a GM dashboard of key metrics which will be supported by case study materials, improvement advice and social movement resources to help reduce variation across localities. Building on this work will be a 5 year GM programme, to be launched in March 2016, which will improve the lived experience to people with dementia and their carers and reducing health and social care spend.

8.7 **Workforce policy alignment** – This will support delivery of the workforce agenda and work continues to develop an infrastructure to enable HR/workforce activities to be co-ordinated with key stakeholders and partners. This project aims to deliver by December an agreement across providers to:

- adopt common standards for
  - Pre-employment checks
  - Statutory and Mandatory training
- Agree common rates for specific targeted locum and agency staff.
8.8 Mental health and work – An announcement will be made on impacts on mental health improvement arising from the Working Well pilot and a new integrated delivery model for supporting unemployed residents with a mental health-related barrier to work by November 2015.

8.9 CAMHS – the inaugural CAMHS Board met for the first time in September. It is responsible for the development of a GM strategy that will provide vision and ambition for the locality responses to Future in Mind. The Board will also have a role in supporting localities in developing their CAMHS transformation plans. There will be some specialist areas that will also sit at the GM level. The Board will need to build the evidence behind these and gain agreement.

8.10 Learning Disability Fast Track – a GM LD Fast Track bid for an additional £4.1m to support the work in GM has been submitted to NHS England. This will be matched locally and will also have contributions from Lancashire for the Calderstones element of the programme.

9 Links to the wider GM Devolution programme
9.1 The GM health and social care devolution programme has looked to ensure it is aligned to the work of the wider GM Devolution programme, as the leaders of health and social care are well aware of the impact this programme will have on the wider determinants of health. The system leadership understands that health has a key role to play in the economic growth of this city and is keen to ensure the strategic direction is aligned.

9.2 There are a number of ways this is happening:
• CSR submission alignment
• Collaborative working between the health and social care team and the PSR team including some staff seconded.
• Regular updates to the Informal leaders and WLT

10. Recommendations
10.1 The GM Joint Health and Scrutiny Committee is asked to note the report.

Warren Heppolette
14th October 2015
PURPOSE OF REPORT:

• The purpose of the presentation is to provide an update on the Heathier Together Programme and overview of the next steps of the programme.

RECOMMENDATIONS:

• It is recommended that Committee Members note the content of the presentation.

CONTACT OFFICERS:

• Leila Williams, Director, Tel: 0161 625 7791 , Email: leila.williams1@nhs.net
• Jonathan Mason, Senior Project Manager, Tel: 0161 625 7142 , Email: jonathan.mason2@nhs.net
Healthier Together Programme Update

Leila Williams
Greater Manchester Service Transformation

14th October 2015

High Quality • Safe • Accessible • Sustainable
Healthier Together is a clinically led programme with 3 elements:

Transforming Primary care
- 7 day access to primary care
- Reduce unwarranted variation to improve health outcomes

Joined up care
- The NHS and councils working together to provide a better service
- 50,000 more people treated in their local community instead of hospital

Hospitals working together as part of single services
- A&E, Acute Medicine and General surgery (abdominal surgery)
- Patients will be seen quicker by a senior doctor
- Up to 300 fewer deaths each year
- At least 35 additional consultants
Our vision
For Greater Manchester to have the best health and care in the country

No hospital in GM currently meets all of the GM Quality and Safety Standards

Up to 300 lives could be saved in GM every year if we achieve the standards of the best hospital nationally
None of our hospitals can achieve the standards on their own so...

“Single services” will be formed - networks of linked hospitals working in partnership to deliver the A&E, Acute Medical and General Surgery standards for all patients.

This means care will be provided by a team of medical staff who will work together across a number of hospital sites within the single service.
What will this mean?

Standards at all 10 hospitals will be improved:
• Consultant present in every A&E at least 12 hours a day 7 days a week
• Consultant present in every Acute Medical Ward 12 hours a day 7 days a week
• Daily clinics at every site for assessment of patients with an urgent general surgical problem

One hospital in each single service will specialise in general surgery for patients with life threatening conditions
• A&E consultant present in A&E at least 16 hours a day 7 days a week
• Consultant surgeons and consultant anaesthetists available to perform emergency operations 24-hours per day
• A consultant surgeon and consultant anaesthetist present for all operations on patients with life threatening conditions
Under Healthier Together proposals all Hospitals will retain their specialisms

Royal Bolton Hospital
- Specialist care for women and new born babies
- Bowel screening
- Breast screening

Fairfield General Hospital
- Stroke services
- Cardiology (heart) care

North Manchester General Hospital
- Infections diseases
- Joined up Health and Social Care Services

Rochdale Infirmary
- Dementia care

Royal Albert Edward Infirmary
- Orthopaedics
- Breast screening

Salford Royal Hospital
- Major Trauma
- Stroke services
- Emergency medicine and Specialist abdominal surgery*

Ashton Leigh & Wigan

Bolton

Bury

Salford

Central Manchester

Oldham

Trafford

South

Tameside & Glossop

Stepping Hill Hospital
- Stroke services
- Trauma and Orthopaedics

University Hospital of South Manchester
- Cardiovascular (heart) services
- Respiratory (lung) services
- Burns care & plastic surgery

TRAFFORD HOSPITAL
- Planned orthopaedic surgery
- Complex rehabilitation

Manchester Royal Infirmary
- Cardiac (heart) care
- Vascular (veins and arteries) Surgery
- Emergency medicine and Specialist abdominal surgery*

Tameside Hospital
- Joined up Health and Social Care Services

Examples of Specialist Services provided at Greater Manchester Hospitals

*In the future
What information was used to select the preferred option?

Criteria

Quality & Safety

Travel & Access

Transition

Affordability & Value for Money

Other information:

Public consultation feedback

Integrated Impact Assessment

All information is contained in the Healthier Together Decision Making Management Report

9.0 Hospital: Options appraisal overview

9.1 Introduction

This section describes the options appraisal that was completed pre-consultation; the options that were presented during consultation; the analysis of the consultation; the feedback received from the public consultation about the options; how this has been assessed; how this has informed the Healthier Together options; and the options that were considered during the decision making options appraisal.

9.2 What is an option?

The Healthier Together model of care proposes that single services will be formed. Single services are reiterations of inpatient hospital working in partnerships deliver better care for patients and are developed with the consultation process. The options within the single services model develop single sites to provide a full suite of services that currently exist. They will be a single service combination of inpatient care and out-patient care. One hospital specialises in providing certain types of care - for example some hospital specialises in stroke care, others in cancer care. Hosting one of the hospitals within each of the single services will specialise in general surgery for patients with the appropriate speciality.

An "option" describes the location of the site that will specialise in general surgery for patients with the appropriate speciality and those that will not. For example, under option A, a central Manchester Foundation Trust, St. Mary's Foundation Trust, Royal Manchester hospital, Royal Albert Edward hospital (Wigan) and Wythenshawe Hospital (Manchester) will specialise in general surgery for patients with the appropriate speciality.

Under the options, there are different "single service configurations." A single service configuration describes how the development of individual hospital sites will work in partnership to deliver the core services. For example, option 1 is three single service configurations, this is shown below.
Decision 6: Which option should be implemented?

All 12 CIC members agreed unanimously that **Stepping Hill, Stockport** will be the fourth hospital in Greater Manchester to provide emergency medicine and specialist abdominal surgery as part of a single service.
Agreed option: 4.4a

North West Shared Single Service Site for Specialist General Surgery

North East Shared Single Service Site for Specialist General Surgery

Manchester South & Central Shared Single Service Site for Specialist General Surgery

South East Shared Single Service Site for Specialist General Surgery
| Condition 1 | Regular data collection, review and monitoring is implemented |
| Condition 2 | Structured process of peer review across GM |
| Condition 3 | Establishment of a Greater Manchester Clinical Alliance |
| Condition 4 | Joint appointments to Single Services |
| Condition 5 | Appointment of GM clinical leadership for implementation |
| Condition 6 | Formation of Single Service Research Hubs |
| Condition 7 | Development of a GM governance framework |
| Condition 8 | Formation of a CCG and Regulatory Body Alliance to support implementation |
Next steps – timelines

• **September – December**: Pre Implementation
  – Potential Legal Challenge
  – CCG workshops
  – Directors of Strategy / Programme Board Sept, Oct, Nov
  – Sign off of approach – Nov / Dec CIC

• **January 2016**: Implementation start
What is already agreed?
Sequential implementation

- Go-live of single services will be sequential to manage clinical risk
- This means that patients will be moved one single service at a time

<table>
<thead>
<tr>
<th>Approach</th>
<th>Indicative timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blended approach (recommended)</td>
<td>2-3 Years</td>
</tr>
<tr>
<td>Single Service 1</td>
<td></td>
</tr>
<tr>
<td>Single Service 2</td>
<td></td>
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<td>Single Service 3</td>
<td></td>
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<tr>
<td>Single Service 4</td>
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</tbody>
</table>

Lessons can be learned
Time for recruitment and capital build if required
Quicker to implement than sequential approach
DRAFT Implementation Governance

GM CCGs Committees in Common/Joint Committee

HT Programme Board

GM Clinical Alliance
GM HR and Workforce Group
GM Finance and Investment Group
GM Patient Panels
GM Equality Groups

Primary and Jointed Up care Programmes

Programme Commissioning
Programme Partner
Scrutiny and Oversight

AGG
AGMA
GM OSC

Single Service Governance

Thank You - Questions
PURPOSE OF REPORT

To report on the involvement of the Joint Health Scrutiny Committee on the Healthier Together Programme including their investigations, recommendations and outcomes of their review.

RECOMMENDATIONS:

Members of the Committee are invited to note the contents of the report, and provide additional comments as appropriate.

CONTACT OFFICERS:

Contact Officer: Tim Griffiths
Tim.griffiths@agma.gov.uk

BACKGROUND DOCUMENTS

Previous Joint Health Scrutiny Committee agendas and reports
1. CHAIR’S INTRODUCTION

1.1 Many people have worked hard to deliver the idea of improving patient care, provided at the right place and at the right time within the resources available. It is believed that the proposals brought under the Healthier Together initiative will save many lives and improve the quality of considerably. This initiative will only work if all parties are in agreement to move forward with the aim of providing a better healthcare model which works for the vast majority rather than looking at change in isolation.

1.2 The process of change is always difficult no matter how reasoned the argument to do so. The NHS by virtue of its nature, a large organisation, requires much care and consultation for any remodelling and Healthier Together was a classic example. As note at 7.8, comments, ensuring the correct information rather than misinformation is conveyed is very important. There were many times when it was obvious that some sectors in promoting their own cases via the media led to the public believing their local services would suffer from this change. Frankly this behaviour that was not acceptable as it leads to unnecessary worry and stress for patients and staff and could have been avoided.

1.3 In addition, I would like to thank the officers who have offered detailed reports, the panel who have made a much valued input, and the members who have served on the committee. It is through their hard work and collective contribution that we have had an effective scrutiny process.

2. BACKGROUND

2.1 Since 2002 a health scrutiny panel has focussed on ensuring that providers meet the health needs of the people of Greater Manchester. From 2014 this role has been undertaken by the Joint Health Scrutiny Committee (JHSC). This committee was formally established to respond to the reconfiguration proposals for primary and acute healthcare in Greater Manchester through the Healthier Together (HT) consultation. Having being involved since the programmes initial case for change Members of the panel, and then the JHSC, have been able to offer challenge and scrutiny at each key milestone point and became key stakeholders as the programme developed.

3. CONTEXT

3.1 The Healthier Together ‘case for change’ identified that the health economy in Greater Manchester faced a significant financial challenge by the end of 2018. The ‘case for change’ also identified that the that there were too many variations in the quality of care in Greater Manchester – particularly within hospital emergency care but importantly also within primary care.

3.2 Consequently, Healthier Together was designed to review health provision to:

- Ensure that each hospital in GM meets all the national quality standards

1 Healthier Together, Case for Change 2012
• Meet the increasing demand on NHS services
• Make better use of healthcare resources
• Help Greater Manchester provide the best health and care to all its residents.

3.3 The Healthier Together project is led by the 12 Clinical Commissioning Groups (CCGs) in Greater Manchester, that from April 2013 replaced the 10 former Primary Care Trusts. The work undertaken in relation to Healthier Together is undertaken by a Service Transformation team that is accountable to the CCGs.

3.4 The Healthier Together proposals were formulated after a period of engagement and consultation which began in 2012, and involved the JHSC in preparing consultation plans, proposed models of care, and governance arrangements.

4. VISION
4.1 The vision behind the programme is to:

• Improve the health and wellbeing of people in Greater Manchester
• Improve the equality of access to high quality care
• Improve people’s experience of health care services
• Makes better use of healthcare resources.
• Increase the rate of survival following critical care intervention.

4.2 The Healthier Together programme specifically focused on reviewing three key element: Transforming Primary Care; Joined Up Care; and, In-Hospital Services.

4.3 Its task was to develop a clinically and professionally led strategy that puts forwards options for new ways of providing health care services in Greater Manchester.

4.4 Members of the health scrutiny panel expressed their support for the main aim of the Healthier Together programme which was to provide ‘best care’ for everyone in Greater Manchester and were committed to ensuring that they provided effective scrutiny for the programme going forward.

5. STATUTORY REQUIREMENTS, COMPOSITION AND PROCEDURAL ARRANGEMENTS FOR THE JOINT COMMITTEE
5.1 The Greater Manchester Health Scrutiny Panel was established in 2002 as a response to the Health and Social Care Act 2001; which conferred that Local Authorities Scrutiny Committees have the function of reviewing and scrutinising matters relating to the health service in their area and making reports and recommendations to local NHS bodies on these matters.

5.2 The Act also refers to the need for joint scrutiny arrangements in some instances because some NHS bodies cover geographical areas that are not co-terminus with local authority boundaries.
5.3 The GM Health Scrutiny Panel objectives were:

- To undertake the necessary function of health scrutiny in accordance with Section 7 of the Health and Social Care Act 2001 relating to reviewing and scrutinising health services matters where these are at a Greater Manchester level.
- To ensure the needs of local people are considered as an integral part of the delivery and development of health services and contribute to the reduction of health inequalities by ensuring that services are accessible to all local people.
- To review proposals for consideration or items relating to proposed substantial developments across Greater Manchester.
- To keep abreast of organisational changes and key policy implementation within the NHS.

5.4 The panel was given delegated powers from the 10 Authorities of Greater Manchester. In addition, neighbouring authorities can attend meetings if they wish, as many of the sub-regional issues the Panel considers can have wider implications for neighbouring districts.

5.5 The GM Health Scrutiny Panel met on a regular basis and can make recommendations to any NHS partner organisation, or to Joint GMCA/AGMA Executive Board.

5.6 In June 2014 the panel was re-constituted under a Joint Health Scrutiny Committee for the purposes of the Healthier Together consultation and the Terms of Reference refreshed. The reviewed arrangements took into account the extended role of Health Scrutiny as detailed in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (“the Local Health Scrutiny Regulations”).

Composition of the Joint Health Scrutiny Committee

5.7 The Committee was made up of ten GM Local Authority representatives, and representation from Derbyshire CC. Across the review, the following members were elected and served on the Committee:

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Health Scrutiny Panel 2013/14</th>
<th>JHSC 2014/15</th>
<th>JHSC 2015/16</th>
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<tbody>
<tr>
<td>Bolton Council</td>
<td>M Donaghy</td>
<td>A Ibrahim</td>
<td>C Mistry</td>
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<td>Bury Council</td>
<td>P Bury</td>
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<td>S Kerrison</td>
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<tr>
<td>Derbyshire CC</td>
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<td>C Bisknell</td>
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<td>Manchester CC</td>
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<td>L Robinson</td>
<td>L Robinson</td>
<td>S Rowbotham</td>
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<tr>
<td>Salford CC</td>
<td>V Burgoyne</td>
<td>M Morris</td>
<td>M Morris</td>
</tr>
<tr>
<td>Stockport MBC</td>
<td>J Somekh</td>
<td>T McGee</td>
<td>T McGee</td>
</tr>
<tr>
<td>Tameside MBC</td>
<td>J Sullivan</td>
<td>C Reynolds</td>
<td>C Reynolds</td>
</tr>
<tr>
<td>Trafford Council</td>
<td>J Lamb</td>
<td>P Young</td>
<td>P Young</td>
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</tbody>
</table>
5.8 In June 2014, the JHSC held its Annual General Meeting electing a Chair and Vice Chair. Each meeting across the Healthier Together review was chaired by Councillor John O’Brien.

5.9 Clear lines of communication were established between all partners and a commitment to providing any information for scrutiny was sought from the NHS.

5.10 Derbyshire County Council were invited to elect a member to the JHSC for the period of the Healthier Together consultation, as the programme could have an impact on residents within their local authority.

5.11 It was agreed that the JHSC would be formally constituted for a limited time period, ending when the NHS formally reports its decision on the consultation outcome. Once this task was completed, the Committee would revert back to their original arrangements and terms of reference.

5.12 Over the course of the review the Scrutiny Committee met 18 times, and through the formal consultation period they met four times, all of the meetings were held in public.

Scope and Methods of Investigation

5.13 The Health Scrutiny Panel began its review of the Healthier Together Programme in its initial conceptual stages under the project title Safe and Sustainable. During these stages members were privy to the early engagement activity, the development of a case for change and the proposals for new governance structures within the delivery team.

5.14 Throughout 2014 the committee were able to offer detailed scrutiny on all the preparatory work prior to the decision by the Committees in Common (CiC) of the GM Association of GM Clinical Commissioning Groups (CCGs) to move or not to formal public consultation. The first two meetings focussed on developing members’ understanding of the HT proposals to enable members to comment on the developing consultation documentation and to identify which areas they would like to scrutinise. Members agreed a work programme which was reviewed at each meeting, this detailed where their attention would be focussed at each stage of the review.

5.15 In April the Panel received presentations giving an overview on the Healthier Together Pre Consultation Business Case (PCBC) and Options Appraisal Process. It was advised that the PCBC was made up of two parts; Part 1 an outline of which was given at the meeting and Part 2, which would provide the technical and analytical analysis to support the final decision to proceed, details of which to be published at a later date. Members also considered extensive communications and engagement to be implemented should the decision be made to move to a formal public consultation. The Panel commented on the process for the development of proposed options for the consultation and next steps.
5.16 At its meeting in June 14, the Panel continued to scrutinise the Healthier Together programme. It received additional updates on the programme, which included the suggested communications and marketing strategy, and gave comments on a draft version of a proposed consultation document.

5.17 The JHSC held meetings in July, August and September to consider the following agenda items during the consultation period:

- The overall case for change and summary of the proposals
- Finance
- Workforce transformation
- Patient and carer transport
- Primary care.

5.18 On 2nd July 2014 the JHSC considered and approved a final draft "Healthcare in Greater Manchester is Changing" consultation document prior to further endorsement by the CiC of the CCGs and formal launch subject to NHS England approval. An overview of proposed strategy/marketing plans for consultation was also received together with an outline of the financial aspects and analysis of the Healthier Together Pre-Consultation Business Case. The JHSC requested further detail on community care, primary care services (access) and the potential for salaried GPs in Greater Manchester. The JHSC noted that Local Health Overview Scrutiny Committees needed to play a valuable role in holding partners to account in delivering the integrated models and improving primary care.

5.19 In August 2014 the JHSC received presentations on patient transport and workforce transformation in relation to the Healthier Together proposals. Transport for Greater Manchester (TfGM) outlined an assessment process and assembled data analysis on patient transport in relation to the proposals. The JHSC requested further analysis on peak period travel times and evenings; and asked that additional public events on transport to be undertaken during the Healthier Together consultation period.

5.20 At its meeting in September 2014 the JHSC considered further updates on the Healthier Together proposals and consultation. These included a presentation from Opinion Research Services (ORS) which provided background on the independent social research organisation and initial findings on the then current consultation results together with an update and overview on primary care reform.

5.21 On 8th October 2014 responses were received, and considered by the JHSC, from Healthwatch Bolton and Manchester City Council on the Healthier Together proposals. It was agreed at the meeting that further submissions from Healthwatch and local Scrutiny Committees would be circulated to Members of the GM Joint Health Scrutiny Committee for information, however, that these bodies would need to submit consultation responses direct to Healthier Together. The JHSC was also presented with a paper setting out the GM Joint Health Scrutiny Committee’s draft response to the NHS Healthier Together consultation, for discussion and additional comments.
5.22 At this meeting, a brief verbal overview was given to Members on details regarding the completion of the consultation and initial statistics. The JHSC was informed that next steps included full analysis of the consultation results. The CiC would meet to agree a staged decision making process based upon criteria, other models of care/options proposed, the number of specialised hospitals and identification of which sites would collaborate together.

5.23 Also at this meeting, a verbal presentation was received on the key aspects of the proposed single service model recommended for (Accident & Emergency, Acute Medicine and General Surgery) to achieve improved hospital standards. The JHSC reiterated its concern regarding the lack of clear messages and terminology used and suggested that a low cost leaflet explaining the basic principles of the proposals be produced.

5.24 On 26th November 2014, the JHSC was presented with the GM Joint Health Scrutiny Committee’s interim response to the NHS Healthier Together consultation which included clear statements on how proposals had been presented and understood. A final report to be submitted once the decision making process has been finalised.

5.25 Updated consultation information from Opinion Research Services (ORS) was also considered which outlined analysis on final awareness, response numbers, events and profiling. Feedback was also received from the Healthier Together CiC on transport analysis to be considered during the decision making phase.

5.26 A verbal report was also received which outlined the views of GM acute hospital on the Healthier Together proposals and consultation. The JHSC was informed that the GM Acute Chief Executives group were considering a "sector" approach. The JHSC expressed concerns that this joint working approach of certain hospitals collaborating and providing a single service, could be deemed as an alternative rather than complementary to Healthier Together and asked for a further update to be given at a future meeting.

5.27 During 2015 the Joint Health Scrutiny Committee looked at how the consultation data would be used to inform a decision making business case, and eventually be developed into the final reconfiguration proposals.

5.28 At their meeting in March 2015, the JHSC received a programme update on the Healthier Together initiative providing feedback on the consultation and how this will be considered during the decision making phase, together with an outlined plan to develop a Decision Making Business Case.

5.29 In June 2015, members were informed of progress which included the launch of 6 Primary Care Demonstrator sites to test the new models of care, proposals relating to in-hospital services and the In-Hospital Programme’s overview of the single service Accident & Emergency, Acute Medicine and General Surgery.

5.30 The CiC made its final decision on the final model of care on 15 July 2015, and outcomes of the programme were circulated to members of the JHSC via email.
6 OUTCOMES FROM SCRUTINY REVIEW

6.1 Throughout their scrutiny process members offered critique and challenge to many elements of the programme, this report details their key recommendations and the actions taken to address these points.

6.2 Transforming Primary Care

6.2.1 With regards to the Primary Care, scrutiny members requested that:

The Primary Care Strategy should focus on:

- Mental Health
- Patients with established conditions
- Patients with conditions they are unaware of
- Patients on the cusp of developing conditions
- Individuals who do not take up free analysis i.e. screening.

In response, the programme included the development of Primary Care Medical Standards which all 12 CCGs have signed up to, including: improving access, outcomes for mental health and learning difficulties patients, early diagnosis, outcomes for patients with long term conditions.

6.2.2 Workforce Planning needs to prioritise:

- The recruitment of GPs
- Training and support for GPs in order to meet the needs of patients (e.g. with hearing/learning difficulties)

In response, the programme included a series of visioning events, an extension of the workforce including new roles, working with Health Education England on new training initiatives and projects which looked at wider workforce initiatives e.g. use of pharmacists and enhanced roles.

6.2.3 Challenges of feasibility of access to patient records be addressed.

In response, the programme included the development of a best practice guide on allowing access to patient records, the 3 Prime Minister Challenge Fund Areas enhancing access to records for GPs and the implementation of a GM IT workstream and strategy.

6.3 Joining Up Healthcare

6.3.1 With regards to the Joined Up Care strand, scrutiny members requested the following.

6.3.2 Information on the system which backs up hospital improvements had not been presented clearly enough and should include some success stories of patients who had been transferred promptly to community settings.

In response, there were improved programme communications including a suite of new communications materials which had been thoroughly tested by the general public and the full embedding of Healthwatch across the programme governance.
6.3.3 The essential handling of funding and staff flows in the correct manner following any strategic re-investment from partners into joined up healthcare which could have the potential to de-stabilise hospitals.

In response, there has been close monitoring of investment into Joined Up Care (JUC) using the integrated care process metrics which have tested the changes of JUC pilots and proved a consistent tool for measuring the impacts.

6.4 In-Hospital Services

6.4.1 With regards to the In Hospital strand, scrutiny members requested the following.

6.4.2 A need to improve communications, specifically clarification of terminology and the use of general and specialism hospitals. To address public confusion in relation to “scope of changes” and to ensure that public confidence is addressed through addressing individual concerns about their local hospitals and communicating the benefits of the changes. Improvements in data management and information transfer also needed; as to avoid duplication both in relation to patient communication and diagnostic testing.

In response, the programme office were able to use a DMBC navigator to ensure a response was given to all enquiries. There were a suite of new communication materials introduced including improvements to the website which were all thoroughly tested by the general public. Clear guidelines were adhered to in order to ensure a universal use of terminology i.e. single services.

6.4.3 That Sharing Single Services should not extend beyond those in-scope services.

In response, this was ensured through a clear programme scope.

a) Further analysis of travel times, specifically the potential impact on relatives and carers, particular issues for residents of High Peak and general issues around peak travel times.

In response, the programme initiated a Travel Time Analysis piece of work which included the High Peak area and reviewed travel times throughout the day/night week/weekend.

6.4.4 Workforce planning with particular focus on the lack of emergency medicine consultants, shortfalls in nursing, practicalities of staff working across multiple sites and the impacts on the workforce through new models of care.

In response, workforce has remained a key priority for the programme and was a key factor in making the decision for four specialist sites. There has been a series of implementation plans and ongoing work by HR, Workforce Development and Clinical Groups.
7 CONCLUSIONS OF THE SCRUTINY REVIEW OF HEALTHIER TOGETHER

7.1 In September 2014 the Joint Health Scrutiny Committee submitted their formal response to the Healthier Together Consultation. Its initial comments included their review of each of the thematic strands and offered additional general comments on the consultation and programme as a whole.

Transforming Primary Care

7.2 The JHSC concluded that improvements to the overall health and social care system rest upon improvements in primary care, improved standards and improved access to services. More patients need to be supported to live independently and to avoid unnecessary hospital admissions. Members of the JHSC agreed with the standards for Primary Care as set out in the consultation document\(^2\).

Joining up healthcare

7.3 The JHSC broadly agreed with the need for a joined up health care system, however, they identified risks around the wider reform agenda relating to the potential de-stabilising of hospitals following partner re-investment. Members felt it was essential that funding and investment were handled in a rigorous manner.

In-hospital services

7.4 The JHSC received a presentation on NHS finance which evidenced how the in-hospital proposals are based upon improvements in quality and patient safety and not about making savings. Members recognised that following the completion of the programme all GM Trusts would remain in financial deficit and that any savings made through the re-configuring services would be relatively small in the context of the overall financial challenge.

7.5 The JHSC was unable to comment in detail about the single service and the proposal for staff to work in teams across Specialist and local General hospitals as these had yet to be determined.

7.6 Members recognised that patient transport featured as an issue at public engagement events and were broadly satisfied that concerns were addressed and that the proposed options met the standards that had been identified. However, the JHSC suggested further analysis was required, particularly in relation to peak travel times.

Overall conclusions

7.7 Members of the Joint Health Scrutiny Committee were broadly supportive of the consultation which had been carried out regarding Healthier Together, particularly given the complexity of the consultation.

7.8 Having attended consultation events and discussed the HT proposals with partners the JHSC wished to note its concerns about how the programme was received by the public. The JHSC were adamant during their involvement in the scrutiny of the programme that there would be no Accident and Emergency...

\(^2\) Consultation document – appendix 3
closures, or downgrading of services within departments as a result of the proposals, however members felt that this was not well understood at some public meetings or within the media. The JHSC requested that there is a strong partnership between CCG commissioners and NHS acute trusts in the future to ensure that misinformation is kept to a minimum.

7.9 Throughout their review, members identified some of the further misunderstandings on the nature of the consultation and commented how although it was important to describe the wider narrative, the consultation document (which included information on primary care, joined up services and in hospital services) was confusing to residents. The JHSC felt that the statutory consultation should have focussed solely on in-hospital changes, specifically single service model and the development of General and Specialist hospital sites.

7.10 Members felt that partners should have been able to demonstrate with more clarity the purpose and remit of HT in order to reduce misunderstandings amongst staff and members of the public. The Committee were also concerned about how their involvement in the process and how their comments and views were reported through the media.

7.11 The JHSC recognised the interdependencies of primary care, integrated care and hospital reform and supported the increased appetite from partners to look at governance models which supported the whole system rather than seeing each element in isolation.

7.12 In their initial consultation response, members of the JHSC reiterated that the analysis of the consultation should not be based on numbers of responses, but that this should be one factor in determining the best option for Greater Manchester.

7.13 The JHSC agreed that changes to healthcare systems in Greater Manchester are urgently needed, and recognises the joint principles agreed by AGMA and the CiC during 2013. ³

³ Greater Manchester Joint Health Scrutiny Committee – Submission to the NHS consultation on Healthier Together – 25.09.14
GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE

Date: 14/10/2015

Subject: Specialised OG & Urology Cancer Surgery Service Transformation Update

Report of: Leila Williams, Director. Greater Manchester Service Transformation

PURPOSE OF REPORT:

• The purpose of the presentation is to provide an overview of the Specialised OG & Urology Cancer Surgery Service Transformation Programme within Greater Manchester

RECOMMENDATIONS:

• It is recommended that Committee Members note the content of the presentation.

CONTACT OFFICERS:

• Leila Williams, Director, Tel: 0161 625 7791 , Email: leila.williams1@nhs.net
• Jonathan Mason, Senior Project Manager, Tel: 0161 625 7142 , Email: jonathan.mason2@nhs.net
Specialised OG & Urology Cancer Surgery Service Transformation Update

Leila Williams
Greater Manchester Service Transformation

14th October 2015
National Context:
Developing Strategic Scenarios for Specialised Services

The Five Year Forward View has set out a clear ambition to conduct 3-year rolling reviews of specialised services

- One of the aims of these reviews is to drive consolidation where the relationship between quality and volumes is strong
- Also need to achieve sustainable services that are fully compliant with national service specifications
- Service reviews will be undertaken at national; regional; and local level

As the service reviews get underway, the North region wants to establish an overarching vision to inform service design

Create a set of principles and criteria for the design of specialised services in the region

- Informed by national policy (e.g., Forward View) and local considerations (e.g., shared priorities across the three sub-regions and agreed with CCGs)

Develop potential strategic scenarios for service bundles by applying criteria, e.g.,

- Minimum catchment populations to generate appropriate activity
- Service and pathway interdependencies
- Patient experience

Discuss and prioritise scenarios with national and local stakeholders

Design implementation plans for selected scenarios and execute them
### National Context:

#### Design Principles: What are we trying to achieve?

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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<tbody>
<tr>
<td>Large number of services, managed individually, creating complexity</td>
<td>Clear 'bundling' to help simplify management and contracting</td>
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</tbody>
</table>

For many services, too many providers to meet minimum volumes / 7 day working  
- Some in breach of specifications

Limited data on activity and outcomes for each service delivered by each provider  
- Limited comparability

Momentum case contact renewal  
- With cost pressure

Ambiguity on who and how to engage on the changes required

Variation in access and outcomes across the region; driven by unplanned historical evolution of services

Consolidation or networked arrangements to ensure sufficient volumes and rotas  
- No service in breach

Path to measuring activity and outcomes for each service  
- Ability to compare across providers

Path to new contracting mechanisms - eg lead provider that accelerate the above

Strong case for change and engagement plan

Equitable service provision, responding to specific needs of the population
National Context:
8 Service Bundles

1. Cardio-Respiratory Care Bundle
2. Maternity & Children Care Bundle
3. Mental Health Care Bundle
4. Internal Medicine Care Bundle
5. Blood & Infection Care Bundle
6. Lower GI & Pelvis
7. Trauma, Neuro & Imaging
8. Cancer
Greater Manchester Devolution and Specialised Services

- As part of GM Devolution, there is a need to develop a strategy for GM Specialised Services
- Devolution provides us with the opportunity to shape and influence the content of each of the Bundles so that they fit with the GM landscape
- Collaborative work is now underway to between NHS England, Trafford CCG (Lead CCG commissioner for Cancer) and GM Service Transformation to develop the strategy and future arrangements for Specialised Commissioning.
Greater Manchester Context:
Specialised Services

- The initial immediate priority area agreed by the Association Governance Group (AGG) for system transformation is Cancer.

- The **two priority areas** for clinical service transformation are the two non-compliant service areas:
  - Oesophago-Gastric (Upper Gastro-intestinal) Cancer surgery, and:
  - Urology Cancer surgery.

- These services have **never achieved compliance** with the standards expressed in Improving Outcomes Guidance (IOG), as published in 2001 and 2002.
GM Transformation for Specialised Urology and OG Cancer Surgery

Aim:
“To develop and implement a robust transformation of OG & Urology cancer surgical services across Greater Manchester. In order to achieve world-class standards and outcomes”

It will be a **standards-based** and **co-designed** transformation process continually engaging with stakeholders and informed by:

1) Patient experience
2) World-class Clinical Practice
3) Operational Co-dependencies
Transformation Process

The proposed Urology and OG cancer surgery transformation process is similar to GM wide service transformations, such as Healthier Together

• It is enhanced by incorporating learning from the GM Healthier Together process, Major Trauma, Making it Better and other transformation programmes around the country

• Incorporates new thinking on future Commissioning and Provider Models
1. Why is change needed?

2. What does best care for patients look like?

3. A GM Clinical Cancer Summit

4. What does the current OG and Urology service look like?

5. Design new model of care

6. Engagement with Health Overview and Scrutiny

7. Public Discussion

8. Commissioning process and options appraisal - decision on best option for GM patients

The Transformation Process

Patient and Clinician Engagement

Governance and Assurance
Patient insight and experience

- Co-designed approach to develop a set of “world class” patient outcomes
- Working with local patients
- Demonstrating value, influence and impact

I am treated as a person, not a cancer condition
I have quick access to the services I need
I want to be treated in a service that has a great reputation

I am communicated with about different choices
I want to be given time for big decisions
I don’t mind travelling a little further for specialist treatment
Any Questions?