AGENDA

1. APOLOGIES

2. DECLARATIONS OF INTEREST - Attached
   To receive declarations of interest in any item for discussion at the meeting. A blank declaration of interest form has been circulated with the agenda. Please ensure that this is returned to the GMIST officer at the start of the meeting.

3. MINUTES OF THE MEETING HELD ON 26 NOVEMBER 2014 - Attached
   To approve as a correct record the Minutes of the meeting held on 26 November 2014.

4. MEMBERSHIP
   To note the appointment of Councillor Margaret Morris, replacing Councillor Val Burgoyne on the GM Joint Health Scrutiny Committee, with immediate effect.

5. HEALTHIER TOGETHER UPDATE - Attached
   Report to be presented by Leila Williams, Director of Service Transformation.

6. TRAUMA – SPECIALISED COMMISSIONING UPDATE – To follow
   Report to be presented by Dr Chris Brookes, Executive Medical Director, Salford Royal NHS Foundation Trust.

   The Chair has agreed, under paragraph 11.2 , schedule 3, paragraph 4 (vi) of the AGMA constitution, to this report being submitted as a late item. This is to enable the report to contain the most update information necessary to aid discussions.

7. DATES OF FUTURE MEETINGS
   Wednesday, 24 June 2015 – venue tbc
   Wednesday, 14 October 2015 - venue tbc
   Wednesday, 9 December 2015 - venue tbc
   All meetings will commence at 10am.
Contact Officer: Julie Gaskell
Tel: 0161 234 4264 / Email: j.gaskell@agma.gov.uk
## Declaration Of Councillors’ Interests in Items Appearing on the Agenda

**NAME OF COUNCILLOR** ______________________________

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<th>Minute Item No. / Agenda Item No.</th>
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MINUTES OF THE GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE HELD ON 26 NOVEMBER 2014 AT GMFRS, STRETFORD FIRE STATION, PARK ROAD, STRETFORD, MANCHESTER.

Present:
Bolton Council Councillor Asif Ibrahim
Bury Council Councillor Peter Bury
Derbyshire CC Councillor Caitlin Bisknell
Oldham Council Councillor Brian Ames
Stockport MBC Councillor Tom McGee
Trafford MBC Councillor Patricia Young
Wigan Council Councillor John O’Brien (in the Chair)

Advisors/Officers:
GM NHS Leila Williams
Derbyshire CC Jackie Wardle
JHOSC Pennine Acute Alice Rea
NHS England Ann Gough
NHS England Ben Squires
NHS England Alison Tonge ) Items HSC/14/73
NHS England Louise Sinnot ) a & c only
Stockport NHS FT Ann Barnes
GMIST Andrew Burridge
GMIST Julie Gaskell

HSC/14/68 APOLOGIES
Councillors Glynn Evans, Linda Robinson, Val Burgoyne and Claire Reynolds and Steven Pleasant.

HSC/14/69 DECLARATIONS OF INTEREST
None were received.

HSC/14/70 MINUTES
RESOLVED/-
To approve the minutes of the meeting held on 8 October 2014 as a correct record.

HSC/14/71 COMMITTEE RESPONSE TO NHS CONSULTATION
The meeting was presented with the final GM Joint Health Scrutiny Committee response to the NHS Healthier Together consultation which included clear statements on how the proposals have been presented and understood.

Leila Williams, GM NHS, then gave a brief verbal summary on information, previously circulated to the Committee, compiled by the independent social research organisation,
Opinion Research Services (ORS), which outlined analysis on final awareness, response numbers, events and profiling.

The summary included:

- That final number of attendees to events totalled 23,437
- Public engagement events included; 56 formal events, 262 informal events and 14 informal hospital foyers
- Staff engagement events included; 38 HT staff listening events, 16 locality events and 56 informal/on street events
- Stakeholder engagement events included; 19 formal events including 9 Healthier HT transport events and 10 health impact assessments
- 29,347 consultation responses were considered for analysis
- Analysis was broken down into borough, age, gender and ethnic group.

Consideration was also given to a paper which outlined feedback on transport analysis from the Healthier Together Committee in Common during the decision making phase. Members were informed that the proposed updates will include:

- Expansion of the population travel data set to include the current catchment areas of all GM hospitals (e.g., High Peak and West Lancashire)
- Latest timetables and car travel data to be used to reflect up to date public transport and car travel times – including the new metrolink line
- Review of availability of evening and weekend data – including existing travel times: AM peak, PM peak and interpeak.

The Committee noted that the refreshed work is being carried out in conjunction with Transport for Greater Manchester and will be documented in the Decision Making Business Case. The Chair raised concern that the previous report, without peak travel times analysis, had been previously examined by the CCG’s without challenge.

In response to queries raised by Members concerning the distribution of the household Healthier Together leaflet, as mentioned at the Committee’s previous meeting, Leila confirmed that the leaflet drop had generated significant interest and that it was possible that some households were not aware of receiving the information. To help dispel queries regarding distribution, it was reported that the Royal Mail had been tasked to provide a report on where and when the household leaflets had been delivered.

A discussion followed which highlighted proposed NHS reviews and consultations, the way forward and lessons to be learned from the Healthier Together consultation. Comments included confusing terminology, lack of early engagement with hospital based staff and public misconception. In conclusion, the Chair welcomed all concerns raised and gave assurance that these had been included in the Committee’s response.

**RESOLVED/-**

1. That the final GM Joint Health Scrutiny Committee response to the NHS Healthier Together consultation be noted.

2. That the ORS presentation be re circulated to Members.

3. That the “bite size” fact sheets giving additional information on Healthier Together also be re-circulated to Members.
HSC/14/72 ACUTE HOSPITAL PROVIDERS

A verbal report was given by Ann Barnes, Chief Executive, Stockport NHS Foundation Trust and Chair of Acute Greater Manchester Chief Executives, which outlined GM acute hospital views on the Healthier Together proposals and consultation.

Ann described how the GM Acute Chief Executives group set about their approach to discuss issues and give advice concerning Healthier Together and the consultation. Members were advised that the debate and conversations initially contained some resistance to the proposals but that in time views progressed to greater consideration across “sector” groups of hospitals, i.e. certain hospitals grouped together providing a “single service” of doctors working across all sites. The Acute Chiefs felt that post Healthier Together, future considerations should be given to an approach which also incorporates primary and social care services.

The Committee recognised the benefits of a sector approach but believed that this should not be at the cost of any hospital specialist services being removed. Members reiterated that the main ambition of Healthier Together proposals was not in relation to costs but regarding having the right staff in the right place.

Concern was also raised that this joint working approach would be considered as an alternative rather than complementary to Healthier Together. The Committee felt that attention should be given to correcting misconceptions surrounding this.

The Chair thanked Ann for the information and invited her to the next meeting of the Committee for a further update.

RESOLVED-

1. That the update be noted.

2. That Ann Barnes is invited to the next meeting of the GM Joint Health Scrutiny Committee in March 2015.

HSC/14/73 FUTURE NHS REVIEWS AND POTENTIAL CONSULTATIONS

Consideration was given to the following NHS reviews and consultations:

a) Trauma – Specialised Commissioning Update

Further to the Committee’s meeting in August, Alison Tonge and Louise Sinnott, NHS England, gave a further update on commissioning arrangements for adult major trauma. Members were reminded that there are currently 3 collaborative Adult Major Trauma Centre’s (MTC’s) in Greater Manchester; Central Manchester Foundation Trust, Salford Royal Foundation Trust and University Hospital Foundation Trust, and that a review had been undertaken by a panel of clinicians to consider the possibility of reorganising services to 2 or even 1 centre in GM and review commissioning plans. The main focus of the review being to improve clinical outcomes in relation to quality standards and having the correct staff available to provide 24/7 cover.

Members were informed that the detailed review concluded that a decision should be made to restructure services from 3 to 1 single site but retaining working in partnership with the other two hospitals; and that deemed site be Salford Royal.
A feasibility plan is currently being developed for Salford and further information regarding this will be brought back to the Committee’s meeting in March 2015.

The Committee was assured that these proposals would not impact on Healthier Together or any other services. That the reorganisation would help save more lives.

Plans for patient and public involvement are being delivered throughout December and January 2015 in order to raise awareness for the reorganisation and explain the benefits of a single trauma centre in Greater Manchester.

**RESOLVED**

1. That the update be noted.

2. That further update be submitted to the GM Joint Health Scrutiny Committee meeting in March 2015.

**b) New Congenital Heart Disease Review**

Members considered a presentation from Alison Tonge, Area Director, NHS England, explaining a review of congenital heart disease and consultation on draft standards and service specifications.

The meeting was informed that the review is designed to ensure that NHS England secures the best outcomes for all patients (not just lowest mortality), addresses variation and improves patient experience. That the purpose of the consultation is to consult on whether these are the correct standards to deliver these outcomes.

In conclusion, the Committee was informed that the consultation will run until the middle of December 2014 with an aim to have approved standards and specifications by March 2015.

**RESOLVED**

That the update be noted.

**c) APM Contract Reviews**

The Committee received a verbal brief from Ann Goff and Ben Squires, NHS England, regarding a review of a number of Alternative Primary Medical Services (APMS) time limited contracts. Reference was made to a letter issued to GM Healthwatch Chairs and GM Health & Overview and Scrutiny Committees which outlined the proposals and raise awareness.

Members were informed of 37 GM APM contracts split across 11 of 12 GM Clinical Commissioning Groups.

The Chair thanked the officers for the update but emphasised that these proposals should be addressed at each individual local authority and not at a Greater Manchester level. Many Members expressed the view that the letter circulated at the meeting and dated 24 October 2014, had not been received by them in their capacity as members of local health scrutiny committees. That some Members were aware of the process but had not been formally advised of it. It was agreed that contact details of the Committee would be provided to the officers.
RESOLVED:\n1. That the update be noted.
2. That Julie Gaskell provide the NHS officers with contact details of the GM Joint Health Scrutiny Committee Members.

HSC/14/74 DATES OF FUTURE MEETINGS

RESOLVED:\n1. That the next meeting on 21 January 2015 is cancelled.
2. That Julie Gaskell arrange the next meeting in March 2015 and advise the Committee accordingly.

Chair..................
To provide a Healthier Together Programme Update; an overview of the feedback themes from consultation and information regarding the Decision Making Process. The GM Joint Health Scrutiny Committee are asked to receive this report as information, no decisions are required but any comments are welcome.
1. Introduction

1.1 Purpose of this document

This document details the themes which have been fed back through the Healthier Together Public Consultation, outlines the plan to deliver a Decision Making Business Case (DMBC) and explains how the consultation feedback and other criteria will be considered during the Healthier Together decision making phase.

1.2 Context

Healthier Together completed its public consultation presenting options for change to in scope hospital services during the summer of 2014. The consultation was supported by a comprehensive Pre Consultation Business Case (PCBC). The programme has now moved into a decision making phase which will be supported by a Decision Making Business Case – this will be a similarly comprehensive document to the PCBC. The diagram below illustrates the stages of the programme and the current phase.

*Figure 1: Healthier Together programme overview*

- **Feb 12’ – Dec ‘13** Development of Case for Change, Vision and Model of Care
- **Jan – Jun ‘14** Pre-Consultation Including a PCBC
- **Jul – Oct ‘14** Public Consultation
- **Nov 14’ – Aug ’15** Decision Making
- **Sep 15’ onwards** Transition to implementation

- Identifying the need for change & vision for the future
- Identifying the options for change and engagement with stakeholders
- Explaining the options and understanding views
- Refining and agreeing the change
- Preparing for change

1.3 Activity Post Consultation

Post Consultation, a number of reports were delivered by the central programme team to conclude the consultation phase:

- **Reach and Engagement Report** – contains a summary and assessment of the activity undertaken during the consultation to ensure appropriate reach and engagement. This is supported by a comprehensive record of all activity undertaken during the consultation (advertising, media, distribution, engagement)
- **Equalities Report** – assesses how accessible the consultation was to protected groups
In addition, a number of reports from external groups concluded the consultation:

- **Opinion Research Services (ORS) Report** - analysing the consultation responses
- **Integrated Impact Assessment** (received in two parts – Initial and Final)
- **External Reference Group (ERG) Report** – ERG assessment of the accessibility of the consultation

This phase of the programme was underpinned by a comprehensive range of lessons learned events which provided all programme stakeholders with an opportunity to feedback on their experience of the consultation process

### 2. Consultation Feedback - Key Findings

Following consultation, independent Opinion Research Services (ORS) reported the following findings:

- **Case for Change**: Strong support, *73% agree need for change*, widely recognising that the status quo not sustainable
- **Best Care for you**: Providing confidence in services and outcomes with good access to services
- **Primary Care Standards**: Deemed to be the bedrock for success of Healthier Together
- **Joining up Care**: Widespread support but will need investment, partner co-operation and careful service design
- **Hospital Services**: *82% agree the need for change* and *89% support Single Service*, Quality & Safety are most important, but many want identified services locally

These findings, and the detail which sits behind this headline information, will be clearly woven throughout the DMBC and will be made available to the Committees in Common (CiC) to support robust decision making
3. The Process and Purpose of a Decision Making Business Case

3.1 What is a DMBC?
A DMBC is created following a public consultation to record how decisions about the selection of an option for implementation are made, taking account of the responses gathered during a consultation as well as analysis of data.

3.2 Why is a DMBC needed?
A DMBC will provide an open and transparent record of the rationale for the selection of a particular reconfiguration option to support communication of the decision and importantly the rationale for the decision. Being open and transparent about the decision and analysis supporting the decision may reduce the risk of judicial review and other challenges.

Further, as with the PCBC, the programme will be required to complete assurance processes during the Decision Making phase. This will include assurance by:
- NHS England
- Office for Government Commerce Health Gateway review
- Clinical Senate (to be confirmed)

The content developed to satisfy these assurance processes will be recorded in the DMBC as well as a record of the assurances provided by these bodies.

3.3 What will the Healthier Together DMBC contain?
The DMBC will contain a summary of the consultation responses and these will be used in the following four sections:
- a) Re-assessment of the Case for Change, Model of Care and the 8 options (taking account of consultation responses and any additional analysis then carried out);
- b) Definition of the criteria used to select an option for implementation; and,
- c) The supporting data and rationale for the selection of an option for implementation.
- d) A record of the assurances provided about the Decision Making phase.

A) Re-assessment of the Case for Change, Model of Care and options in light of feedback received
The consultation questionnaire asks for views on the Case for Change, Model of Care and Options as well as for proposals of alternative models of care or options. All questions, queries, and alternatives proposed about the model of care and options will need to be fully considered. This will require a significant amount of clinical review as well as further analysis. The outputs of this work will be recorded and presented in the DMBC. Through this work, an assessment will be made and presented as to whether:
- There is a need for change;
• Major insurmountable challenges to the model of care are proposed;
• Viable alternative models of care are proposed;
• Any other viable options are proposed.

B) Definition of the criteria used to select an option for implementation
The consultation questionnaire asks for views on the criteria that should be used to select an option for implementation. The responses to these questions will be presented along with the rationale for the final criteria that are selected.

C) Options Appraisal - Selection of an option for implementation
The consultation questionnaire asks for views on whether there should be four or five specialist hospitals as well as opinions on the options. These will be presented along with the data and rationale for selecting either four or five specialist hospitals and the data and rationale for selecting a particular option.

D) Record of the assurance processes
The content to satisfy the assurance processes the programme is required to complete during the Decision Making phase will be recorded in the DMBC as well as a record of the assessments made by the assuring groups.

3.4 The Healthier Together Programme Timescales
The Decision Making Phase will run from **November 2014 – August 2015**. During this time, both the Model of Care and Options will be confirmed and the criteria for decision making will be agreed. During this time, the data used to inform the PCBC will be refreshed and a decision will be made as to whether there is a material difference in this data, and if so, whether the refreshed data will be used to inform the DMBC.

Following this, there will be an options appraisal, which will be appropriately assured and the DMBC will be ready towards the end of this phase to support formal decision making.

The Implementation Phase will follow this, commencing **September 2015 – onwards**.
4. Overview of DMBC Decisions

In order for the Committees in Common (CiC) to be able to make the final decision of which option should be implemented, a number of other decisions will need to have been agreed beforehand:

1. Confirmation of the Case for Change

   All in favour – CiC confirmed the Case for Change
   21st January 2015

2. Is the Model of Care Supported?

   All in favour – CiC supported the Model of Care
   21st January 2015

3. Are there any Alternative Options?

   All in favour - CiC reconfirmed that only options with 4 or more specialist sites are considered and that options with no more than 5 sites are considered
   21st January 2015

4. What Criteria will be used to Select and Option for Implementation?

   All in favour – CiC agreed that all relevant inputs will be considered holistically without criteria weightings
   18th February 2015

4.1 Remaining DMBC Decisions

There are two remaining DMBC decisions:

5. How Many Single Services Should there be?

6. Which Option Should be Implemented?

CiC decisions Summer 2015
5. Approach to Decisions 5 and 6

5.1 Principles and Approach

The decision making process from start to finish will be a clear, open and transparent process outlining how the public consultation responses have been considered and have influenced decisions.

To ensure consistency, the same data sets will be used as in the Pre Consultation options appraisal. Data will only be updated where there is feedback from the consultation or identified material changes, and this will be fully documented in the DMBC, which will be publically available.

5.2 Process for Selection of an Option for Implementation

CiC is the only decision making body for this decision and will be advised and assured of the validity of the data and relevant inputs by the groups in the governance structure.

Figure 5: Illustrates the revised post consultations governance structure

Decision making assurance will be received via NHS England and the GM Joint Health Scrutiny Committee.
5.3 Consideration of Decisions
All data and information will be provided to allow key lines of enquiry to be pursued:

- What is the optimal configuration of four Single Services across GM?
- Is there a qualitative and quantitative case for a fifth Single Service?
- Where should the fourth Specialist Site be located?
- If appropriate, where should the fifth Specialist Site be located?

These will be considered and judged together to ensure a holistic approach to decision making and this may be an iterative process. Several inputs will inform this process:

- **Activity data**: How many patients will move? How does this compare between options?
- **Workforce**: How many more consultants do we need and how long will recruitment take? How does this compare between options?
- **Estates**: Do we need additional estate? How does this compare between options?
- **Capital**: How much does new estate cost? Is any existing estate released? How does this compare between options?
- **Finance**: How much does each option cost? How does this compare between options?
- **Transport and Access**: Can the population access specialist services? How does this compare between options?
- **Transition**: How much will it cost/how long will it take to achieve the standards? How does this compare between options?
- **Quality and Safety**: Are the standards achieved? What is the patient experience? How does this compare between options?
- **Public/Stakeholder Consultation Feedback**: What does the public feedback say? What do stakeholders say?
- **Integrated Impact Assessment**: What is the impact on protected groups? How does this compare between options?
- **Provider/Sector Plans**: How does the option fit with provider/sector plans?
- **Greater Manchester Coherence**: Does the option ‘work’ at a Greater Manchester strategic level?
Selecting the ‘best option’ aims to improve standards and reduce variation. In selecting the best option, there will be both qualitative and quantitative considerations:

Qualitative Considerations
- Achieves quality and safety standards
- Provides good patient experience
- Ensures good equitable access
- Congruent with public feedback

Quantitative Considerations
- Costs the least
- Provides best savings profile
- Most achievable
- Quickest to achieve

When addressing these considerations, the CiC will need to bear in mind that:

1. A qualitative difference between options not considered material but quantitative differences are material (e.g. Capital Spend)
2. A material qualitative benefit would be hard to resist if it was affordable, practical and in keeping with the public and other stakeholder responses

5.4 Next Steps in the Decision Making Process

The next steps in the process to support decision making will include a CiC workshop (to be held Spring 2015), where all relevant inputs will be considered holistically, followed by a CiC meeting (to be held Summer 2015) where both decisions 5 and 6 will be considered together

In order for Spring CiC workshop to take place, considerable work will need to be completed to ensure that CiC have detailed information relating to all aforementioned inputs. Following this workshop and having considered all inputs, the DMBC will be written to support the formal decision making meeting which will follow

6. Implementation

Once an option for implementation is agreed, implementation preparation will commence. It is proposed that this is delivered on a Single Service (sector) basis with central oversight. Learning from Making it Better in particular (implemented on a sector basis) demonstrates that central oversight is required, for example in relation to:

- **Patient transfer across Greater Manchester** – as sectors are implemented, the management of patient transfers will need to be managed during implementation. Similarly, close working will be required with NWAS to manage this and ensure Pathfinder is working effectively.
- **Equality of care** – standard clinical pathways across Greater Manchester ensure consistency of care – required to eliminate the variation that currently exists.
• **Recruitment** – ensure that the first sector implemented does not recruit all staff, leaving fewer options for the subsequent sectors implemented. Greater Manchester workforce and recruitment policies and plans are required to mitigate this.

• **Recruitment and remuneration** – there is a risk that different sectors remunerate similar roles differently, again affecting the ability of some sectors to recruit. Development of a standard policy mitigates this.