

Our Ref JG  
Your Ref HSC/JG  
Date 20 July 2016  
Please ask for Julie Gallagher  
Direct Line 0161 2536640  
Direct Fax  
E-mail julie.gallagher@bury.gov.uk

Legal & Democratic Services  
Division

Jayne Hammond LLB (Hons)  
Solicitor  
Assistant Director of Legal &  
Democratic Services

**TO: All Members of Health Scrutiny  
Committee**

**Councillors :** P Adams, N Bayley, M D'Albert, J Grimshaw, S Haroon,  
K Hussain, Kerrison (Chair), O Kersh, J Mallon, A McKay,  
Sarah Southworth and R Walker

Dear Member/Colleague

**Health Scrutiny Committee**

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

<b>Date:</b>	Thursday, 28 July 2016
<b>Place:</b>	Meeting Rooms A&B, Bury Town Hall
<b>Time:</b>	7.00 pm
<b>Briefing Facilities:</b>	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
<b>Notes:</b>	<b>*** please note there will be a pre-meeting briefing for elected members only commencing at 6pm</b>



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**Town Hall  
Knowsley Street  
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## **AGENDA**

### **1 APOLOGIES FOR ABSENCE**

### **2 DECLARATIONS OF INTEREST**

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

### **3 PUBLIC QUESTION TIME**

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

### **4 MINUTES (Pages 1 - 6)**

Minutes for the meeting held on 20<sup>th</sup> June are attached.

### **5 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE (Pages 7 - 10)**

Jon Hobday, Public Health Consultant will report at the meeting. Report attached.

### **6 HEALTH AND WELLBEING BOARD ANNUAL REPORT (Pages 11 - 26)**

The Social Development Manager, Bury Council will provide members of the Committee with a verbal presentation. Report attached.

### **7 NON URGENT PATIENT TRANSPORT SERVICE (Pages 27 - 44)**

Andy Hickson, Assistant Director of Commissioning representing Northwest Ambulance Service and a representative from Blackpool Clinical Commissioning Group will report at the meeting. Presentation attached.

### **8 CITY OF MANCHESTER SINGLE HOSPITAL SITE (Pages 45 - 94)**

A representative of Bury Clinical Commissioning Group will report at the meeting. Report attached.

### **9 URGENT BUSINESS**

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

**Minutes of: HEALTH SCRUTINY COMMITTEE**

**Date of Meeting:** 20 June 2016

**Present:** Councillor S Kerrison (in the Chair)  
Councillors P Adams, M D'Albert, J Grimshaw, S Haroon, K Hussain, O Kersh, J Mallon, A McKay, Susan Southworth and R Walker

**Also in attendance:** Councillor Trevor Holt, Cabinet Member Health and Wellbeing  
Karen Whitehead, Strategic Lead Children and Families  
Kate Allam, IWSS Manager  
Marcus Connor, Corporate Policy Manager  
Chris Woodhouse, Improvement Advisor, Corporate Policy Team  
Julie Gallagher, Democratic Services Officer

**Public Attendance:** 2 members of the public were present at the meeting.

**Apologies for Absence:** Councillor Bayley and Lesley Jones

#### **HSC.51 DECLARATIONS OF INTEREST**

Councillor Joan Grimshaw declared a personal interest in respect of all items under consideration as a member of the Patient Cabinet.

#### **HSC.52 PUBLIC QUESTION TIME**

There were no questions from members of the public present at the meeting.

#### **HSC.53 MINUTES OF THE LAST MEETING**

With regards to Minute HSC.835 Alternative Provider Services, Councillor Mallon requested that when the CCG conduct further consultation exercises that the consultation is more far reaching than just engaging with "heads of household" so as not to alienate people. Democratic Services reported that his comments will be fed back to Bury CCG.

#### **It was agreed:**

The minutes of the meetings held on 17 March 2016 be approved as a correct record.

#### **HSC.54 CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)**

Karen Whitehead, Strategic Lead Children and Families and Kate Allam, IWSS Manager, attended the meeting to provide members of the Committee with an

update in respect of the Child and Adolescent Mental Health Services. The presentation contained the following information:

Bury Local Transformation Plan (LTP) is 5 year forward plan to provide emotional mental health, CAMHS support to children and young people in Bury. The vision is to offer the right help and support at the right time to ensure best outcomes for emotional mental health and well being.

The following information provides an overview of scheme already in existence and working well;-

### **Single Point of Access – Enhanced Duty System**

In order to move towards a stepped model of care (The Thrive model) Healthy Young Minds, in the interim, will be developing an enhanced duty system, all emotional health and wellbeing referrals will come directly to the service, regardless of eligibility for a tier 3 service

### **Bury Youth Service**

Bury Youth Service offers an Emotional and Wellbeing Package as part of the School Offer to all Bury High Schools. The project is designed for pupils in need of extra support for their personal, emotional and social wellbeing  
The Chair invited questions from those present and the following points were raised.

### **Safe Project**

The SAFE project was developed in 2011 as a response to increasing concerns about Child Sexual Exploitation and internet safety. SAFE is a preventative programme delivered to Year 8/9 pupils in Bury High Schools which aims to help young people understand risk and how to manage it

In order to strengthen further service provision Third Sector organisations have been invited to provide expressions of interest for additional funding to offer within Communities emotional health, well being consultation, awareness raising and one to one support. These interviews are planned for 22 June 2016, with successful Third Sector organisations notified by mid July.

The Chair invited questions from those present and the following points were raised.

In response to a question in relation to the virtual team, the Strategic Lead reported that a system of providing support via community hubs continues to be developed as well as phone applications and instant information available via the website.

With regards to the enhanced duty team, the team will consist of therapy and nurse clinicians providing seven day cover. The enhanced duty team will conduct an initial triage and provide a graded risk assessment.

In respect of quality assurance and monitoring of the CAMHS provision; the Strategic lead reported that information in respect of waiting times, safety and clinical outcomes is reported to Bury Clinical Commissioning Group.

Health Scrutiny Committee, 20 June 2016

Kate Allam, IWSS Manager, reported that the SAFE project is available to all of Bury's 13 high schools, places are allocated on a needs/first come first case basis. In respect of support available in primary schools, Barnado's provide support via a teacher led 'Real Love Rocks' programme.

In response to a Member's question in respect of the prevalence of child sexual exploitation within Bury, the Strategic Lead reported that the issue is not as problematic in Bury as it is some of the neighbouring authorities. There does not appear to be systematic organised grooming, but rather problems with individuals as well as the sharing of inappropriate images.

In response to a Member's question in respect of the support provided to Academy schools; the Strategic Lead reported that there is a statutory duty placed on the Local Authority to provide some services. However, Academy Trusts will have to enter in to Service Level Agreements with the Local Authority, it is hoped that they would continue to purchase services from the Council and in going so enabling a continuity of service provision.

In response to concerns raised by Elected Members, the Strategic Lead reported that greater emphasis is placed on getting children who are experiencing problems early to try and prevent the escalation of the problems. Costs escalate as children require more intensive support therefore it is cost efficient and in the best interest of the child to intervene early.

### **It was agreed:**

1. That Karen Whitehead, Strategic Lead and Kate Alam.... be thanked for their attendance.
2. Information in respect of the support provided to Academy schools in particular with respect of Child and Adolescent Mental Health Services will be provided to the Committee.
3. Further information will be considered in respect of Child and Adolescent Mental Health Services at future meetings of the Health Overview and Scrutiny Committee.

*The Health Scrutiny Committee resolved to consider an item of urgent business in relation to the provision of speech therapy services at Millwood School, Bury.*

### **HSC.55 SPEECH THERAPY MILLWOOD PRIMARY SCHOOL**

Councillor Mallon expressed concerns in respect of the availability of speech and language services at Millwood Primary School.

The Strategic Lead for Children and Families reported that the full time speech and language therapist left in November 2015 and five day cover was provided with no break in support by two locums. Pennine Care Foundation Trust has tried to recruit to the post, the recruitment process has not been completed and a new speech and language therapist will begin work at the school imminently.

### **HSC.56 DEVOLUTION MANCHESTER A LOCAL AUTHORITY PERSPECTIVE**

Chris Woodhouse, Improvement Advisor attended the meeting to provide members with an update in respect of the devolution proposals. The presentation contained the following information:

Bury Council's approach to Devolution Manchester in respect of social care perspective will focus on the following areas:

- Asset based approach
- Prevention and Early Intervention
- Contact, assessment and referrals
- New models for care at home
- Residential and Nursing care
- Support for carers
- Workforce
- Transforming services for people with Learning Difficulties

The Locality Plan is Bury's response to devolution. It outlines proposals for Health and Social Care Services in the Borough for the next five years and concentrates on the following areas of work; the redesign and improvement of services; moving services into the community; prevention and early intervention; helping people to self-care.

The Locality plan is one part of the Devolution agenda other areas of work include; the development of the Local Care Organisation, One Commissioning Authority and Bury's continuing role in the North east sector (the Pennine Acute footprint).

The Chair invited questions from those present and the following points were raised.

Members of the Health Scrutiny Committee discussed the proposals to create a City of Manchester Single Hospital Trust. Members of the Committee expressed concerns with regards to the proposals and in particular the viability of the Pennine Acute NHS Trust if North Manchester is transferred into the newly created Trust. Members discussed problems in respect of patient pathways, impact on the management structure and financial arrangements.

Members of the Committee sought assurances that as NHS Colleagues attempt to reduce demand on Urgent Care services while at the same time moving services into the Community that the patient pathways and the services provided are fully integrated and data is shared between stakeholders.

In response to a question in respect of inpatient bed numbers, the Improvement Advisor reported that work is underway in respect of the number and type of beds across Greater Manchester. The Improvement Advisor reported that there is a mixed picture of in-patient bed provision across Greater Manchester.

In response to a Member's question in respect of the growth in the number of obese patients and the need to ensure that there is still the capacity in the acute sector to accommodate their needs; the Improvement Advisor reported that prevention work and in particular neighbourhood working will help to alleviate some of the demand. Members discussed the prevention agenda and that there is a need to try and tackle these issues as early as possible however this will not be a quick fix.

Members of the Committee discussed the funding arrangements for General Practice in light of the devolution Manchester proposals as well as other changes

in particular the agreement between the CCG and the Local Authority to set up a joint commissioning organisation.

**It was agreed:**

1. Chris Woodhouse, Improvement Advisor be thanked for his attendance.
2. That a representative from Bury's Clinical Commissioning Group be invited to attend a future meeting of the Health Overview and Scrutiny Committee to discuss the funding arrangements for General Practice.

**HSC.57 WORK PROGRAMME DISUCSSION**

Julie Gallagher, Principal Democratic Services Officer, submitted a report setting out the terms of reference for the Committee along with a Work Programme Prioritisation Protocol to assist members in the development of a Work Programme for 2016/2017.

**It was agreed:**

That the following items would be considered in the municipal year 2016/17:

- Provision of Child and Adolescent Mental Health Services
- Relationship between the Health Scrutiny Committee and the Care Quality Commission
- Provision of non-urgent patient transport service
- Delayed discharge
- Devolution Manchester
- City of Manchester Single Hospital Site
- CQC inspections of Pennine Acute and Pennine Care

**COUNCILLOR SARAH KERRISON**  
**Chair**

**(Note: The meeting started at 7pm and ended at 8.20pm)**

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<b>REPORT TO HEALTH SCRUTINY COMMITTEE</b>
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<b>TITLE:</b>	<b>Joint Strategic Needs Assessment (JSNA) development and launch</b>
<b>DATE OF MEETING:</b>	<b>Health Scrutiny Committee – 28/07/16</b>
<b>REPORT FROM:</b>	<b>Lesley Jones – Director of Public Health</b>
<b>CONTACT OFFICER:</b>	<b>Jon Hobday – Consultant in public health j.hobday@bury.gov.uk</b>

## 1. PURPOSE AND SUMMARY

The purpose of this report is to provide Health scrutiny with an update around the JSNA official launch and the 2-year development plan for 2016-2018.

## 2. INTRODUCTION/BACKGROUND

The statutory definition of a Joint Strategic Needs Assessments (JSNAs) is 'an assessments of the current and future health and social care needs of the local community.' – These are needs that could be met by the local authority, CCGs, or the NHS Commissioning Board. However, it is important to highlight that this is not just about supporting traditional health and social care services. It will act as a broader support for all services related to supporting residents around the wider determinants of health such as housing, education, business, planning and employment.

The JSNA is a core function of health and wellbeing boards. To be fit for purpose, JSNAs should support strategy and commissioning by providing "an objective analysis of local, current and future needs for adults and children, assembling a wide range of quantitative and qualitative data, including user views"

In this current climate of reduced capacity both in time and money the JSNA is important

- To help all partners use best intelligence to allow them to make best use of resources
- To exchange valuable intelligence and information
- To maximise the use of qualitative as well as quantitative data to understand the drivers of behaviour, felt need and local community assets
- To enable us to better understand potential future needs as well as needs in the here and now
- To bring together analytical expertise from across the partnerships
- To understand what questions local stakeholders would like to have answered about local needs and assets

- To act as a resource to support the whole of Team Bury in effective decision making

The previous JSNA was a paper based stand-alone document which although very informative was not accessed and used as much as we would hope by council staff and key partners. As such a new JSNA was planned which would be an online, dynamic and iterative suite of documents. This would be more up to date and accessible for users and could support policy and strategy makers as well as commissioners in making effective decisions and ensuring we have the best use of our resources.

## **Current Picture**

Since October 2015 a range of work has taken place to support the development of a new JSNA, including

- An extensive consultation to obtain stakeholders views around whether a new JSNA would be useful and what information should be included within it
- Development of a JSNA operational group with representation from all key partners within Bury
- Development of a web based resource ([www.theburyjsna.co.uk](http://www.theburyjsna.co.uk))
- The upload of over 150 pieces of data and intelligence onto the JSNA
- Development of clear governance structures
- Development of user guides
- User testing with key partners

## **Vision**

By March 2018 the vision is that we have

- A detailed and refined insight resource which outlines the detailed needs and assets of our local population, through an evidence based dynamic online resource
- An extensive network of intelligence leads from Team Bury, coming together regularly to share data and intelligence which helps partners and support commissioners in making effective decisions
- An up to date web based JSNA which provides access to a range of intelligence, key data sets and resources
- Robust integration of JSNA intelligence into the commissioning cycle for both within Bury Council and wider partner agencies
- A forum for commissioners and decision makers to come together to influence and inform what future intelligence and research is carried out through a collaborative work and planning process
- A JSNA which is the first place staff from organisations across Bury go to when they need key information about Bury residents to inform any strategy, policy, plan or service

## **3. FUTURE PLANS**

The JSNA is currently still at the soft launch phase (e.g. the site is up and running but still being refined with only a select number of partners and stakeholders have been asked to review and provide feedback on the content). However, the official launch is scheduled for the **25<sup>th</sup> August** at Team Bury Wider Leadership Group. Following the official launch the JSNA will be promoted through a number of mechanisms; in addition training on how to effectively use the JSNA will be available for all council staff, members and partner agency staff.

**List of Background Papers:-**

**Contact Details:-** Jon Hobday, Consultant in Public Health – [j.hobday@bury.gov.uk](mailto:j.hobday@bury.gov.uk)

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## Bury Health and Wellbeing Board

Title of the Report	Health and Wellbeing Annual Report 2015-16		
Date	21 <sup>st</sup> July 2016		
Contact Officer	Heather Crozier		
HWB Lead in this area	Councillor Trevor Holt (Chair)		
<b>1. Executive Summary</b>			
Is this report for?	Information <input type="checkbox"/>	Discussion <input type="checkbox"/>	Decision <input checked="" type="checkbox"/>
Why is this report being brought to the Board?	The Health and Wellbeing Annual Report is being brought to the Board for decision. The report covers Bury's Health and Wellbeing Board for the period from April 2015 to March 2016.		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy)	The Health and Wellbeing Annual Report relates to all priorities.		
 Our Vision Priorities and Principles for Hea  Refreshed HWB Strategy.pdf			
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to.	This report relates to all Joint Strategic Needs Assessment priorities.		
Key Actions for the Health and Wellbeing Board to address – what action is needed from the Board and its members? Please state recommendations for action.	The report is for decision therefore the Board is requested to note its content and agree that it is a true record of Bury's Health and Wellbeing Board for the period from April 2015 to March 2016.		
What requirement is there for internal or external communication around this area?	None.		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	<u>Bury Council</u> <ul style="list-style-type: none"> <li>• 11/07/2016- Department for Communities &amp; Wellbeing Management Board</li> <li>• 11/07/2016- Senior Leadership Team (SLT)</li> </ul>		

## 2. Introduction / Background

The Health and Wellbeing Annual Report is an overview of the Health and wellbeing Board from the period April 2015 – March 2016.

The Health and Wellbeing Board are requested to approve the annual report.

## 3. key issues for the Board to Consider

The Board is asked to consider if the report accurately reflects its key achievements, challenges and activities from April 2015 – March 2016.

## 4. Recommendations for action

The Board needs to consider the content of the report and agree it as a true reflection of the Health and Wellbeing Board from the period April 2015 – March 2016.

## 5. Financial and legal implications (if any)

If necessary please seek advice from the Council Monitoring Officer Jayne Hammond ([J.M.Hammond@bury.gov.uk](mailto:J.M.Hammond@bury.gov.uk)) or Section 151 Officer Steve Kenyon ([S.Kenyon@bury.gov.uk](mailto:S.Kenyon@bury.gov.uk)).

None

## 6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

None

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### CONTACT DETAILS:

**Contact Officer:** Heather Crozier

**Telephone number:** 0161 253 6684

**E-mail address:** H.Crozier@bury.gov.uk

**Date:** 21.07.2016

Bury Health and Wellbeing Board

# Annual Report for 2015/16



**Our Vision,  
Priorities  
and Principles  
for Health and  
Wellbeing  
in Bury**

# Bury Health and Wellbeing Board

## Annual Report for 2015-16

### Contents

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1.	Foreword from the Chair of Bury Health and Wellbeing Board	<b>3</b>
2.	Background to the Health and Wellbeing Board	<b>4</b>
3.	Activities and achievements	<b>7</b>
4.	Future plans and activities	<b>9</b>
5.	Executive summary	<b>10</b>



## 1. Introduction

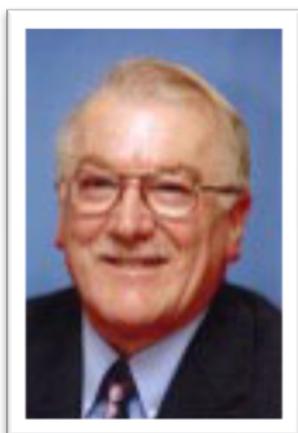
It gives me great joy to introduce the annual report of Bury's Health and Wellbeing Board covering the period from April 2015 to March 2016.

I have recently taken on the role of Chair for the Health and Wellbeing Board. On behalf of everyone involved with the Health and Wellbeing Board, I would like to thank the previous Chair, Councillor Andrea Simpson, for her direction and commitment in helping the Board to develop and grow.

2015-16 has been an exciting year for the board, a number of key improvements are:

- Strengthened governance arrangements for the Health and Wellbeing Board and Health and Wellbeing Strategy
- Developed the performance framework to support the Health and Wellbeing Strategy
- Identified leads for each priority area that are now responsible for successful delivery of the priority.
- In order to help people know about and understand work of the Health and Wellbeing Board we have developed:
  - A plan on a page
  - A Health and Wellbeing Board Section on the Bury Directory
  - Business Cards
- The membership has been expanded to include greater Elected Member presence on the board and welcome Greater Manchester Fire and Rescue Service as a member of the Board
- There has been a continued programme of Member and Chair development sessions
- The Board has overseen the development and creation of:
  - The new Joint Strategic Needs Assessment (JSNA)
  - The Bury Directory and its recent upgrades to the site
- We have embedded work of Greater Manchester Devolution and included this as a standing item on meeting agendas
- Signed off the Better Care Fund (BCF), Bury Locality and Pharmaceutical Needs Assessment (PNA)

We are looking forward to working on the key objectives for 2016-17.



Councillor Trevor Holt  
Chair of Health and Wellbeing Board

## 2. Background to the Health and Wellbeing Board

### 2.1 Team Bury

Team Bury is Bury’s local strategic partnership – a network of geographic and thematic partnerships across the Borough which involves the public, private and voluntary sectors. The network of partnerships is focused on improving the quality of life for the people of the Borough.

Team Bury has three priorities:

- Health and Wellbeing
- Stronger Safer Communities
- Stronger Economy

The Health and Wellbeing Board has responsibility for the delivery of the Health and Wellbeing, Team Bury priority.

### 2.2 Bury Health and Wellbeing Board

The Bury Health and Wellbeing Board is a statutory committee of Bury Council and brings together senior leaders from across Bury Council and the NHS with Elected Members, Healthwatch, Greater Manchester Police, Greater Manchester Fire and Rescue and representatives from the community and voluntary sectors – to set out a vision for improving health and wellbeing in the Borough.

The Health and Wellbeing Board supports and encourages partnership arrangements to ensure that services are effectively commissioned and delivered across the NHS, social care, public health and other services. Its main purpose is to ensure improved health and wellbeing outcomes for the whole population of Bury.

**Bury’s Health and Wellbeing Board’s Vision:**  
 “Improve health and wellbeing through working with communities and residents to ensure that all people have a good start and enjoy a healthy, safe and fulfilling life”

Between April 2015 and March 2016, Bury's Health and Wellbeing Board had the following members:

<b>Chair</b>	<ul style="list-style-type: none"> <li>• Cllr Andrea Simpson, Cabinet Member for Health and Wellbeing</li> </ul>
<b>Vice Chair</b>	<ul style="list-style-type: none"> <li>• Pat Jones-Greenhalgh, Executive Director for Communities and Wellbeing</li> </ul>
<b>Elected Members</b>	<ul style="list-style-type: none"> <li>• Cabinet Member for Finance and Housing</li> <li>• Cabinet Member for Children and Young People</li> <li>• Shadow Cabinet Member for Health and Wellbeing</li> </ul>
<b>Local Authority</b>	<ul style="list-style-type: none"> <li>• Executive Director for Children, Young People and Culture</li> <li>• Director of Public Health</li> </ul>
<b>Partners</b>	<ul style="list-style-type: none"> <li>• Chair Bury CCG</li> <li>• Chief Operating Officer, Bury CCG</li> <li>• Health Watch</li> <li>• Third Sector</li> <li>• GM Police</li> <li>• GM Fire and Rescue</li> </ul>
<b>Other</b>	<ul style="list-style-type: none"> <li>• Policy Lead</li> <li>• Democratic Services Officer</li> <li>• Assistant Improvement Advisor</li> </ul>

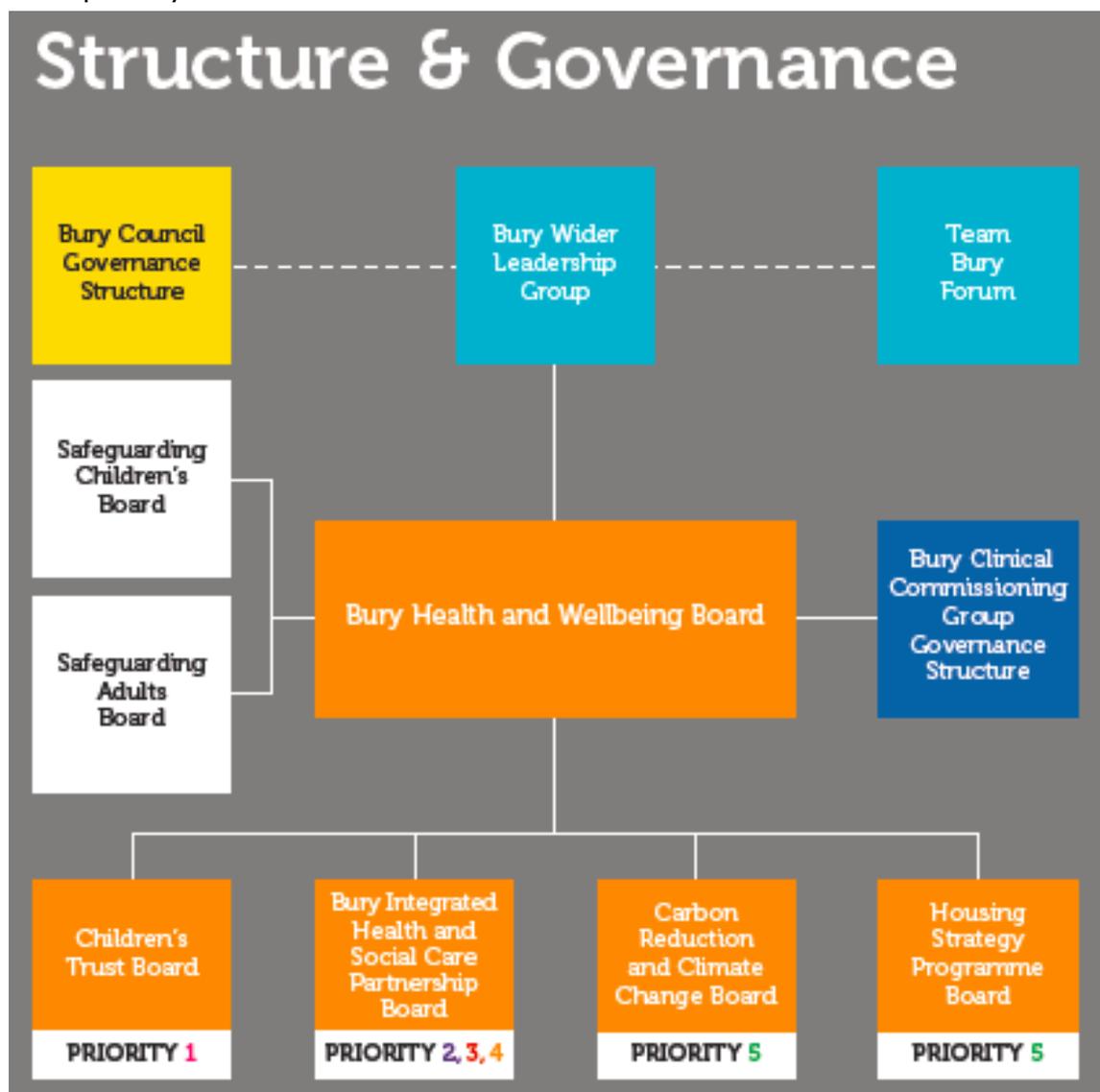
### 2.3 Functions of the Board

Health and Wellbeing Boards have a number of core responsibilities in relation to health, public health and social care. These include:

- strategic influence over commissioning decisions
- bring together clinical commissioning groups (CCGs) and councils to developed a shared understanding of communities' health and wellbeing needs
- lead the preparation of a Joint Strategic Needs Assessment (JSNA)
- develop a health and wellbeing strategy to address needs identified in the JSNA including recommendations for joint commissioning
- drive local commissioning of health care, social care and public health
- consider and contribute to debate about issues which affect health and wellbeing, such as housing and education services
- overseeing the production of Pharmaceutical Needs Assessment
- contributing to and approving the Better Care Fund
- overseeing the development of the Joint Strategic Needs Assessment

### 2.4 Structure and governance

The structure and governance has been finalised for the Health and Wellbeing Strategy and sub groups have been assigned to oversee the successful delivery of each priority.



## **2.5 Health and Wellbeing Board Strategy**

The Health and Wellbeing Board has a duty to ensure effective delivery of the Health and Wellbeing Strategy.

The Priorities are:

- Priority 1 – Starting well
- Priority 2 – Living well
- Priority 3 – Living well with a long term condition or as a carer
- Priority 4 – Ageing well
- Priority 5 – Healthy Places

Progress updates are provided on a six monthly basis for all priority areas to demonstrate progress.

## **3. Activities and Achievements**

### **3.1 Strengthened governance arrangements for the Health and Wellbeing Board and Health and Wellbeing Strategy**

The Health and Wellbeing Board is a statutory committee of the Council and is subject to the same requirements of openness and transparency as other Council committees.

The governance for the Health and Wellbeing Board are now finalised and the subgroups responsible for the successful delivery of the priorities provide their minutes to the Health and Wellbeing Board.

The governance for the Health and Wellbeing Strategy is now finalised and the subgroups provide an update every six months on the delivery of the priorities.

### **3.2 Developed the performance framework to support the Health and Wellbeing Strategy**

The performance for the monitoring of the priorities has been looked at in detail and the subgroups responsible for the priorities have taken ownership of their performance

### **3.3 Identified sub groups for each priority area that are now responsible for successful delivery of each priority.**

- Priority 1 – Starting Well Children’s Trust Board
- Priority 2 Living Well Bury Integrated Health and Social Care Partnership Board
- Priority 3 Living Well with a Long Term Condition or as a carer Bury Integrated Health and Social Care Partnership Board
- Priority 4 Ageing Well Bury Integrated Health and Social Care Partnership Board
- Priority 5 Healthy Places
- Housing Strategy Programme Board and Carbon Reduction and Climate Change Board

### **3.4 In order to help people know about and understand work of the Health and Wellbeing Board, the following developments have been made:**

- A plan on a page:
  - This explains how the Health and Wellbeing Board aligns with Team Bury
  - The Vision, Priorities and Principles for the Health and Wellbeing Board
  - Functions of the Health and Wellbeing Board
  - Health and Wellbeing Board Membership
  - One page summary of the Health & Wellbeing Strategy
  - The structure and governance of the Health and Wellbeing Board and Strategy
- A Health and Wellbeing Board Section on the Bury Directory
  - This has a shortened URL  
[www.theburydirectory.co.uk/healthandwellbeingboard](http://www.theburydirectory.co.uk/healthandwellbeingboard)
  - This contains pages promoting the work and membership of the board
- Created Business Cards
  - This shows the vision, principles and website link for the Board

### **3.5 Membership**

The membership has been expanded to include:

- Greater Elected Member presence on the board
- Greater Manchester Fire and Rescue Service

### **3.6 Member and Board development**

There has been a continued programme of Member and Chair development sessions. This included a member development day in March 2016 where the Board successfully completed the Royal Society of Public Health – Understanding Health Improvement, Level 2 Qualification, themed member development sessions prior to each Board meeting and three Chair development sessions.

### **3.7 The Board has successfully overseen the development and/or signed off:**

- The new Bury Joint Strategic Needs Assessment (JSNA)
- The Refreshed Health & Wellbeing Strategy for Bury
- The Bury Directory and its recent upgrades to the site
- The work of Greater Manchester Devolution
- The Better Care Fund (BCF)
- Bury Locality Plan
- Pharmaceutical Needs Assessment (PNA)
- Health & Wellbeing Board Annual Report 2014/15
- Director Of Public Health's Report for 2014/15
- The Better Care Fund Quarterly performance reporting
- Quarterly NHS England Commissioning Reports
- Greater Manchester Primary Care Strategy – NHS England
- Development of a Single commissioning unit

### **3.8 Matters brought to and considered by the Board during the year included split by Health & Wellbeing Strategy Priority Areas:**

#### **Linked to Priority 1- Starting Well:**

- Child Death Overview Panel Report
- Children's Services Devolution update
- Annual Safeguarding Children's Report

***Linked to Priority 2- Living Well:***

- Director of Public Health Annual Report
- Physical Activity and Sport Strategy
- Domestic Abuse Strategy
- The new Healthy Lifestyle Service
- Drug & Alcohol Strategy
- Public Health Memorandum of Understanding

***Linked to Priority 3- Living Well with a Long Term Condition or as a Carer:***

- Greater Manchester Working Well Expansion
- Carers in Employment
- Presentation on the work of the AFN (Armed Forces Network)

***Linked to Priority 4- Ageing Well:***

- Annual Safeguarding Adults report

***Linked to Priority 5- Healthy Places:***

- Fuel Poverty and its effects presentation

**4. Future Plans and Activities**

In 2016-17, the Board will continue with its strategic role of influencing and leading delivery of health and social care in Bury. It will:

**4.1 Further Develop the Health and Wellbeing Strategy:**

- produce info graphics for the priority updates;
- have regular priority themed meetings;
- hold an event to help the Health and Wellbeing Strategy come alive by educating the Board on a detailed look at each priority;
- look at new ways of monitoring performance in an OBA method.

**4.2 Governance:**

- develop the membership to reflect the responsibilities for helping people to self-care
- work with the new chair to continuously develop the Health and Wellbeing Board
- to have representation from the Leader of the Council on the Health and Wellbeing Board.

**4.3 Marketing and Communication:**

- to distribute all Plans on a page and Business cards
- improve links with the wider community to promote the work of the Health and Wellbeing Board

**4.4 Meetings:**

- pre board member development sessions to be refined by having them dedicated to thematic groups and two away days
- develop the forward planner for 16/17
- including devolution as a standing item
- including communication and marketing as a standing item
- all items to align to the priorities

**5. Executive Summary**

<b>Membership</b>			
	<b>Where have we come from (April 2014 – March 2015)</b>	<b>Where are we now (April 2015 – March 2016)</b>	<b>Where we want to be (April 2016 – March 2017)</b>
<b>Chair</b>	<ul style="list-style-type: none"> <li>• Cllr Rishi Shori, Cabinet Member for Health and Wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Cllr Andrea Simpson, Cabinet Member for Health and Wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Cllr Trevor Holt, Cabinet Member for Health and Wellbeing</li> </ul>
<b>Vice Chair</b>	<ul style="list-style-type: none"> <li>• Pat Jones-Greenhalgh, Executive Director for Communities and Wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Pat Jones-Greenhalgh, Executive Director for Communities and Wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Pat Jones-Greenhalgh, Executive Director for Communities and Wellbeing</li> </ul>
<b>Elected Members</b>	<ul style="list-style-type: none"> <li>• Deputy Cabinet Member for Healthier Living</li> </ul>	<ul style="list-style-type: none"> <li>• Cabinet Member for Finance and Housing</li> <li>• Cabinet Member for Children and Young People</li> <li>• Shadow Cabinet Member for Health and Wellbeing</li> </ul>	<ul style="list-style-type: none"> <li>• Leader of the Council (Business Engagement and Regeneration)</li> <li>• Cabinet Member for Children and Families</li> <li>• Shadow Cabinet Member for Health and Wellbeing</li> </ul>
<b>Local Authority</b>	<ul style="list-style-type: none"> <li>• Executive Director for Children, Young People and Culture</li> <li>• Director of Public Health</li> </ul>	<ul style="list-style-type: none"> <li>• Executive Director for Children, Young People and Culture</li> <li>• Director of Public Health</li> </ul>	<ul style="list-style-type: none"> <li>• Executive Director for Children, Young People and Culture</li> <li>• Director of Public Health</li> </ul>
<b>Partners</b>	<ul style="list-style-type: none"> <li>• Chair Bury CCG</li> <li>• Chief Operating Officer, Bury CCG</li> <li>• Health Watch</li> <li>• Third Sector</li> <li>• GM Police</li> <li>• NHS England</li> </ul>	<ul style="list-style-type: none"> <li>• Chair Bury CCG</li> <li>• Chief Operating Officer, Bury CCG</li> <li>• Health Watch</li> <li>• Third Sector</li> <li>• GM Police</li> <li>• GM Fire and Rescue</li> </ul>	<ul style="list-style-type: none"> <li>• Chair Bury CCG</li> <li>• Chief Operating Officer, Bury CCG</li> <li>• Health Watch</li> <li>• Third Sector</li> <li>• GM Police</li> <li>• GM Fire and Rescue</li> </ul>
<b>Other</b>	<ul style="list-style-type: none"> <li>• Policy Lead</li> <li>• Democratic Services Officer</li> </ul>	<ul style="list-style-type: none"> <li>• Policy Lead</li> <li>• Democratic Services Officer</li> <li>• Assistant Improvement Advisor</li> </ul>	<ul style="list-style-type: none"> <li>• Policy Lead</li> <li>• Democratic Services Officer</li> <li>• Assistant Improvement Advisor</li> </ul>

## Board Management

	<b>Where have we come from (April 2014 – March 2015)</b>	<b>Where are we now (April 2015 – March 2016)</b>	<b>Where we want to be (April 2016 – March 2017)</b>
<b>Board Meetings</b>	7 Meetings per year	7 Meetings per year	7 Meetings per year
<b>Forward Planner</b>	Introduced	Developed and split into key parts: <ul style="list-style-type: none"> <li>- Interactive Discussion</li> <li>- Reports for Discussion</li> <li>- Reports for Decision</li> <li>- Reports for Information</li> </ul>	Refined further to include: <ul style="list-style-type: none"> <li>- Standing agenda items</li> <li>- Align all agenda items to priorities of the H&amp;WB Strategy update per meeting</li> </ul>
<b>Meeting Scheduler</b>	Introduces to include: <ul style="list-style-type: none"> <li>- Agenda Set</li> <li>- Papers sent out</li> <li>- Member Development</li> <li>- Chair Development</li> </ul>	Developed to include: <ul style="list-style-type: none"> <li>- Member Development full days</li> </ul>	Refined to include: <ul style="list-style-type: none"> <li>- Pre populated themes for all member development sessions and full member development days</li> </ul>
<b>Chair Development Sessions</b>	Introduced – 3 per year	Developed to evaluate progress of the Health and Wellbeing Board and set the future direction of travel – 3 per year	Refined to evaluate the progress of the Health and Wellbeing Board and set the future direction of travel – 3 per year
<b>Member Development Sessions</b>	Introduced – 7 per year prior to each Board Meeting	Developed to cover specific service areas – 7 per year prior to each board meeting	<ul style="list-style-type: none"> <li>- Refined to become thematic based on the boards priorities – 7 per year prior to each board meeting</li> </ul>
<b>Member Development Days</b>	Introduced – one per year	Developed to include Royal Society for Public Health (RSPH) Understanding Health Improvement, Level 2 qualification	Refined and will increase to two per year to include: <ul style="list-style-type: none"> <li>- Market place to make the H&amp;WB Strategy 'come alive'</li> <li>- Member Thematic Training</li> </ul>

<b>Health and Wellbeing Strategy</b>			
	<b>Where have we come from (April 2014 – March 2015)</b>	<b>Where are we now (April 2015 – March 2016)</b>	<b>Where we want to be (April 2016 – March 2017)</b>
<b>General</b>	Refreshed H&WB Strategy priorities	Developed : <ul style="list-style-type: none"> <li>- Governance arrangements</li> <li>- Performance indicators</li> <li>- Reporting back to the board on successful delivery of the strategy</li> </ul>	Refined: <ul style="list-style-type: none"> <li>- Governance arrangements</li> <li>- Performance indicators</li> <li>- Reporting back to the board on successful delivery of the strategy</li> </ul>
<b>Priorities</b>	Refreshed priorities and developed a new priority – ‘Healthy Places’	Ensure successful delivery of each priority area in Year 1 via a detailed workplan.	Ensure successful delivery of each priority area in Year 2 via a detailed workplan
<b>Governance</b>	Review of all governance arrangements relating to each priority area	Developed Governance Framework to establish HWB Board Sub groups responsible for the development of a detailed workplan for each priority area.	Refined Governance Framework for each priority area to identify governance for each subgroup and refined workplan so the progress can be reported as a ‘plan on a page’ infographic
<b>Performance</b>	Refreshed measures on success using outcome based accountability framework	<ul style="list-style-type: none"> <li>• Created Performance Dashboard</li> <li>• Developed Local Indicators</li> </ul>	Outcome based accountability scorecard created for each priority also included on the ‘plan on a page’ infographic
<b>Leads</b>	N/A	Identified priority leads responsible for the successful delivery of a priority	Priority leads responsible for annual progress update to the board (one priority per meeting)
<b>Promotion of the Strategy</b>	N/A	Identified a ‘plan on a page’ to summarise the work of the board and strategy in one easy to read document	<ul style="list-style-type: none"> <li>• Promote the plan on a page and progress to date of the strategy</li> <li>• Make the strategy ‘come alive’ by holding an event as one of the member development day</li> </ul>

<b>Work of the Board</b>			
	<b>Where have we come from (April 2014 – March 2015)</b>	<b>Where are we now (April 2015 – March 2016)</b>	<b>Where we want to be (April 2016 – March 2017)</b>
<b>Led in the successful development of:</b>	<ul style="list-style-type: none"> <li>Board Membership</li> <li>Board Management</li> <li>Member Development</li> <li>Chair Development</li> </ul>	<ul style="list-style-type: none"> <li>Refreshed Board Membership</li> <li>Board Management</li> <li>Member Development</li> <li>Chair Development</li> <li>Interactive JSNA</li> <li>The Bury Directory</li> </ul>	<p>Continue:</p> <ul style="list-style-type: none"> <li>To Refresh Board Membership</li> <li>To update Board Management</li> <li>Member Development</li> <li>Chair Development</li> <li>Further development of interactive JSNA</li> <li>Further development of the Bury Directory</li> </ul>
<b>Overseen work areas relating the Health and Wellbeing Strategy</b>	<ul style="list-style-type: none"> <li>Refreshed Health and Wellbeing Board Strategy</li> </ul>	<ul style="list-style-type: none"> <li><b>Starting Well</b> <ul style="list-style-type: none"> <li>Child Death Overview Panel Report</li> <li>Children’s Services Devolution update</li> <li>Annual Safeguarding Children’s Report</li> </ul> </li> <li><b>Living Well</b> <ul style="list-style-type: none"> <li>Director of Public Health Annual Report 2014/15</li> <li>Physical Activity and Sport Strategy</li> <li>Domestic Abuse Strategy</li> <li>The new Healthy Lifestyle Service</li> <li>Drug &amp; Alcohol Strategy</li> <li>Public Health Memorandum of Understanding</li> </ul> </li> <li><b>Living Well with a Long Term Condition of as a Carer</b> <ul style="list-style-type: none"> <li>Greater Manchester Working Well Expansion</li> <li>Carers in Employment</li> <li>Presentation on the work of the AFN (Armed Forces Network)</li> </ul> </li> <li><b>Ageing Well</b> <ul style="list-style-type: none"> <li>Annual Safeguarding Adults report</li> </ul> </li> <li><b>Healthy Places</b> <ul style="list-style-type: none"> <li>Fuel Poverty and its effects presentation</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Continue to develop the work of the board in relation to the Health &amp; Wellbeing Board Priority Areas</li> </ul>
<b>Thematic</b>	<ul style="list-style-type: none"> <li>Integration of Health and Social Care</li> </ul>	<ul style="list-style-type: none"> <li>Integrated of Health and Social Care</li> <li>GM Devolution</li> <li>Greater Manchester Primary Care Strategy – NHS England</li> <li>Development of a Single commissioning unit</li> </ul>	<ul style="list-style-type: none"> <li>Continue to develop the work of the board in relation to the Health &amp; Wellbeing Board Thematic Areas</li> </ul>
<b>Signed off:</b>	<ul style="list-style-type: none"> <li>The Better Care Fund</li> <li>Pharmaceutical Needs Assessment</li> </ul>	<ul style="list-style-type: none"> <li>The Better Care Fund</li> <li>Pharmaceutical Needs Assessment</li> <li>Locality Plan</li> <li>Health &amp; Wellbeing Board Annual Report 2014/15</li> </ul>	<ul style="list-style-type: none"> <li>Continue to sign off:                             <ul style="list-style-type: none"> <li>The Better Care Fund</li> <li>Pharmaceutical Needs Assessment</li> <li>Locality Plan</li> <li>Health &amp; Wellbeing Board Annual Report 2015/16</li> </ul> </li> </ul>
<b>Communication and Marketing</b>	N/A	<ul style="list-style-type: none"> <li>Plan on a page produced for the board and strategy</li> <li>Development of a Health and Wellbeing Board Webpage on The Bury Directory <a href="http://www.theburydirectory.co.uk/healthandwellbeingboard">www.theburydirectory.co.uk/healthandwellbeingboard</a></li> <li>Created Business Cards to promote the Board</li> <li>Promote the Board and members at key events</li> </ul>	<ul style="list-style-type: none"> <li>Raise profile of board members via members section of the website to include videos and member profiles</li> <li>Develop the content of the website further</li> <li>Engage communities in the work of the board</li> <li>Continue to promote the board at events.</li> </ul>



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North West Ambulance Service



NHS Trust

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# Patient Transport Services

for

# Greater Manchester

from

# 1<sup>st</sup> July 2016

# Aims

- q PTS in Greater Manchester - what we are contracted to deliver
- q How it will work
  - § Our operating model
  - § Booking transport
  - § Managing the patient journey
- q Working together
  - § Engagement and information
  - § If things go wrong
- q Provide opportunities for question



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# The Contract

- q Greater Manchester CCG registered patients only
- q To/from any NHS treatment centre for NHS funded treatment
- q Five year contract
- q Revised and simplified KPIs
- q Three service specifications
  - § Enhanced Priority Service - renal dialysis and oncology
  - § Planned - advanced bookings & appointments
  - § Unplanned - 'on the day'
- q Future proofed - 7 day operating and service reconfiguration

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# Enhanced Priority Service - renal dialysis & oncology

Provision	Description
Operating Hours	<p>Between 6:30am and 1am the next day Monday to Saturday (including Bank Holidays). These hours represent the earliest drop off time and latest collection time. Include Sundays at Christmas and New Year.</p> <p>Cut off time is 3pm the day prior to travel. Bookings made after this time will be counted as Short Notice bookings subject to the booking request being made no less than 90 minutes prior to the requested collection time.</p>
Call Answering	75% of calls to be answered within 20 seconds
Travel Time	85% of patients to travel on the vehicle for no longer than 60 minutes
Arrival	90% of patients to arrive within 45 minutes prior to their scheduled appointment time
Collection	<p>85% of patients to be collected within 60 minutes of scheduled collection time or Patient Readiness Notification</p> <p>90% of patients to be collected within 90 minutes of scheduled collection time or Patient Readiness Notification</p> <p>Patient Readiness Notification - 90 minutes notice of collection must be given to the Provider</p>

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# Planned Service - advanced bookings & appointments

Provision	Description
Operating Hours	<p>Between 8am and 6pm Monday to Friday (excluding Bank Holidays)</p> <p>The booking cut off time for planned activity is 3pm on the day prior to travel.</p> <p>Bookings received after this time will count as unplanned activity and be moved according to the requirements set out in the specification relating to Unplanned Activity.</p>
Call Answering	75% of calls to be answered within 20 seconds
Travel Time	80% of patients to travel on the vehicle for no longer than 60 minutes
Arrival	90% of patients to arrive within 60 minutes prior to their appointment time and no later than their appointment time
Collection	<p>80% of patients to be collected within 60 minutes of scheduled collection time or Patient Readiness Notification</p> <p>90% of patients to be collected within 90 minutes of scheduled collection time or Patient Readiness Notification</p> <p>Patient Readiness Notification - 90 minutes notice of collection must be given to the Provider</p>

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# Unplanned Service – ‘on the day’

Provision	Description
<b>Operating Hours</b>	<p>The earliest drop off time and the latest collection times are between:</p> <ul style="list-style-type: none"> <li>• 8am and 11pm Monday to Friday</li> <li>• 8am to 6pm Saturday &amp; Sunday;</li> <li>• 8am to 11pm Bank Holidays</li> </ul> <p>The booking cut off time for unplanned activity is:</p> <p>4 Hours prior to the end of service hours for transport journeys the same day (outpatient activity) and 1 Hour prior to the end of service hours for discharge and transfer activity</p>
<b>Call Answering</b>	<p>75% of calls to be answered within 20 seconds</p>
<b>Travel Time</b>	<p>80% of patients to travel on the vehicle for no longer than 60 minutes</p>
<b>Arrival</b>	<p>No arrival standard – contract provides for 4 hour notice period for on the day outpatient bookings</p>
<b>Collection</b>	<p>Less than 60 minutes wait - 80% of journeys where the patient is picked up no later than 60 minutes after booked collection time</p> <p>On the day pick up within 90 minutes - 90% of on the day bookings where the patient is picked up within 90 minutes of the booking’s acceptance</p>

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# How will it work?

# Our operating model



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# Access – Contact Centre

## q Telephone

- § Booking Centre for GPs and patients making 1st appointments
- § NWS 0800 numbers for Acute Trusts making follow up appointments and enquiries
- § Non Contracted Activity (NCA)

## q Online

- § Integrated eligibility
- § Book, cancel & amend journeys
- § Check journey status
- § Book ready
- § Available 24/7/365

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# Booking Centre numbers for GPs and patients - 1<sup>st</sup> appointments

## **Bolton**

Tel: **01204 462 882**  
Hours: Mon – Fri 8.30am – 6.30pm

## **Heywood, Middleton and Rochdale**

Tel: **0161 716 5900**  
Hours: Mon – Fri 8:00am – 6:00pm

## **Tameside and Glossop**

Tel: **0161 335 2700**  
Hours: Mon – Fri 8:00am – 4:00pm

## **Wigan**

Tel: **01942 482 990**  
Hours: Mon – Fri 8:00am – 6:00pm

## **Stockport and Salford**

Tel: **0161 947 0770 or 0800 092 4020**  
Hours: Mon – Fri 8:00am – 6:00pm

## **Bury**

Tel: **0161 762 3155 option 1**  
Hours: Mon – Thurs 8:30am – 5:00pm  
Fri 8:30am – 4:45pm

## **Oldham**

Tel: **0161 627 7494**  
Hours: Mon – Fri 8:30am – 6:00pm

## **Trafford**

Tel: **0161 976 2555 option 1 then option 3**  
Hours: Mon – Fri 8:00am – 5:00pm

## **Central South and North Manchester**

Tel: **0161 947 0770 or 0800 092 4020**  
Hours: Mon – Fri 8:00am – 6:00pm

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# Booking numbers for Acute Trusts - follow up appointments and enquiries

q Enhanced Priority Service

**0800 0289 224**

q Planned and Unplanned Services

**0800 0323 240**

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# Ineligible Patients

## Signpost

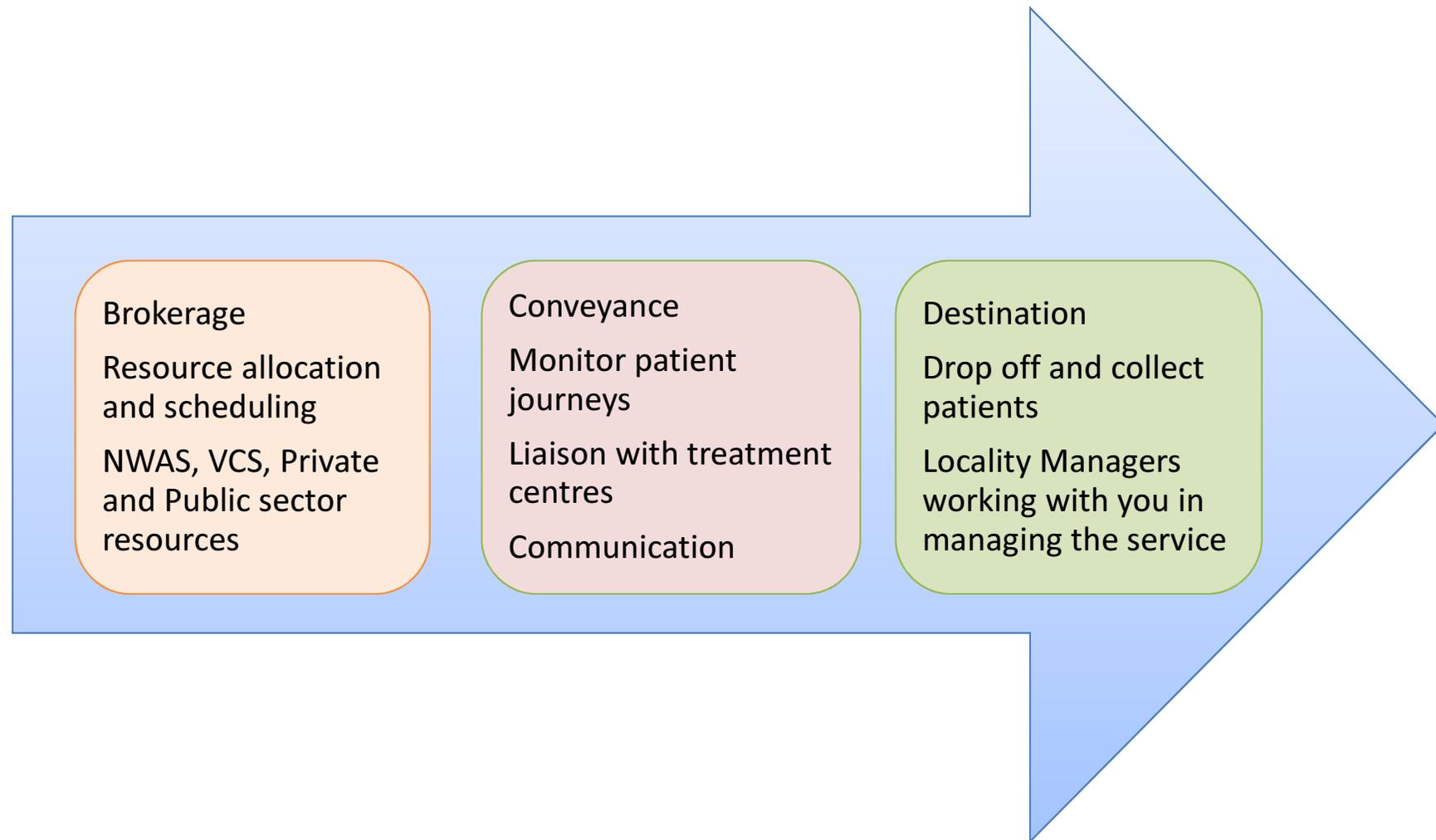
- Transfer to Information Line
- Alternative Providers
- CCG numbers outside of the NW

## Need further advice

- Escalate to Contact Centre Manager
- Consider contacting GP and/or treatment centre
- Patient Experience Team

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# Managing the patient journey



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# Non-GM Patient Journeys

Cumbria, Lancashire and Merseyside patients - NWAS is your PTS provider

Patients registered outside of the North West - the CCG with which the patient is registered is responsible for the patient's PTS

Cheshire, Warrington and Wirral patients - WMAS is your PTS provider



Effective liaison with other providers - seamless patient journey

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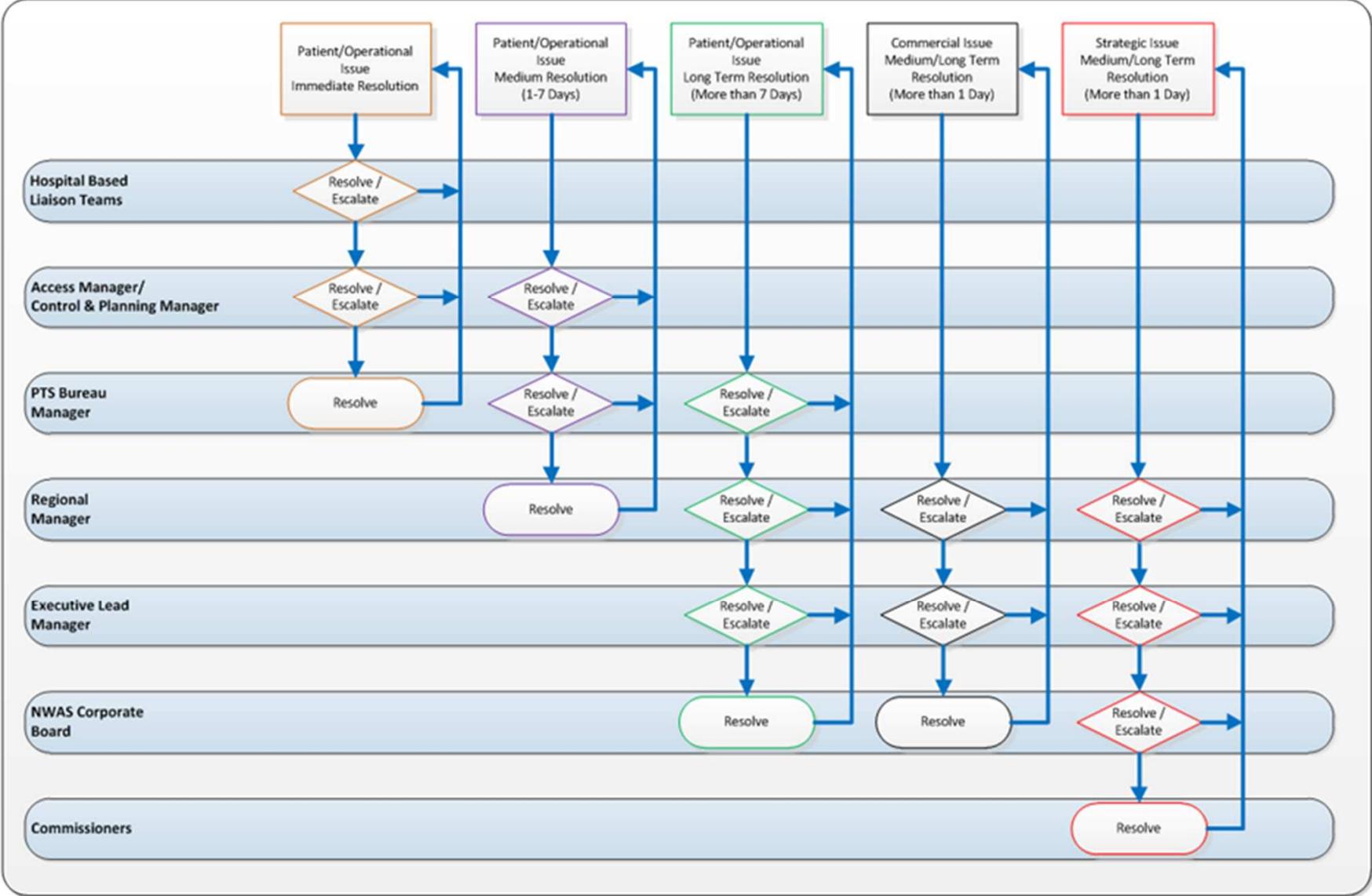
# Engagement

- § GM event (17 May 2016)
- § Stakeholder letters and briefings
- § Established Tripartite and Acute Trust meetings
- § Engagement with local Healthwatch
- § Patient and community engagement activities
- § Revised patient information leaflet and web content
- § New Patient Charter

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# If things go wrong!





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# Questions?

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**Manchester Health and Wellbeing Board  
Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 8 June 2016

**Subject:** Single Hospital Service Review

**Report of:** Sir Jonathan Michael, Independent Review Director, Single Hospital Service Review

### Summary

The first stage of the Single Hospital Service Review was considered by the Health and Wellbeing Board on the 27<sup>th</sup> April. The second stage of the review has now been completed. A report outlining this work, with a covering letter from Sir Jonathan Michael, is attached for the consideration of the Manchester Health and Wellbeing Board.

Feedback from the Boards of Central Manchester University Hospital NHS Foundation Trust (CMFT), Pennine Acute NHS Trust (PAT) and University Hospital of South Manchester NHS Foundation Trust (UHSM) is also attached for consideration (Appendices 3-5).

### Recommendations

The Board is asked to endorse the Second Stage report and accept the recommendations provided in section 7.0 of the report.

### Board Priority(s) Addressed:

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The development of a Single Hospital Service is a key component of the Manchester Locality Plan. This plan aims to support the Health and Wellbeing Strategy by identifying the most effective and sustainable way to improve health and social care for the people of Manchester
Improving people's mental health and wellbeing	
Enabling people to keep well and live independently as they grow older	
One health and care system – right care, right place, right time	
Self-care	

**Lead board member:** Steve Mycio, Barry Clare, Jim Potter

## **Contact Officers:**

Name: Alison Olivant  
Position: Programme Manager, Single Hospital Service Review  
Telephone: 0161 625 7125  
E-mail: Alison.olivant@uhsm.nhs.uk

## **Background documents (available for public inspection):**

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

- The Manchester Locality Plan
- Single Hospital Service Review Terms of Reference
- Manchester Single Hospital Service Review Stage One Report

## 1. Introduction

The Single Hospital Service Review commenced in January 2016. The first stage of this review, which identifies the benefits of adopting a Single Service Model, was presented to the Health and Wellbeing Board on the 27th April 2016. The second stage of the review has now been completed and is ready for consideration by the Manchester Health and Wellbeing Board.

## 2. Background

The proposal to establish a Single Hospital Service for the City of Manchester forms one of the three pillars of the Manchester Locality Plan and provides opportunities to improve health outcomes for the city population through:

- A partnership between the three current acute hospital providers PAT, CMFT and UHSM
- Development of single service models for a range of specific services
- A clear Manchester focus
- Standard operating procedures/patient pathways
- Reduced duplication/triplication and elimination of service gaps or weaknesses
- Improved opportunities to attract staff with specialist skills
- Improved use of estate
- Support services
- Back office functions
- Information management and technology, including electronic patient record systems
- Improved planning
- Opportunities to enhance patient care through research and innovation

The work will take account of Healthier Together and the North East Sector Transformation Programme. It will also recognise the impact that a Single Hospital Service might have on neighbouring populations (e.g. Trafford).

The Terms of Reference for the review outlined a two phase approach.

Phase 1 – Benefits Assessment

Phase 2 – Governance and Organisational Arrangements

The first phase of the review was completed on 27th April 2016.

## 3. Progress

Since the last meeting of the Manchester Health and Wellbeing Board, good progress has been made in relation to the development of a potential single hospital service for the City of Manchester:

- The second stage of the Review has been completed and a report finalised for consideration by the Manchester Health and Wellbeing Board.

- A draft version of this report has been considered by each Board of the three current acute hospital providers and feedback provided.

#### **4. Next Steps**

The Board is asked to accept the recommendations contained within the Stage Two report.

#### **5. Conclusion**

The Independent Review Director is pleased to present the Single Hospital Service Review Stage Two Report for consideration by the Manchester Health and Wellbeing Board. The Board is also requested to consider the feedback provided by the Board of each of the acute hospital providers.

## City of Manchester Single Hospital Service Review

*Sir Richard Leese*

*Chairman*

*Manchester Health and Wellbeing Board*

*27<sup>th</sup> May 2016*

Dear Sir Richard

### **A new vision for Acute Hospital services in Manchester**

In January 2016 I was appointed to undertake an independent review of the potential benefits and mechanisms for the development of improved cooperation and alignment between hospital services in the City of Manchester. The Single Hospital Service Review was commissioned by the Manchester Health and Wellbeing Board and was designed to take place in two stages. In April 2016 the Health and Wellbeing Board received the first stage of this review, which detailed the potential benefits of developing a single hospital service.

The second stage of the review was to provide an appraisal of the most appropriate organisational/governance arrangements for hospitals in Manchester, in order to deliver these benefits. I'm pleased to say that this part of the review has been completed and I enclose a copy of this report for formal consideration by the Manchester Health and Wellbeing Board on the 8<sup>th</sup> June 2016.

You will recall that the first stage of the review identified that there currently exists an unacceptable level of variation in clinical outcomes, patient experience and access to hospital services across the City. Patients who live within 10 miles of each other, and who have the same severity of the same condition, are less likely to survive, or more likely to stay in hospital for an unduly long time, depending on where they live and the part of the system that they first attend. The City's health services are facing a number of significant challenges. Health outcomes for the population are generally poor and in many instances are the worst in the country. All hospitals in the City are facing staff recruitment difficulties, and existing financial pressures and future efficiency requirements are significant. Without action this situation is only likely to worsen. To maintain the status quo in the way hospitals work would result in a failure to deliver the Manchester Locality Plan, which clearly identifies that there needs to be a marked change to the way that health care is delivered within the City. I do not believe that you can expect the existing organisational arrangements to deliver this change.

The first stage of my review concluded that the introduction of a Single Hospital Service within the City will not only address the existing variation in services but will also help to tackle some of the other challenges that Manchester is facing. In my opinion improving co-operation between

the hospital sites is essential, if the current difficulties are to be resolved. The model of separate Trusts, delivering similar services in competition with each other, has demonstrably failed to deliver improved quality or efficiency.

The benefits of a Single Hospital Service cover a range of areas including quality of clinical care, patient experience and access, workforce recruitment and training and research and innovation opportunities. There are a series of 'enablers' that need to be in place to ensure that these benefits are delivered. The most essential of these requirements is an organisational structure that can deliver all the changes that will be necessary to improve services. The second stage of my review has considered a range of organisational models and has assessed each, to determine which would be best placed to deliver the benefits that a single hospital service model offers.

My conclusion is that the creation of a new NHS Trust, that takes responsibility for the services currently provided by Central Manchester University Hospitals NHS Foundation Trust (CMFT), the University Hospital of South Manchester NHS Foundation Trust (UHSM) and by Pennine Acute Trust (PAT) from North Manchester General Hospital (NMGH), offers the best opportunity to realise these benefits.

It is my opinion that a new organisation would provide a cohesive identity for hospital services in the City. The integration of all acute hospital services across the City of Manchester, into a new organisation, will provide the best opportunity for ensuring that all services are raised to the standard of the best. I believe that the resulting organisation would provide the clarity of leadership and the decision-making authority necessary to ensure current variation in hospital services is addressed.

The delivery of Manchester's Locality Plan and essential collaboration with the new Local Care Organisation would also be enhanced. A new Trust would form an exciting and innovative organisation, with which all staff could align, and which would help reinforce Manchester's position as a major Academic Health Centre.

I recognise that my suggestion is no small undertaking. Certainly, the creation of a new integrated NHS Trust within the City will require a great deal of management capacity and capability and the resources required to bring about the proposed organisational change should not be underestimated. During my work over the last six months I have been extremely impressed by the commitment and enthusiasm of people who work within the health services in Manchester and I have no doubt that the vast majority acknowledge the need to change and will fully commit to the delivery of the best solution to bring about meaningful benefits for patients.

There are, however, a few key areas that will require particular attention. As you're aware the North Manchester General Hospital (NMGH) site currently sits within the Pennine Acute NHS Hospitals Trust. My recommendation proposes that this hospital site and its services should be transferred into a new City-wide NHS Trust. This change should not be to the detriment of hospital services outside of the City; care for those who live in the areas surrounding the City of Manchester should not be compromised. A detailed assessment is required, to look at the strategic alignment between the implementation of the recommendations of the Manchester

Single Hospital Service Review and those arising from the on-going North East sector review. It will be important to evaluate the impact that the realignment of NMGH might have on the sustainability of remaining services provided by both Pennine Acute and the proposed new City-wide Hospital Trust. Plans to mitigate any risks in this area should be agreed amongst all partners.

In line with the Terms of Reference of the Review, the conclusion that I have reached, regarding the creation of a new hospital organisation, represents my independent assessment and is based on the evidence that I have seen during the course of the review and also my own personal experience of implementing organisational change in the NHS. If the Manchester Health and Wellbeing Board agrees with my recommendation, I would suggest that the three existing hospital Trusts are requested to enter into discussions to consider the programme that would be required to deliver a new organisation and are asked to report back on the initial outcome of these discussions within 6 weeks.

Finally, I would like to emphasise the need to focus on delivering real and meaningful change to the health and wellbeing of people in Manchester. Although organisational form is important, the creation of a new organisation per se, is not the prize that Manchester should be reaching for. It is clinical transformation that will deliver the real benefits to the local population and the success of a Single Hospital Service will be judged by the impact it has on the quality and provision of clinical services across the City. I believe that a new NHS Trust, spanning the City, provides the appropriate structure, authority and accountability to ensure that this clinical transformation takes place, but all must acknowledge that organisational change is simply the means to an end.

Manchester has an ambitious plan for the future of its health and social care services and the creation of a new single Hospital Trust within the City forms a crucial strand of this work. Together with the development of the Local Care Organisation, the Single Hospital Service provides an opportunity to transform the way that local healthcare is provided and forms an ideal platform to address the challenges that Manchester is facing. I am confident that all will seize the opportunity to work together to ensure that the healthcare services provided to the local population are amongst the best in the country. I look forward to discussing the content of my Stage Two report with the Health and Wellbeing Board on the 8<sup>th</sup> June.

Yours sincerely



Sir Jonathan Michael FRCP

**Independent Review Director,**

**City of Manchester Single Hospital Service Review**



## Manchester Single Hospital Service Review

### Stage Two Report

May 2016

*Sir Jonathan Michael*

*Independent Review Director*

## Acknowledgments

The Single Hospital Service Review would not have been possible without the support of a range of individuals from across the health and social care system in Manchester and surrounding areas.

I would like to express my thanks to all those who have been involved in the process of completing Stage Two of the review and I am grateful for the continued support of the three Trusts involved in the process.

I am confident that the organisations in Manchester will seize the opportunity to work together to deliver the benefits that a Single Hospital Service offers. I have no doubt that all are committed to improving healthcare services for the local population and to establish Manchester as a major academic health centre, rivalling the best in the country.

In line with the Terms of Reference for the review, the opinions expressed and the recommendations made in this report are my responsibility alone.

A handwritten signature in black ink that reads "Jonathan Michael". The signature is written in a cursive style with a large initial 'J'.

**Sir Jonathan Michael, Independent Review Director**

27<sup>th</sup> May 2016

## Contents

<b>EXECUTIVE SUMMARY.....</b>	<b>4</b>
<b>1.0 INTRODUCTION.....</b>	<b>6</b>
<b>2.0 APPROACH.....</b>	<b>8</b>
<b>3.0 WHAT DOES THE ORGANISATIONAL FORM NEED TO DELIVER? .....</b>	<b>9</b>
3.1 BENEFITS FROM STAGE ONE REPORT .....	9
3.1.1 <i>Quality of Care</i> .....	9
3.1.2 <i>Patient Experience</i> .....	10
3.1.3 <i>Workforce</i> .....	10
3.1.4 <i>Financial and Operational Efficiency</i> .....	10
3.1.5 <i>Research and Innovation</i> .....	10
3.1.6 <i>Education and Training</i> .....	10
3.2 ENABLERS TO SUPPORT SINGLE SERVICE WORKING AND THE REALISATION OF BENEFITS .....	11
3.3 THE SCALE OF AMBITION FOR CHANGE .....	12
<b>4.0 APPRAISAL OF ORGANISATIONAL FORMS.....</b>	<b>13</b>
4.1 ORGANISATIONAL FORMS .....	14
4.1.1 <i>Model One: ‘Do Nothing’ Option</i> .....	14
4.1.2 <i>Model Two: Partnership between organisations (Clinical Network)</i> .....	15
4.1.3 <i>Model Three: Prime Contractor</i> .....	16
4.1.4 <i>Model Four: Franchise</i> .....	17
4.1.5 <i>Model Five: Joint Venture</i> .....	19
4.1.6 <i>Model Six: Hospital Chain</i> .....	20
4.1.7 <i>Model Seven: Creation of a new integrated organisation</i> .....	22
4.2 PREFERRED ORGANISATIONAL MODEL.....	24
<b>5.0 REQUIREMENTS FOR IMPLEMENTATION OF ORGANISATIONAL CHANGE .....</b>	<b>26</b>
5.1 COMPETITION REQUIREMENTS.....	26
5.2 GOVERNANCE AND REGULATORY REQUIREMENTS.....	26
5.3 ENGAGEMENT AND COMMUNICATION.....	27
5.4 INTERDEPENDENCIES .....	27
5.5 PROGRAMME MANAGEMENT AND PLANNING.....	28
5.5.1 <i>Programme Delivery Team</i> .....	28
5.5.2 <i>Implementation Plan</i> .....	28
5.5.3 <i>Quick Wins</i> .....	28
<b>6.0 CONCLUSION .....</b>	<b>30</b>
<b>7.0 RECOMMENDATIONS.....</b>	<b>32</b>

## Executive Summary

This is the Stage Two Report of the Manchester Single Hospital Service Review. It recommends an organisational form for hospitals in Manchester that provides the best opportunity to deliver the benefits of a Single Hospital Service. These benefits were identified in the Single Hospital Service Review Stage One Report presented to the Health and Wellbeing Board on 27<sup>th</sup> April 2016.

The Single Hospital Service Review covers hospital services in the City of Manchester provided by University Hospital of South Manchester NHS Foundation Trust (UHSM), Central Manchester University Hospitals NHS Foundation Trust (CMFT) and those provided by the Pennine Acute Hospitals NHS Trust (PAT) on the North Manchester General Hospital (NMGH) site. The development of a Single Hospital Service comprises one of the three key components of the Manchester Locality Plan and sits alongside the creation of a Local Care Organisation and the development of a single commissioning function, as a key priority for the City. The review was commissioned by the Manchester Health and Wellbeing Board, at the end of 2015, as a response to the challenges faced by health and social care systems across Manchester. These challenges are significant and need to be addressed as a matter of urgency. Although all hospital services in Manchester can point to examples where outstanding care is provided there is an unacceptable variance in the quality, experience and provision of care across the City. Patients who live within 10 miles of each other are not consistently able to access the same standard of services and many struggles to access healthcare that is appropriate to their need. In addition, healthcare services in the City are facing major workforce, financial and operational difficulties. All recognise that the status quo cannot, and should not, be maintained. Collaboration and integration are the only ways by which service provision can be standardised and that the current challenges can be successfully tackled.

The first stage of the Review was completed in April 2016 and was undertaken with extensive engagement from key stakeholders, including senior clinicians. This first part of the review concluded that a number of benefits could be realised by developing a Single Hospital Service within the City. These benefits extend to a range of areas including Quality of Care, Patient Experience, Workforce, Finance and Operational Efficiency, Research and Education/Training. The Stage One report also identified a series of 'enablers' that stakeholders felt would need to be in place in order to successfully deliver the benefits of a Single Hospital Service.

The second stage of the review has considered the governance/organisational arrangements that would need to be in place in order to successfully deliver the benefits of a Single Hospital Service. A series of organisational models have been considered and each has been appraised to determine the extent to which they might allow the enablers and benefits of a Single Hospital Service to be realised.

This process has resulted in the recommendation that the creation of a new acute NHS provider organisation, which would encompass the full range of services currently provided by CMFT, UHSM and those services provided by PAT on the North Manchester General Hospital Site, is most likely to provide the best opportunity to successfully provide a Single Hospital Service.

The review has also identified the issues that will need to be considered if the recommendations of this report are accepted. It is important that any developments in the City of Manchester must be considered as an integrated part of a wider set of changes within the Greater Manchester

conurbation. Although hospital services in the City need to work together to improve their offer this must not adversely affect the sustainability of hospital services in the wider area.

### Recommendations

The recommendation of the second stage of the Single Hospital Service Review is that:

- **The Health and Wellbeing Board should request CMFT, UHSM and PAT to enter into discussion to consider the creation of a new, single organisation and to provide an initial assessment on implementation requirements and timescale. The Trusts should report back the outcomes of these discussions to the Health and Wellbeing Board within 6 weeks.**

A range of issues will need to be addressed in these conversations including the following:

- The process and phasing that might be needed to create a single organisation within the City. For example, the establishment of a new Foundation Trust through the bringing together of UHSM and CMFT, might precede the subsequent integration of NMGH.
- The need to ensure the safe and reliable provision of hospital services within the City. Where there are clinical services in which significant risks to patient safety are identified, the three organisations should work together to ensure the safety and stability of such services, even if this precedes formal organisational change.
- The strategic alignment between the Manchester Single Hospital Service review and the North East sector review. This would include minimising any adverse impact from the realignment of North Manchester General Hospital on the sustainability of either the remaining clinical services provided by Pennine Acute Trust or the proposed new City wide Hospital Trust.
- The communication, engagement and/or consultation processes required to ensure that patients, the public, staff and other stakeholders are engaged in and able to influence the future Single Hospital Service.
- A programme for the delivery of the benefits described in the Stage One Report including improvements to the quality of services, improvements to patient experience, addressing existing workforce challenges and tackling financial deficits.
- Commissioner expectations for the overall size and shape of hospital services in Manchester.
- The requirement to ensure that work within the City of Manchester is co-ordinated to complement an integrated set of changes across Greater Manchester.

**Sir Jonathan Michael**

**27<sup>th</sup> May 2016**

## 1.0 Introduction

Acute hospital services in the City of Manchester are currently provided by three different NHS organisations: Central Manchester University Hospitals NHS Foundation Trust (CMFT), University Hospital of South Manchester NHS Foundation Trust (UHSM) and The Pennine Acute NHS Hospitals Trust (PAT) which provides services from its North Manchester General Hospital (NMGH) site.

All three hospitals provide a range of core District General Hospital (DGH) services and a variety of specialist/tertiary care to patients. The UHSM and CMFT sites are both well established University teaching hospitals with associated and embedded educational and research activities. All hospital sites can point to examples of services providing exemplary care to patients, and health services in the City are served by a vast number of talented, dedicated teams and individuals. However, each of the hospital sites works independently of each other with a variable range of services, different ways of working and different priorities. This has led to duplication in some areas and gaps in others. More importantly it has led to a situation where patients may receive different standards of care depending on the hospital they first attend.

In order to rectify this situation the concept of a 'Single Hospital Service' within the City of Manchester was established by the Manchester Health and Wellbeing Board in 2015. The development of a Single Hospital Service is a key component of the Manchester Locality Plan and supports the delivery of a Local Care Organisation within the City. It also compliments the wider Greater Manchester aspiration to standardise acute and specialist care across the conurbation.<sup>1</sup> The aim of a Single Hospital Service is to provide a fully aligned model of hospital care which would encompass a range of clinical services, support services, estates utilisation, back office function, education, research and innovation.

An independent review of the feasibility of a Single Hospital Service was commissioned by the Manchester Health and Wellbeing Board, with the full support of the three Acute Trusts. The Review was established to consider two distinct areas. The first stage of the review would identify the potential benefits of a fully aligned hospital services model; the second stage would advise on the most effective governance arrangements to deliver the identified benefits.

The first stage of the Review has been completed and was undertaken with extensive engagement and involvement of key stakeholders including a large number of senior clinicians from each hospital Trust. Its findings were presented to Manchester Health and Wellbeing Board on the 27th April 2016 and can be found in the "Manchester Single Hospital Service Review: Stage One Report"<sup>2</sup>. This initial part of the review confirmed that the current organisational and geographical boundaries in Manchester have led to unacceptable variation in clinical outcomes, patient experience and access to services. The report also notes that the variations in care are happening in the context of significant challenges facing health and social care services in the City. Population health outcomes in Manchester are poor, in many cases the worst in England. All hospitals are struggling to have enough staff to provide care to patients evenly over the seven days of the week – and this is even more difficult in those services where there is a national shortage of specialist staff. Financial pressures are also evident across the City's health service and future efficiency requirements are significant. It is important to ensure that Manchester's healthcare funding is spent as efficiently and effectively as possible. The scale of these challenges are likely to worsen if no action is taken and

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<sup>1</sup> Taking Charge of our Health and Social Care in Greater Manchester, December 2015

<sup>2</sup> [http://www.manchester.gov.uk/meetings/meeting/2828/health\\_and\\_wellbeing\\_board](http://www.manchester.gov.uk/meetings/meeting/2828/health_and_wellbeing_board)

the report identified that existing arrangements are unlikely to enable the degree of change required.

The Stage One report identified that operating a Single Hospital Service within Manchester would deliver significant benefits in Quality of Care, Patient Experience, Workforce, Financial and Operational Efficiency, Research, Training and Education. The first stage of the review concluded that introducing a Single Hospital Service across the City will address some of the current variation in services and will also help resolve other challenges that Manchester's health services are facing. Improving co-operation between the hospitals would also assist Manchester in establishing its rightful place as a major academic health centre and would enhance the City's reputation as a place to work and be trained.

The Stage One Report also identified a series of enablers that would be required to successfully implement a Single Hospital Service. These enablers included a range of factors, notably the need to have a common IT system, particularly for patient records. In addition, all stakeholders highlighted the need to have appropriate governance arrangements to support the effective delivery of single service models.

This report is the second stage of the Single Hospital Service Review and seeks to consider a full range of organisational models in order to determine which might best deliver the enablers, and therefore the benefits, identified in the Stage One Report.

## 2.0 Approach

In order to identify the organisational arrangement most likely to deliver the benefits of a Single Hospital Service a range of organisational forms were considered. The models chosen for consideration were agreed by the Single Hospital Service Review Steering Group and all currently exist within the NHS, health systems internationally and/or other relevant sectors.

Each model was assessed by the Review Team and case examples from both within and outside of the NHS were identified. The benefits and limitations of each organisational form were discussed and reviewed using the following criteria:

- The degree to which the organisational form would support the delivery of the benefits of a Single Hospital Service, as identified in the Stage One Report.
- The degree to which organisational form would allow the enablers identified in the Stage One Report to be put in place
- The benefits, limitations and implementation considerations of each organisational model (including any mitigations)
- Commissioner views as to which organisational form would best support the Single Hospital Service
- Other local context

This approach allowed a recommendation regarding organisational form to be made. In addition, the factors that need to be considered to make organisational change successful were also identified.

### 3.0 What does the organisational form need to deliver?

In the first stage of the Single Hospital Service Review eight exemplar clinical areas were selected to identify the benefits that might be delivered through the introduction of single service models. These exemplar services comprised: Critical Care; Radiology; Rheumatology; Secondary Paediatrics; Maternity Services; Cardiac Services; Infectious Diseases (ID) and Respiratory Services. It is important to note that a 'single service model' will vary greatly between and even within clinical specialties. The range of single service models include:

- Sharing of best practice across sites and developing common protocols/pathways
- Sharing staff and facilities across the three hospital sites
- Differentiating services by site
- Moving some services to be provided from a single site

Within each of the exemplar services a clinical working group (CWG), made up of approximately nine senior clinicians from across each of the hospital sites, was established. These CWGs examined, at a high level, how a single service model might operate in their specific area and the benefits that might be derived from working in this way. In addition the CWGs identified the implementation factors (or "enablers") that would need to be in place to successfully deliver these models. Using this work allowed the potential benefits of a Single Hospital Service to be identified.

Any governance/organisational arrangement that is proposed for the hospitals in the City of Manchester must be able to provide a mechanism by which these enablers and therefore benefits can be successfully delivered. Organisational change per se must not be the end; rather, it should be the key mechanism that supports and delivers the benefits identified in the Stage One Report.

The benefits that can be expected by operating a Single Hospital Service are described in more detail, in section 3.1; the enablers are outlined in section 3.2.

#### 3.1 Benefits from Stage One report

The Single Hospital Service Stage One Report identified a range of benefits that would be delivered from the creation of a Single Hospital Service. These are summarised below.

##### 3.1.1 Quality of care

A Single Hospital Service would:

- Reduce the variation in the quality and effectiveness of patient care and raise it to the standard of the best.
- Reduce variation in the safety of care and raise it to the standard of the best.
- Support the development of highly specialised clinicians and ensure equitable access for all patients to the best technologies and expertise available.

### 3.1.2 Patient experience

A Single Hospital Service would:

- Increase the coordination and efficiency of clinical services being delivered across different sites.
- Enhance the ability of the hospital service to work with the Local Care Organisation to provide more care in the community.
- Improve patient access and choice in respect of hospital services.
- Improve the consistency of the quality and service delivery of diagnostic and therapeutic services available to patients.

### 3.1.3 Workforce

A Single Hospital Service would:

- Improve the recruitment and retention of a high quality and appropriately skilled workforce.
- Support the delivery of a seven day service.
- Reduce the reliance on bank and locum/agency staff.
- Support teams to meet the needs of current and future demand for services.

### 3.1.4 Financial and operational efficiency

A Single Hospital Service would:

- Reduce costs in supplies in services (including drug costs).
- Reduce staff costs through reduction in agency costs, improvement in productivity and changes in skill mix.
- Limit future capital outlay and ongoing fixed costs of assets.
- Improve operational performance.

The Stage One report estimated that a Single Hospital Service model would allow the operating costs of the services to be reduced by 8-10%.

### 3.1.5 Research and innovation

A Single Hospital Service would:

- Increase opportunities for research programmes and research related income.
- Create a single point of entry to all clinical trials therefore improving the opportunity for patients to participate in clinical trials.
- Enhance the ability of services to adopt improved treatments resulting from research and evidence based best practice guidelines are implemented consistently to improve care to patients.

### 3.1.6 Education and training

A Single Hospital Service would:

- Optimise curriculum delivery, clinical exposure and reduce the variability in student and trainee experience.

- Widen student and trainee exposure to different clinical and working environments.
- Enhance the reputation of Manchester as a place to come and be trained and to work.

### 3.2 Enablers to support single service working and the realisation of benefits

The Stage One Report, following input from the Clinical Working Groups (CWGs), highlighted a range of enablers that would need to be in place to ensure the most effective delivery of Single Hospital Service benefits. Specifically the CWGs felt that, to be effective in delivering benefits to patients, the single service models would require:

- **Clarity of leadership.** Where staff are operating across multiple sites a clear leadership and management structure, which is responsible for all sites, is required.
- **Accountability for care.** Staff need to feel accountable for care across the whole of the single service - on all hospital sites. Staff also need to feel responsible and incentivised to act when there are sub-optimal pathways, protocols and patient care on other sites.
- **Integrated IT system.** This is required to enable clinicians to rapidly and effectively access patient information across the City regardless of the place where care is delivered.
- **Standardised HR processes.** In order to allow staff to work across multiple hospital sites there need to be common HR processes and also synchronisation of expenditure, budgets and staffing structures.
- **Effective triage.** In order to ensure the patient is always treated in the correct location standardised triage processes and pathways need to be in place.
- **Ability to transfer patients and specimens.** Effective processes need to be in place to ensure patients and specimens can be rapidly transferred between hospital sites in order to best meet the clinical needs of the patients.
- **Shared diagnostics.** To reduce duplication and fragmentation diagnostic services across all sites need to work to common standards/protocols.
- **Clear and consistent communication** with staff and patients.
- **Clear leadership and accountability of trainees and training** to ensure Deanery approval.

It is essential that these enabling requirements are implemented in order to realise the benefits that a Single Hospital Service can offer. Delivering these enablers would require a significant degree of change in a system that is currently very complex. These essential enablers point to a harmonisation of leadership and clinical management structures, of IT systems/processes and of HR procedures. In addition they require the management authority to ensure that if a particular part of the system is not working effectively, issues can be rectified quickly and easily. Currently acute hospital services in Manchester are provided by three separate NHS Trusts each with their own management, culture, priorities and ways of working. If the organisations continue to work in isolation of each other, the enablers outlined above cannot be implemented and so the benefits of a Single Hospital Service will not be delivered. When assessing the most appropriate organisational form to support the function of a Single Hospital Service, the requirement to ensure that these enablers can be delivered at scale and at speed would seem to be an essential requirement.

### 3.3 The scale of ambition for change

The challenges faced by the health and social care system across Manchester are significant. Population health outcomes in Manchester are poor, in some cases the worst in England. Care across the City is fragmented resulting in unacceptable variations in the provision and quality of care provided. Although duplication (and triplication) exists across some clinical services, in other specialties patients still struggle to access healthcare that is appropriate to their need. All services are facing workforce challenges and the national imperative to move to more consistent service provision across all seven days of the week will exacerbate the staffing and financial pressures.

Operational performance across all three is also variable and may come under increased pressure as demand for hospital services increases in the face of staffing and financial constraints. All three NHS Trusts covered by the review are predicting financial deficits for 2016/17 and the projected deficit for healthcare services in Manchester, if nothing changes, is at least £163m by 2021.

To overcome these challenges Manchester has set an ambitious plan for large scale change to support the future of its health and social care services. The proposal for a Single Hospital Service sits alongside plans for integrated commissioning of health and social care services and a Local Care Organisation to provide integrated out of hospital care across the City. These plans will need to support a dramatic improvement in the health outcomes for the people of Manchester, a 20% shift of activity out of acute hospitals and the re-balancing of the health economy's finances.

The ambition for healthcare services in Manchester is clear and is greater than the sum of existing parts. There is also urgency to the pace of change required. Although the Single Hospital Service Review Stage One Report identified exemplar single service models in eight clinical areas, a fully aligned single hospital service will need to deliver similar benefits across all services. Across the three organisations there are more than sixty clinical service areas, each with a number of sub-specialty areas. In addition there are a range of back-office service functions including HR, finance, IT, Estates etc. Each of these services needs to address challenges that might be specific to their own area whilst also working together to ensure interdependencies are managed and that the overall objectives of the Single Hospital Service are met. Change is required not only to individual service areas but to whole organisations. The scale and complexity of this change should not be underestimated and it is vital, when considering organisational form, that the organisational model best equipped to deliver this change, and to deliver it successfully and at pace, is selected. Whichever organisational model is adopted there will be a need to ensure that there is the management capacity and capability in place to deliver the change.

## 4.0 Appraisal of organisational forms

A range of organisational forms have been considered in order to provide a recommendation for the model that would best deliver the benefits of a Single Hospital Service. This section sets out different types of organisational forms, discusses their benefits and the implementation considerations and suggests how they could be applied to the City of Manchester. The list of organisational forms is not exhaustive but rather points to a representative range of organisational models which are in place in the NHS and/or in other relevant sectors.

When assessing the suitability of each organisational model a number of factors have been considered, including:

- The degree to which the organisational form would support the delivery of the benefits of a Single Hospital Service, as identified in the Stage One Report.
- The degree to which organisational form would allow the enablers identified in the Stage One Report to be put in place.
- The benefits, limitations and implementation considerations of each organisational model (including any mitigations).
- Commissioner views as to which organisational form would best support the Single Hospital Service.
- Other local context

A range of issues relating to the implications for implementation of a particular model were also considered including:

- How easily the required organisational change can be made
  - Over what timeframe will benefits be realised?
  - What are the costs of delivering the change?
  - Is there sufficient alignment of cultures between the organisations?
  - Are there further challenges, for example political hurdles, that would stop the changes to be put in place
- Complexity of arrangement
  - Does the proposed organisational form require large numbers of skilled management and increase back office costs?
- Governance and accountability
  - Is there a clear governance and leadership structure for effective decision making?
  - Does the organisational form always provide clarity about who is accountable? For example when a patient is being transferred from one site to another.
- The need to consider the impact of organisational form on patient choice and competition (including national competition guidelines)
  - What impact will the organisational form have on patient choice, access and competition?
  - Does the organisational form substantially reduce the commissioner's choice of provider?

It should be noted that Manchester commissioners have given a very clear indication that the existing structure and arrangements for providing hospital services in Manchester are no longer

acceptable. Manchester commissioners have defined their minimum requirements as creating single system with a unified focus for authority and accountability and a single contract for hospital services in the City.

## 4.1 Organisational Forms

All organisational forms have been considered equally, including a 'do-nothing' option.

### 4.1.1 Model One: "Do nothing" option

#### **Description**

The organisational forms are maintained in their current state. Each of the sites would continue to be separate organisations. The organisations would pursue a single hospital model, but would not enter into partnership or participate in any organisational or governance change.

#### **Benefits**

Money and time would be focused on attempting to make direct changes to service delivery rather than being distracted by a focus on organisational change.

#### **Limitations**

The current organisational arrangement does not have combined accountability across sites, so staff are not incentivised to support service delivery at other sites.

As leadership is disparate, it is not possible to make the big decision necessary to drive significant changes to service delivery.

Organisational self-interest may limit the extent to which individual organisations can reach agreement regarding difficult issues.

#### **The ability of the current organisational arrangements to deliver the benefits described in Stage One**

There are significant challenges to the health system in Manchester and they are likely to increase over time if there is no change to the current arrangements. The current organisational form has thus far supported a number of examples of excellent care but only in specific services and individual parts of the City. The current silo configuration has not succeeded in delivering coordinated, integrated care across all services in the City of Manchester, despite numerous efforts. There is no evidence to suggest that maintaining the status quo will do anything to address the current variation in the quality and provision of care across the City. In addition, the mounting financial, workforce and operational challenges cannot be tackled by the organisations operating independently. The assessment of Manchester commissioners is that doing nothing is simply not an option; organisational change is needed to give leaders the levers necessary to deliver the described benefits.

#### 4.1.2 Model Two: Partnership between organisations (clinical networks)

##### **Description**

Partnerships between organisations exist in many parts of the NHS and in health care systems in other countries. These partnerships enable clinicians to work together across locations and organisations to ensure high quality care for patients. Common examples of these partnerships include Cancer networks and Diabetes networks.

Partnerships vary from a light touch model of collaboration where clinicians work together to agree common protocols and patient pathways, whilst still delivering care in individual organisations; through to more structural collaborations where patients may be transferred across sites within a network to enable access to more specialist care. Stroke or Cardiac networks are an example of the latter, where one hospital might provide the specialist/emergency element of care for all eligible patients from within the network while the other hospitals provide outpatient care and on-going rehabilitation and support.

UCL Partners is an example where several hospitals have agreed to work together to explore how services can be provided in a more collaborative form across sites/organisations. Common protocols and care pathways have been developed for a range of services, in some instances staff and facilities are shared (for example radiology training rotations centred at The Royal Free Hospital, Bart's Health and University College London Hospital) and in a few instances there has been some differentiation of services by site, for example cancer, cardiac and stroke care.

##### **Benefits**

Partnerships have been shown to deliver significant benefits to quality of care for patients at sites included in the network. For example, five London Cardiac and Stroke Networks reconfigured services to reduce stroke mortality by 10% and length of stay from 15 to approximately 11.5 days<sup>3</sup>. A partnership supports financial and workforce benefits as staff and equipment are deployed more effectively across a number of hospitals rather than being replicated in multiple sites. Partnerships can be relatively quick to implement, as they do not require formal changes to contracts or large-scale reshaping of organisations, and they are less politically contentious than some other forms of organisational change.

##### **Limitations/Implementation Considerations**

Partnerships can be limited in their effectiveness, particularly in more light-touch arrangements. Staff remain employed by different organisations and so may be working under different terms and conditions of employment and lines of accountability can be blurred as it is not clear whether staff are accountable to the partnership or to their employing organisation. There can be difficult negotiations around finances with some organisations "winning" and others "losing". Transfer of patients between organisations is not always as smooth as it could be. Service change requires the approval of each and every organisation involved and clinically logical change often stumbles over local organisational interests.

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<sup>3</sup> Source: UCL Partners, Reconfiguring Stroke Care in North Central London, June 2011, For UCL Partners Value In Health Care Delivery Program

### **The ability of a Partnership Model to deliver the benefits described in Stage One**

In Stage One of the Review the Clinical Working Groups expressed concern over the ability of a partnership arrangement to enforce real changes in care delivery when there is not a formal agreement in place to hold clinicians/organisations to account. This review process agrees that a partnership model would be limited in its ability to deliver the benefits set out in Stage One.

Partnerships are also unlikely to deliver on the key enablers of leadership and governance and provide limited support for joined-up IT systems, and wider cultural integration across the organisations.

The commissioners in the City of Manchester are concerned that partnerships may not have the necessary governance to enforce the implementation of common protocols and therefore have indicated that they would not support this as an organisational form to deliver the change required.

#### 4.1.3 Model Three: Prime contractor

##### **Description**

In this organisational model, one hospital/organisation is contracted by a commissioner to provide a service across a population, served by a number of providers. The prime contractor then sub-contracts with other providers to provide some elements of the service. The prime contractor remains responsible for the overall delivery of care, including quality of care, financial performance and so on. The prime contractor may hold the employment contract for more specialist staff (consultants, specialist nurses) but may work with other staff (for example non-specialist nurses, therapists, administrative staff) who support the delivery of care at a local level. Commissioners in effect transfer the delivery, quality and financial risk to the lead contractor, who then has to ensure delivery of the service to agreed standards and to budget through subcontracts with the other providers in the supply chain.

An example of this model is the cancer and end-of-life care prime contract being developed by Cannock Chase CCG, North Stafford CCG, Stafford & Surrounds CCG, Stoke-on-Trent CCG, and NHS England (cancer only) in partnership with Macmillan cancer support. The commissioners are looking to appoint two lead organisations, one for cancer care and the other for end of life care. The lead organisations will be 'service integrators' to co-ordinate cancer and end of life care across Staffordshire and Stoke-on-Trent. The focus of this change is an integrated clinical pathway to improve patient experience.

##### **Benefits**

This organisational model can result in significant benefits being realised as the prime contractor should be able to ensure high quality care across all sites/organisations in the supply chain and hold the staff other organisations employ to account through contractual rather than direct management mechanisms. It can capture financial benefits by ensuring more efficient delivery of care by through standardised pathways, sharing staff effectively across sites and by differentiating services by site.

Bexley CCG in South East London now commissions a musculoskeletal service under a prime contractor model. The contract was awarded to Kings College Hospital NHS Foundation Trust which operates as the prime contractor and commissions additional services from Oxleas NHS Foundation Trust. Patients now receive a more joined up approach to their treatment and waiting times have reduced – for example physiotherapy waiting times in Bexley for routine appointments have

dropped from 22 weeks to four weeks<sup>4</sup>. Taking on this contract has exposed King's College Hospital to additional risk (discussed further in the limitation section), which could be a particular challenge for the Trust given current operational and financial difficulties.

#### **Limitations/implementation considerations**

A prime contractor is dependent on cooperation and alignment from all the organisations with which it subcontracts. Despite the notional ability of the prime contractor to put in place contractual obligations with sub-contractors, the enforcement of those obligations might not be enough to engender the cooperation and alignment required, and there may be limited choice of providers with which to sub-contract. The prime contractor would also need to have in-house commissioning skills that most current providers do not have. To obtain this resource would require financial investment.

There is also a potential problem with risk exposure for the prime contractor when management of the supply chain could require downstream contracts with a significant number of other organisations. This transfer of risk from commissioner to provider is one of the main reasons why such models are often not accepted or run into problems. For example, the community care contract in Cambridgeshire between the CCG and Uniting Care failed for financial reasons linked in part to the transfer of risk from the commissioner to the provider<sup>5</sup>.

This model could also add complexities to the relationship between the commissioner and the provider. For example where Trust X is the prime contractor for service A but the sub-contractor for services B and C there could be confusion in the commissioner's approach to Trust X as a single entity. The model could also add additional complexities to provider relationships if multiple providers are operating different services on the same site. Finally, significant additional contract management capacity would be needed to operate a system of this sort and the associated costs would limit the financial benefits.

#### **The ability to deliver the benefits described in Stage One**

The ambition for care in the City of Manchester is for a Single Hospital Service across all specialties and sub-specialties. This is necessary to meet the scale of the clinical and financial challenges described in the Stage One Report. Whilst it is possible to consider a prime contractor model for changes in specific specialties (as has been done elsewhere in the country), it would be extremely challenging to create prime contractor models for all specialties without adding many additional layers of managerial/governance complexity and increased back office costs. Further challenges to the delivery of benefits come from the contractual difficulties of ensuring effective implementation of the changes required.

#### **4.1.4 Model Four: Franchise**

##### **Description**

One provider, the "franchise owner" is responsible for the provision of a clinical service (or services) at multiple sites. The franchise owner employs staff based at a number of sites and retains operational control over those sites. Such a system is often applied to specialised services. There is a contractual arrangement between the commissioner and the Franchise owner to deliver the services

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<sup>4</sup> Source: NHS Bexley Clinical Commissioning group. Annual report summary 2014/15

<sup>5</sup> Source: NHS England. Review of Uniting Care contract, April 2016

at a range of sites. There would also be contractual agreements in place between the franchise owner and the organisations on whose sites the services were to be provided, usually covering accommodation and non-clinical support services. Moorfields Eye Hospital FT successfully operates as a Franchise at 33 locations in different hospitals. This includes, District General Hospitals, local surgical centres and community based outpatient clinics across London and the South East of England– all working as franchisees. Moorfields, as part of its role as a “New Models of Care Vanguard”, is looking to develop a tool kit for the development of franchise or satellite models of care that could be used across a range of service lines.

Other examples include:

- The Christie franchise for the delivery of radiotherapy and chemotherapy on different sites across Greater Manchester, which provides an excellent example of a single integrated service with consistently high quality care wherever patients access it.
- The Neuro Network provides neurology and spinal services across Merseyside from the Walton Centre at Fazakerley Hospital, similarly ensuring consistency of service standards across sites

### **Benefits**

A franchise brings skills and capabilities to a range of locations across a defined geography and helps to reduce variation in care within a particular specialty or service area. Alignment of incentives and operational control between sites leads to better quality.

The franchise owner can share staff and resources across sites according to need thereby enabling the best use of the workforce. There is single point of accountability for the delivery of the service with unified management and governance.

All sites providing a franchised service will provide the same quality of care, providing patients with confidence. Clear branding is therefore a key determinant of a successful franchise.

### **Limitations/implementation considerations**

Franchises can lead to governance complexity because of the various contractual arrangements between the commissioner, franchise owners and franchisees/individual sites. This can lead to ambiguity in accountability regarding how services not in a franchise relationship should work together, for example, reporting on patient safety. Multiple franchises can also lead to increased back office costs because of the greater number of contracts and relationships that need to be managed. Where multiple providers are operating on one site there could be conflicts over resources and capacity at that site.

### **The ability to deliver the benefits described in Stage One**

Franchises are most often put in place for a single service and/or a limited range of specialised services. To gain the benefits of single service working in all specialities many franchises would be needed. This would add a high degree of governance complexity inhibiting the delivery of benefits and increasing cost.

#### 4.1.5 Model Five: Joint venture

##### **Description**

A joint venture (JV) is an arrangement in which two or more parties agree to pool their resources to capture benefits. A separate entity (the JV) is formed by a contractual agreement between a set of partner organisations. These organisations then become joint owners of the JV. The JV has its own management and governance structure. In healthcare, a JV normally involves activity (and associated income and costs) being pooled across multiple providers and delivered at a single, or selected sites, for example a dedicated elective centre, in order to improve quality of care and reduce costs of care. Pooling of activity can be done at a specialty level, for example orthopaedics, or more broadly, for example including all elective inpatient activity. Joint Ventures typically incorporate a degree of risk sharing and effective joint ventures are heavily dependent on the quality of the working relationships between the organisations involved.

Joint ventures do not involve any change in structure of the participating organisations but they effectively sub-contract delivery of services and their prime contractual responsibilities to a separate legal entity i.e. the Joint Venture, of which the participating organisations are equity partners. Decentralised management structures often improve working relationships and performance management.

Liverpool Clinical Laboratories (LCL) is the largest pathology service provider in Cheshire and Merseyside, formed from the amalgamation of the pathology clinical services and laboratories of the Aintree University Hospital NHS Foundation Trust (AUHT) and the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT). LCL provides specialist clinical laboratory services, regionally and nationally, meeting the needs of acute, primary and specialist healthcare providers. The amalgamation of pathology services has enabled LCL to become research leaders in the cellular and molecular changes in Eye Tumours, Lung Cancer and Pancreatic cancers.

South West London Elective Orthopaedic Centre (SWLEOC) provides elective activity for four local trusts (St George's Healthcare NHS Foundation Trust, Croydon Health Services NHS Trust, Kingston Hospital NHS Foundation Trust, and Epsom and St Helier University Hospitals NHS Trust) and serves around 1.5m people. The profits/losses are shared in proportion to the respective share of SWLEOC patients originating from each Trust. SWLEOC is overseen by a partnership board with representation from each of the four Trusts, which are also party to a financial risk-sharing agreement. It is staffed primarily by surgeons from the four host Trusts and is now one of the largest hip and knee replacement centres in Europe.

##### **Benefits**

Consolidation of activity can bring clinical and financial benefits. Consolidation provides scale, enabling lower costs of procurement and allowing for more efficient working. Consolidation also enables improvements in quality of care – ensuring staff have greater experience and can share specialist skills and equipment.

SWLEOC reduced average length of stay from 4.8 to 4.4 days while slot utilisation increased to 98%. It has some of the best clinical results in the country – for example 0.02% infection rate; blood transfusion well below UK average.<sup>6</sup>

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<sup>6</sup> Source: Better Services Better Value for South West London, Planned Care Clinical Working Group, December 2011

In a JV, all of the organisations involved benefit from the quality and financial benefits without having to compromise their organisational independence.

#### **Limitations/implementation Considerations**

JVs can be complicated to establish. A key issue for these types of arrangements is to ensure that the appropriate governance model is in place to manage the shared financial and clinical risk. Joint ventures require each organisation to understand the costs of the service that are going to be pooled. They require each organisation to understand interdependencies with other services, for example specialist diagnostic services which will still need to support other services in each individual organisation. Joint ventures can run substantial risks if:

- The objectives of the venture are not totally clear and communicated to everyone involved
- The partners have different objectives for the joint venture
- There is an imbalance in levels of expertise, investment or assets brought into the venture by the different partners
- Different cultures and management styles result in poor integration and co-operation
- The partners do not provide sufficient leadership and support in the early stages

There can also be legal complexities with JVs. For example, there can be additional costs in setting up and running a separate entity, and some forms of JV might even run the risk of incurring additional tax liabilities.

The success of a JV depends on thorough research and analysis of aims and objectives. This should be followed up with effective communication to everyone involved. There also needs to be clear governance and accountability, including agreement to share risk. There may be misalignment of incentives if the scope of the joint venture and rules are not clearly defined.

#### **The ability to deliver the benefits described in Stage One**

Using joint ventures to support single service working in the City of Manchester may encounter similar problems to prime contractor models and franchises. To support single service working across all service lines, numerous joint ventures might be needed, adding governance complexity. Again this would increase cost and inhibit the delivery of the benefits. Enacting a joint venture comprehensively across all hospital services would leave a very limited residual role for existing Trusts, and would therefore effectively lead to the creation of a single organisation.

#### **4.1.6 Model Six: Hospital Chain**

##### **Description**

A hospital chain is a group of hospitals, or hospital Trusts, bound by a governance form that enables fast decision making and implementation across populations that are larger than that served by each individual organisation. Often, such chains are organised in such a way as to enable each hospital to have autonomy on local decisions that impact on the day to day delivery of quality and efficiency of services. Importantly, this decision making includes a level of seniority that enables good relationships with local stakeholders. This is coupled with a central decision making body that makes strategic decisions on service configuration, estates, IT, workforce development, leadership, and back office functions. The central management normally holds and organises the resources required for analysis, development and change management. The benefits that accrue from the model include economies of scale, ability to attract and retain talent, and ability to attract investment. The

central team is able to leverage innovation and best practice and ensure widespread dissemination at a pace and scale that might not be achieved by hospitals operating individually. There is evidence that chains that operate across a 1.5- 2.0m population size are able to optimise benefits

Intermountain in the USA consists of a hospital chain of 22 hospitals. The organisation has a central decision making body that determines strategy, undertakes development and innovation and supports and assures effective implementation. It is a chain that is rapidly exploiting the benefits of proven digital technologies to support the delivery of highly reliable and efficient care.

AMEOS is a hospital chain, which maintains 68 facilities across Germany and Austria, with a headquarters in Zurich and four regional offices which mirror the structure of the central office. It is, in effect, a single organisation running a large group of hospitals.

### **Benefits**

This model enables the clinical benefits of collaboration to be captured, allows for some financial savings in back office costs, and supports collaborative working and standardised protocols.

The model offers the potential to balance the advantages of scale and a single corporate HQ function, with the flexibility to take account of local circumstances in making operational management decisions, and this will be particularly relevant for groups of hospitals that are distributed over a wide geographical area or where there are, or are planned to be a significant number of hospitals in the chain.

The AMEOS group does not utilise as much standardisation of systems and processes as other hospital chains, but it is clear about what a corporate expectation is, and where there is scope for local variation. AMEOS are increasingly realising the benefits of standardised pathways in a number of areas and are looking to expand this in the future. The chain has also realised savings from procurement and group improvement methodologies.

### **Limitations/implementation Considerations**

A hospital chain may find it difficult to develop a cohesive culture, with different management teams on each site. With decision making split between local sites and the central headquarters there may be ambiguity in governance and accountability. This makes clarity of leadership in a chain model very important. Many chains are either loose partnerships of separate statutory organisations or they are effectively a single organisation running a number of individual hospital sites under the same organisational umbrella but with enhanced, but not independent, local management. The hospitals in the City of Manchester are closely co-located, and share a consistent set of local circumstances (demography and epidemiology, workforce availability, commissioner arrangements, etc), and in this context the local flexibility afforded by the hospital chain model may not be a significant advantage.

There are a number of NHS organisations that run multiple hospitals and other facilities under one overarching organisation (e.g. University College London Hospitals; Oxford University Hospitals; Sheffield Teaching Hospitals; Leeds Teaching Hospitals). However, these organisations are run as a single integrated organisation rather than a hospital chain arrangement. Experience with a formal chain model is still limited in the NHS, and pursuing an approach of this sort could create delays in implementation and the potential for “false starts” as organisational governance models are explored.

### **The ability to deliver the benefits described in Stage One**

If separate leadership and distinct cultures are maintained at the different sites a hospital chain may not create the sense of cohesion that the Stage One report has identified as being fundamental to delivering the benefits of the Single Hospital Service model. If more power is devolved to a central governance board, then the residual role of local management would be very limited, and the hospital chain would have similar impact on patient choice and competition as a single organisation would, but with greater ambiguity and complexity of governance.

#### 4.1.7 Model Seven: Creation of a new integrated organisation

##### **Description**

A number of previously separate organisations are combined to form a single new organisation in order to capture scale, share best practices, enable improved access to a broader range of services for patients, and reduce back office costs. Examples of different hospitals/organisations moving to a new organisation include:

- Guy's Hospital and St Thomas' Hospital becoming Guy's and St Thomas' NHS Foundation Trust
- St Barts and the Royal London becoming Barts and the London NHS Trust
- Winchester and Eastleigh NHS Trust and Basingstoke NHS Foundation Trust becoming Hampshire Hospitals NHS Trust
- Frimley Park Hospital NHS Foundation Trust and Heatherwood and Wexham Park Hospitals NHS Foundation Trust becoming Frimley Health NHS Foundation Trust.

##### **Benefits**

Often a single organisation is the quickest way of ensuring standardised protocols and care pathways, clear leadership, accountability, common IT systems and clarity for responsibility of the delivery of benefits. The creation of a single organisation from several organisations can sometimes ease the challenges involved in changes to clinical services. Service reorganisation typically requires a trade-off, with a sense that one site “loses” activity and income, whilst another site “gains” both. When the two sites are in the same organisation these changes may be easier to arrange, with reorganisation of individual services being seen in the wider context of a shared clinical service strategy that optimises the use of all sites and facilities.

The creation of a new organisation, with a single governance and management arrangement is likely to facilitate more rapid progress on implementing standardisation of back office and corporate support arrangements, and some of these (e.g. HR, IT, Estates) can be key enablers for the implementation of clinical service changes and improvements.

The West Hertfordshire Hospitals Trust provides a good example. Since the Trust was formed in 2000 through the combination of four smaller hospitals, commissioners have been able to reconfigure services effectively.<sup>7</sup>

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<sup>7</sup> Source: West D. Controversial hospital reconfiguration cuts death rates. Health Serv J. 21 October 2009

Similarly, the acquisition of the Royal National Throat Nose and Ear Hospital by University College London Hospitals enabled substantial reductions in back office costs. The clinical benefits then came from the service changes that this enabled.

At the time of the combination of Frimley Park Hospital NHS Foundation Trust and Heatherwood and Wexham Park Hospitals, Heatherwood and Wexham Park was in special measures. Monitor advised it would benefit from the leadership of its neighbouring Trust. The Care Quality Commission now rates the new combined hospital as “good” overall and “outstanding” for critical care and emergency services. Sir Mike Richards, the independent Chief Inspector of Hospitals, described it as the “the most impressive example of improvement” he had seen.<sup>8</sup>

### **Limitations/implementation considerations**

Creating a new organisation is a very significant undertaking. Dissolving existing organisations is a complex task, as is the transfer of services, staff and assets out of one organisation and into a new one. There would also be a considerable amount of work in providing appropriate assurance to the Boards of Directors and Councils of Governors of the existing organisations, and to regulatory bodies. It can take a long time to complete the move to a new organisation. Bringing together different historical cultures can be difficult and take many years to overcome, and there can be extensive resistance to change. Due to the time and level of change required, creating new integrated organisations can sometimes be more expensive than options that require lower levels of organisational change.<sup>9</sup>

There have been mergers in the NHS in recent history that have been less successful than expected, and there is academic evidence that suggests nationally and internationally mergers are not always successful.<sup>10,11,12</sup>

This may, however, be partly due to a lack of published examples of successful mergers. There seems to be two key elements missing from unsuccessful mergers. The first is a lack of a compelling strategic rationale linking to an absence of substantive changes in service delivery. The second is a lack of effective pre- and post-merger management. Where these elements are in place the success of mergers appears to be far higher.

### **The ability to deliver the benefits described in Stage One**

In the City of Manchester there have historically been challenges and differences between the separate organisations. In other locations such difficulties have been shown to limit the benefits of integration. This was discussed and recognised in the Clinical Working Groups (CWGs) in Stage One of the Review. However, the CWGs also displayed an overwhelming sense of goodwill and willingness to overcome these challenges. For example in the third clinical working group, members of the cardiac services breakout group were able to set aside the differences imposed by organisational boundaries and demonstrate the benefits of working together.

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<sup>8</sup> Source: Monitor, Success at Wexham Park is a model for the rest of the NHS, 2 February 2016

<sup>9</sup> Source: The King’s Fund, Foundation Trust and NHS Trust Mergers 2010 to 2015, September 2015

<sup>10</sup> Source: Kastor JA. Failure of the merger of the, Mount Sinai and New York University, Hospitals and Medical Schools. Part 1., Acad Med. 2010; 85(12):1823-1827,

<sup>11</sup> Source: Kastor JA. Failure of the merger of the Mount Sinai and New York University Hospitals and Medical Schools. Part 2. Acad Med. 2010; 85(12):1828-1832,

<sup>12</sup> Source: Kjekshus L, Hagen T. Do hospital mergers, increase hospital efficiency? Evidence from a national health service country. J Health J Health Ser Res Policy. 2007;12(4):230-235

A new integrated organisation is likely to provide the best forum to deliver the key enablers identified in section (3.2) (i.e. effective deployment of agreed clinical protocols and pathways, HR arrangements that allow staff to work flexible across all sites, progress towards effective shared information systems, centralised arrangements for communicating with patients). This is because a new integrated organisation will provide greater clarity of leadership and accountability and will have the decision making power to push through the changes that the enablers require.

In the City of Manchester there have been numerous attempts to operate with greater levels of cohesion between the organisations. Whilst there are now some examples of collaborative working between sites, the current arrangements offer no prospect of single service models for all services across the City being achieved. This is partly due to a lack of clear organisational form through which to drive the necessary change. A single organisation could provide the structure and the cohesive identity coupled with the necessary authority and accountability to deliver the benefits of a single hospital service.

#### 4.2 Preferred organisational model

Any organisational arrangement for hospital services in the City of Manchester must deliver:

- The enablers of a Single Hospital Service as identified in section (3.2)
- The benefits of a Single Hospital Service as identified in section (3.1)
- Commissioner requirements regarding a single contractual arrangement and a unified focus of authority
- A clear consideration of implementation issues

It is important that the organisational form is not seen as the end point; instead it is the means by which the benefits of a Single Hospital Service are realised. It is vital that the transformation of health care services in Manchester is delivered and therefore any organisational form must facilitate this change, rather than hinder it.

The appraisal of organisational forms has indicated that options which maintain the status quo (with existing organisational structures) and/or to create a 'partnership' do not meet commissioner requirements. Neither are they likely to deliver the enablers required for a successful Single Hospital Service and therefore the benefits. For some time, hospitals in Manchester have attempted, in their current organisational forms, or through loose partnership agreements, to work more collaboratively in order to improve services. Too often organisational boundaries, disagreements about finances and/or the perception of 'winners' and 'losers' have prevented real co-operation and there is little to suggest that trying to pursue these types of arrangements further will achieve any real benefits.

The prime contractor, franchise and joint venture options have a number of benefits but their use is best suited to a small number of individual single service models. Manchester commissioners are clear that their requirement is for a single contract and point of authority for *all* hospital services. In addition, a Single Hospital Service will encompass a large range of services, specialties and sub-specialties and trying to effectively manage a prime contractor, franchise or joint venture arrangement, at this scale would be likely to prove too complex and costly to deliver effectively and consistently. It is therefore unlikely that these options would deliver the benefits of a full single hospital service.

The remaining options for delivering a Single Hospital Service are a hospital chain and the creation of a new integrated organisation. Although the creation of a hospital chain offers a range of benefits, it may not bring about the sense of organisational cohesion and accountability that was identified in

the Stage One report as being an essential enabler for successful single service models. In addition, the hospital sites in the City of Manchester are in close geographical proximity of each other and the single service models highlight the need to move away from the 'site based' clinical services that a hospital chain may perpetuate. Finally, the organisational model of a hospital chain is still a relatively new concept in the NHS and governance models are yet to be clarified. Its infancy may limit the extent to which it would be able to offer the scale and pace of change needed to bring about the required benefits. For these reasons I do not think that a chain is the correct model for the Manchester Single Hospital Service to adopt.

I have therefore concluded from this review that the organisational form most likely to deliver the enablers, and therefore the benefits of a Single Hospital Service, would be the creation of a single new organisation, which would take responsibility for the full range of hospital services currently provided by CMFT, UHSM and NMGH . This new organisation would have authority to deliver the enablers of a single hospital service and would have the levers and organisational resource available to ensure that all the benefits of a single hospital service could be realised.

The creation of a new organisation is not without challenges and there are key implementation issues that will require consideration. These are discussed in more detail in section 5.0.

## 5.0 Requirements for implementation of organisational change

The implementation of any change to organisational structure will require a series of issues to be addressed. The greater the change, the greater the complexity and time required. The creation of a new organisation therefore has a high level of challenge. The sections below outline some of the key issues that will require consideration if a new hospital organisation in the City were to be created.

### 5.1 Competition requirements

If the recommendation to create a new hospital organisation for the City of Manchester were accepted by all relevant parties, the resulting organisational change would need to demonstrate relevant patient/customer benefits against the potential loss of choice and competition both in and for the market. The proposed changes are significant in scale; the existing organisations have similar service portfolios and are geographically adjacent. It is probable that the creation of a new organisation would be subject to review by the Competition and Markets Authority (CMA). NHS Improvement would then need to provide advice to CMA on the extent of relevant patient benefits and the Manchester stakeholders would need to consider what binding undertakings could be given to mitigate the effect of loss of competition. To support this process, it will be necessary to develop:

- A clearly articulated vision of what the parties were trying to achieve for the local patient population and for patients from further afield.
- A description of the major benefits associated with these changes and the quantified impact of these on patients and the quality of care, on education, research and finances, as well as on the impact on the wider healthcare system.
- An explanation for why these changes can only be achieved through the creation of a single new organisation, and not through other collaborative vehicles or other organisational forms.
- A detailed implementation plan, showing phasing, cost implications associated with delivering the change (capital investment, one-off costs and ongoing operating costs).
- A Counterfactual to the change which clearly describes what the parties can and will still do if they cannot form a single new organisation, including the associated costs and patient, staff, student and financial benefits. The CMA weighs up the lessening of competition associated with change against the counterfactual, when assessing the creation of a single new organisation.

### 5.2 Governance and regulatory requirements

Two of the three existing organisations are Foundation Trusts and the third is an NHS Trust. There are different regulatory requirements for the different organisational regimes. There may be more than one approach that could be taken to establishing a new integrated hospital services organisation for Manchester, and the existing organisations will need to seek advice from NHS Improvement about the most appropriate and effective process to go through. In this connection, it may be helpful to consider breaking the organisational changes down into more than one transaction. It is important to note, however, that the scale of the proposed changes is such that

NHS Improvement's risk assessment process will undoubtedly consider the changes to constitute a "significant" transaction, and so a more detailed review by NHS Improvement will be required.

For the Foundation Trusts, the role of the Councils of Governors is also important, both in respect of the approval of the proposed changes, and because the establishment of a new organisation would require a revised constitution and a different structure for the Council of Governors. These matters will need to be given considerable thought, with detailed processes for engaging and involving the existing Governors in the process.

### 5.3 Engagement and communication

Engagement and communication provide the opportunity for all stakeholders to input into the proposals. Although significant engagement has occurred with a range of key stakeholder through the Single Hospital Service review process, there will be a requirement to expand this engagement in the event that a formal proposal around the creation of a new organisation is made. Extensive and transparent communication about the rationale for and the implications of, the proposed change will be essential to ensure wider acceptance of the change.

Developing a compelling case for change and narrative for delivery of any change is critical for securing the engagement of the public and staff. The narrative should include the following components:

- **Strategic Direction.** A clear strategic direction and a well-articulated description of what change will achieve will need to be developed. This should highlight that organisational change is a means to an end and that the end is the ideal service model that has optimum benefits for patients.
- **Rationale for organisational change.** There will need to be an explicit rationale for change and a description of the implications should change not occur. This case should be built on formal input from clinicians.
- **Description of benefits.** The benefits for patients, for staff and for tax payers will need to be set out in detail. The benefits identified in the Stage One report (quality of care, patient experience, workforce, financial and operational efficiencies, research and education) could form the basis of this work.

### 5.4 Interdependencies

There will need to be an effective assessment of the impact of any change on the wider health economy, and interdependencies with other health and social care systems.

- Changes proposed within by the single hospital service review are interdependent with other changes happening within the local health economy – in particular the establishment of Local Care Organisations (LCO) aiming to reduce acute sector activity by ~ 20% and the move to a single commissioner.
- Changes sought as a result of the Single Hospital Service Review will need to align with the wider Healthier Together programme across Greater Manchester.
- Changes sought as a result of the single service review will need to take account of the impact on other health economies served by the organisations involved, in particular those of Trafford, Bury, Rochdale and Oldham.

## 5.5 Programme Management and planning

Any large scale organisational change requires a significant level of planning and dedicated resource. These requirements are outlined in more detail in sections 5.5.1 – 5.5.3.

### 5.5.1 Programme delivery team

A dedicated and sufficiently resourced management team would need to be put in place specifically to lead the organisational change: the effort needed to plan and oversee the tasks required by large changes cannot easily be delivered by senior staff with a full portfolio of existing commitments. The team needs to be led by an experienced senior executive, who will report to the Senior Responsible Officer(s) and be held accountable by an appropriately constituted Programme Board.

Responsibilities within the integration team should also be clearly identified, and timetables for all activities should be established. Lines of accountability to the Trusts' governing bodies will need to be clarified, including recognition of any statutory requirements.

A great deal of emphasis will also need to be placed on the cultural integration of the three hospitals. Currently each Trust will have its own set of values, beliefs and assumptions. To work effectively, as a single organisation, work must be undertaken to start to work through these cultural differences and to enact the appropriate Organisational Development strategies to overcome any obstacles.

### 5.5.2 Implementation Plan

The programme team will need to develop an implementation plan that coordinates the programme activities effectively throughout the change. The team will need to:

- Develop and articulate the shared values and beliefs of the new organisation
- Focus on benefits realisation
- Manage the “moving parts” of the organisational change – monitoring and managing any external or internal developments that could affect the change programme.
- Maintain energy and momentum needed during complex and potentially lengthy integration
- Recognise the need to address cultural issues – if not managed effectively, cultural differences can slow the speed of change and increase transition costs considerably.
- Ensure clear and frequent communications tailored to every stakeholder group.

### 5.5.3 Quick Wins

There will be some benefits that can be captured quickly, through relatively small, low risk actions. Some examples of these are:

- Encourage and facilitate staff across sites to collaborate, for example creating methods of sharing information on clinical trials taking place at each site and proposals for future research and innovation
- Agree common pathways and protocols across sites in the eight exemplar specialities
- Agree integrated ways of working with the Local Care Organisation

- Begin joint procurement
- Agree a cap on bank and agency staff to prevent staff shortages driving up prices, and create a combined pool of bank staff
- The stabilisation of any existing clinical services immediately identified as being at risk.

## 6.0 Conclusion

The City of Manchester has three major hospitals within a close geographical proximity. Although there is much to be proud of there are a range of clinical, workforce, financial and operational challenges that need to be resolved. These challenges are significant and their magnitude is likely to increase over time if they are not addressed. The Single Hospital Service Stage One Report concluded that the introduction of a Single Hospital Service, within the City, would provide an opportunity to tackle some of these issues, to reduce variability between hospital sites and to ensure that all clinical services can be raised to the standard of the best. In addition, the Stage One report highlighted the opportunities that a Single Hospital Service would bring to establish Manchester as a major academic health centre and to enhance the City's reputation as a place to work and be trained.

The Stage One Report also highlighted a range of enablers that would be required in order to successfully implement a Single Hospital Service. These include clarity of leadership, accountability for care, joint IT systems and common HR processes. This Stage Two report has considered which organisational form might best support the successful delivery of these enablers and therefore the benefits of a Single Hospital Service. A number of organisational models have been considered and an assessment of their suitability to deliver the enablers and the benefits has been made.

Whilst undertaking this assessment a number of key issues have been considered. The first of these relates to commissioner requirements. Manchester commissioners have made it clear that the existing structure and arrangements for providing hospital services are no longer acceptable. Their minimum requirement is a single system with a unified focus for authority and accountability and a single contract for hospital services in the City.

The scale and complexity of the change required has also been considered. Many of the organisational forms reviewed might be suitable for successfully managing a small and limited number of single service models within the City. However the Single Hospital Service model applies to all clinical service areas, back office functions, estates, education, research and innovation. The interdependency between clinical services and also between clinical and non-clinical services has to be managed as part of a whole system approach. It is therefore important that the organisational form is able to manage both the interdependency issues and also the scale of change required. In addition, there is also a degree of urgency with which change is required. Any organisational form must support the benefits of a Single Hospital Service to be delivered at pace and should not add unnecessary layers of complexity, bureaucracy or cost into the system.

As a result of the review I have concluded that the organisational form most likely to support the enablers and to deliver the benefits of a Single Hospital Service would be the creation of a new NHS organisation that would take responsibility for the full range of services currently provided by Central Manchester University Hospitals NHS Trust (CMFT), University Hospital of South Manchester NHS Foundation Trust (UHSM) and by Pennine Acute Trust (PAT) on the North Manchester General Hospital (NMGH) site.

It is important that the creation of this type of organisation does not adversely affect other hospital services within Greater Manchester. The NMGH hospital site currently forms only part of the Pennine Acute NHS Hospitals Trust, which also provides hospital services to the North East Sector of Greater Manchester from Oldham, Bury and Rochdale. The impact that the potential transfer of NMGH, to a new city-wide organisation, could have on other hospitals in the North East Sector

needs to be fully assessed and any resulting risks to the stability of clinical services need to be appropriately managed. In addition, the arrangement of healthcare services for the City of Manchester must take account of healthcare services across Greater Manchester. Any changes to hospital services in the City need to be co-ordinated to work alongside an integrated set of changes within the wider conurbation.

The review process has recommended that the creation of a new City wide hospital organisation provides the best opportunity to deliver the benefits of a Single Hospital Service. However this, in itself, is not without challenges. The creation of a new organisation will be a complex and relatively time consuming process. This process is unlikely to be successful without a clear articulation of a strategic direction for the new organisation and detailed implementation plans to support the process. Strong leadership will be required, across all existing organisations and within the new organisation, to ensure the benefits are well understood and have the support of all key stakeholders. Clear communication and engagement will be required with a range of audiences, most notably the public, patients and staff groups.

Although organisational form is important, the creation of a new organisation, in itself, is not the prize that Manchester should be reaching for. Organisational change, on its own will not deliver the benefits identified in the Stage One Report. Rather, the new organisation provides the structure, the authority and the accountability to ensure that clinical transformation takes place and all the benefits of a Single Hospital Service can be delivered. The new organisation provides the City with a real opportunity to deliver hospital services that rival the best in the country and to ensure that patients within the City are able to access high quality, efficiently run hospital services regardless of where they live.

## 7.0 Recommendations

The recommendation of the second stage of the Single Hospital Service Review is that:

- **The Health and Wellbeing Board should request CMFT, UHSM and PAT to enter into discussion to consider the creation of a new, single organisation and to provide an initial assessment on implementation requirements and timescale. The Trusts should report back the outcomes of these discussions to the Health and Wellbeing Board within 6 weeks.**

A range of issues will need to be addressed in these conversations including the following:

- The process and phasing that might be needed to create a single organisation within the City. For example, the establishment of a new Foundation Trust through the bringing together of UHSM and CMFT, might precede the subsequent integration of NMGH.
- The need to ensure the safe and reliable provision of hospital services within the City. Where there are clinical services in which significant risks to patient safety are identified, the three organisations should work together to ensure the safety and stability of such services, even if this precedes formal organisational change.
- The strategic alignment between the Manchester Single Hospital Service review and the North East sector review. This would include minimising any adverse impact from the realignment of North Manchester General Hospital on the sustainability of either the remaining clinical services provided by Pennine Acute Trust or the proposed new City wide Hospital Trust.
- The communication, engagement and/or consultation processes required to ensure that patients, the public, staff and other stakeholders are engaged in and able to influence the future Single Hospital Service.
- A programme for the delivery of the benefits described in the Stage One Report including improvements to the quality of services, improvements to patient experience, addressing existing workforce challenges and tackling financial deficits.
- Commissioner expectations for the overall size and shape of hospital services in Manchester.
- The requirement to ensure that work within the City of Manchester is co-ordinated to complement an integrated set of changes across Greater Manchester.

**Sir Jonathan Michael**

**27<sup>th</sup> May 2016**



## City of Manchester Single Hospital Service Review Stage 2 Report

### Commentary from Central Manchester University Hospitals NHS Foundation Trust

19 May 2016

The Trust is grateful to Sir Jonathan for the considerable efforts of the Review Team in gathering and analysing evidence and producing positive and independent advice on the future options for hospital services in Manchester.

The evidence laid out in the Stage 1 report provided a compelling assessment of the very considerable benefits that could be delivered by providing hospital services in Manchester in a more coordinated, complementary and collaborative manner. The challenges facing the health and social care system in Manchester have never been greater, and system leaders no longer have the luxury of ignoring real opportunities to make the care delivered to patients safer, more effective, and more sustainable.

The Trust is fully committed to delivering a single hospital service in Manchester, and the achievement of the associated benefits (as described in the Stage 1 Report). The Trust considers this to be a higher priority than the success or otherwise of any individual hospital service or provider organisation.

The Stage 2 Report demonstrates that the Review Team has made a very thorough assessment of a comprehensive range of options, in order to identify the optimal mechanism for Manchester to achieve a single hospital service. It is important to note that the “do nothing” option (ie maintaining the current arrangements) does not meet the requirements of Commissioners, and the report should perhaps express this point more clearly.

The experience of managing hospital services with multiple provider organisations in Manchester tells us that semi-formal agreements to work in closer alignment have a poor history of delivering real benefits for patients. The Report provides compelling evidence that to deliver the maximum benefits in the most timely manner, the Manchester Trusts need to commit themselves to a programme of radical organisational change.

The Trust recognises that Sir Jonathan, as well as seeking evidence from across the NHS and further afield, also has considerable personal experience of overseeing major changes to organisational arrangements in the NHS, and has no doubt drawn on this in making his assessment.

Changing the structure of NHS organisations is no small undertaking. UHSM and CMFT are Foundation Trusts – an organisational form designed to emphasise independence and institutional sovereignty, with built-in protection against seeking change too readily. The services at North Manchester General form part of the set of hospitals managed by the Pennine Acute Hospitals Trust, with a catchment area that also extends across Bury, Rochdale and Oldham. For many years, the guiding principle for these services has been the integration and rationalisation of services over the Pennine footprint, and refocusing the North Manchester services into a single hospital service for Manchester will be a significant undertaking.

Notwithstanding the scale of these challenges, Sir Jonathan has concluded in the second stage of his Review that the establishment of a new organisation to manage the delivery of hospital service in Manchester is the most appropriate and effective way for the Manchester system to deliver the full range of benefits as identified in the Stage 1 Report.



Central Manchester University Hospitals NHS Foundation Trust is fully in agreement with both of Sir Jonathan's reports and, in particular, is strongly supportive of the principal recommendation in the Stage 2 Report that the three Trusts should enter into discussions about how to create a single organisation to run hospital services in Manchester.

CMFT has direct experience of implementing significant organisational change in the recent past, and is acutely aware of the challenge of sustaining services on multiple sites, whilst delivering organisational change and, above all, keeping an unwavering focus on deliver planned benefits. This experience could be drawn on to help the Manchester Trusts to manage the proposed changes in an effective and timely manner.

The report makes a helpful suggestion about the potential to phase the proposed organisational changes. The Trust would go further than this: to deliver the overall programme safely and effectively, it will be of critical importance to break it down into manageable projects. Agreeing the optimal phasing will be one of the key tasks to be undertaken in developing a robust implementation plan.

The Trust notes also Sir Jonathan's sensible suggestion that advice should be sought from NHS Improvement on the most effective way to go about establishing a single organisation for the provision of hospital services in Manchester.

University Hospital of South Manchester   
NHS Foundation Trust

*Chairman's office*  
*Trust HQ*  
*Tel: 0161 291 2021*  
*Fax: 0161 291 2037*

**Wythenshawe Hospital**  
Southmoor Road  
Wythenshawe  
Manchester  
M23 9LT  
Tel: 0161 998 7070

24 May 2016

Sir Jonathan Michael, FRCP  
Independent Review Director  
City of Manchester Single Hospital Service Review

By email to [Alison.Olivant@uhsm.nhs.uk](mailto:Alison.Olivant@uhsm.nhs.uk)

Dear Jonathan,

On behalf of University Hospital of South Manchester NHS Foundation Trust I would like to thank you for the City of Manchester Single Hospital Service Review Stage 2 Report. We welcome your thorough appraisal of the potential single hospital service models and detailed consideration of what model might best support the delivery of the benefits and enablers identified in Stage 1.

We recognise that the current organisational arrangements for hospitals in the City will not meet the scale of quality, operational and financial challenges that the Manchester health system faces. Neither will the current arrangements enable us to deliver the benefits you set out in Stage 1 nor realise the full potential of Manchester as an academic health science centre. We are convinced that major, system wide change is needed to establish the underpinning organisational arrangements that will enable us to realise, in an efficient and timely way, the benefits you described.

Therefore, on behalf of UHSM, we are fully committed, as a Board and an organisation, to working with Central Manchester University Hospitals NHS Foundation Trust and the Pennine Acute Hospitals NHS Trust to consider the creation of a new, single organisation. Given the scale of the undertaking and to deliver the benefits quickly, the resources required are likely to be considerable. Together with the other two trusts, we will report back to the Health and Wellbeing Board within six weeks on our initial assessment of the timescales and implementation requirements.

We believe it is important to emphasise that the single hospital service is only part of the wider transformation of health and social care in Greater Manchester and only one of three key transformational programmes in the Manchester Locality Plan. As we highlighted at Stage 1, it continues to be critically important that the single hospital service work is also aligned with the GM Standardisation of Acute Care strategic theme, the work in the North East Sector and Healthier Together. In Manchester, creating a single locality care organisation which supports people at home and in the community is central to our ambitions to improve the health and wellbeing of the people of Manchester.

The single hospital service, alongside the development of a single commissioning function, will be the key enabler of the single locality care organisation, supporting the shift of care from hospitals into the community.

Building on the energy and clinical engagement developed through the clinical working groups in Stage 1, we are keen to maintain the momentum for change to ensure we start to realise benefits as early as possible. As we said in response to Stage 1, a critical early step will be defining and agreeing with all stakeholders in the system the broad roles of the three hospital sites to ensure that any early changes support the overall ambition for the single hospital service.

In addition it is important to start work on the enablers set out in the Stage 1 report, and critically on the interoperability of IT systems, as soon as possible. Currently the three trusts are taking different approaches to electronic patient records but we believe it will not be possible to realise the full benefits of a single hospital service without the ability to share patient information seamlessly between the different teams, services and sites. We will work with CMFT, PAHT and commissioners to understand and address these issues.

We strongly believe that changing organisational arrangements for hospital services in the City is necessary to enable us to deliver the benefits we have identified, but we must remember that it is not an end in itself. Our focus must remain on improving the health of the people of Manchester and delivering outstanding services to the patients we serve from Manchester, across the North West and beyond. This was absolutely the starting point for this review and will remain the fundamental purpose to which UHSM, in partnership with CMFT and PAHT, is fully committed.

Yours sincerely,



Barry Clare  
Chairman



If calling please ask for:  
**Sir David Dalton**

Direct line / Ext:  
**0161 604 5467**

Our ref: DD/BH-S  
Your ref:

Date 26th May 2016

**Department**  
North Manchester General Hospital  
Delaunays Road  
Crumpsall  
Manchester  
M8 5RB

Telephone: 0161 604 5467  
E-mail: David.Dalton@pat.nhs.uk

Sir Jonathan Michael  
Independent Review Director

Dear Sir Jonathan

**Re: City of Manchester Single Hospital Service Draft Phase 2 Independent Report**

Thank you for attending the Pennine Acute Hospital NHS Trust Board Development session on the 18th May 2016, to present your findings from Phase 2 of the City of Manchester Single Hospital Service Independent Review.

The City of Manchester Single Hospital Service, which forms one of the three pillars of the Manchester Locality Plan, was commissioned by the Manchester Health and Wellbeing Board as a partnership between Central Manchester University Hospital NHS Foundation Trust (CMFT), University Hospitals South Manchester NHS Foundation Trust (UHSM) and The Pennine Acute Hospital NHS Trust (the Trust) and as such we are fully committed to the process.

Building on the Boards response to the Phase 1 Independent Review, there are a number of considerations from the Phase 2 report, which the Board highlighted, including:-

- Where there are identifiable clinical risks, the three organisations should work together to ensure the safety and sustainability of services
- Recognition that the Trust serves the populations of Rochdale, Bury and Oldham, as well as North Manchester and that developments in one locality should not destabilise services in any other locality, and as a consequence
- The Board felt it particularly important to undertake a detailed assessment of the potential impact of implementing the Single Hospital Service for the City of Manchester on those populations
- Clarity on future models should be progressed at pace to avoid any potential negative impact on recruitment and retention



As you are aware, the North East Sector is currently undertaking a review, led by Mike Farrar, to assess the impact on the Trust of the implementation of the four Locality Plans, Healthier Together and the Trust's own Clinical Services Transformation Programme and therefore:

- proposals from the City of Manchester Single Hospital Service Review should take account of the outcome of that work

The Trust was pleased to see the subsequent revised recommendations, received 18th May 2016, which take account of the views of the three Trusts and particularly address bullet point one.

Should you have any questions or require clarification on any of the points raised please do not hesitate to contact: Sandra Good, Director of Strategy and Commercial Development [sandra.good@pat.nhs.uk](mailto:sandra.good@pat.nhs.uk)

With best wishes

Yours sincerely

Handwritten signature of Jim Potter in black ink.

Jim Potter  
**Chair**

Handwritten signature of Sir David Dalton in black ink.

Sir David Dalton  
**Chief Executive**

**Manchester Health and Wellbeing Board  
Report for Resolution**

**Report to:** Manchester Health and Wellbeing Board – 8 June 2016

**Subject:** Commissioning response to Manchester Single Hospital Service

**Report of:** Caroline Kurzeja, Hazel Summers, Martin Whiting & Ian Williamson

**Summary**

This report:-

- Reiterates commissioner support for the first stage report regarding the Single Hospital Service for Manchester.
- Gives support to the recommendations of the second stage report regarding organisational arrangements.
- Sets out the scope of the next stage of implementation.
- Sets out the commissioning arrangements for the next stage of implementation.

**Recommendations**

The Board is asked to note the above.

**Board Priority(s) Addressed:**

Health and Wellbeing Strategy priority	Summary of contribution to the strategy
Getting the youngest people in our communities off to the best start	The single hospital service will enable:- <ul style="list-style-type: none"> <li>• Good outcomes for hospital care</li> <li>• Good access to hospital care when needed</li> <li>• Care which is better connected to community services supporting people to live independently in the community</li> <li>• Resource shift to support investment in proactive and upstream care.</li> </ul>
Improving people’s mental health and wellbeing	
Bringing people into employment and ensuring good work for all	
Enabling people to keep well and live independently as they grow older	
Turning round the lives of troubled families as part of the Confident and Achieving Manchester programme	
One health and care system – right care, right place, right time	
Self-care	

**Lead board member:** Mike Eeckelaers, Mike Greenwood, and Philip Burns

## **Contact Officers:**

Name: Caroline Kurzeja  
Position: Chief Officer – South Manchester CCG  
E-mail: caroline.kurzeja@nhs.net

## **Background documents (available for public inspection):**

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

Manchester locality plan  
Single hospital service review – first stage report  
Single hospital service review – second stage report  
Greater Manchester Health and Care Strategy – ‘Taking Charge’  
Greater Manchester Commissioning Strategy

## 1.0 Introduction

The three Manchester CCGs and Manchester City Council (the commissioners) have previously supported the first stage report for the Single Hospital Service which outlined clear benefits of closer working between the three Manchester trusts.

Manchester commissioners support the recommendation of the second stage report which outlines the proposed organisational arrangements to realise these benefits and we will consider more formally shortly.

This paper outlines next steps relating to the Single Hospital Service programme. As with all elements of the Locality Plan we will work collaboratively with Health and Wellbeing Board (HWB) members. The next steps fall into two themes:-

- 1. To set out parameters for the implementation of the single hospital service recommendations.**
- 2. To set out how we plan to commission for a single hospital service.**

These are set out in broad terms and will be developed in the coming weeks.

## 2.0 Scope for implementation

Commissioners wish to see realisation of the benefits set out in the first stage report as soon as possible. Changes in organisational form are necessary to fully realise these benefits.

### 2.1 Benefits realisation

The Single Hospital Service is a key part of the Manchester Locality Plan. Alongside reform of both commissioning and out of hospital care, hospital services are critical to achieving the fastest improvement to population health as well as financial sustainability. Benefits relating to quality of care, patient experience, workforce and financial & operational efficiency make the strongest contribution to health gain and alignment to the aims of the Manchester Locality Plan. They will also benefit residents outside of Manchester. These should, therefore, have emphasis in implementation.

The full benefits of the Single Hospital Service can only be fully realised through the recommended changes to organisational form. In addition, collaborative services in place and in development, (e.g. General Surgery and the 'exemplar' services) can progress at pace. This can be supported through new commissioning arrangements with the trusts which can be put in place in the short term.

In the immediate term the closer working arrangements between the trusts should aid shorter term issues of resilience (demand and workforce) and quality to be tackled collaboratively where possible.

Enabled by the change in organisational form the trusts will be able to build upon their existing high quality services. It is important that each hospital site remains vibrant, valued and delivers high quality services for the local population. Where

there are clear benefits to deliver services on fewer sites these will be agreed with commissioners. In summary we will need to agree with the trusts the following:-

- The standards to be achieved for all patients using hospital services.
- The range of services to be provided from each site.
- The patient outcome improvements required in the short and longer term.
- The financial benefits delivered via the 20% resource shift to community.

## **2.2 Wider context**

The development of the Single Hospital Service sits within a wider strategic context. The Greater Manchester strategic plan 'Taking Charge' theme for acute and specialist care sets the context for these changes. In addition there are clear interdependencies with other hospital sector transformation programmes in Greater Manchester, particularly those in the North East Sector (North Manchester, Oldham, Bury and Rochdale).

The benefits will extend to the population outside of Greater Manchester. It is important that this is a key feature of the implementation and hospital services effectively connect with other parts of the GM health system, especially their community services. Service contracts relating to Manchester hospitals represent the majority of the total district general and specialised services commissioned by Manchester and Trafford CCGs. For most other Greater Manchester commissioners, contracts with Manchester hospitals are significant, often their second largest by size.

## **3.0 Commissioning**

The Single Hospital Service changes are significant in terms of service change and organisational arrangements. Changes will bring significant opportunities but potentially bring new risks. Therefore, commissioning arrangements will change accordingly.

Manchester commissioners will work with the Association of Greater Manchester CCGs and the Greater Manchester Joint Commissioning Board to develop the Acute Standardisation theme of the Greater Manchester strategy.

The locality plan and commissioning strategy plan for a reduction in hospital sector spend in order to rebalance the health and social care economy. This will need to be factored into the implementation of the Single Hospital Service in terms of generating shift to the Locality Care Organisation but also managing the risk of a reduced hospital share of the overall Manchester budget. The change in organisational form and transformation of services will help to mitigate these.

Commissioning can drive forward implementation, benefits realisation and progression to a new organisational form. As with the Local Care Organisation we intend to start contracting for the Single Hospital Service from April 2017.

## **4.0 Recommendations**

Health and wellbeing board is asked to note.

- Commissioners' support to the recommendations of the stage one and stage two reports.
- The actions set out determining the scope of the next stage of this work and the need for a collaborative approach to implementation planning.
- The commissioning actions relating to the Single Hospital Service.