Joint Health Overview and Scrutiny Committee

Healthier Together Briefing
November 2016

1. Background

As the Joint Health Overview and Scrutiny Committee are aware, work has been progressing to implement Healthier Together (HT) since July 2015. In strategic terms, this sees the Royal Oldham Hospital become a high acuity site for general surgery for the North East Sector (Bury, Rochdale, Oldham and North Manchester).

2. Developing the Business Case

Originally, the NE sector was required to complete an outline business case by December 2016 and a final business case for the implementation of the Healthier Together changes by March 2017. This business case, along with the other three sectors would then be amalgamated into one by HT and one GM funding bid submitted.

The start of this process was the creation by HT of a Greater Manchester position statement which was to be submitted to the Theme 3 Delivery Board. However, it became apparent that there were issues with the HT GM position statement. This has resulted in the position statement being reworked in November/December which has in turn impacted on the business case timetable. A new timetable has yet to be communicated by HT.

The NES is actively involved in the reworking of the position statement data. Stuart North from Bury CCG is the Senior Responsible Officer for the NES work at GM level.

3. Implementation timelines

No implementation date has been agreed. HT originally suggested April 2017 as the date when the first moves of high-risk elective GS could take place with emergency GS to move later. However, the risks listed below around a phased implementation and surgical independencies are still to be worked through. HT is comfortable with this. However, a number of points that other sectors are being asked to get in place by April 2017 are already in situ in the NES, namely; sector wide colorectal MDTs, a single GS lead, a single GS consultant team.

4. Brief description of what Healthier Together implementation means for NES

Under HT the following procedures will move from non-hub sites to specialist hospitals;

- All high risk elective General Surgery (GS). GS being defined as activity codes 100-General surgery (minus breast and vascular), 104 colorectal and 106 upper GI surgery. High risk being defined as a high risk procedure on any patient or a low risk procedure on a high risk patient
- All emergency GS

Since the Decision Making Business case was agreed, HT have decided that the difficulty in identifying relevant patients for ambulance crews means that no urgent, emergency or acute medicine (UEAM) will transfer under HT however UEAM still have a number of HT standards they will be expected to meet.

4.1 Activity shifts

Under HT the Royal Oldham Hospital becomes a specialist hospital. Modelling work indicates the following activity numbers will move;

	NMGH	ROH	FGH
High risk elective General Surgery	254 →		
Emergency General Surgery	1974 →		

4.2 General Surgery Model

This model is still in development and is being designed with the full engagement of GS consultants. This model is fully compliant with HT;

	Patient Cohort	ROH (hub)	NMGH (non Hub)	FGH (non hub)	RI (non hub
GS	High Risk Elective Surgery	✓	X	X	X
	Low Risk elective Surgery	✓	✓	✓	X
	Daycase	✓	✓	✓	✓
	Outpatient Clinics	✓	✓	✓	✓
	Emergency General Surgery	✓	X	X	X
	Ambulatory general Surgery Care	Delivered by a shared pathway across the sites			

4.3 Resource requirements

Modelling undertaken by HT and NES (using actual patient spell data) indicates that to accommodate the GS activity moving from NMGH the following additional resource will be required at ROH;

- 43 beds
- 4 Critical Care Beds
- 2 theatres

- Additional diagnostic and endoscopy resource requirement for GS is still being calculated
- Supporting infrastructure

The workforce requirements to deliver the GS model are currently being worked through.

This is still work in progress and will continue to be refined as part of the business case.

5. Main issues and risks

The main issues and risks are noted below for the Board's attention:

- It is still unclear as to where additional resources noted for both revenue and capital in the original HT work are going to be secured from.
- There remains a risk that required workforce may not be available or be able to be put in place, particularly around critical care, radiology and the requirement to deliver consultant led care 16 hours a day minimum at the specialist Emergency Department and 12 hours a day minimum at the non-hub Emergency Department
- Moving high risk activity to ROH will put additional strain on critical care which is currently being managed as a fragile service within the Pennine Acute Improvement Plan.
- There remains a view from Surgery is that moving high risk elective GS and emergency GS separately will present a number of issues around continuity of care for patients and the best approach will be to move both elements at the same time. As the emergency GS activity will require capital build to accommodate this will lead to a longer anticipated timeline for implementation
- There are a number of interdependencies between GS and other services which mean that moving GS will increase risk in other specialities. These are still to be worked through and include;
    - GS surgeons are often required to assist with fractured neck of femur patients on an emergency basis
    - The same cohort of junior staff the rotas for both GS and urology at NMGH. Moving the juniors to ROH with GS with destabilise the urology service.

6. Recommendations

The JHOSC is asked to note the progress being made with Healthier Together implementation. Further updates can be provided as the Business Case is nearing completion.