NES Clinical Services: Case for Change

DRAFT DOCUMENT

Summary case for change

The local population is growing and getting older, within a system already delivering some poor outcomes	▪ NES commissioners are responsible for commissioning care for Oldham, Rochdale and Bury, with most care delivered across 4 sites – Fairfield General Hospital (FGH), Rochdale Infirmary (RI), North Manchester General Hospital (NMGH) and Royal Oldham Hospital (ROH) – as well as links to Salford Royal Hospital via the Northern Care Alliance ▪ Collectively, along with Salford CCG, NES CCGs serve a population of ~900,000, which is **growing by 0.5% per year** with the number of people **over 70 projected to grow 12% by 2025**. This will result in a higher prevalence of long term conditions (LTCs) and frailty ▪ **Avoidable mortality rates** are already much **higher than the England average**, while life expectancy is among the lowest nationally
To address this, a different sort of care will be required to that historically provided …	▪ To address rising population health demands, LCOs are seeking to transform **out-of-hospital care** focused on **prevention of ill health, integration** and **moving care delivery closer to home** ▪ Greater Manchester has **been given £450m over 5 years** as part of devolution to invest into delivering these changes in care delivery ▪ Technology will play a key part in supporting many of these new models of care e.g. virtual outpatient clinics or remote monitoring
… resulting in decreased hospital activity and better health outcomes …	▪ The clinical evidence base suggests that a greater focus on prevention of ill health and on caring for people with LTCs and frailty in the community can significantly reduce the need for acute hospital care resulting in better health status and greater independence ▪ CCG plans to implement new models of care to deflect acute activity are underway, and over the past five years, **admissions across PAHT hospitals have fallen by 1% p.a. on average** while **average non-elective LoS is one of the lowest in the country** for its case mix ▪ Currently, **51% of NHS funds** available locally are **spent on acute care** and this percentage has been falling
… this is good for the local population, but will put further pressure on already fragile acute services …	▪ Current acute hospital services are split over five sites – FGH, RI, ROH, Salford Royal Hospital and also NMGH. Declining hospital activity will result in **subscale services** at each site – below levels recommended by national clinical bodies ▪ Services that need to be provided 7 days a week are particularly difficult to provide on sites where volumes of activity are low – this is particularly the case for **critical care**, which has **consultant shortfalls at FGH and NMGH** ▪ Lower volume services have been shown to be associated with **poorer quality of care**, with clinical teams less able to develop and maintain their skills, as well as **higher costs** due to **underutilised estate and workforce** ▪ There is variation in the quality of care across sites serving the NES population, with ROH and NMGH recently rated as **"requiring improvement"** and patients with MI and HF having **relatively poor access to consultant cardiologists** at ROH ▪ Operationally, 4-hour A&E **waiting times performance has been deteriorating** and is below the national average at ROH, NMGH and Salford, while **18-week RTT at ROH and NMGH is lower than the national average** and has been **declining** ▪ In terms of cost, the NCA had an underlying **£82m financial gap** in 2017/18 **projected to reach an underlying deficit of over £100m by 2022/23** assuming productivity increases of just over 2% are delivered each year ▪ Furthermore, recent workforce data shows that **7-18% of medical and nursing positions are vacant** at sites serving NES population, with **high levels of agency spend** to try to cover these positions
Consolidation is one of several ways to address the fragility of acute services	▪ The Healthier Together business case (2015) has already recommended that some services, e.g. general surgery, move in order to capture the benefits to clinical quality, workforce and financial sustainability from delivering services at scale ▪ Further consolidation may deliver similar improvements in other fragile services ▪ In addition, **reductions to length of stay** and **increasing throughput** of theatres, diagnostic services and outpatients will all enable more **efficient hospital services** and allow continued **investment in out-of-hospital care**

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Section summary

- NES CCGs commission care for Bury, Rochdale and Oldham; however any service change will have implications for Salford and North Manchester, as well as vice versa
- The population of the Bury, Rochdale, Oldham and Salford boroughs is slightly younger than the England average and is set to increase by 0.5% p.a. by 2025 with the over 70's and 90's being the fastest growing
- The NES and Salford areas have very high levels of deprivation, with particularly high pockets of deprivation in Rochdale and Salford
- Obesity and smoking are particularly prevalent in parts of Rochdale and Salford
- Respiratory diseases, especially smoking-related ones, and depression are higher than the national average
- Moreover, avoidable mortality rates are higher than other areas of the country with life expectancy generally less than surrounding areas apart from pockets in Oldham and Bury

The NES serves three boroughs; however any service change will have implications for Salford and NM, as well as vice versa

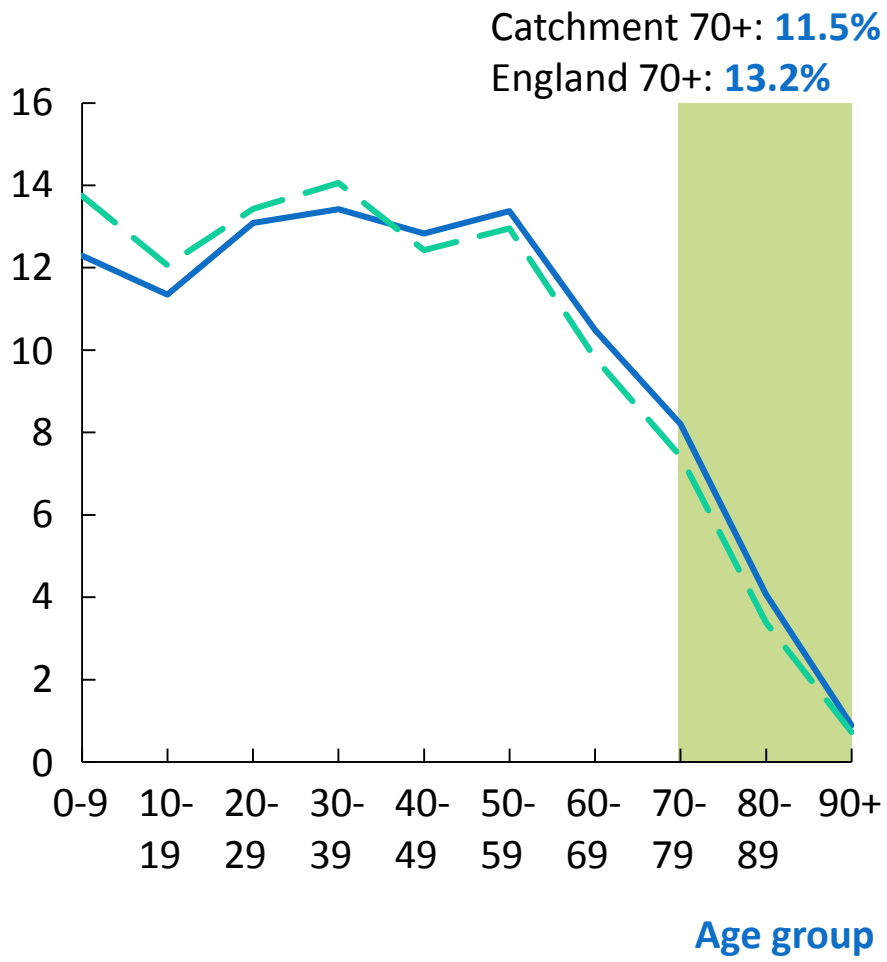
SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

The population of the four boroughs is slightly younger than the England average

70+ years | England | NCA boroughs

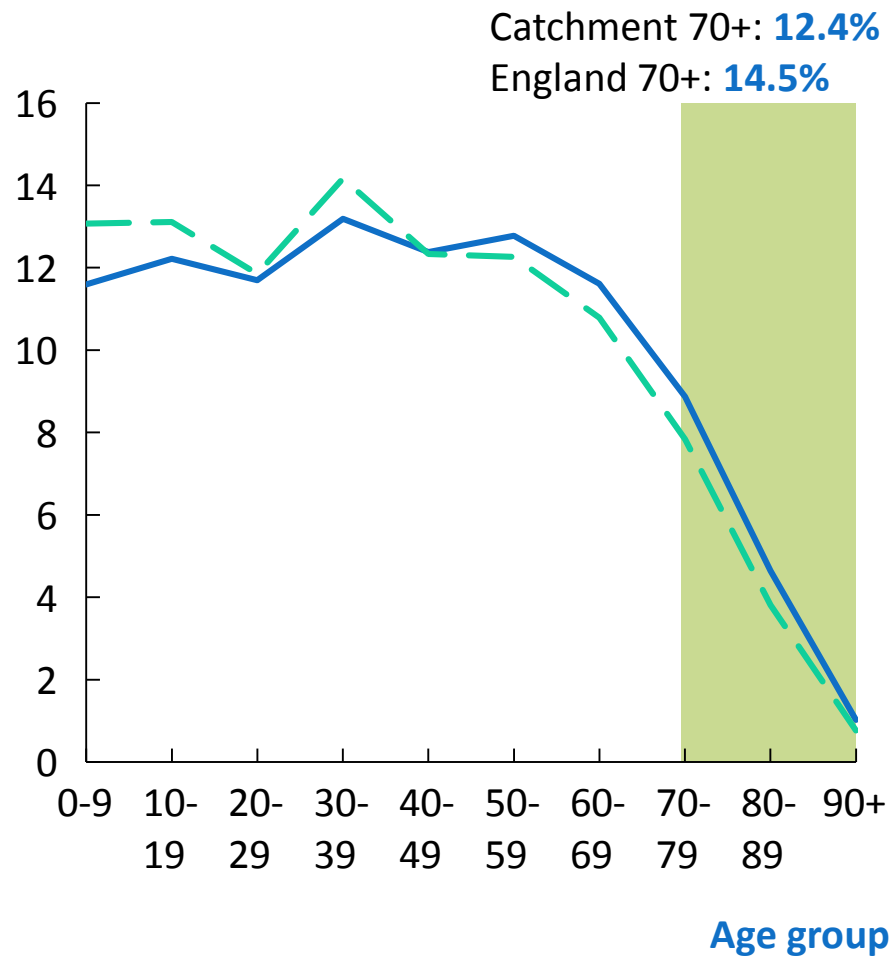
Age distribution of population

%, 2018



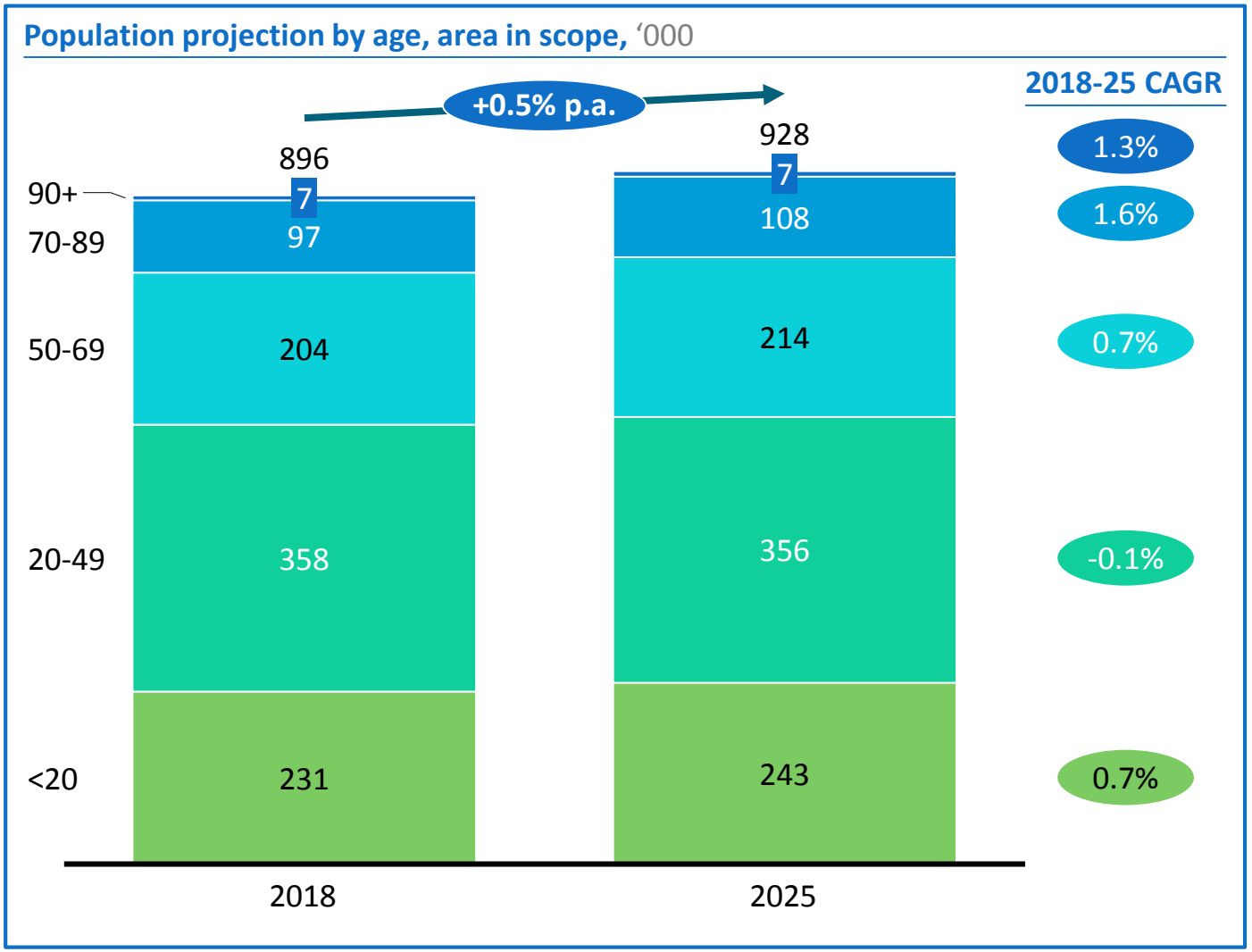
Projected age distribution of population

%, 2025



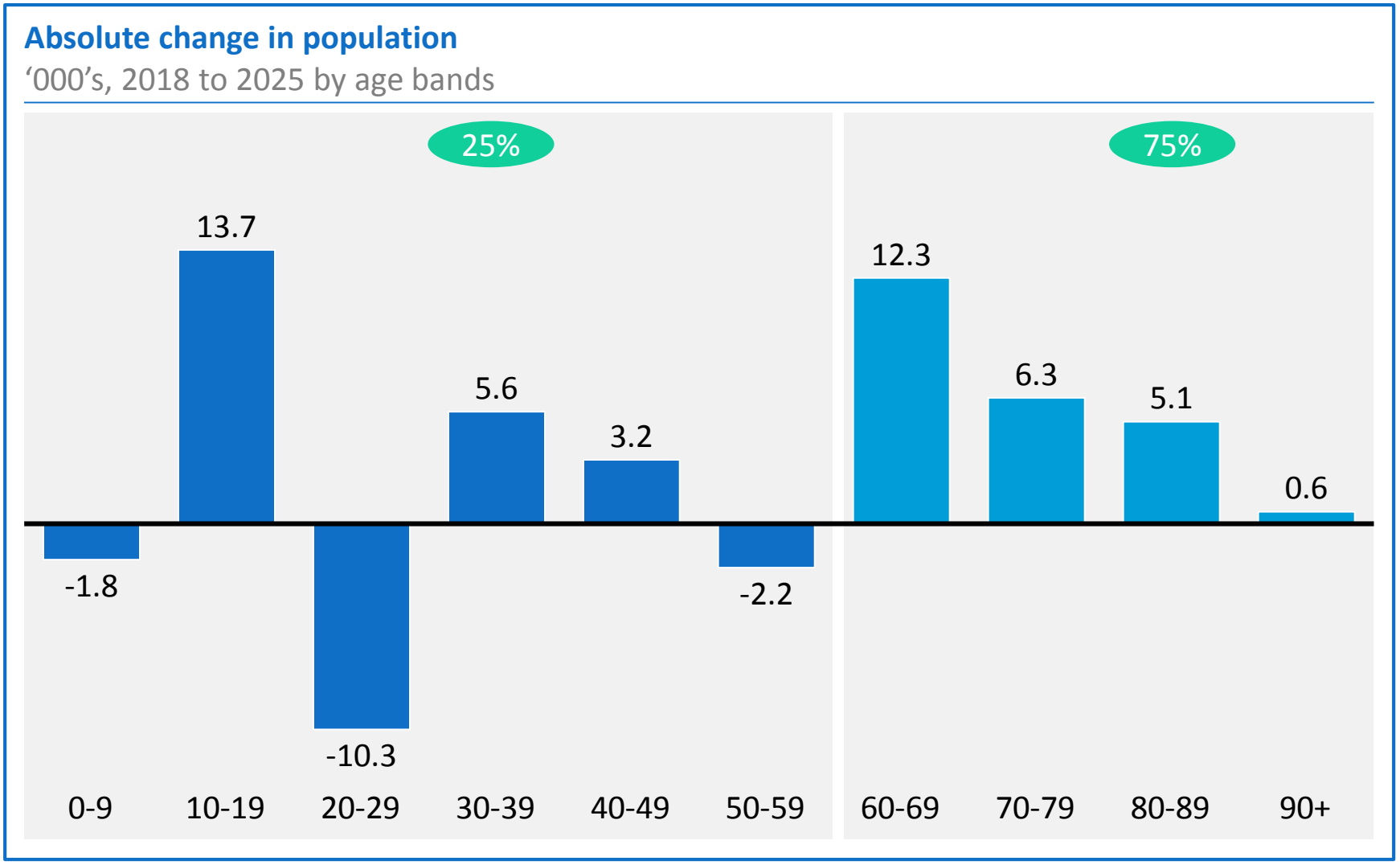
SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

Population in the four boroughs is set to increase by 0.5% p.a. by 2025 with the over 70's and over 90's being the fastest growing



SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

Almost three-quarters of the total population increase between 2018 and 2025 will be in the over 60's

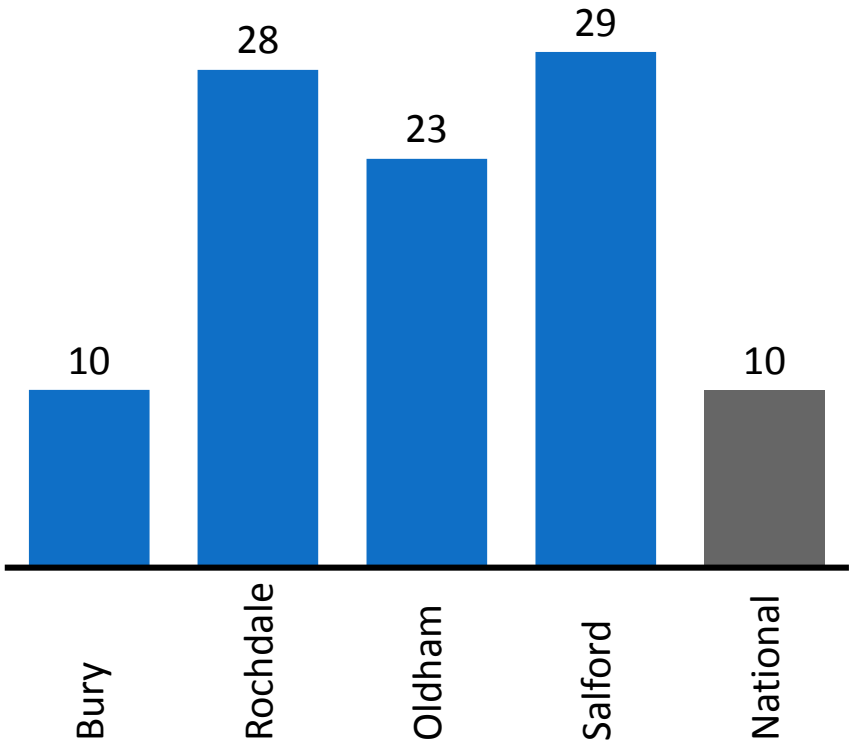


SOURCE: ONS 2018-based Sub National Population Projections; catchment area defined as the wards in the Boroughs of Bury, Oldham, Rochdale and Salford

The NES and Salford areas have very high levels of deprivation, with particularly high pockets of deprivation in Rochdale and Salford

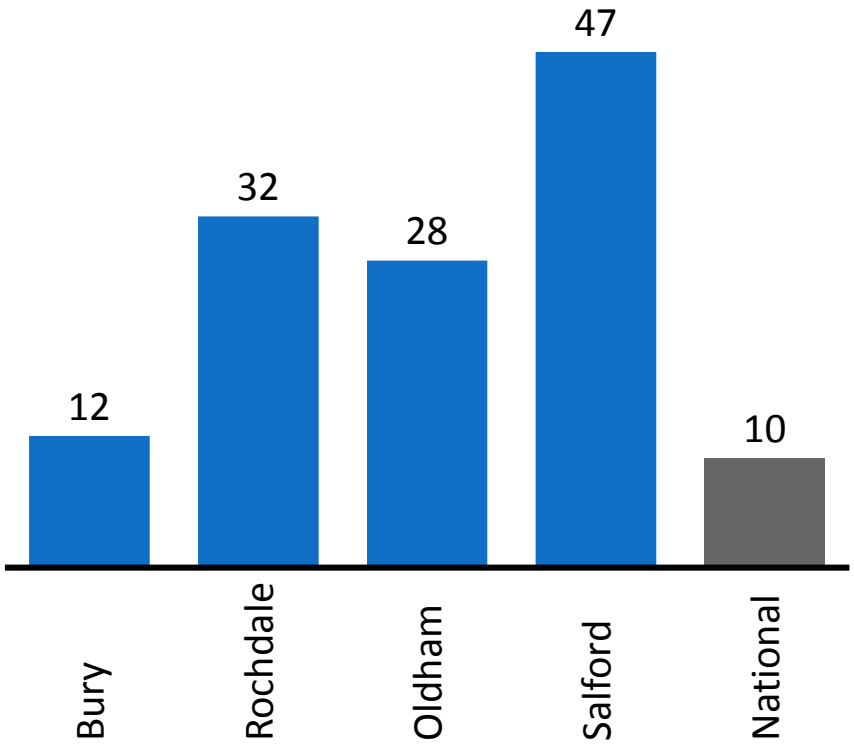
Overall deprivation[1]

% of LSOAs in most deprived decile, 2015



Health and disability deprivation

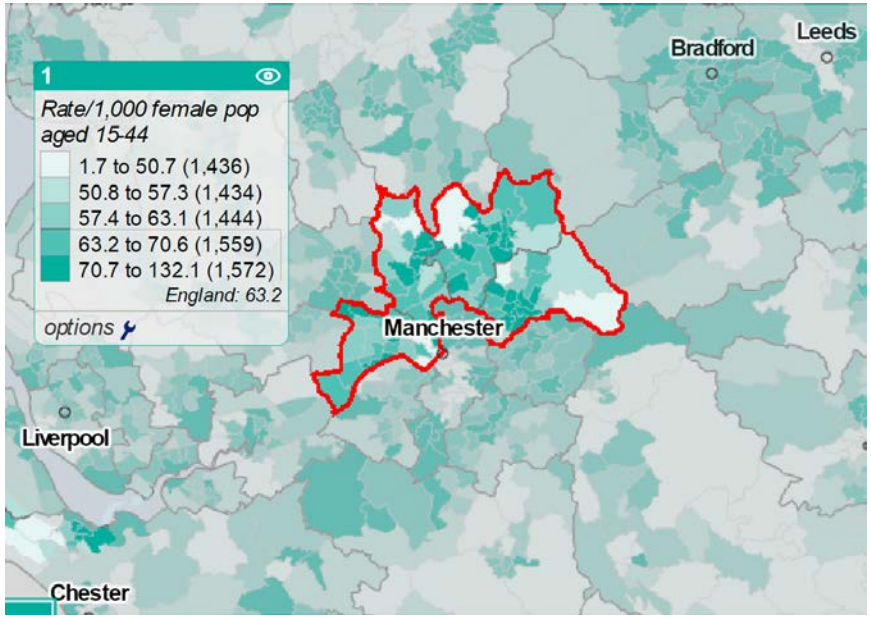
% of LSOAs in most deprived decile, 2015



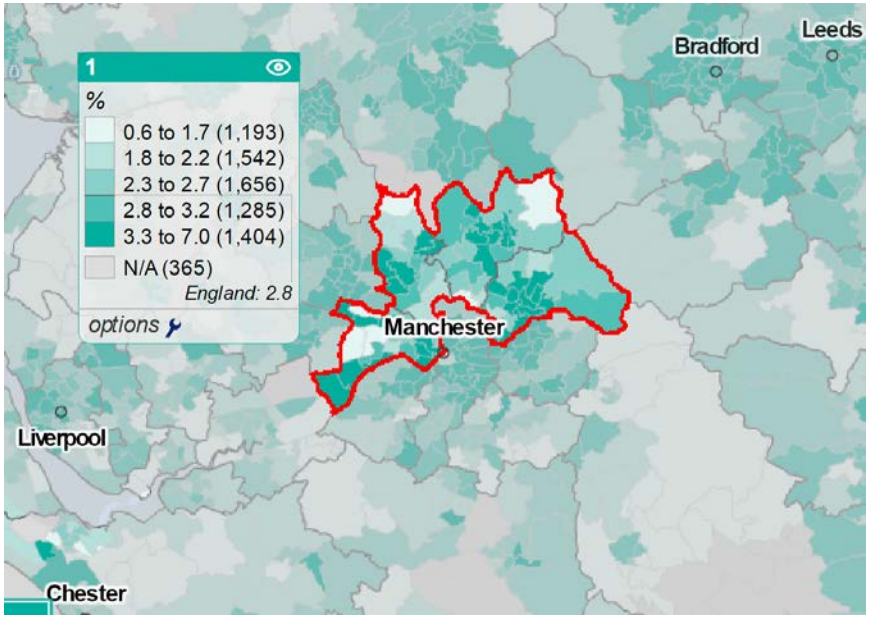
SOURCE: Ministry of Housing, Communities & Local Government – English indices of deprivation 2015

There is low overlap between those areas with high fertility rates and those with low birth weight term babies

Fertility rate, 2011-15 (darker areas indicate higher fertility rate per 1,000 female population)



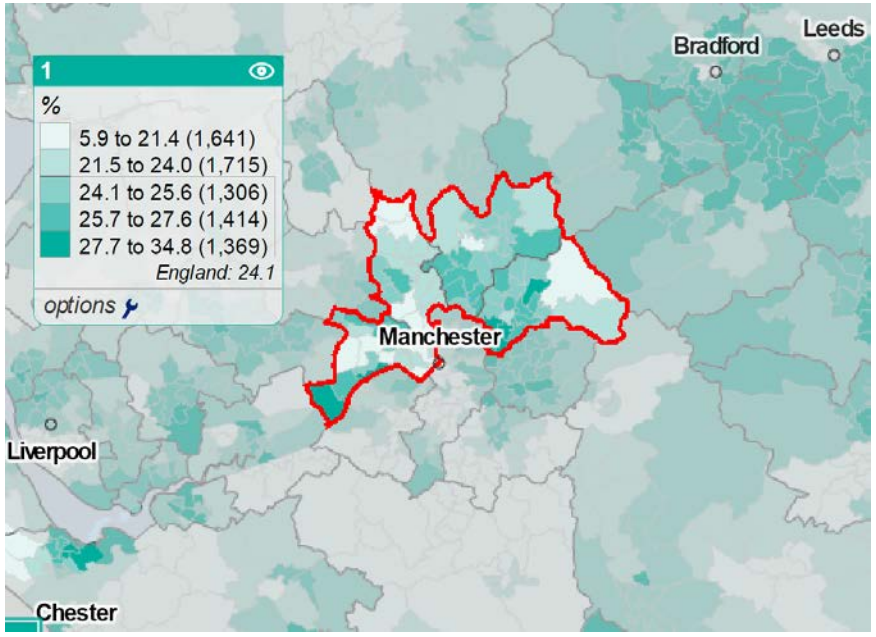
Low birth weight of term babies, 2011-15 (darker areas indicate higher %)



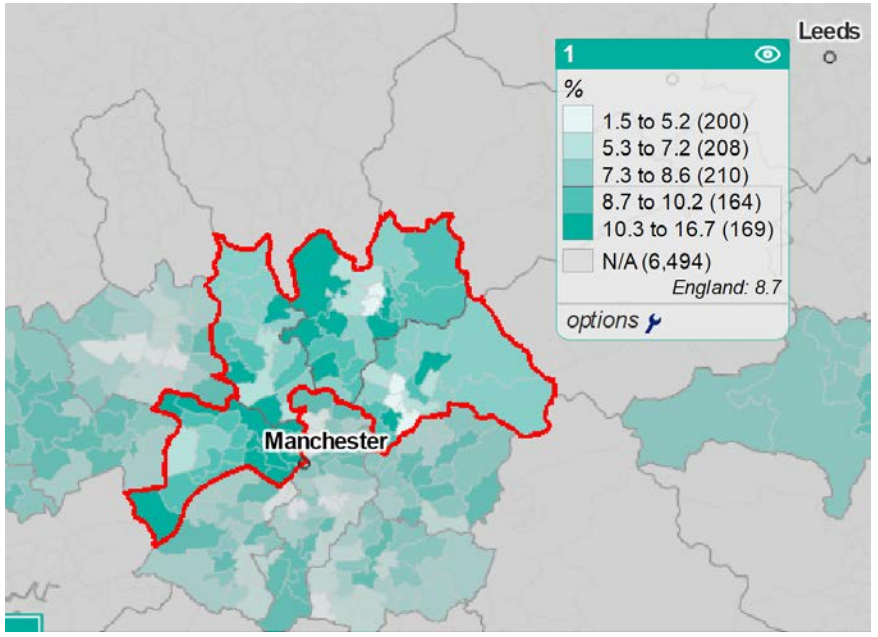
SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

Obesity and smoking are particularly prevalent in parts of Rochdale and Salford

Obese adults, %, 2011-15 (darker areas indicate a higher %)

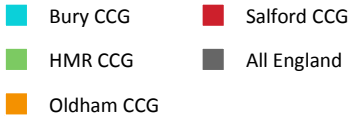


Regular smokers, %, 2011-15 (darker areas indicate higher %)

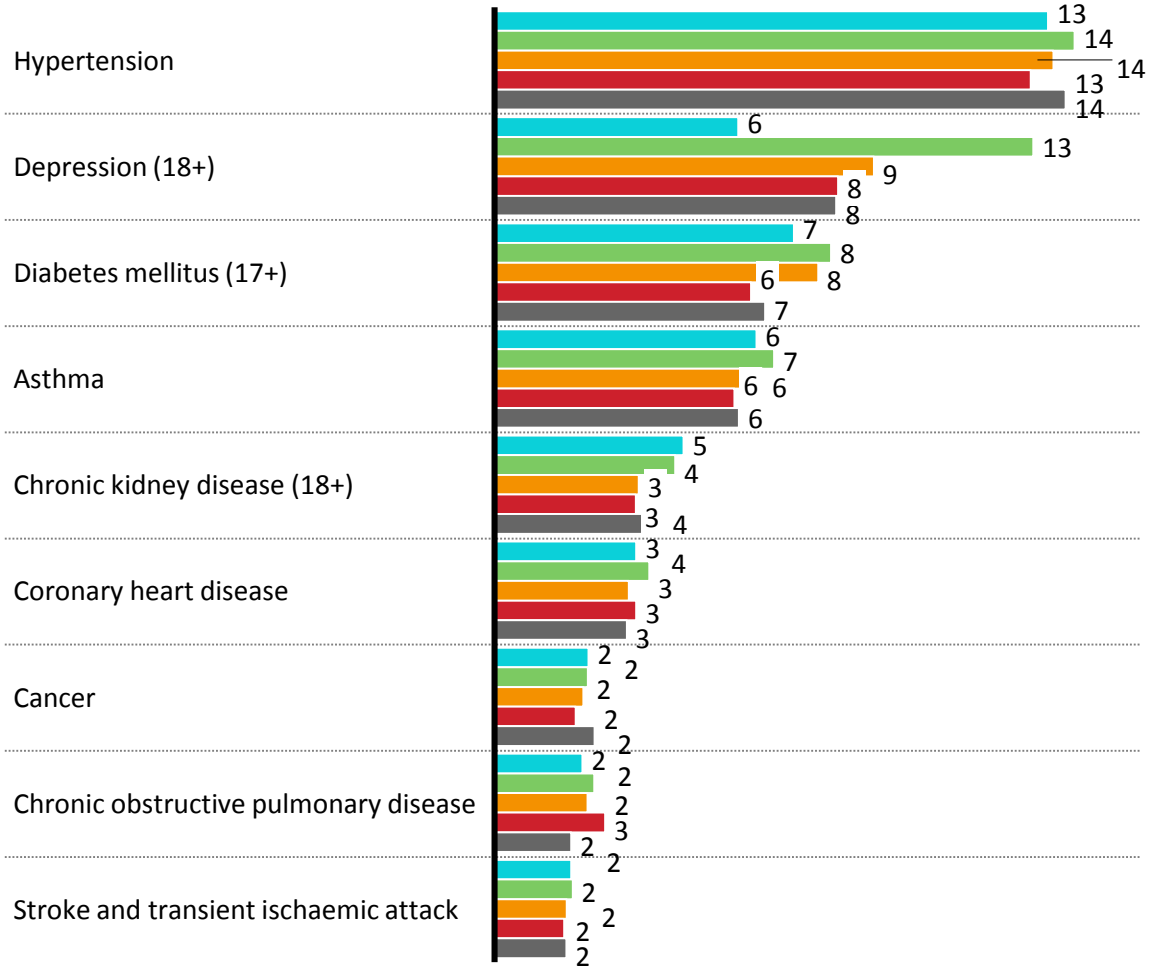


SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

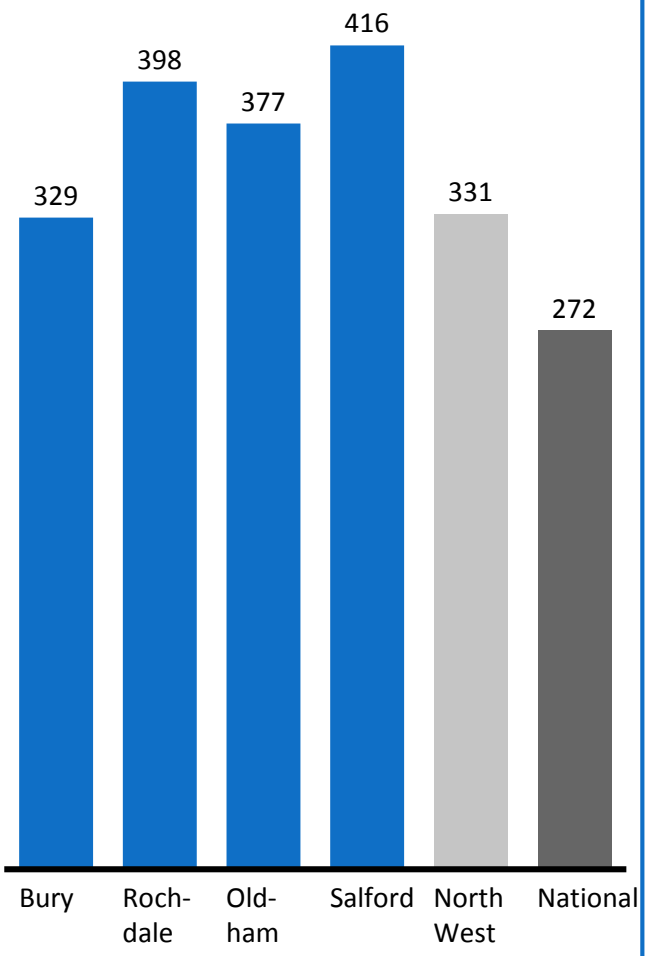
Respiratory diseases, especially smoking-related ones, and depression are higher than the national average



Prevalence of diseases (top 10) – NES & Salford CCGs vs. England average % of population, 2016/17

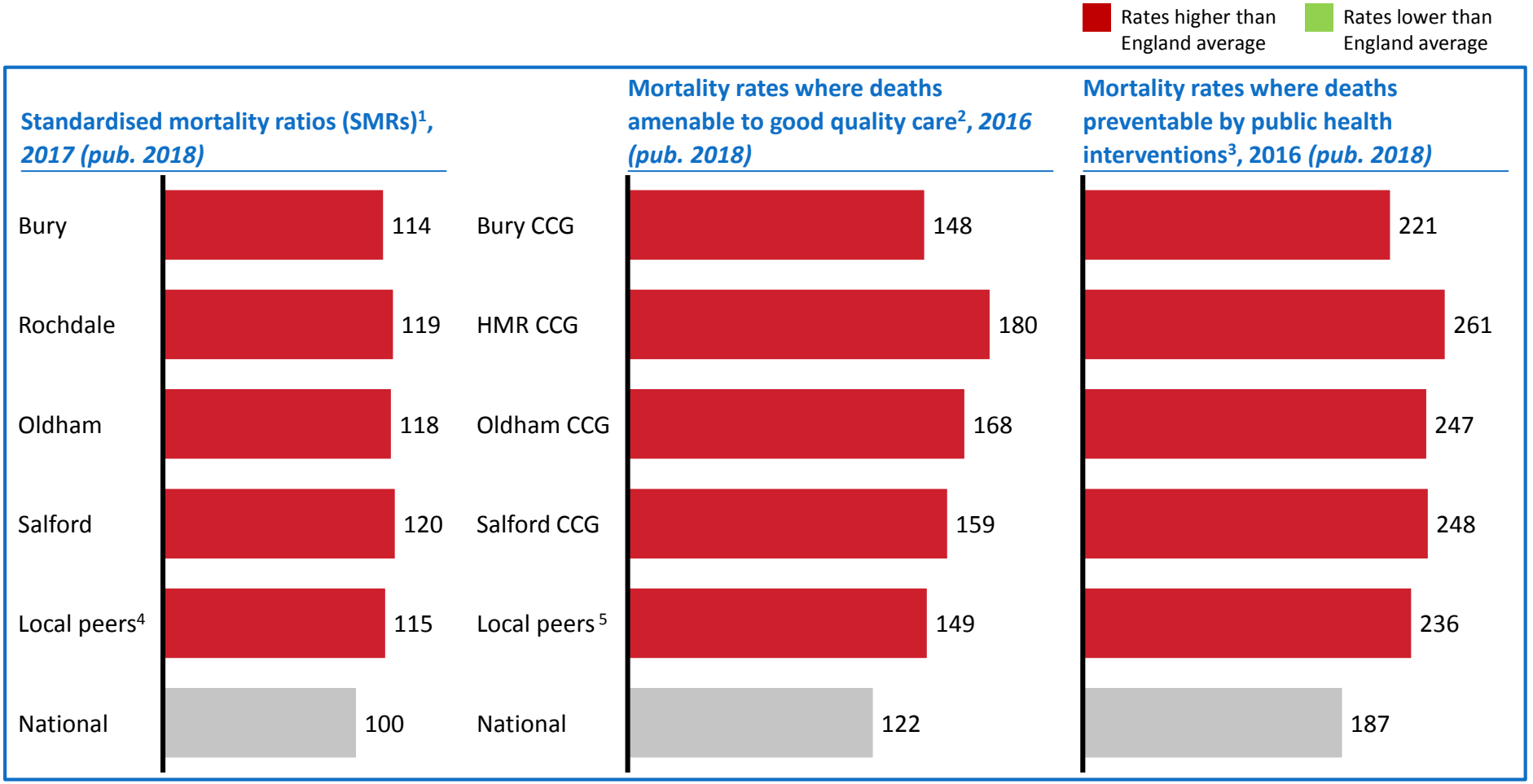


Deaths attributable to smoking by region and borough, rates per 100,000, 2014-16 (published 2018)



SOURCE: QOF 2016/17; NHS Digital Statistics on Smoking - England 2018 reporting data over 2014 to 2016 period

Avoidable mortality rates are higher than other areas of the country

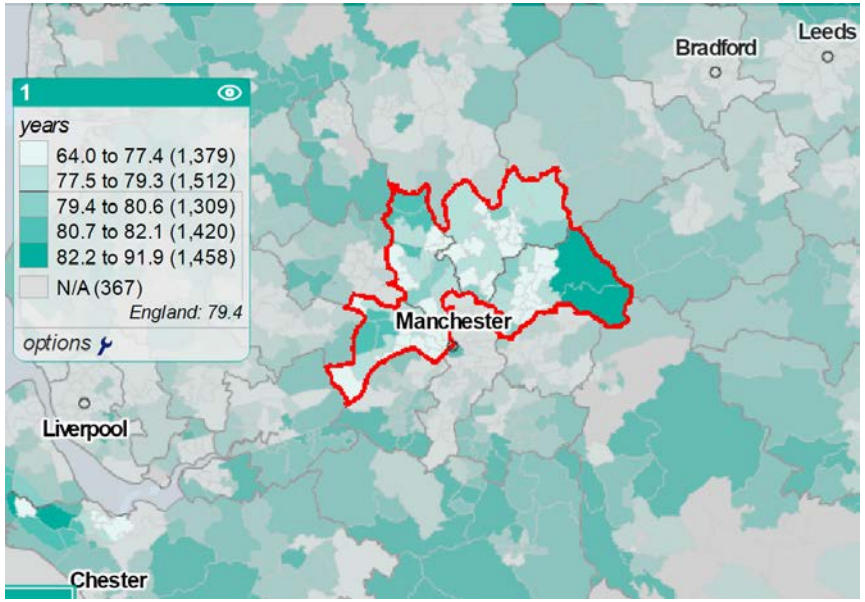


1 SMRs give a comparison of mortality in the borough / region of interest against England population as a whole, while allowing for differences in age structure
2 Age-standardised mortality rate per 100,000 where if, in light of medical knowledge and technology available at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare
3 Age-standardised mortality rate per 100,000 where if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense
4 Local peers as unitary authorities/counties/districts for Bolton, Manchester, Stockport, Tameside, Trafford and Wigan
5 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCGs before the merger

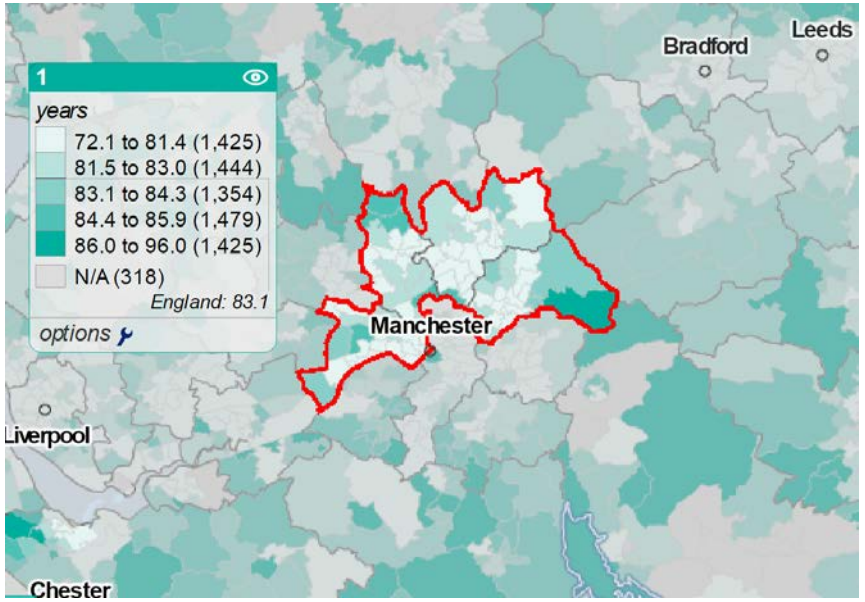
SOURCE: ONS Deaths Registrations Summary Statistics, 2018 reporting data for 2017; ONS Avoidable mortality in England and Wales: 2018 reporting data for 2016

Life expectancy is considerably less than surrounding areas and the England average apart from parts of Oldham and Bury

Life expectancy at birth for males, 2011-15
(lighter colour is associated with lower life expectancy)



Life expectancy at birth for females, 2011-15
(lighter colour is associated with lower life expectancy)



SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

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Summary of this section

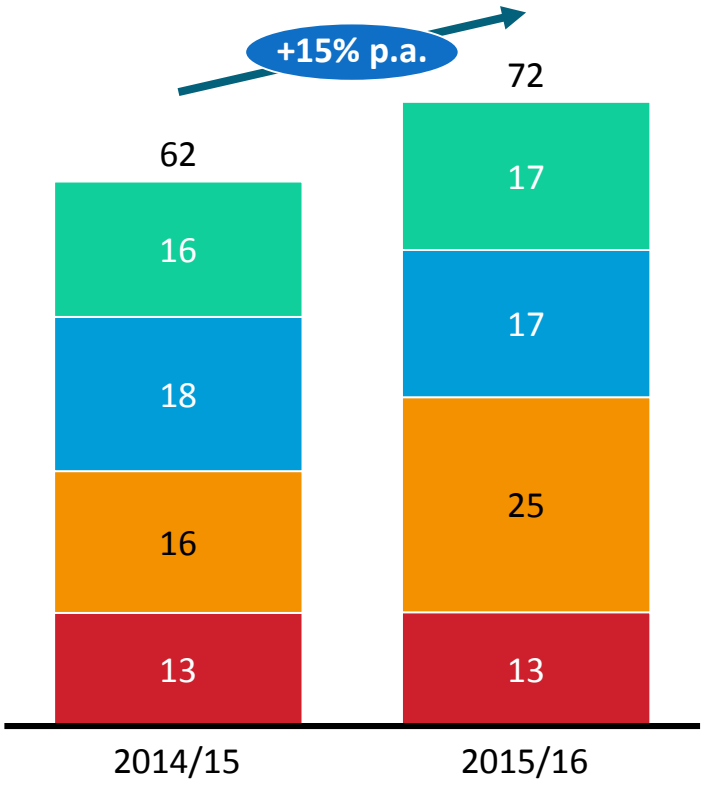
- To address rising population health demands, LCOs are seeking to transform out-of-hospital care through a greater focus on prevention of ill health, integration and moving care delivery closer to home
- To deliver these changes, Greater Manchester has been given £450m over 5 years as part of its devolution agreement
- The proportion of CCG budgets spent on primary and community care rose by 15% and 7%, respectively, between 2014/15 and 2015/16 – in line with LCO plans to shift activity out of hospitals
- In terms of primary care, there are a few very large GP practices in Salford and Oldham
- Oldham in particular has many more registered patients per permanent GP on average than nationally and a slightly higher proportion of GP practices rated inadequate than neighbouring CCGs

The proportion of CCG budgets that has been spent on primary and community care has risen significantly

NHS Bury CCG
NHS Oldham CCG
NHS HMR CCG
NHS Salford CCG

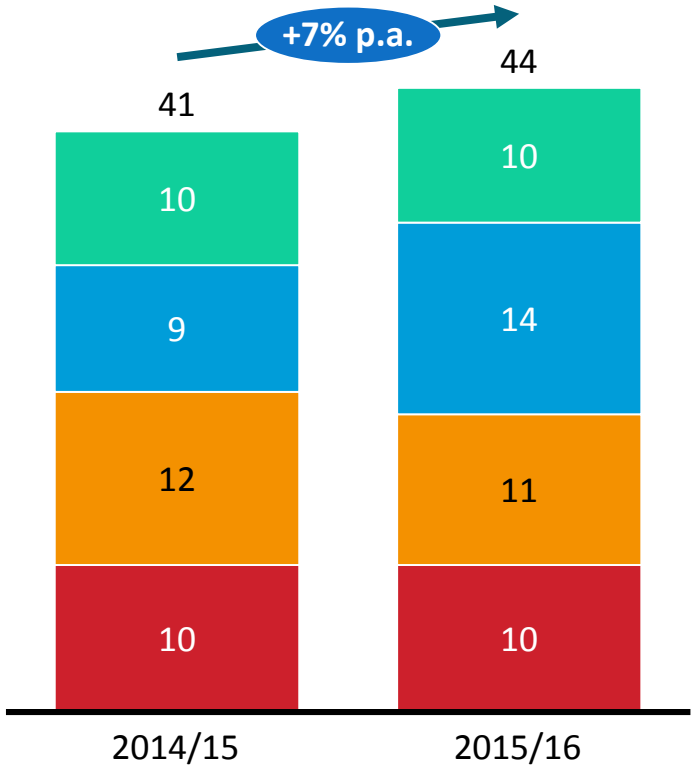
Proportion spent on primary care

% of each CCG's total spend for each year



Proportion spent on community care

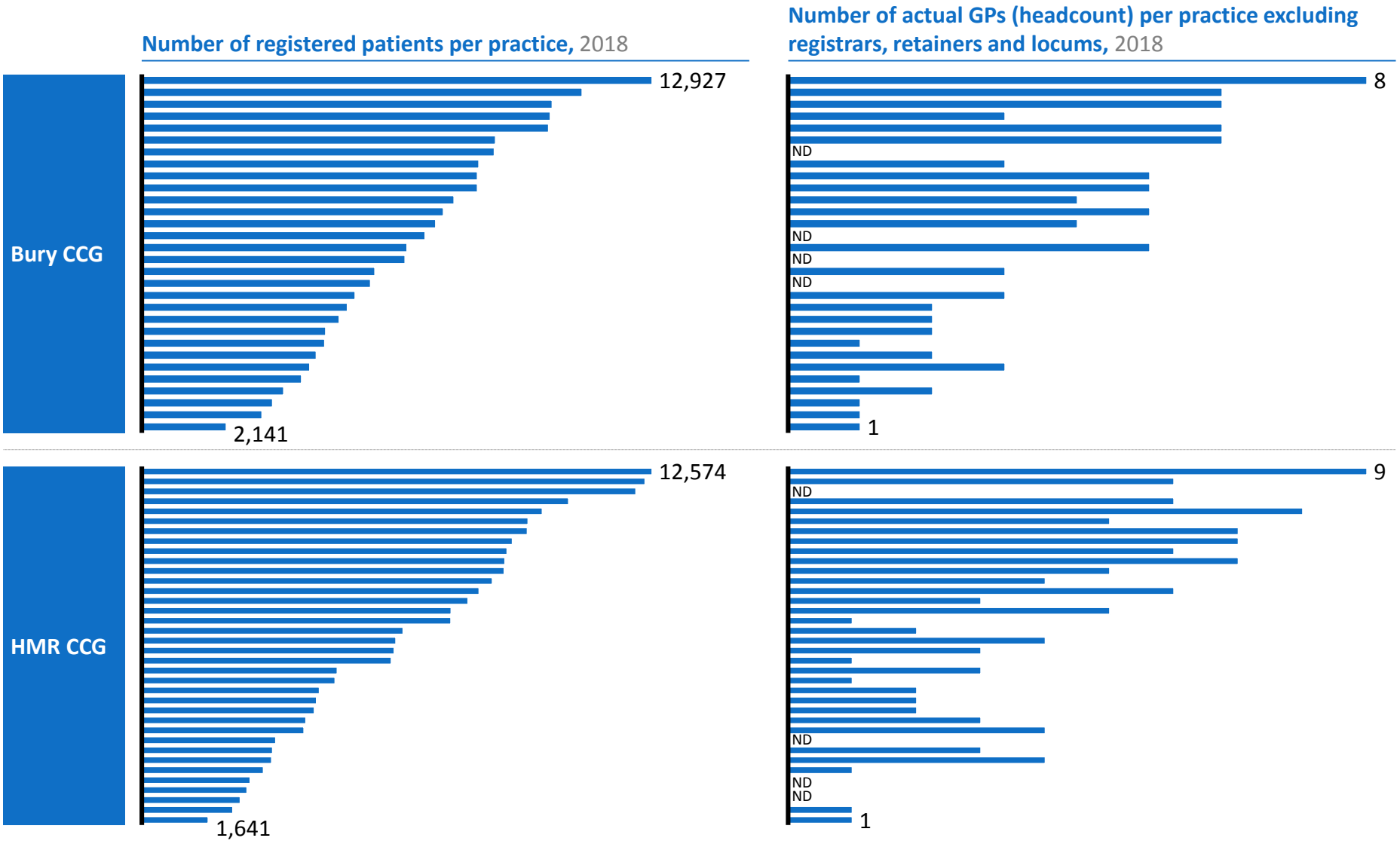
% of each CCG's total spend for each year



Over the same period, the proportion spent on acute care has fallen by 9%

SOURCE: CCG spend breakdown, NHS Digital, 2017

Current list size and GP provision by GP practice (1/2)

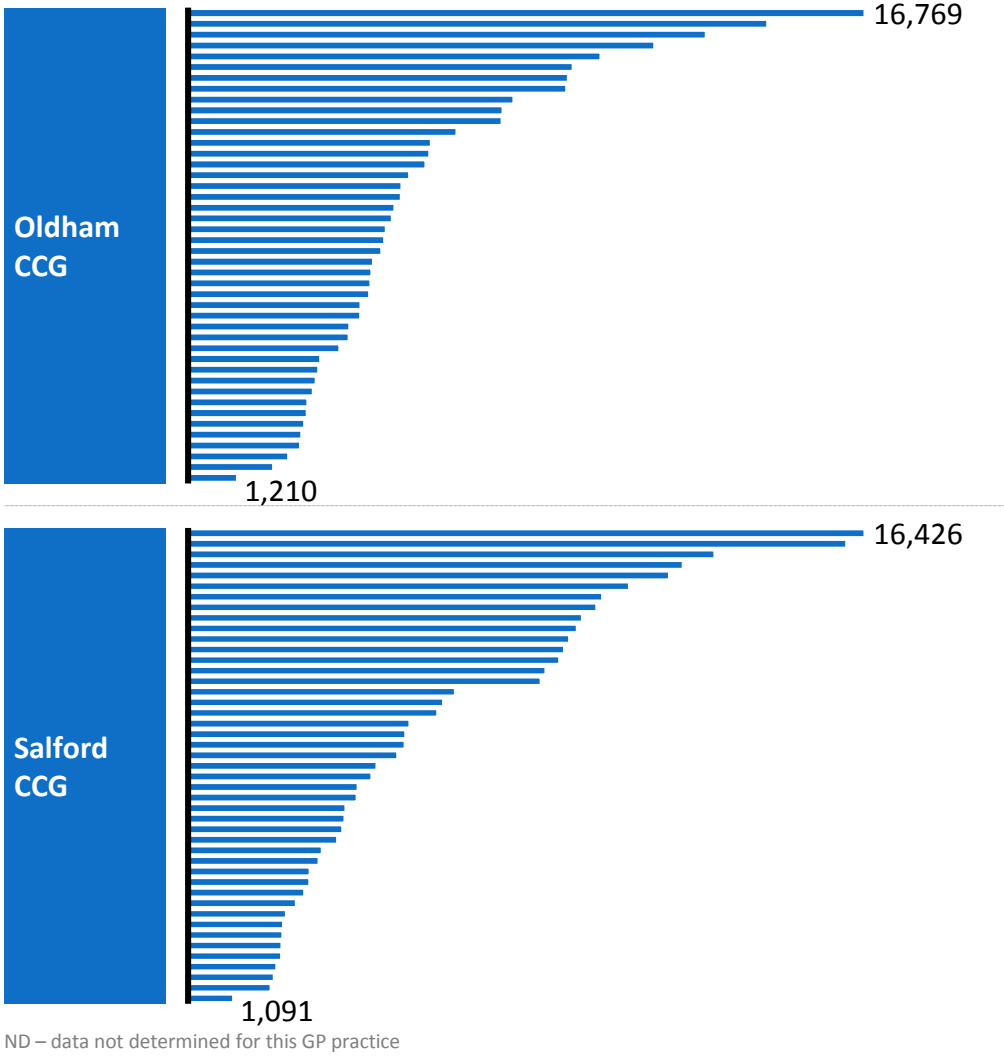


ND – data not determined for this GP practice

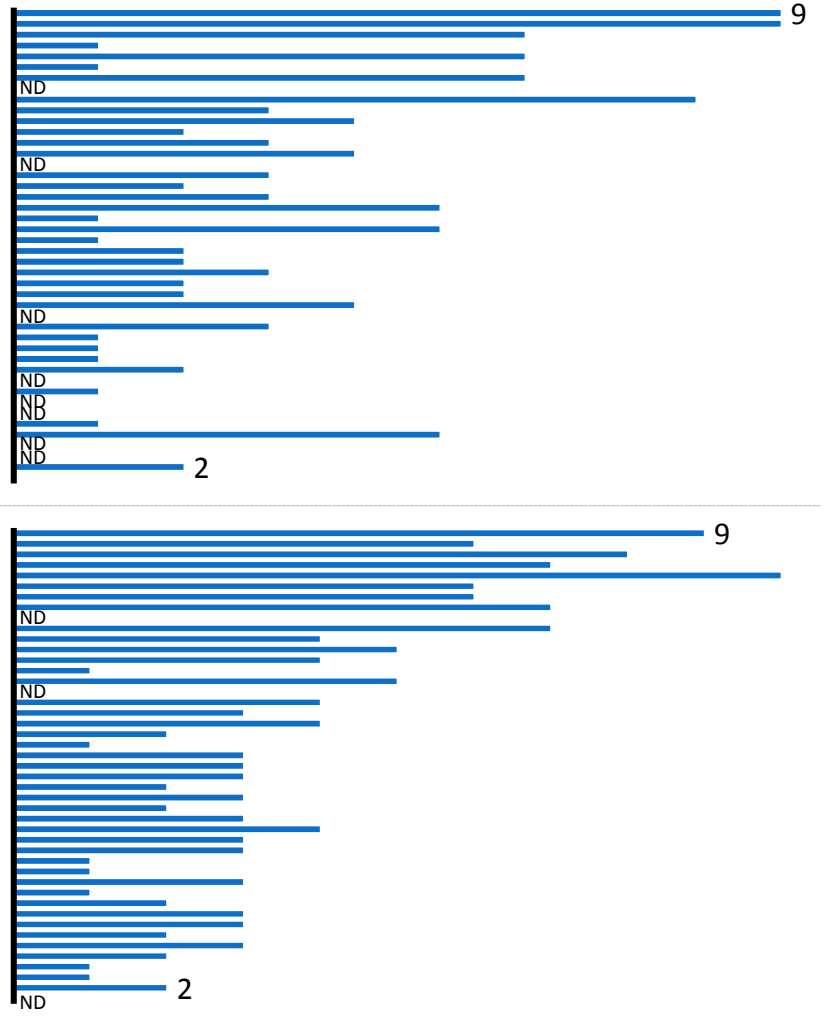
SOURCE: General and Personal Medical Services, March 2018, NHS Digital; Patient List Sizes, March 2018, NHS Digital

Current list size and GP provision by GP practice (2/2)

Number of registered patients per practice, 2018



Number of actual GPs (headcount) per practice excluding registrars, retainers and locums, 2018



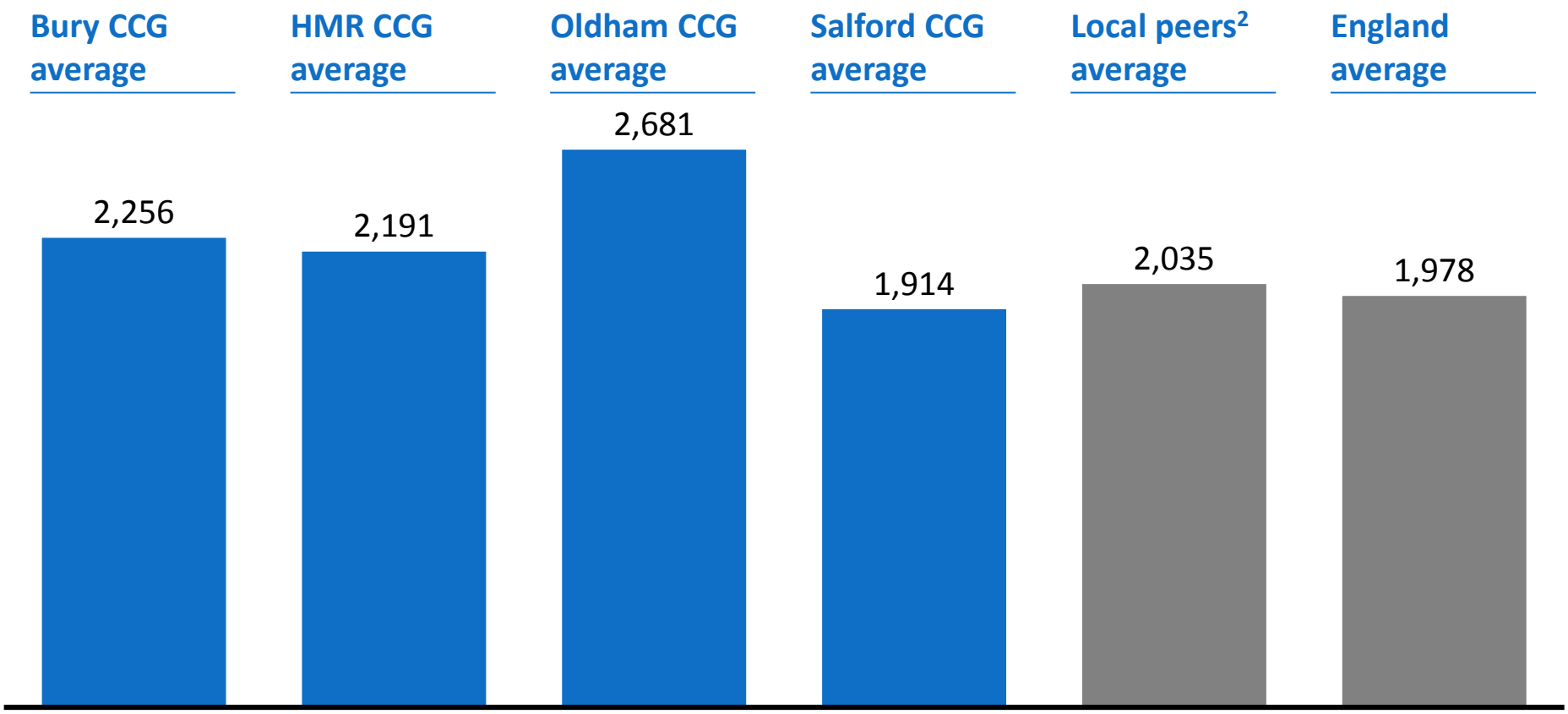
ND – data not determined for this GP practice

SOURCE: General and Personal Medical Services, March 2018, NHS Digital; Patient List Sizes, March 2018, NHS Digital

Oldham in particular has many more registered patients per permanent GP on average than nationally or in other GM CCGs

Patients to permanent GPs at practice level[1]

Number of registered patients per actual GP (headcount), 2018

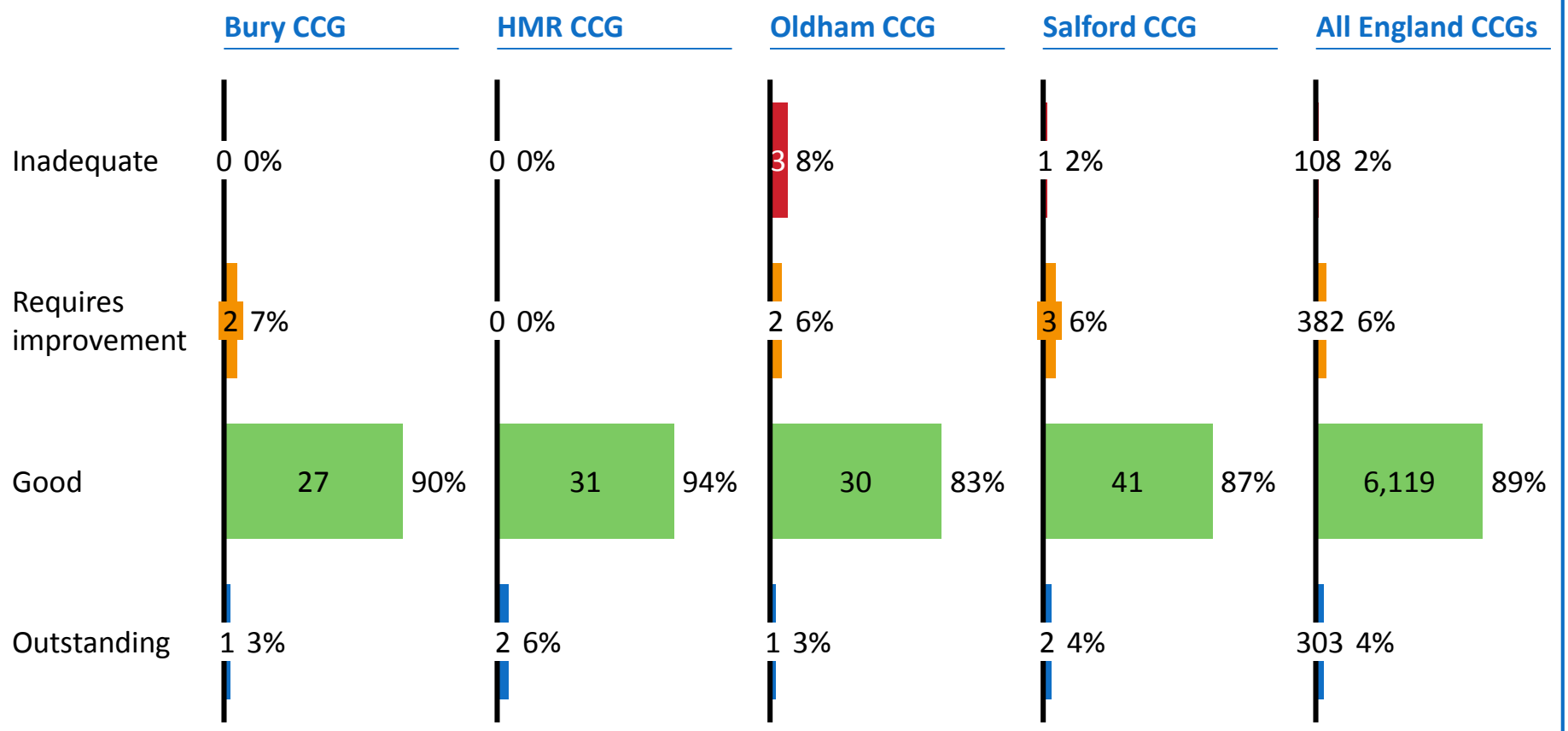


1 Excludes registrars, retainers and locums. Practices where staff numbers were not determined are excluded
2 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCGs before the merger

SOURCE: General and Personal Medical Services, March 2018, NHS Digital; Patient List Sizes, March 2018, NHS Digital

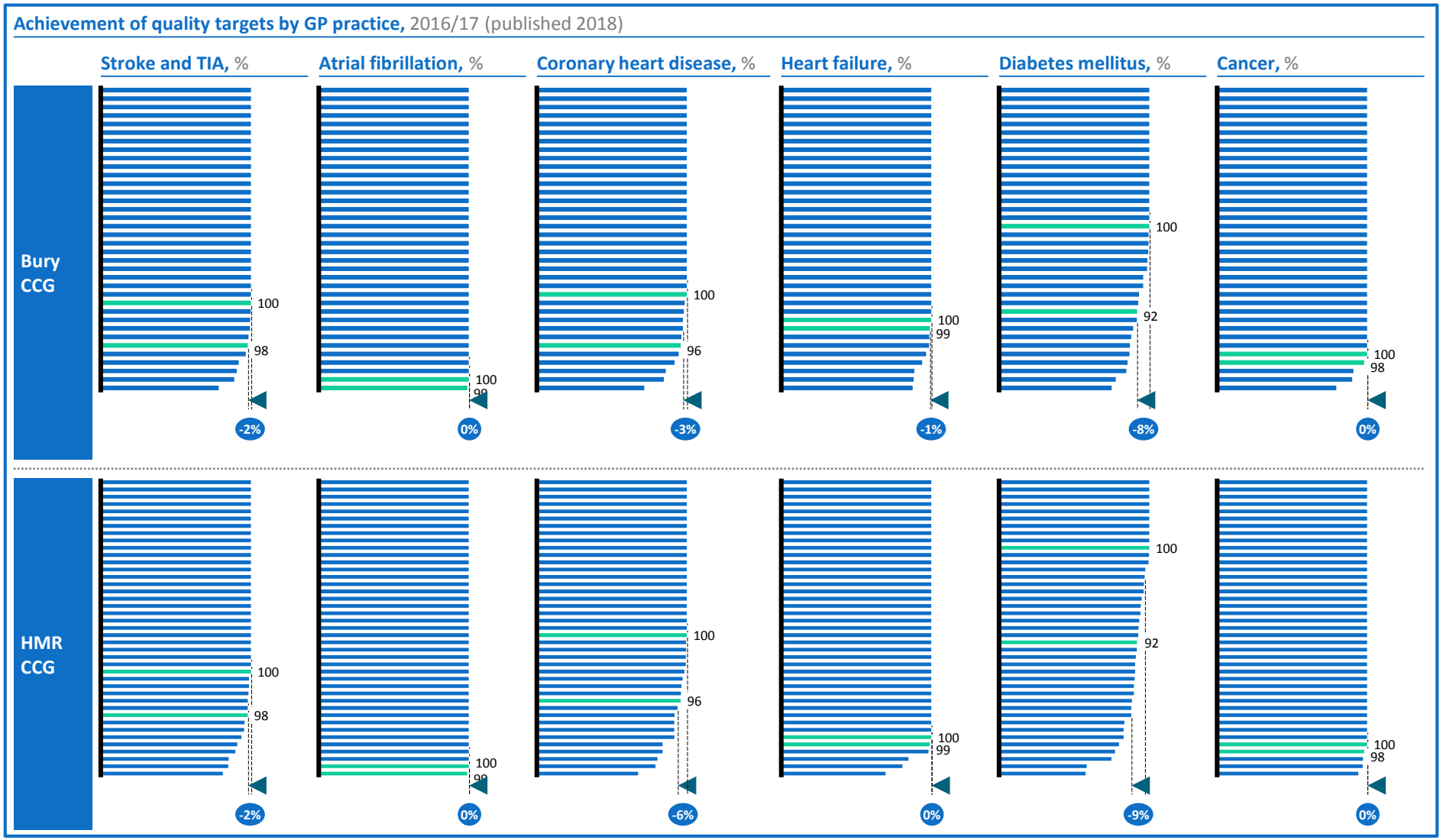
Oldham CCG has a slightly higher proportion of GP practices rated inadequate than neighbouring CCGs

GP practice ratings, % of GP practices in each CCG, 2017

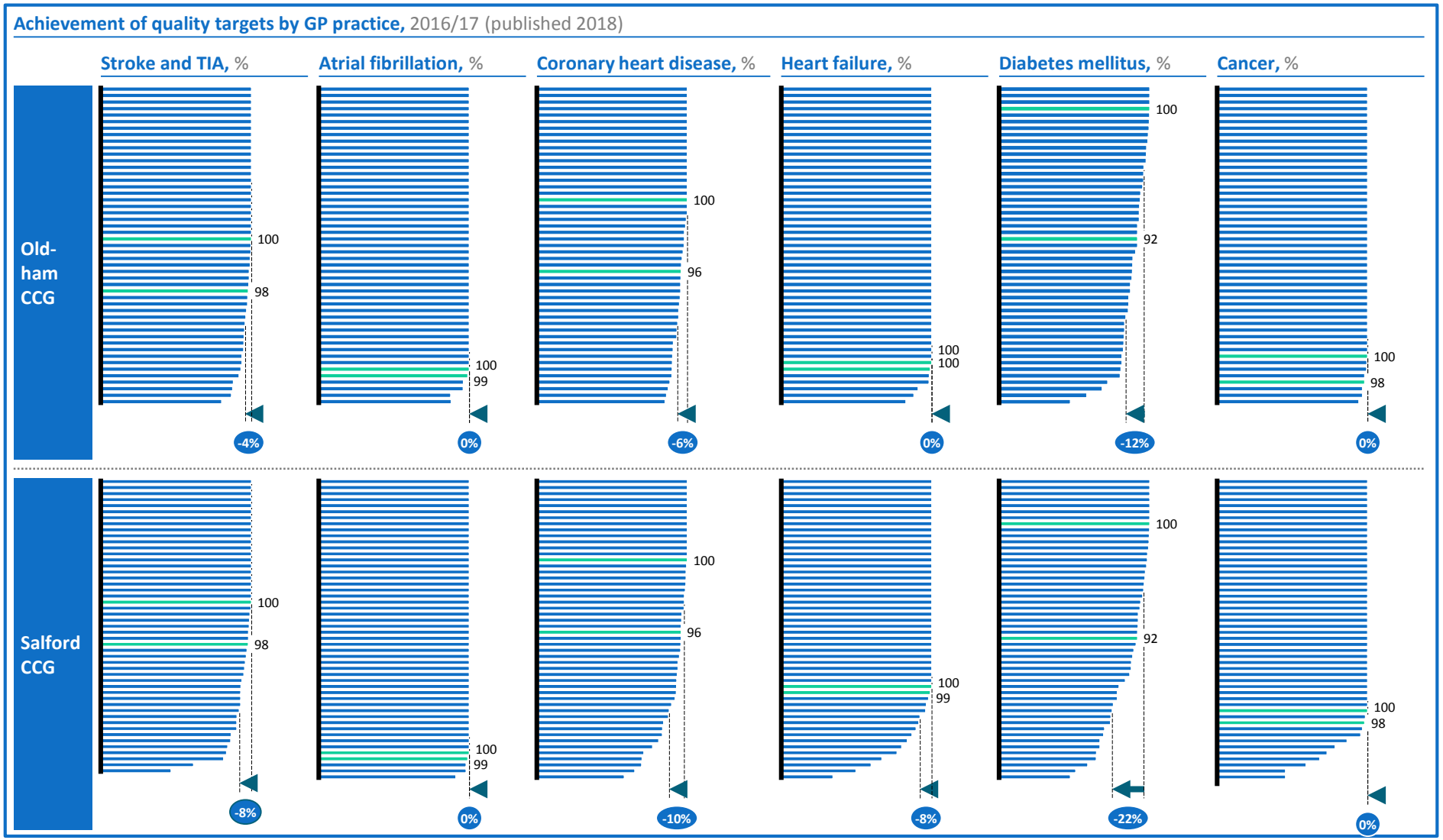


SOURCE: CQC State of Care 2017

There is some variation in quality of care for diabetes mellitus among Bury and HMR GPs



There is some variation in quality, particularly among Salford GPs for CHD and diabetes mellitus



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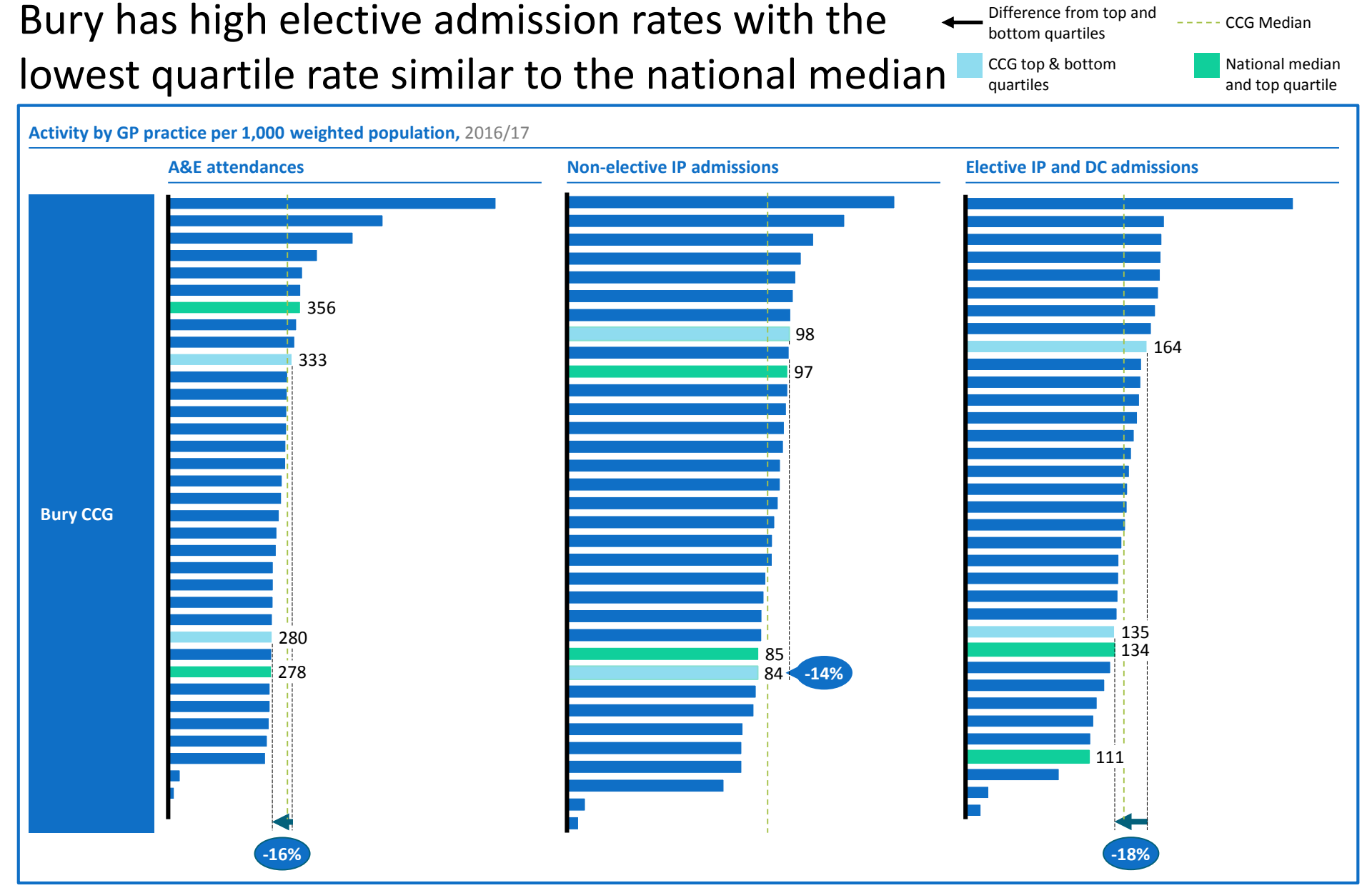
Section summary

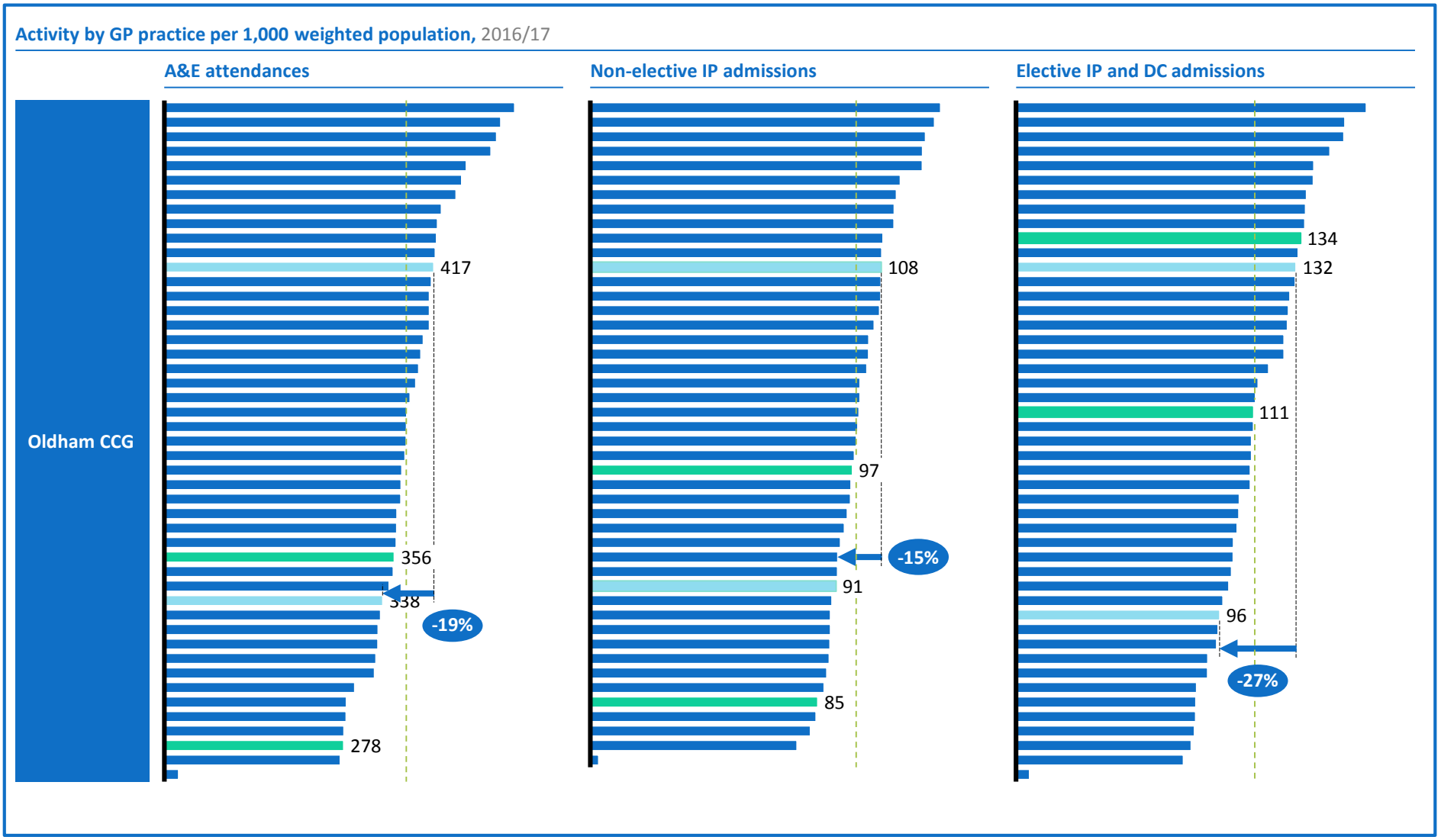
- CCG plans to deliver new models of care to deflect acute activity are underway
- Bury has relatively high elective admission rates, Oldham has high non-elective activity while HMR has high activity for all types
- However, over the past five years, admissions across PAHT hospitals – where NES CCGs commission the great majority of care – have fallen by 1% p.a. on average
- Moreover, the proportion of spending on the acute care sector is equivalent to or lower than the national average for all NES CCGs and this percentage has been falling

Bury has high elective admission rates with the lowest quartile rate similar to the national median



SOURCE: HES 206/17 M13 APC and A&E data, c/o NHS Digital

Oldham has high non-elective / emergency activity and high variation in elective activity

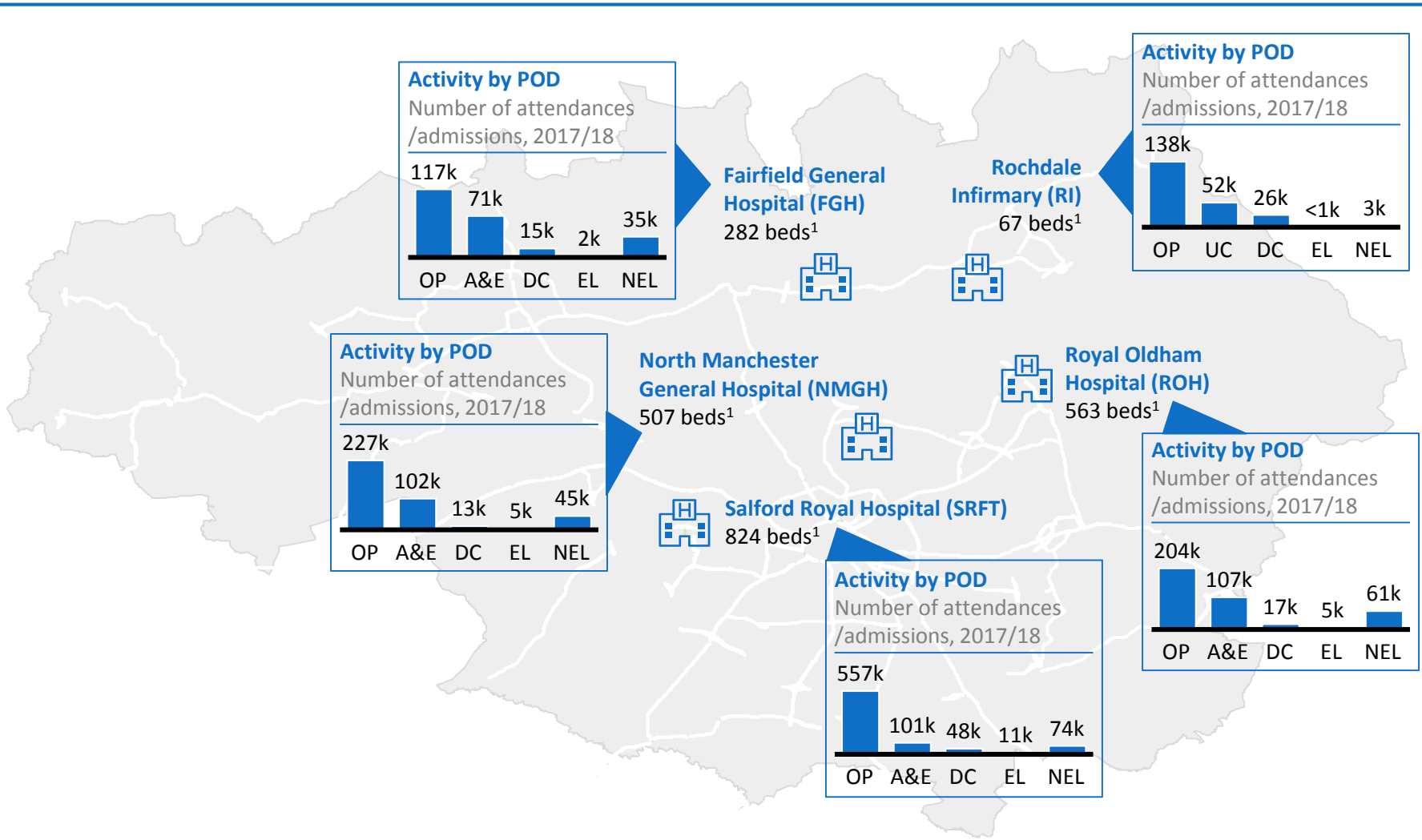


SOURCE: HES 206/17 M13 APC and A&E data, c/o NHS Digital

HMR has high levels of all activity with particulary high variation in A&E attendances

SOURCE: HES 206/17 M13 APC and A&E data, c/o NHS Digital

There are four sites within the NCA with some acute care for the NES commissioned at NMGH

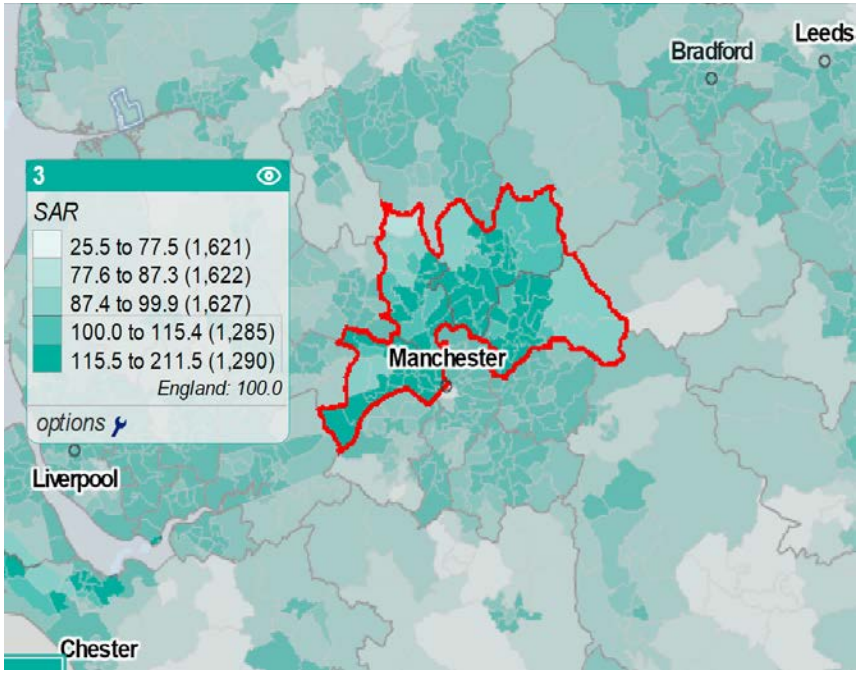


1 Bed numbers include acute, maternity, paediatric and daycase beds
OP are outpatient attendances; IP are inpatient admissions excluding daycase episodes; A&E and UC are A&E and urgent care attendances, respectively

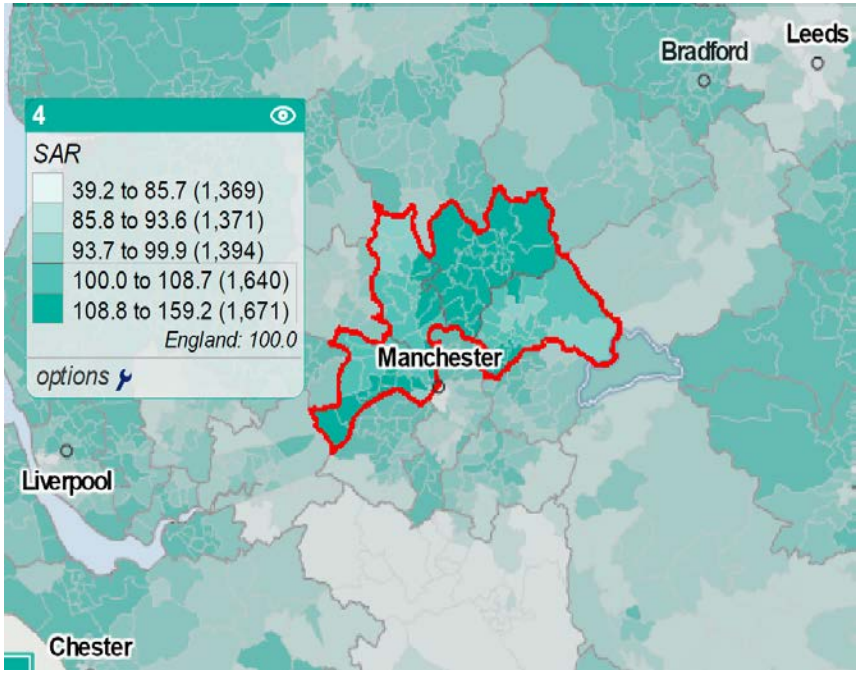
SOURCE: PLICS data 2017/18

Emergency and elective hospital admissions are slightly higher than the national average

Emergency hospital admissions, all causes, 2011/12 to 2015/16 standardised admission ratio (darker areas indicate more admissions)



Elective hospital admissions, all causes, 2011/12 to 2015/16 standardised admission ratio (darker areas indicate more admissions)

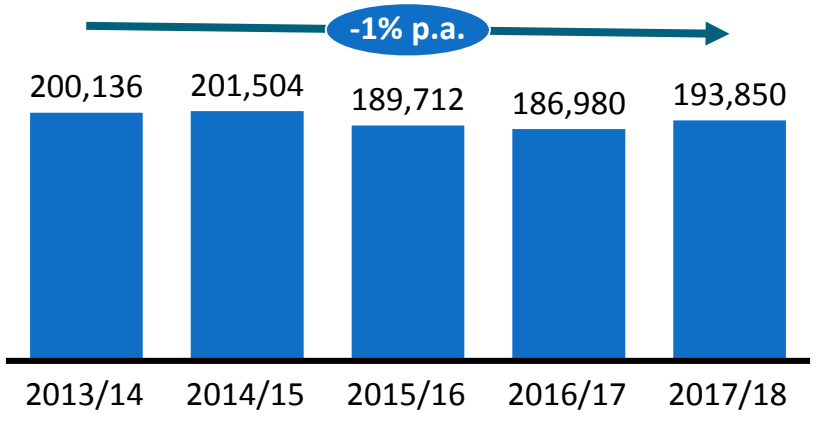


SOURCE: PHE local health tool, accessed online in August 2018 [http://www.localhealth.org.uk]

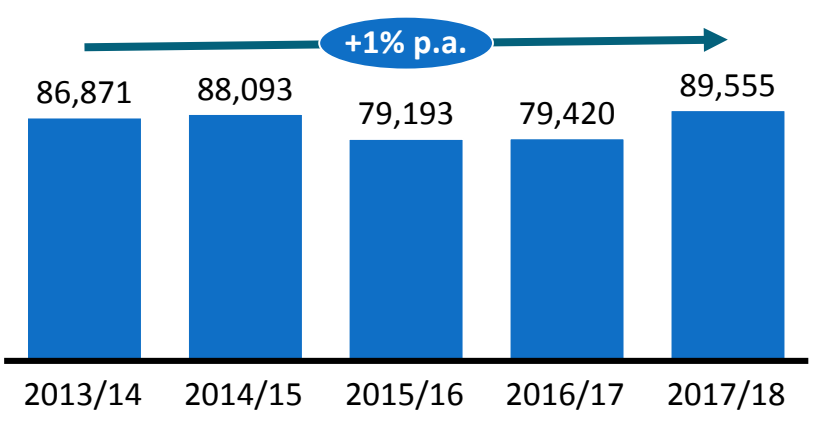
Total admissions at PAHT have fallen with some inter-year fluctuations

Yearly activity at PAHT

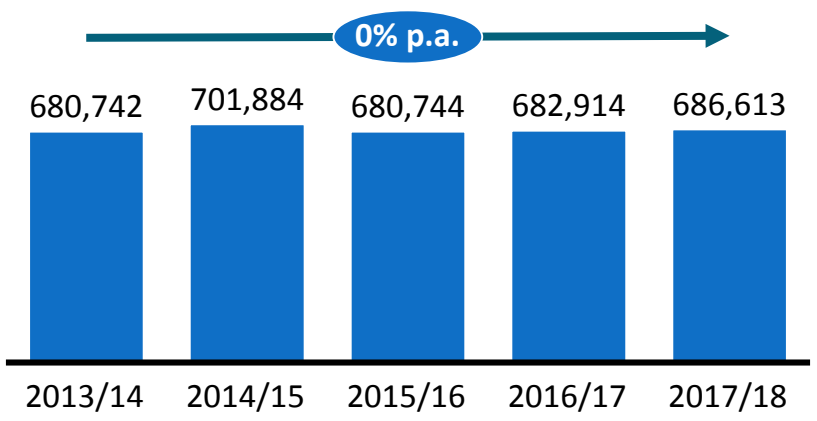
Total Admissions[1]



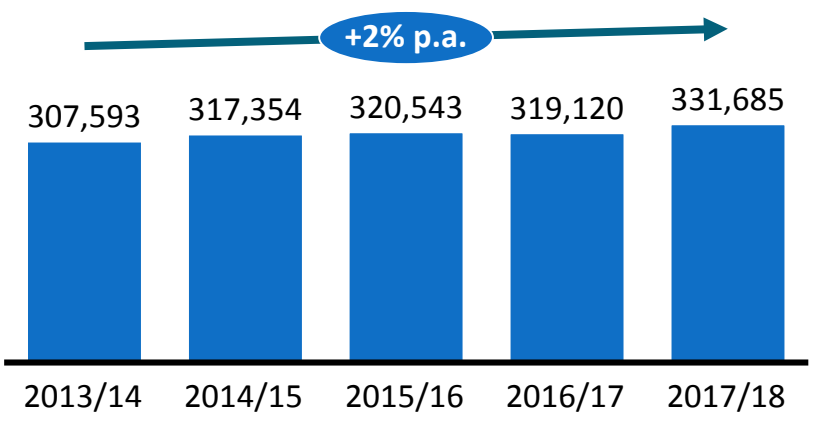
Emergency Admissions[1]



Planned Outpatient Attendances



A&E Attendances



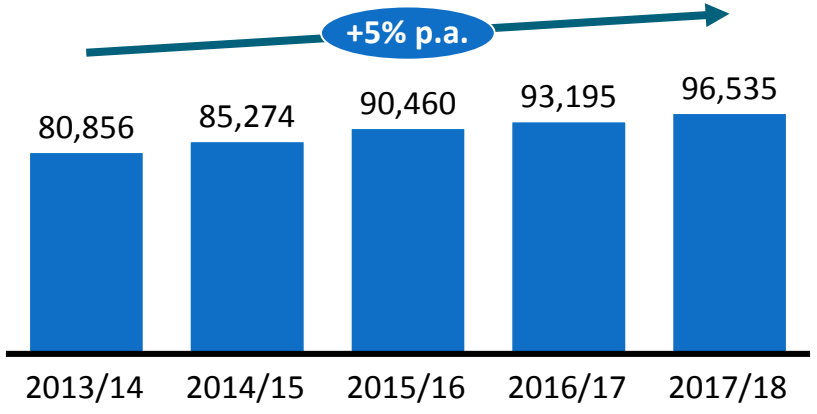
1 Includes daycase episodes

SOURCE: HES Online

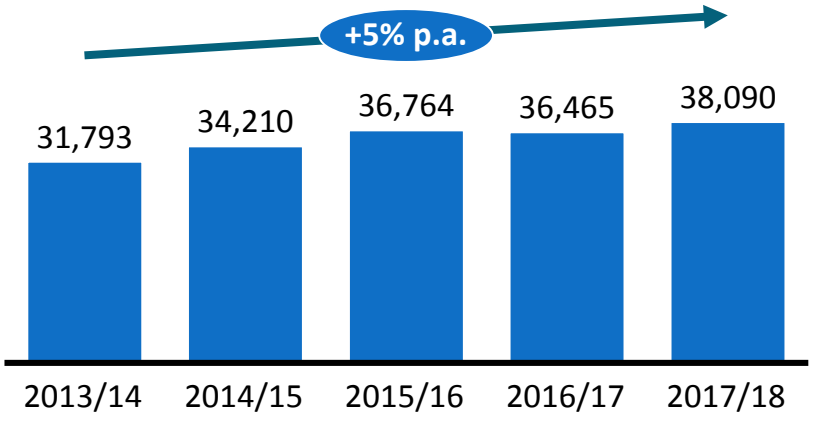
SRFT has seen growth across all activity, especially OP attendances

Yearly activity at SRFT

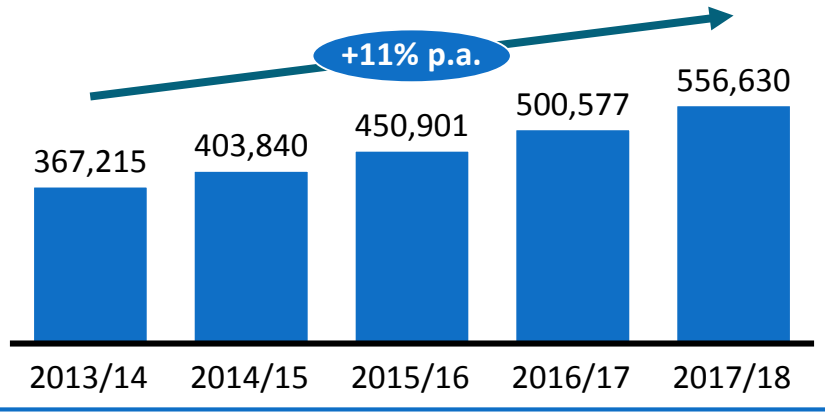
Total Admissions[1]



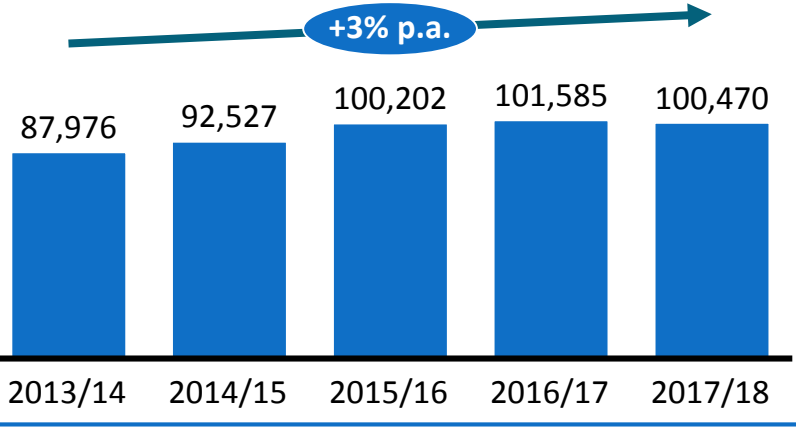
Emergency Admissions[1]



Planned Outpatient Attendances



A&E Attendances



1 Includes daycase episodes

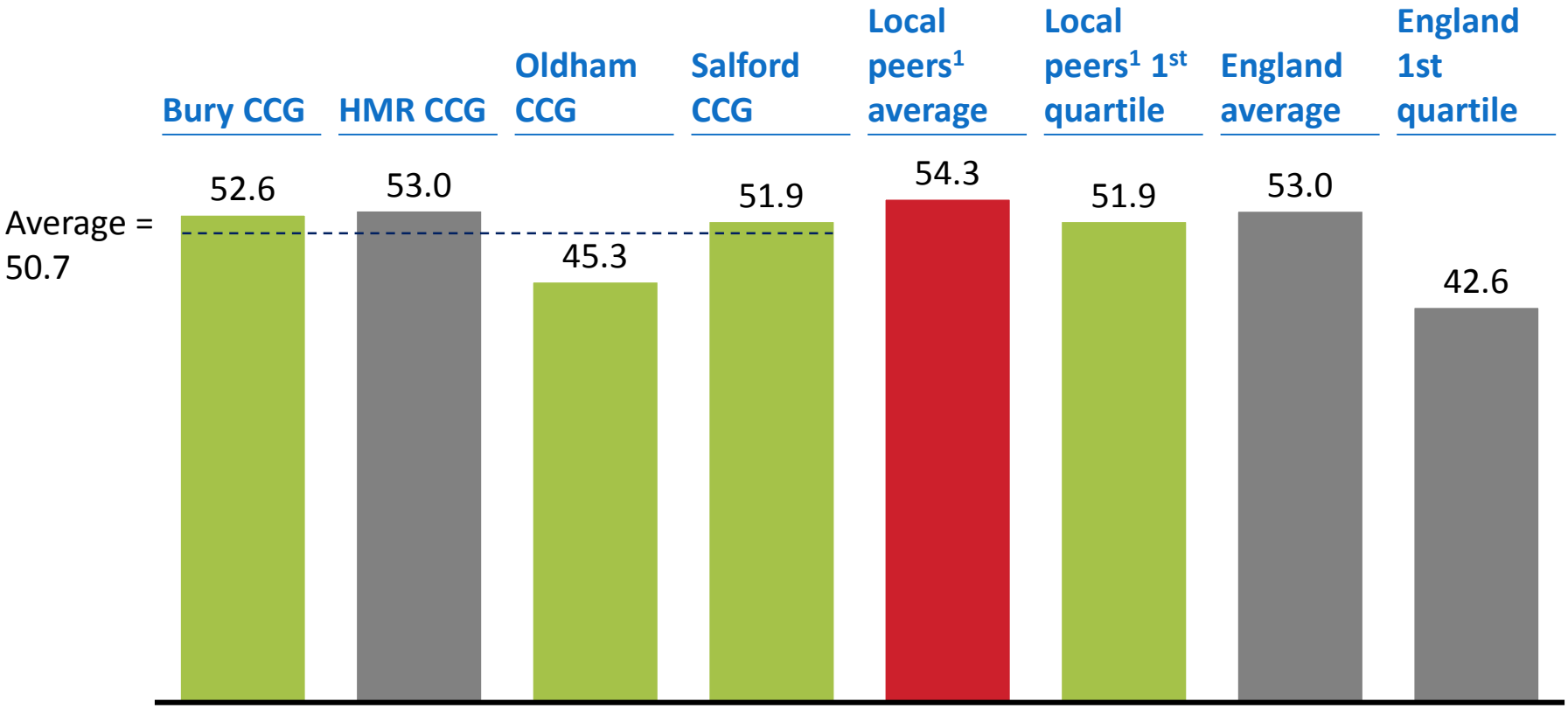
SOURCE: HES Online

Acute care spending is mostly lower than the national average but not as low as the lowest quartile in the country

CCG acute care spend above England average
CCG acute care spend below England average

Acute care sector spend

Percentage of total CCG spend that is spent on general and acute care



1 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCGs before the merger

SOURCE: CCG spend breakdown, NHS Digital, 2017

Contents

Section summary

Focus of today's discussions

- Services that need to be provided 7 days a week will become even more difficult to provide on sites if volumes of activity decrease
- There is already difficulty ensuring that patients with MI and HF have rapid access to specialist staff and procedures at ROH
- In critical care, there have been notable consultant shortfalls at FGH and NMGH
- Recent workforce data shows that 7-18% of medical and nursing positions are vacant with high levels of agency spend to cover these positions
- Operationally, 4-hour A&E waiting times performance has been deteriorating and is below the national average at ROH, NMGH and Salford, while 18-week RTT at ROH and NMGH is lower than the national average and has been declining
- Additionally, ROH was recently rated as "requiring improvement" in critical and medical care safety, effectiveness and responsiveness
- Meanwhile, NMGH required improvement in safety and effectiveness of medical care and surgery, plus responsiveness for critical care and urgent & emergency care
- This is all despite PAHT already having low NEL ALoS – among the top 10% nationally
- In terms of estate, NMGH in particular has high backlog maintenance costs and inefficient use of floor area, driven in part by its age
- In terms of finances, the NCA had an underlying £82m financial gap in 2017/18 that is projected to reach over £100m by 2017/18

HRG codes can be used to categorise A&E visits into major, standard and minor treatments or investigations

Category	Typical investigation	Typical treatment
5		▪ CPR ▪ Thrombolysis
4		▪ General anaesthetic ▪ Manipulation of limb fracture ▪ External pacing
3	▪ Ultrasound ▪ MRI ▪ CT	▪ Primary sutures ▪ Intramuscular injection ▪ Occupational therapy assessment
2	▪ Plain X-ray ▪ Cross-match ▪ Bacteriology	▪ Wound closure with steristrips ▪ Physio for falls prevention ▪ Local anaesthetic
1	▪ ECG ▪ Biochemistry ▪ Urine dip	▪ Remove sutures ▪ Eye drops ▪ Advice/guidance

Category combination

Typical investigation	Typical treatment	
Any	5	MAJOR
3	1-4	
2	4	
2	1-3	STANDARD
1	3-4	
1	1-2	MINOR
None	None	

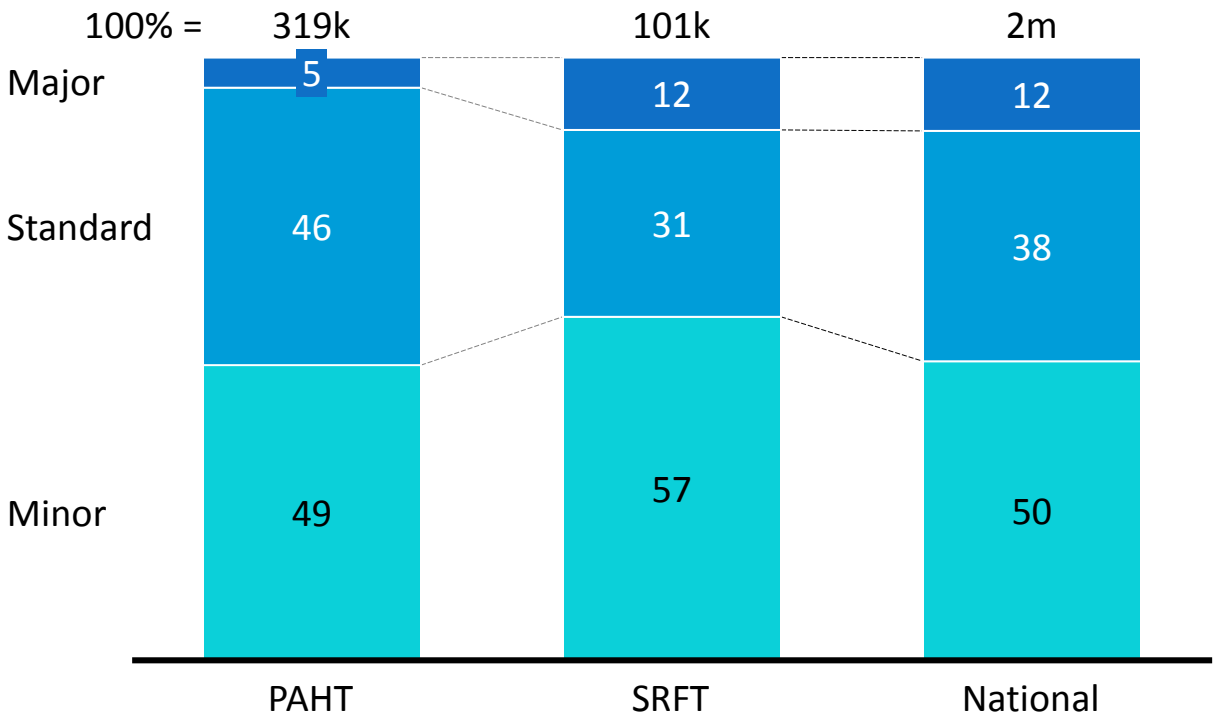
HRG category results depend on what investigations or treatments actually take place in A&E as opposed to other units or departments and how well standards of care are adhered to, and not just acuity

SOURCE: HRG reference data

A higher proportion of A&E attendances at PAHT and SRFT involve Standard and Minor investigations / treatments, respectively, than the national average

A&E attendances by investigation / treatment category vs nationally

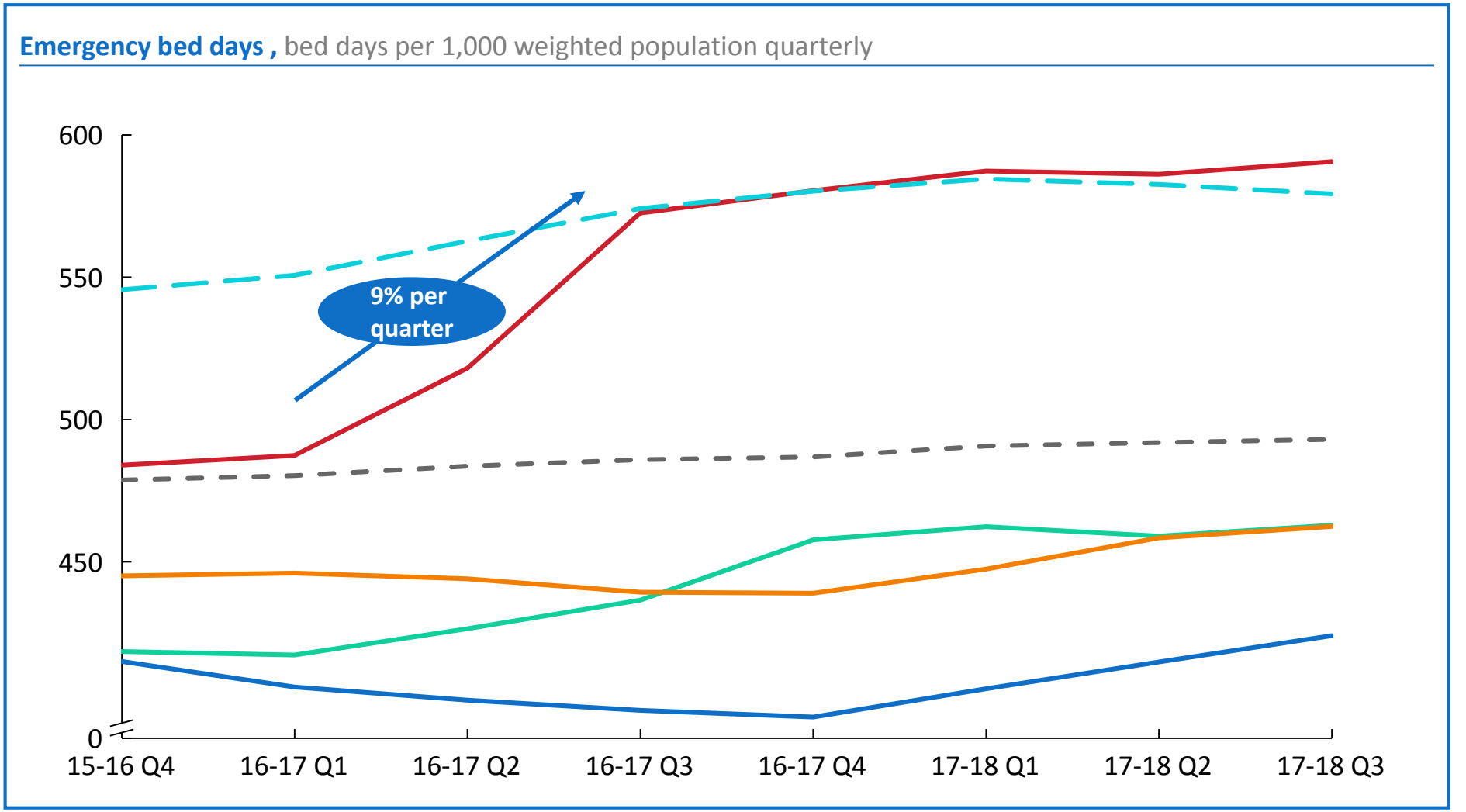
A&E attendances (% of total), 2016/17



HRG category results depend on what investigations or treatments actually take place in A&E as opposed to other units or departments and how well standards of care are adhered to, and not just acuity

SOURCE: A&E HES data 2016/17

Emergency bed days rose 9% per quarter in 16/17 Q1 to Q3 in Salford



1 Local peers as CCGs for Bolton, Stockport, Tameside and Glossop, Trafford, Wigan Borough and Manchester CCG

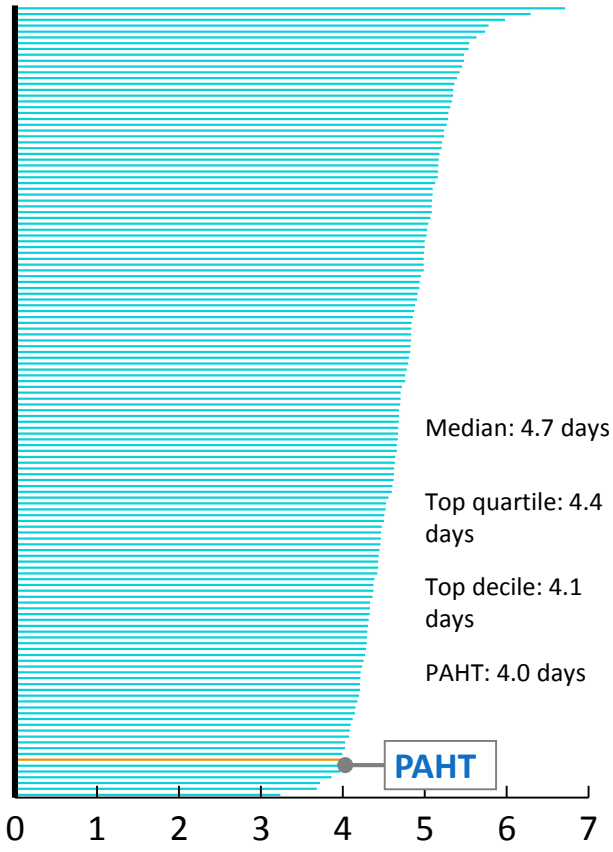
SOURCE: CCG improvement and assessment framework 2017/18

Case-mix adjusted average length of stay is relatively low at PAHT but relatively high at SRFT

- Case-mix adjustment[1] separates Trust performance from the complexity of the case-mix
- The ALoS for all other Trusts is calculated in the scenario in which all other Trusts had the same case-mix of HRGs as PAHT or as SRFT

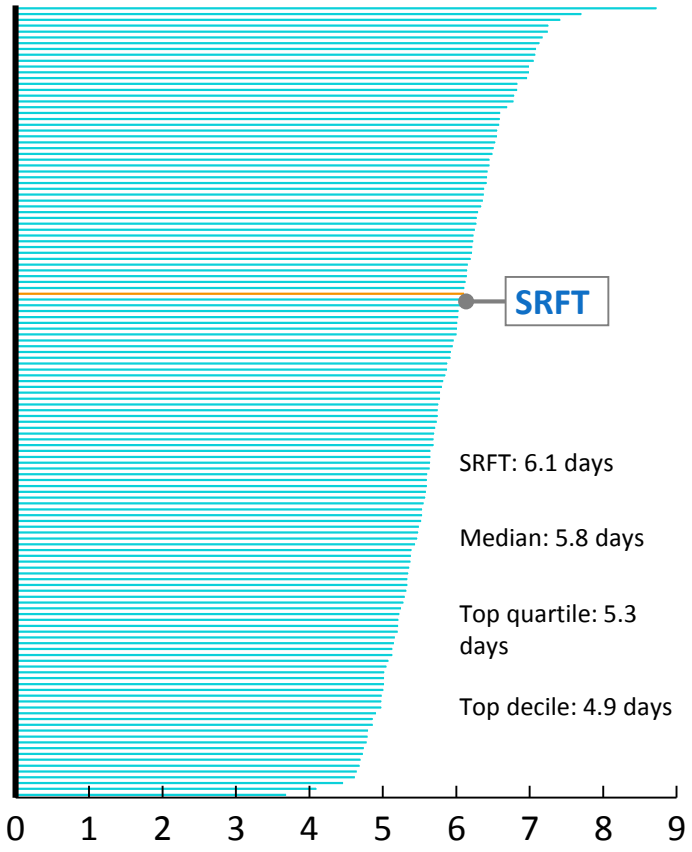
Case-mix adjusted non-elective[1] ALoS, PAHT vs non-specialist acute Trusts in England,

Days, 2016/17



Case-mix adjusted non-elective[1] ALoS, SRFT, vs non-specialist acute Trusts in England

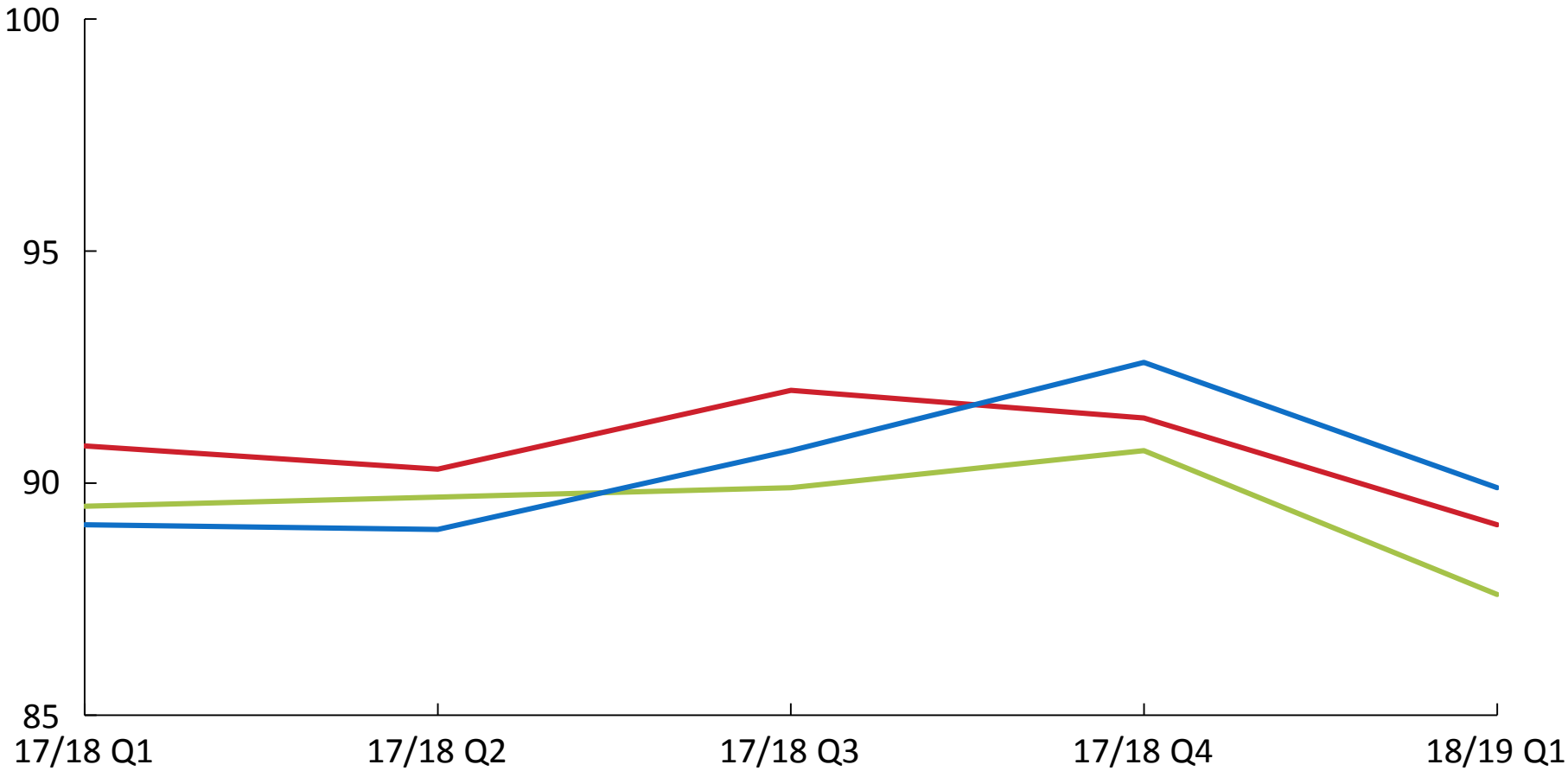
Days, 2016/17



1 Adjusted by taking into account the average length of stay by HRG, in each service line, at all acute NHS Trusts in England
2 Excluding maternity specialty and for acute hospitals only
3 Case-mix adjustment may not account for complexity of specialist services delivered at Salford
SOURCE: HES 2016/17 APC datset M13, c/o NHS Digital

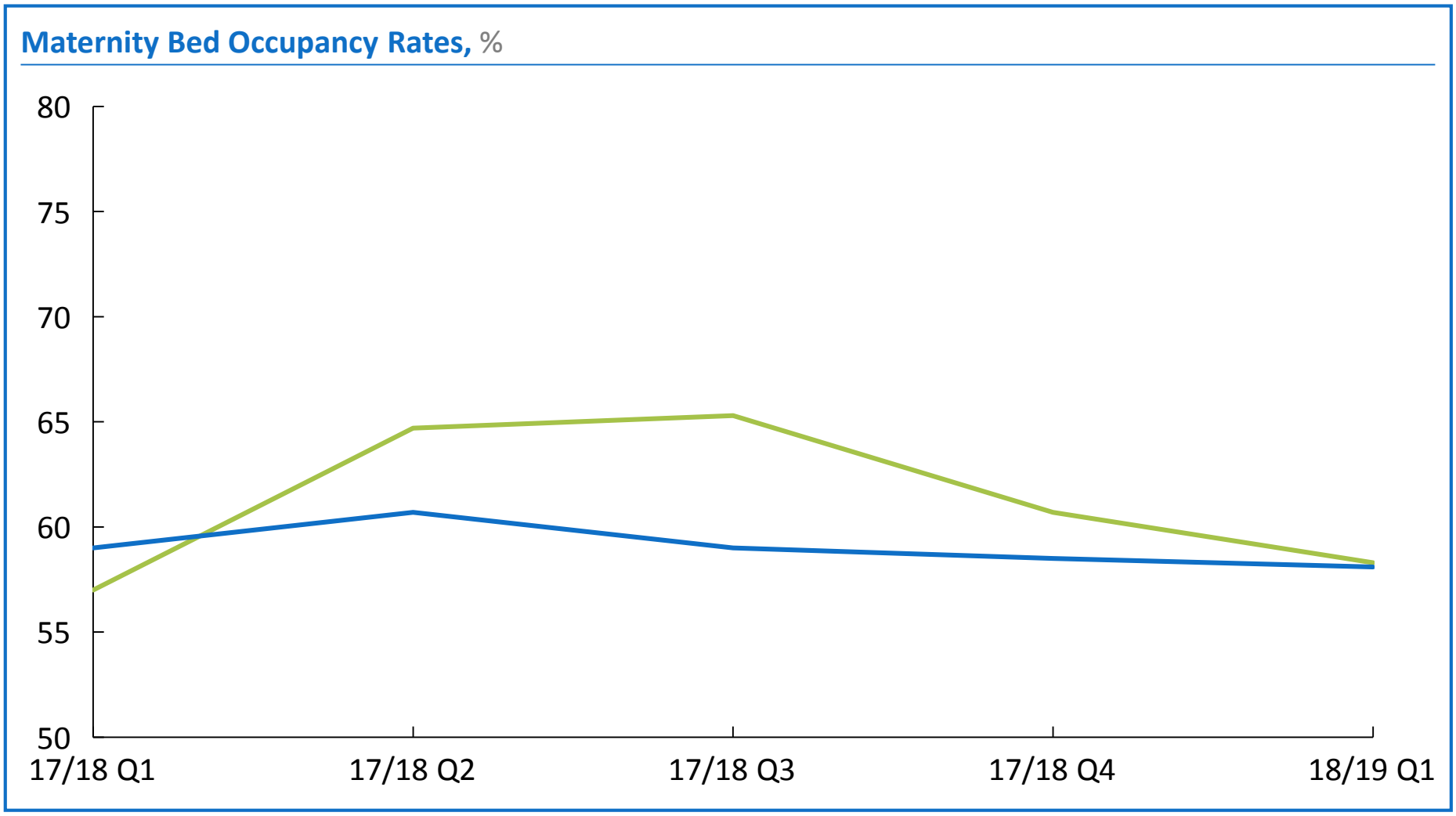
General and acute bed occupancy is consistently higher at SRFT than at PAHT sites

General & Acute Bed Occupancy Rates, %



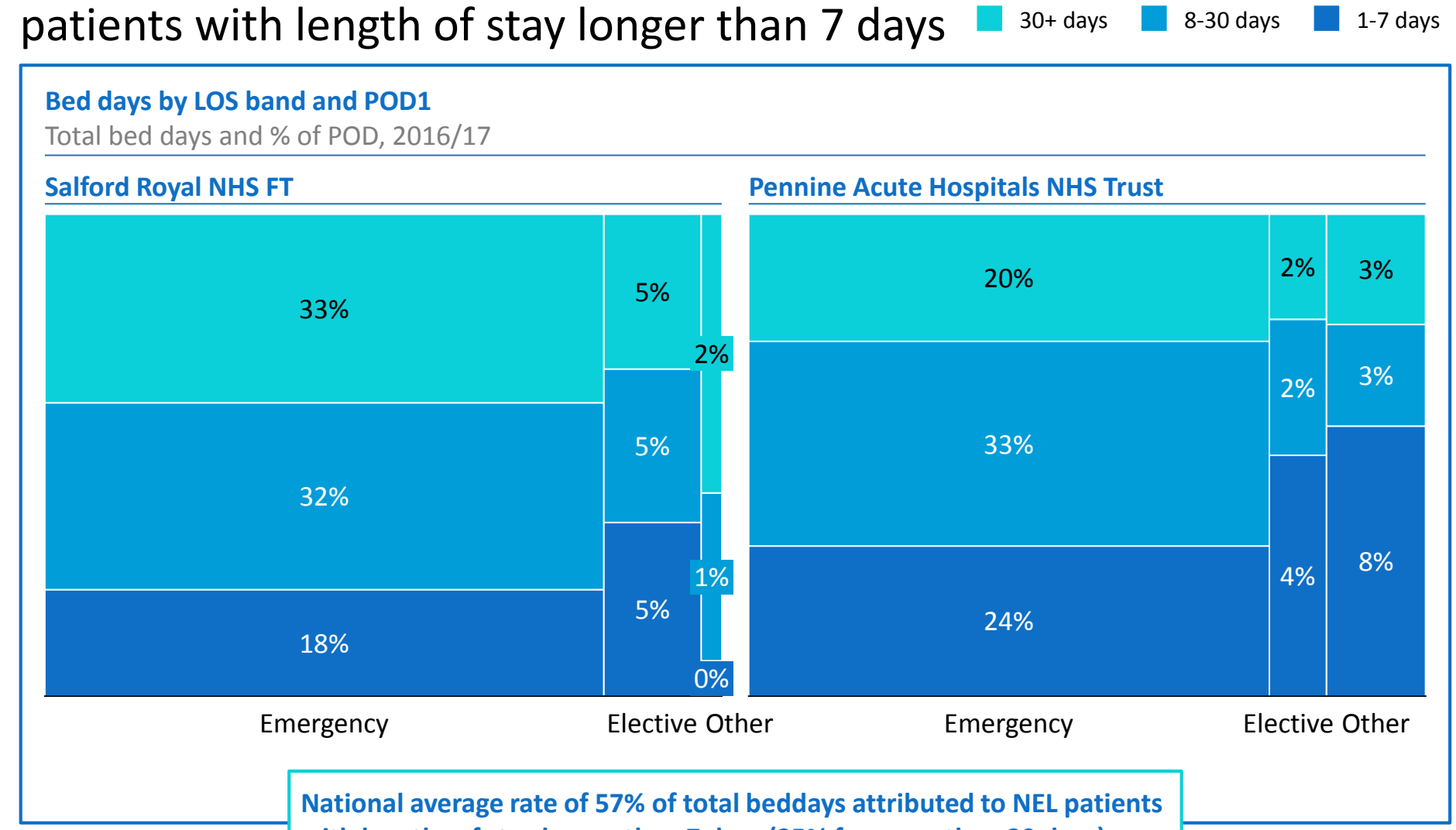
SOURCE: NHS website – Bed Availability and Occupancy statistics 2017/18

Maternity bed occupancy at PAHT has been historically higher than the national average but has recently dipped



SOURCE: NHS website – Bed Availability and Occupancy statistics 2017/18

>50% of all bed days at both trusts are occupied by stranded NEL patients with length of stay longer than 7 days



National average rate of 57% of total beddays attributed to NEL patients with lengths of stay longer than 7 days (25% for more than 30 days)

1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.

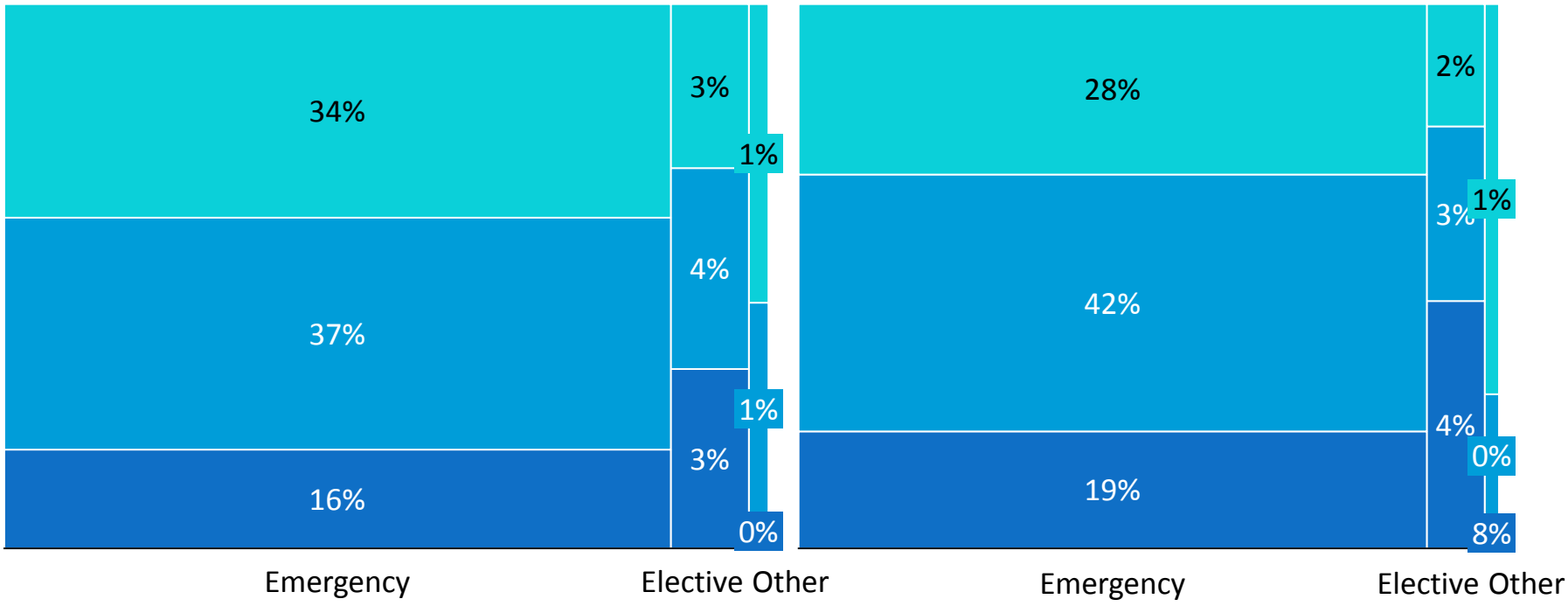
SOURCE: HES 2016/17

>70% of all bed days for people aged 65+ are occupied by stranded NEL patients with length of stay longer than 7 days

30+ days 8-30 days 1-7 days

Bed days by LOS band and POD1

Total bed days and % of POD, 2016/17

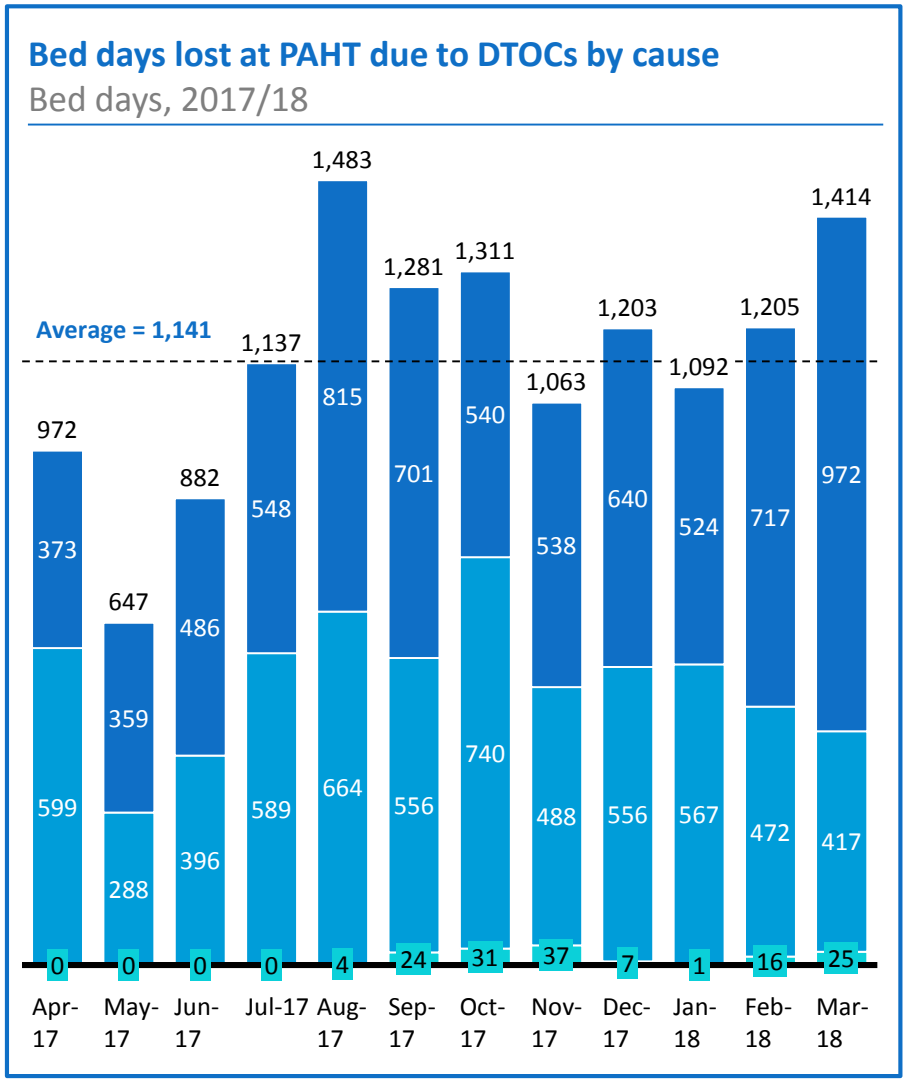


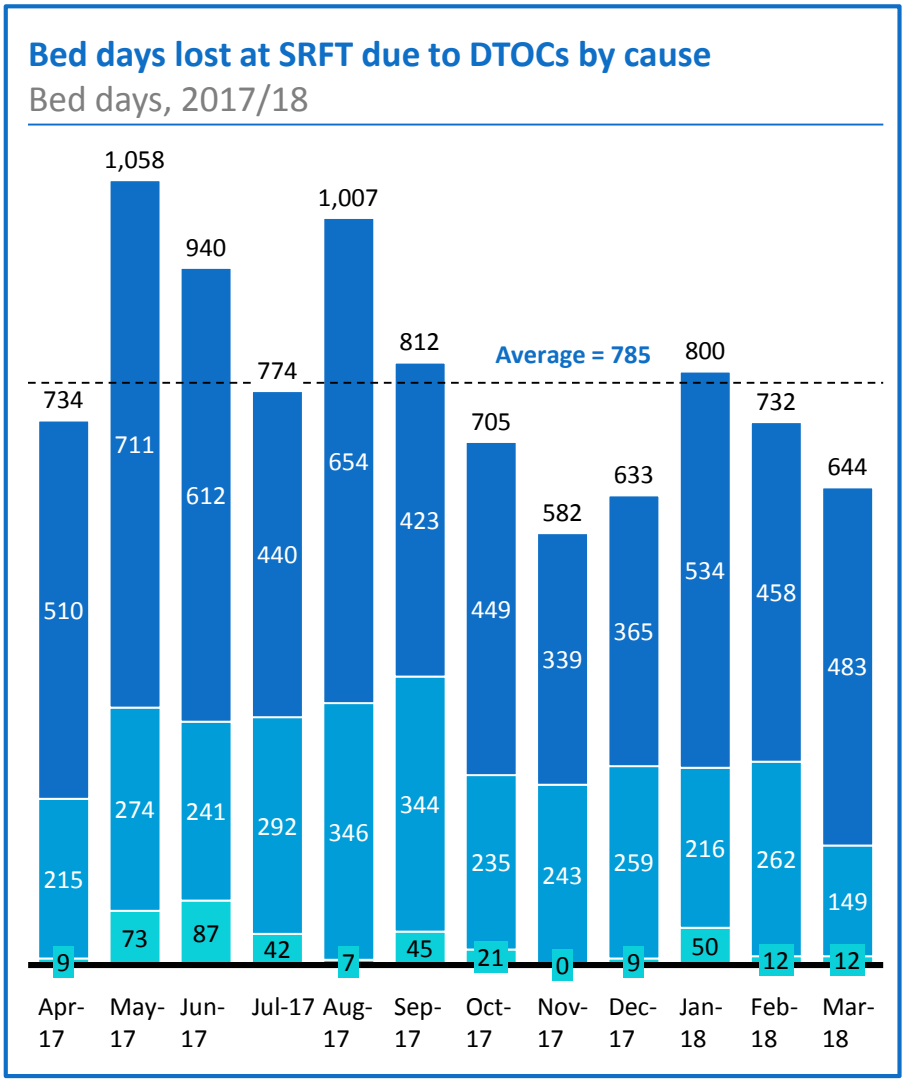
National average rate of 71% of total beddays attributed to NEL patients with lengths of stay longer than 7 days (31% for more than 30 days)

1 Excluding RA (Regular Attenders) and Other (not recorded type), Paediatrics patients are defined by age 0-18 y.o.

SOURCE: HES 2016/17

On average, 1,141 and 785 bed days are lost at PAHT and SRFT, respectively, every month due to DTOCs





SOURCE: HES Online 2018

Both Bury and Rochdale sites were rated good by the CQC while ROH and NMGH required improvement

Requires improvement · Inadequate · Outstanding · Good

Fairfield General Hospital, Bury

Latest inspection in Oct 2017, reported Feb 2018

Overall **Good**	
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Rochdale Infirmary, Rochdale

Latest inspection in Feb 2016, reported Aug 2016

Overall **Good**	
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Royal Oldham Hospital, Oldham

Latest inspection in Oct 2017, reported Feb 2018

Overall **Requires Improve-ment**	
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

North Manchester General Hospital, Manchester

Latest inspection in Oct 2017, reported Feb 2018

Overall **Requires Improve-ment**	
Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

SOURCE: CQC website

Fairfield scored good or outstanding for most services with critical care and end of life care not included in the latest inspection

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	→ ←	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good → ← Feb 2018	Good ↑ Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Good ↑ Feb 2018	Good ↑ Feb 2018	Outstanding ↑↑ Feb 2018	Outstanding ↑↑ Feb 2018	Good → ← Feb 2018	Outstanding ↑↑ Feb 2018
Surgery	Good ↑ Feb 2018	Good ↑ Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018
Critical care	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Requires improvement Aug 2016
End of life care	Requires improvement Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Requires improvement Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires improvement → ← Feb 2018	Good ↑ Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018

SOURCE: CQC website

Rochdale is awaiting inspection, with the previous one from 2016 noting the need to improve urgent and emergency care

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	➔➔	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016
Medical care (including older people's care)	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

SOURCE: CQC website

ROH required improvement in many service areas including critical and medical care, plus care for children and young people

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	→ ←	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018
Medical care (including older people's care)	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↓ Feb 2018	Requires improvement → ← Feb 2018
Surgery	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018
Critical care	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
Maternity	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good ↑ Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Requires improvement Aug 2016
Outpatient and Diagnostic imaging	Requires improvement Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018

SOURCE: CQC website

NMGH required improvement in several service areas, especially in medical care and surgery

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	→ ←	↑	↑↑	↓	↓↓

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑↑ Feb 2018	Good ↑ Feb 2018	Good → ← Feb 2018	Requires improvement ↑ Feb 2018	Good ↑↑ Feb 2018	Good ↑↑ Feb 2018
Medical care (including older people's care)	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Requires improvement ↑ Feb 2018	Requires improvement ↑ Feb 2018
Surgery	Requires improvement → ← Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Good → ← Feb 2018	Good ↑ Feb 2018	Requires improvement → ← Feb 2018
Critical care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016
Maternity	Requires improvement Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018	Good Feb 2018
Services for children and young people	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good ↑ Feb 2018	Good ↑ Feb 2018	Good Feb 2018	Requires improvement ↑ Feb 2018
End of life care	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Outpatient and Diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall	Requires improvement ↑ Feb 2018	Requires improvement → ← Feb 2018	Good → ← Feb 2018	Requires improvement → ← Feb 2018	Good ↑↑ Feb 2018	Requires improvement ↑ Feb 2018

SOURCE: CQC website

Royal Salford was recently rated outstanding by the CQC with kind, caring staff and highly responsive services

Salford Royal Hospital, Salford
Latest inspection in Apr 2018, reported Aug 2018

Rating change since last inspection	Same	Up one rating	Up two rating	Down one rating	Down two rating
Symbol	➔➔	↑	↑↑	↓	↓↓

Overview

Inadequate · Requires improvement · Good · ☆ Outstanding

Overall Outstanding

Safe	Good	Responsive	Outstanding ☆
Effective	Good	Well-led	Good
Caring	Outstanding ☆		

Specific service areas

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↓ Aug 2018	Good ➔➔ Aug 2018	Good ↓ Aug 2018	Good ➔➔ Aug 2018	Good ↓ Aug 2018	Good ↓ Aug 2018
Medical care (including older people's care)	Good ↓ Aug 2018	Good ➔➔ Aug 2018	Good ➔➔ Aug 2018	Outstanding ➔➔ Aug 2018	Good ↓ Aug 2018	Good ↓ Aug 2018
Surgery	Good ↑ Aug 2018	Good ➔➔ Aug 2018	Good ➔➔ Aug 2018	Good ➔➔ Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018
Critical care	Good ➔➔ Aug 2018	Good ➔➔ Aug 2018	Outstanding ↑ Aug 2018	Good ↓ Aug 2018	Good ➔➔ Aug 2018	Good ➔➔ Aug 2018
Services for children and young people	Good Mar 2015	Good Mar 2015	Good Mar 2015	Good Mar 2015	Requires improvement Mar 2015	Good Mar 2015
End of life care	Good Mar 2015	Good Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015	Outstanding Mar 2015
Outpatients	Good Aug 2018	N/A	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Overall	Good ➔➔ Aug 2018	Good ➔➔ Aug 2018	Outstanding ➔➔ Aug 2018	Outstanding ➔➔ Aug 2018	Good ➔➔ Aug 2018	Outstanding ➔➔ Aug 2018

SOURCE: CQC website

Quality indicators for stroke

Quality indicator		FGH	Salford	England average
Process metrics	Stroke patients having a brain scan within 1 h, *%, 2016/17*	77.2	56.4	52.6
	Stroke patients seen by specialist consultant within 24 h, *%, 2016/17*	95.3	97.5	82.9
	Eligible stroke patients given thrombolysis, *%, 2016/17*	92.5	97.8	87.4

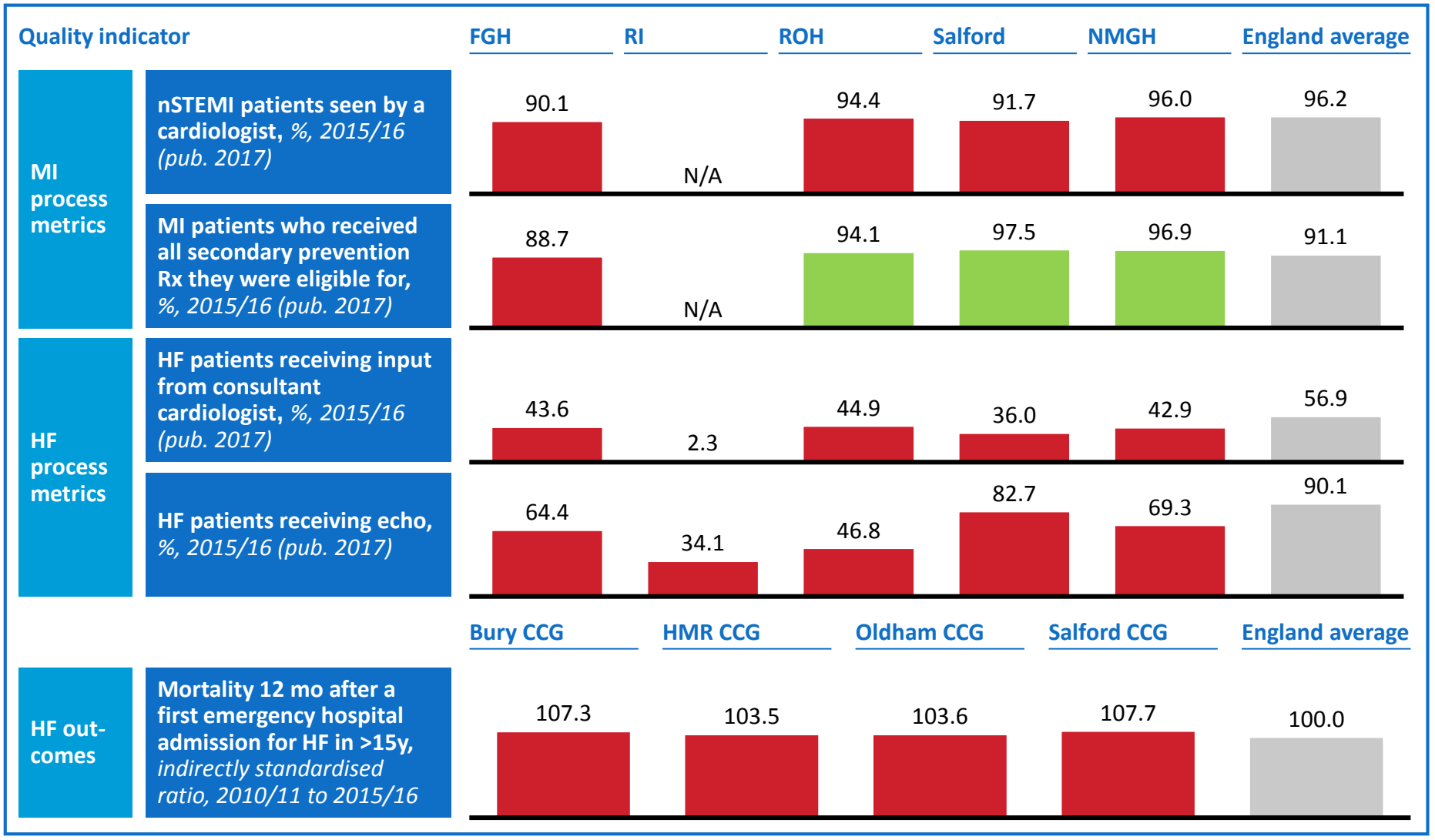
		Bury CCG	HMR CCG	Oldham CCG	Salford CCG	Local peers average	England average
Out-comes	Mortality within 30 days of hospital admission for stroke, *directly standard-ised ratio, 2013/14 to 2016/17*	0.97	1.10	1.33	0.95	1.00	1.03

SOURCE: Sentinel Stroke National Audit Programme 2017, CCG Outcomes Indicators 2018

Quality indicators for myocardial infarction and heart failure

Performance below England average

Performance above England average

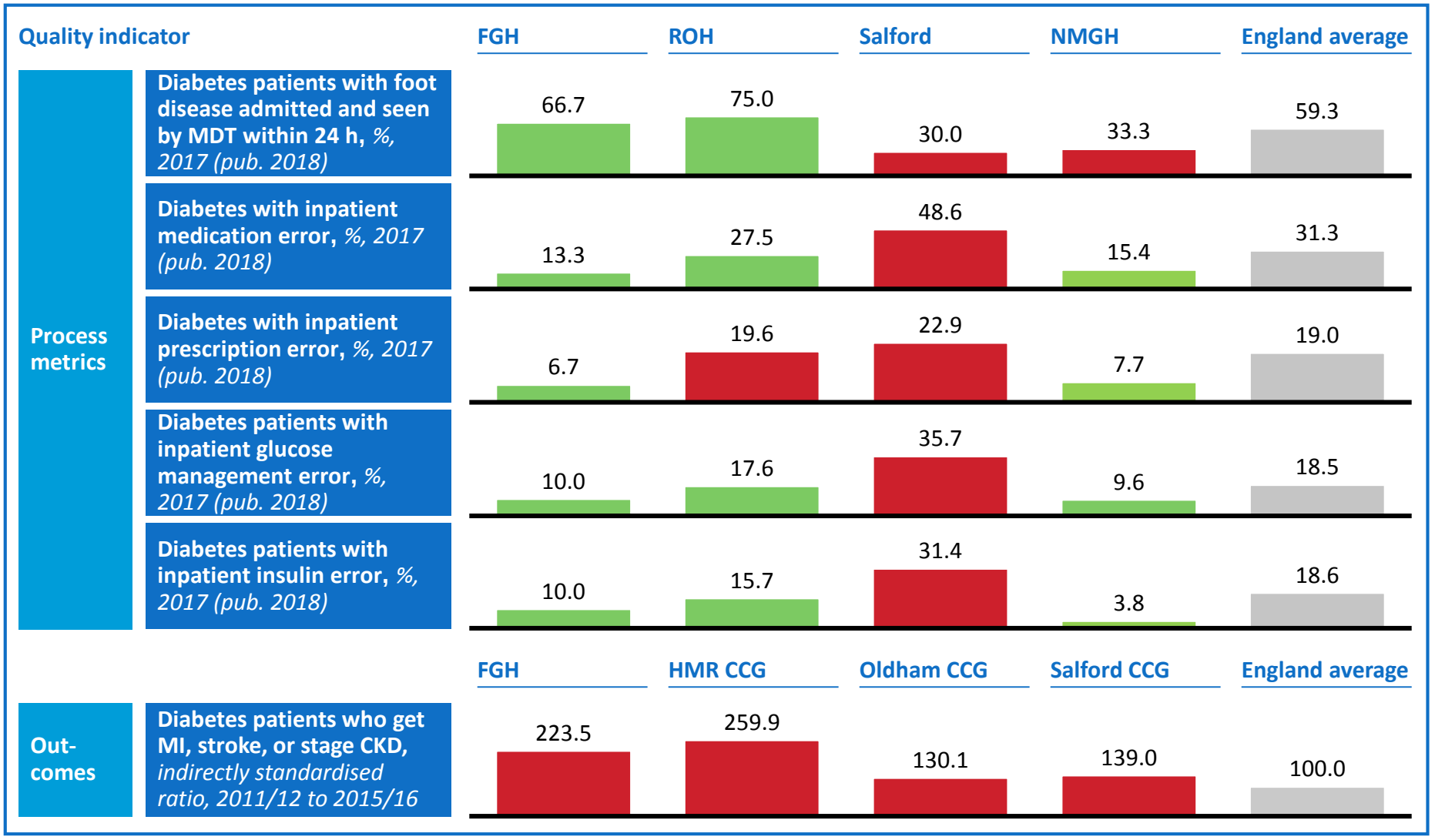


SOURCE: Myocardial Ischaemia National Audit Project 2017, National Heart Failure Audit 2017, CCG Outcomes Indicators 2018

Quality indicators for diabetes mellitus

Performance below England average

Performance above England average

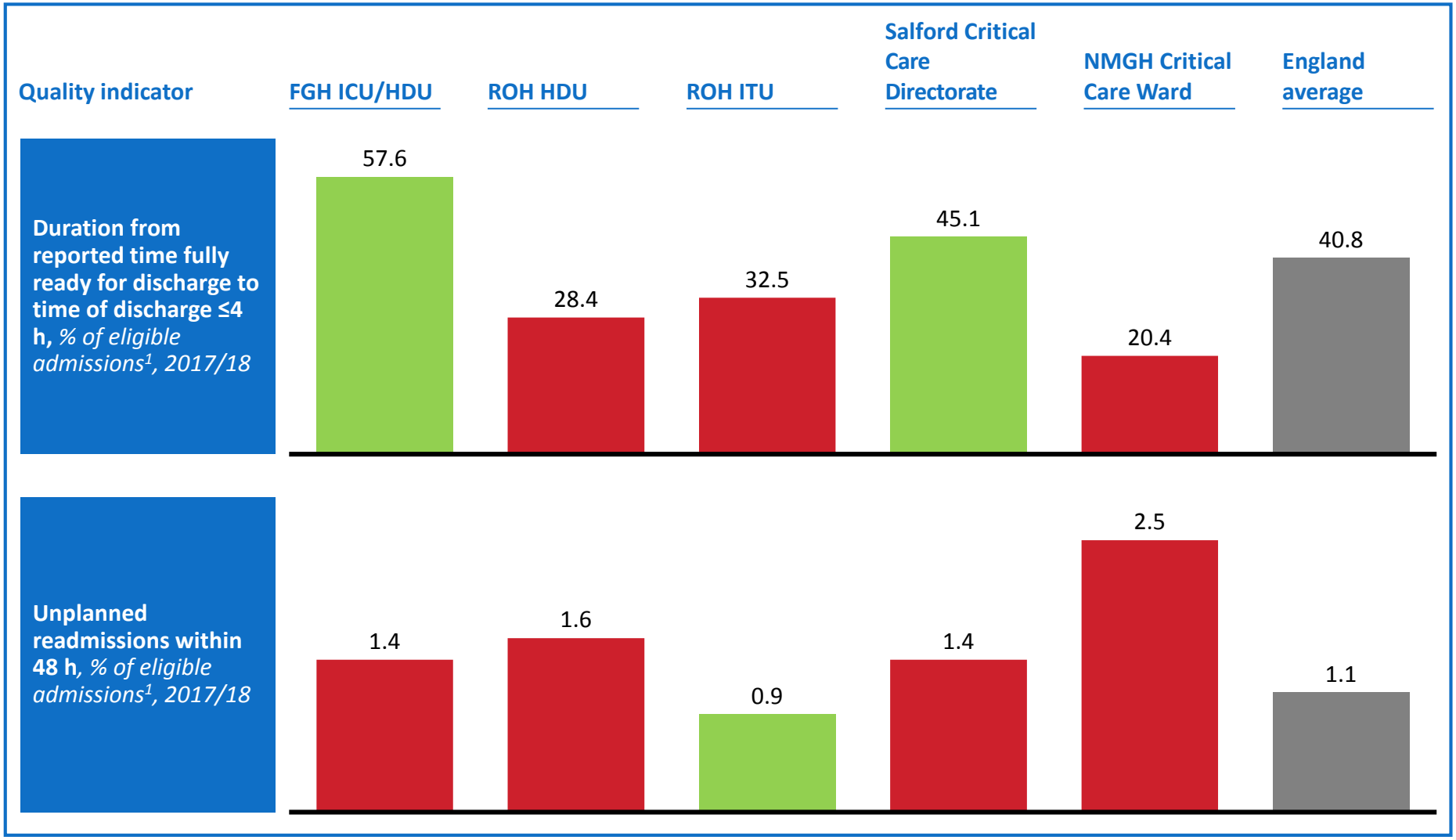


SOURCE: National Diabetes Inpatient Audit 2018, CCG Outcomes Indicators 2018

Quality indicators for adult critical care (1/2)

Trust performance below England average

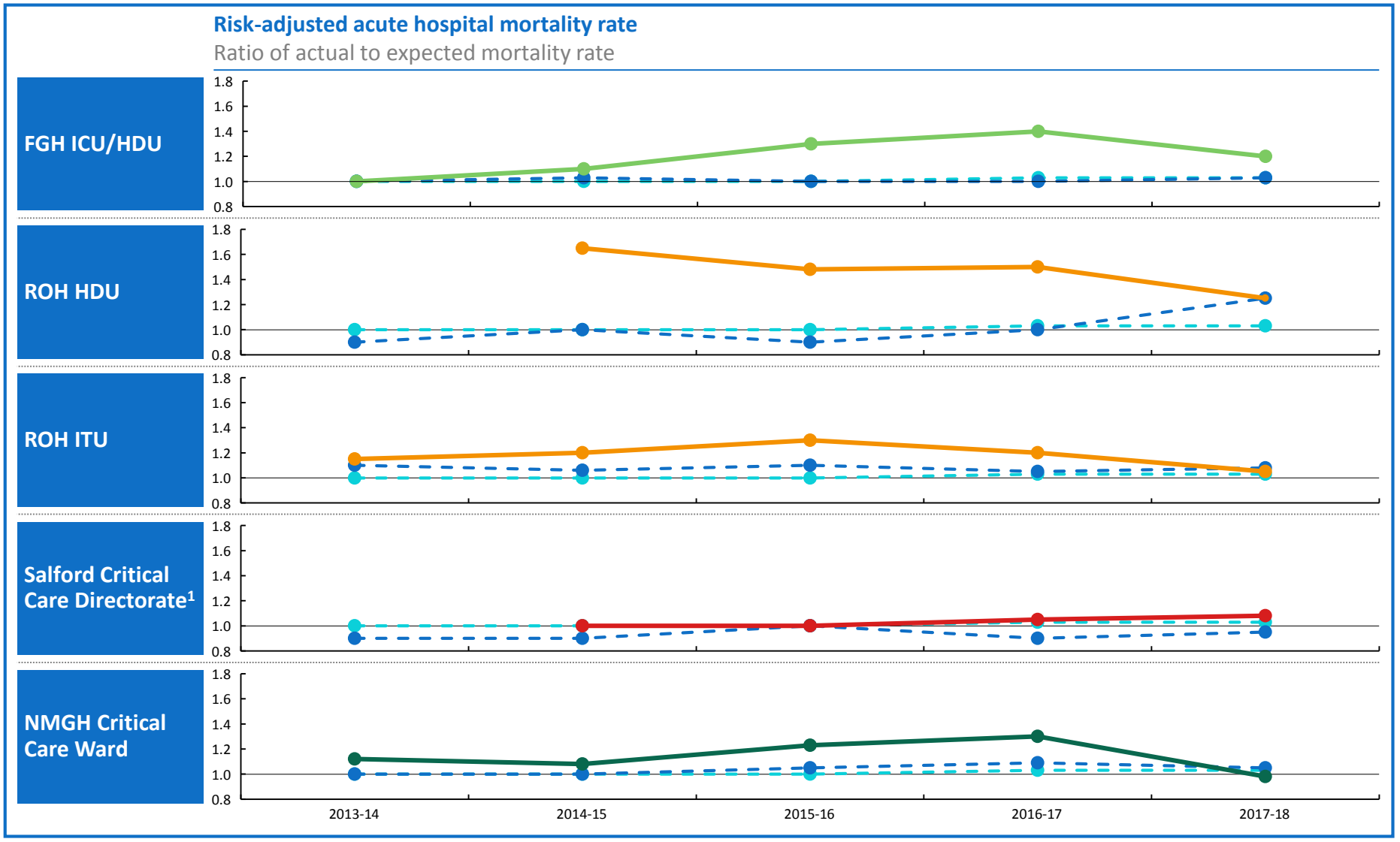
Performance above England average



1 Reported for unit survivors discharged to a ward in the same hospital (or direct to home)

SOURCE: ICNARC Annual Quality Report 2018 for adult critical care

Quality indicators for adult critical care (2/2)



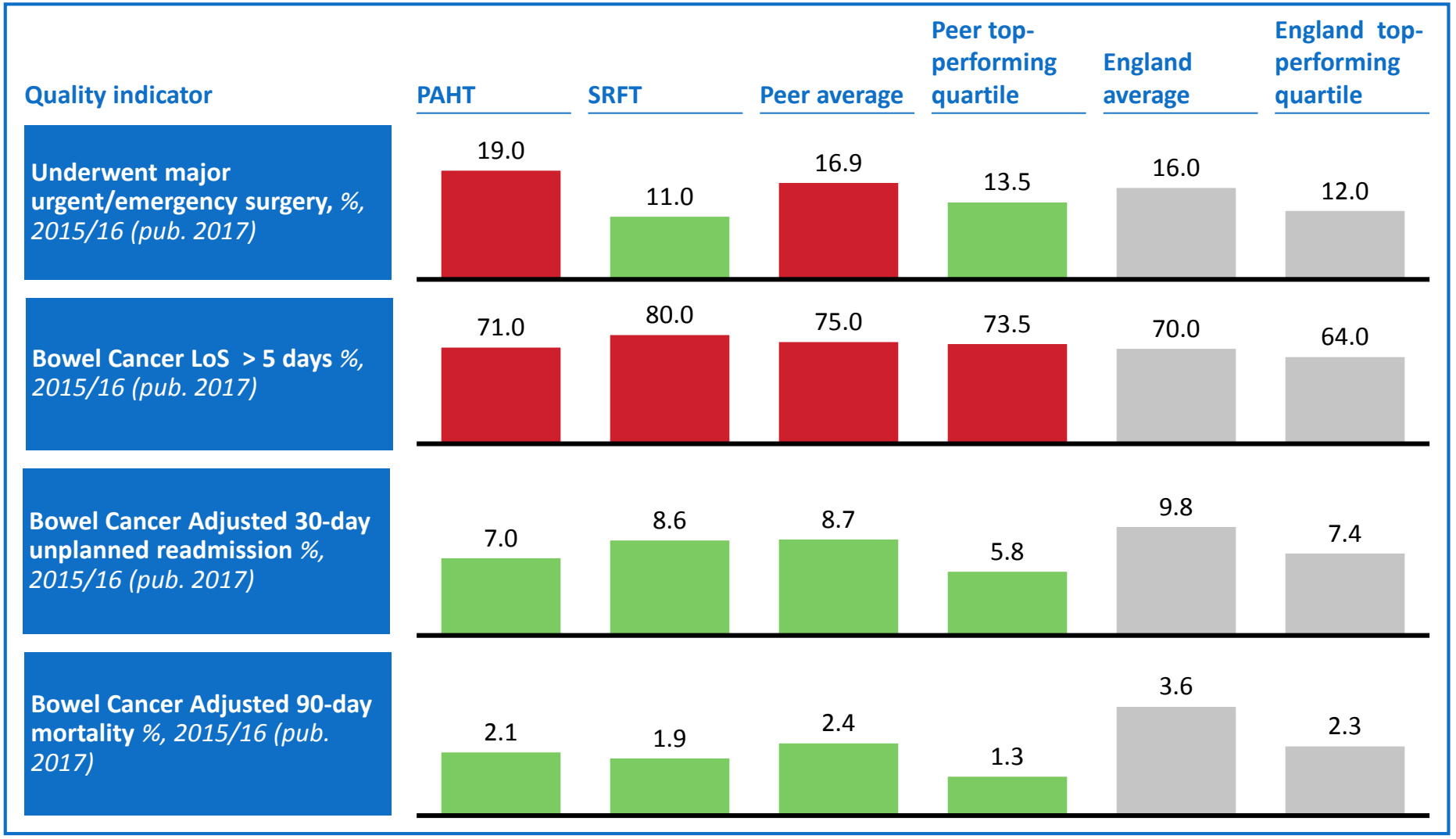
1 Salford recently started admitted patients with devastating brain injuries, which are not explicitly risk-adjusted for

SOURCE: ICNARC Annual Quality Report 2018 for adult critical care

Quality indicators for bowel cancer

Trust performance below England average

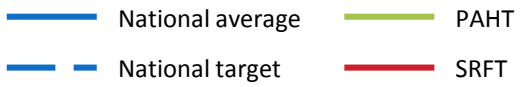
Trust performance above England average



1 Local peers as Bolton; Manchester; Stockport; Tameside & Glossop; Wrightington, Wigan & Leigh Trusts

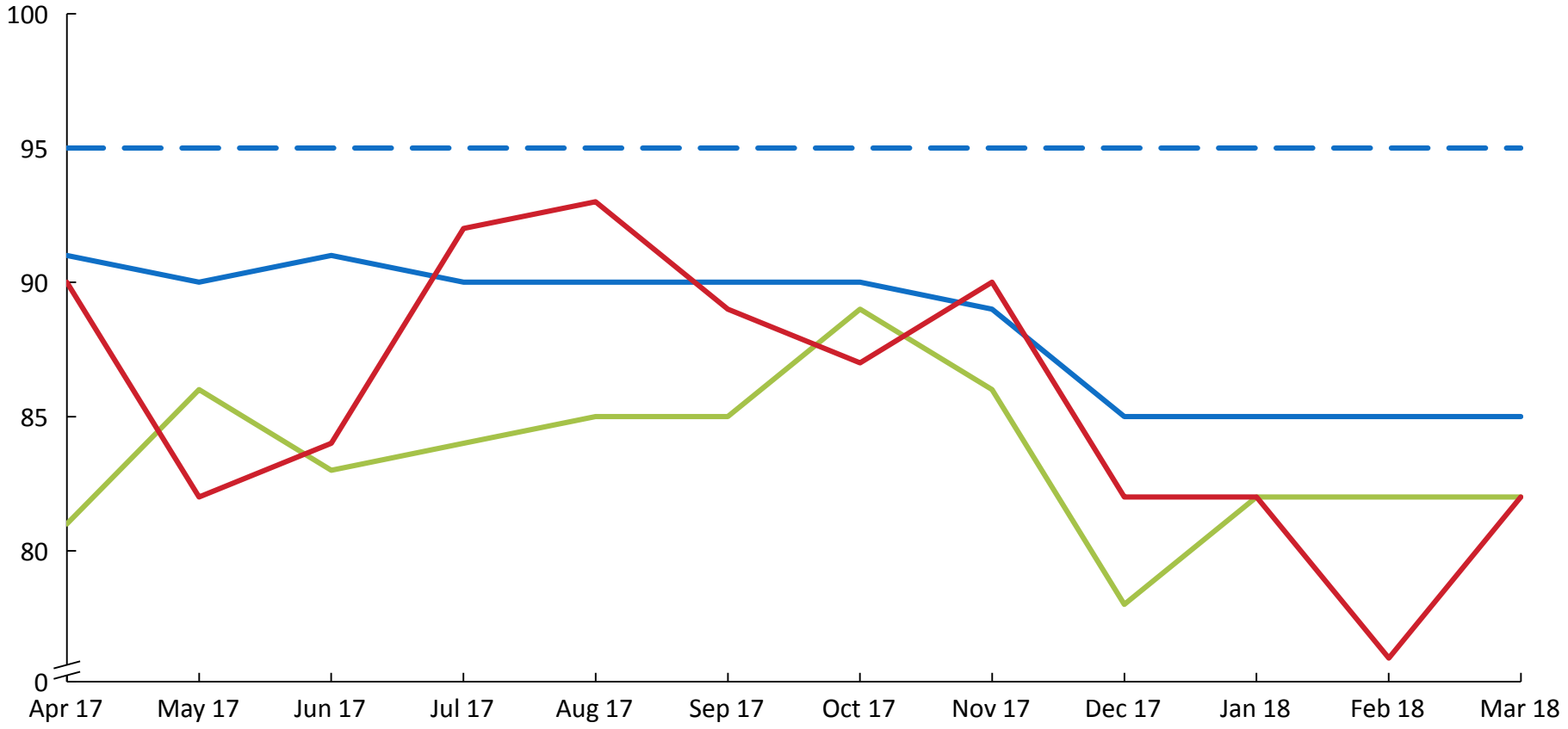
SOURCE: National Bowel Cancer Audit 2017

A&E waiting times are below the national 95% target and trending down



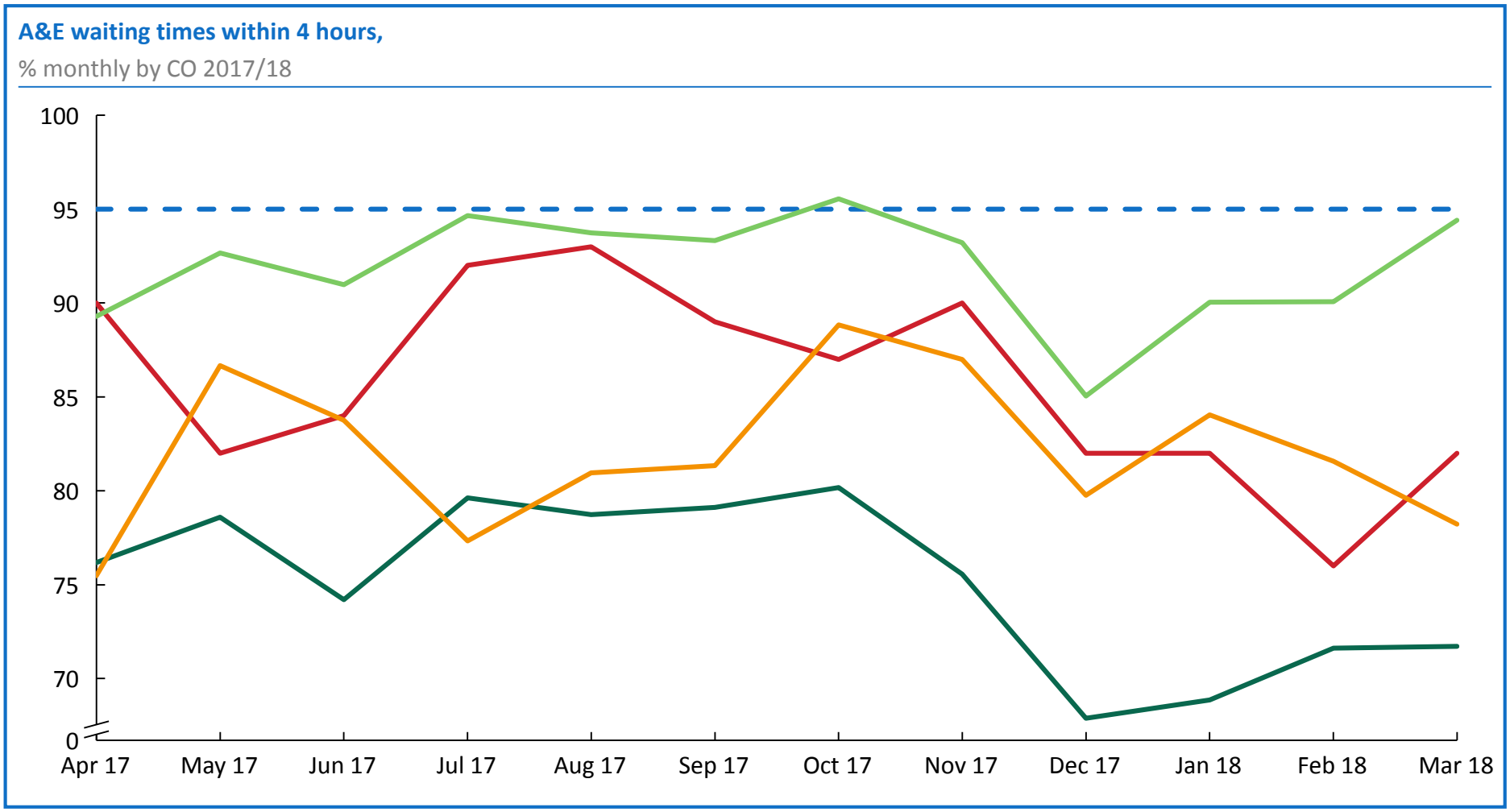
A&E waiting times within 4 hours,

% monthly by Trust 2017/18



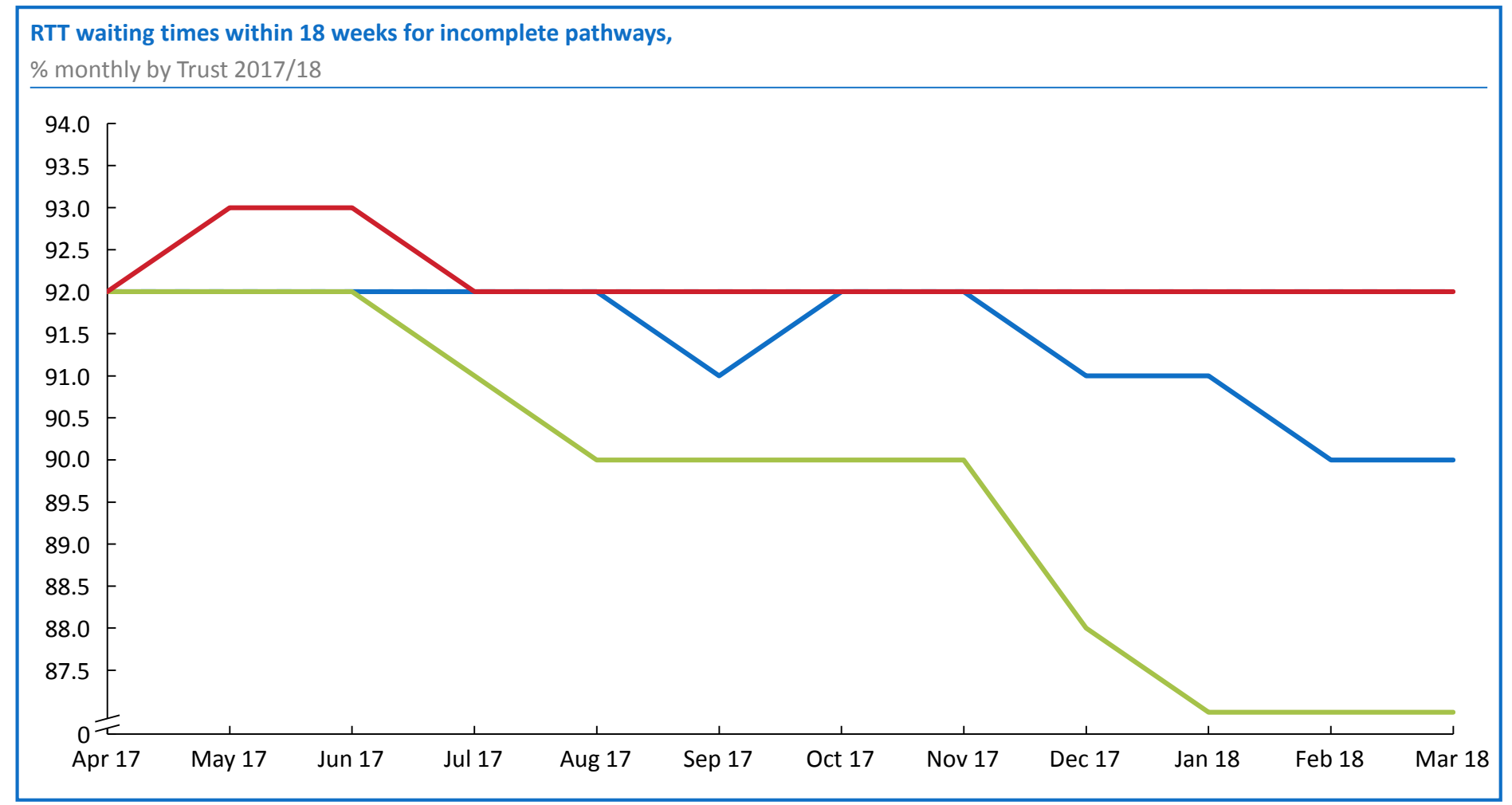
SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

For Pennine, the deteriorating performance is driven by waiting times at NMGH and ROH



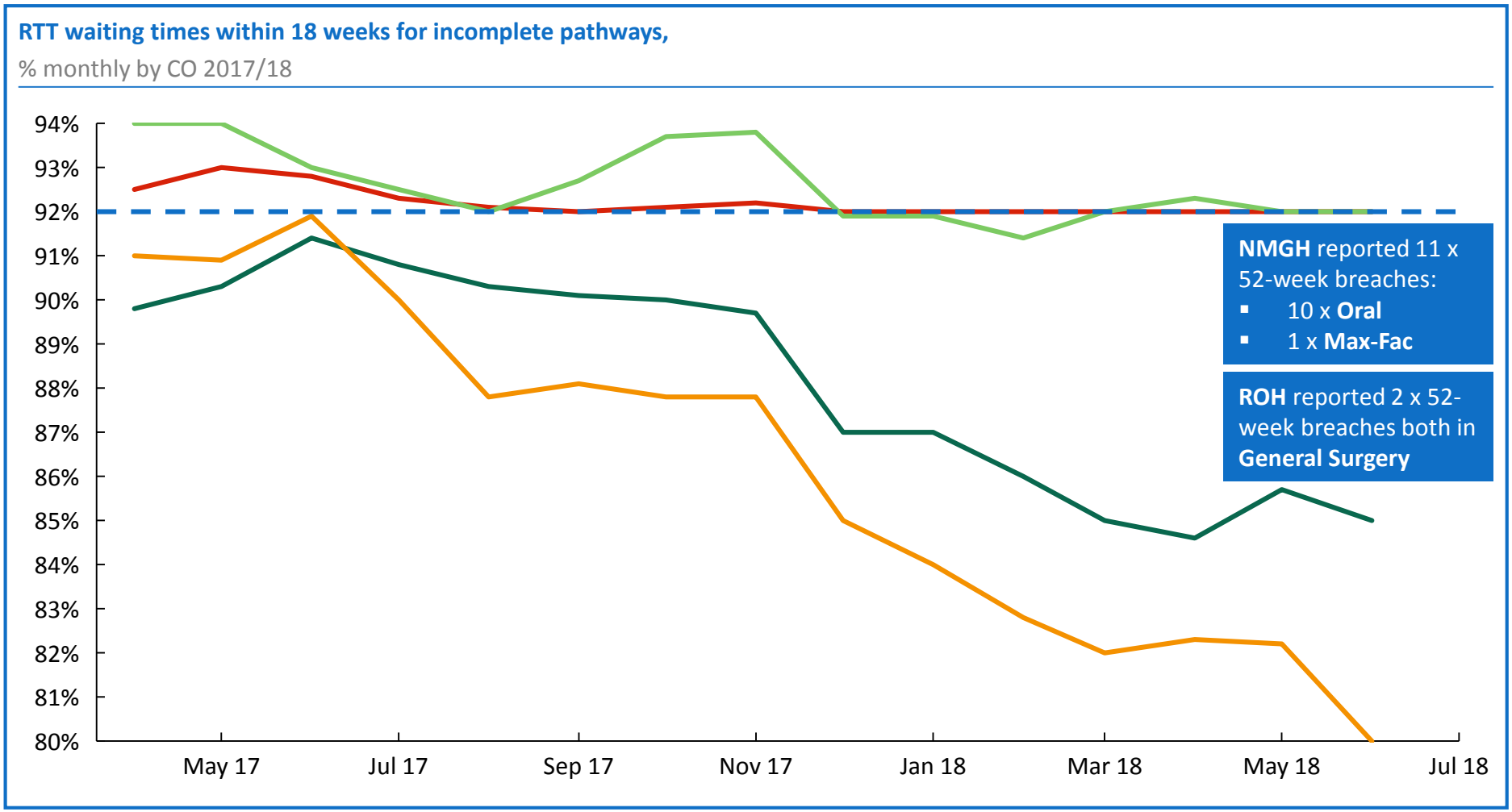
SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

RTT waiting times within 18 weeks are below the national average at PAHT



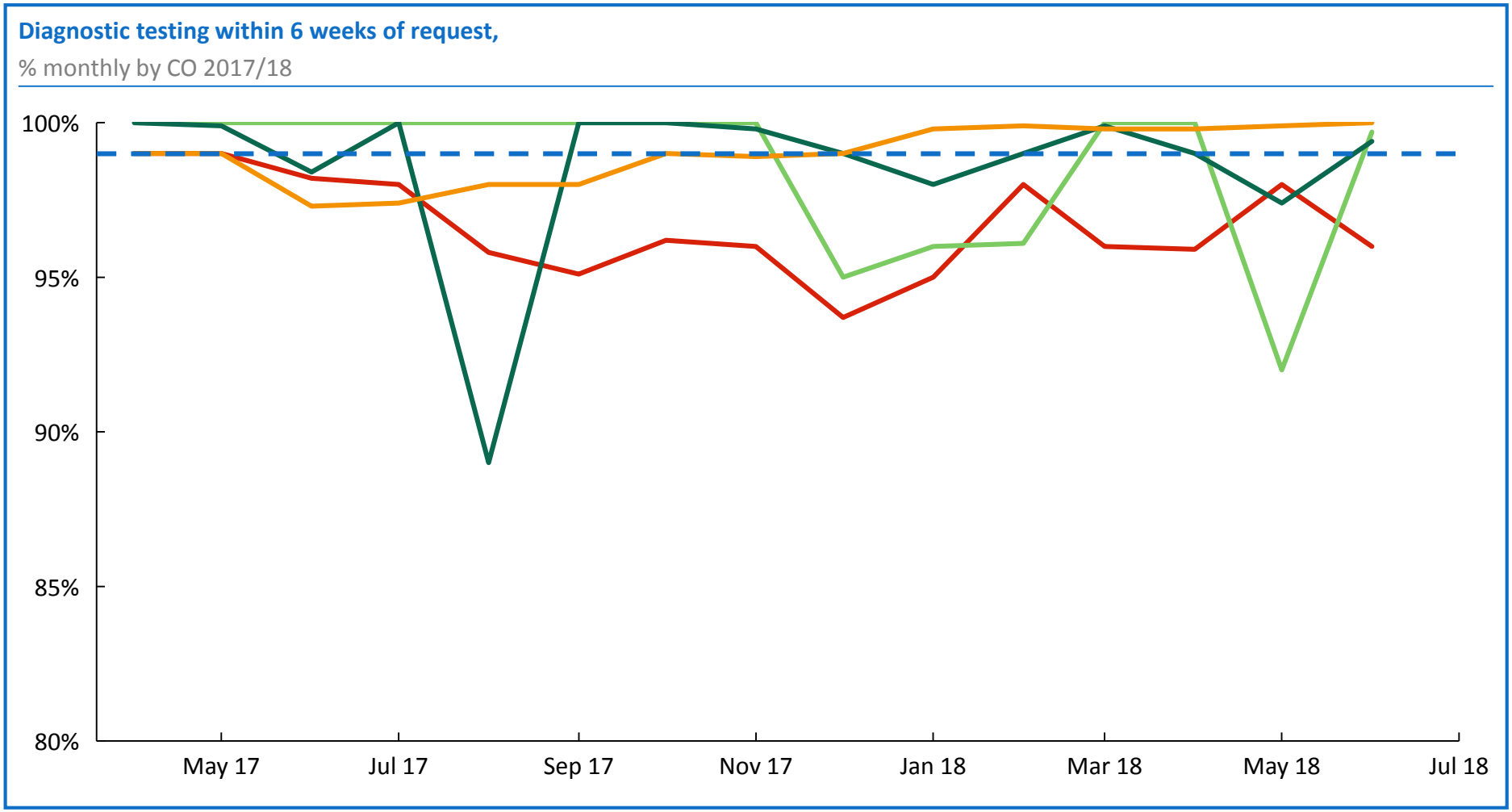
SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

This is primarily driven by declining RTT waiting time performance at NMGH and ROH



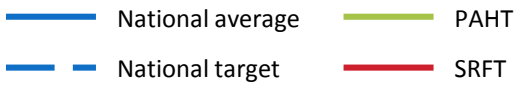
SOURCE: NCA CiC July 2018 pack

Six-week diagnostic performance varies considerably from month to month with Salford CO consistently below the target



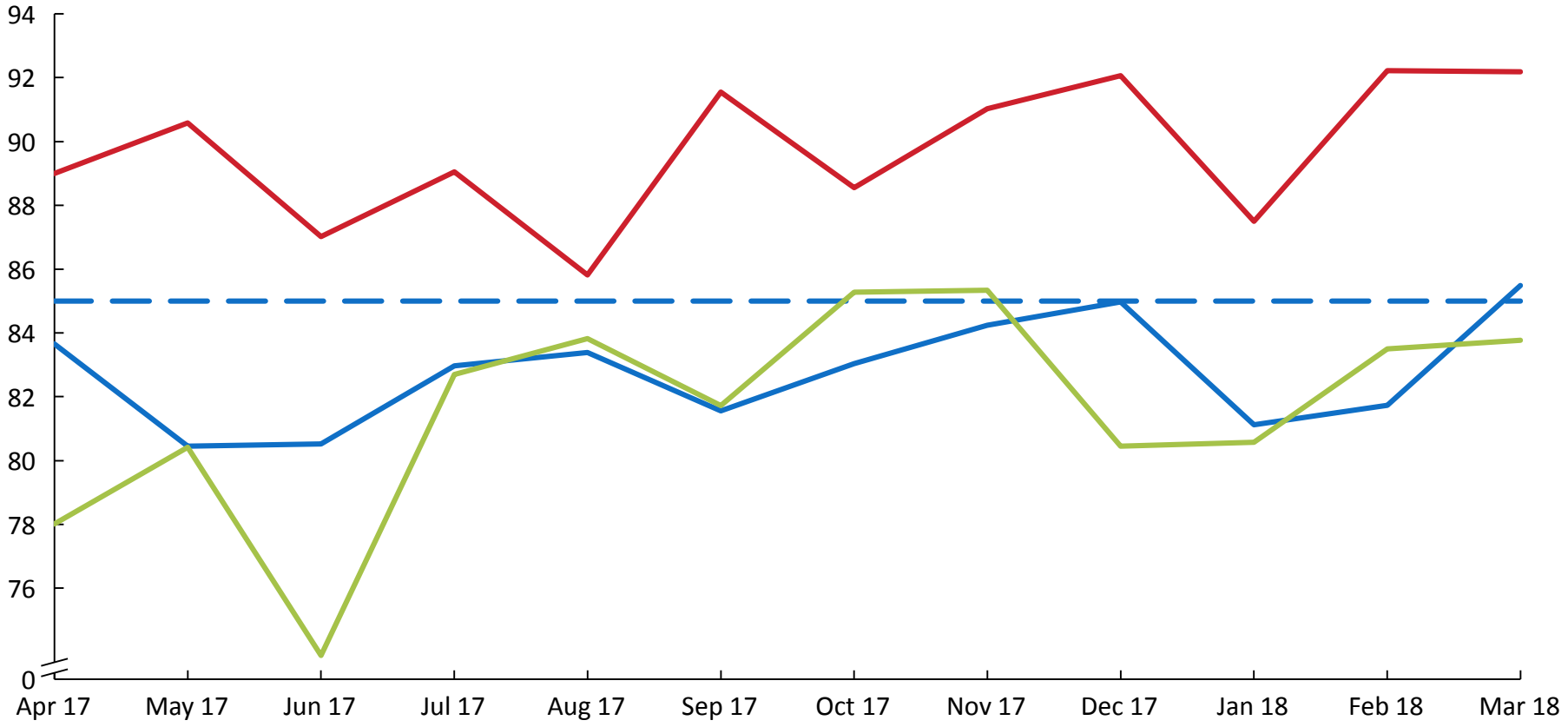
SOURCE: NCA CiC July 2018 pack

Cancer treatment waiting times are better than the national average and the national target at SRFT



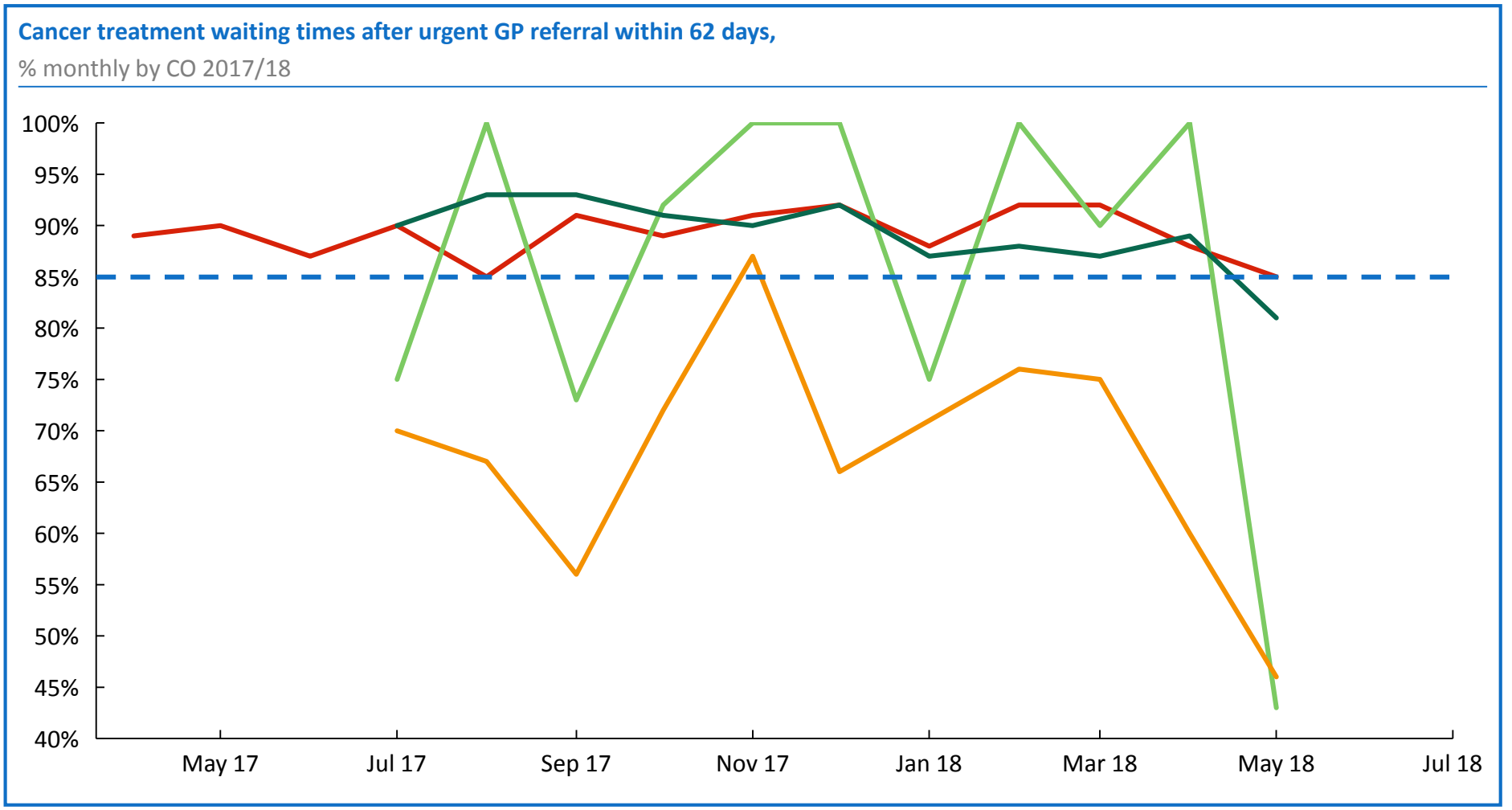
Cancer treatment waiting times after urgent GP referral within 62 days,

% monthly by Trust 2017/18



SOURCE: NHSE A&E Unify2 data collection – MSitAE 2018, HSJ Intelligence 2018

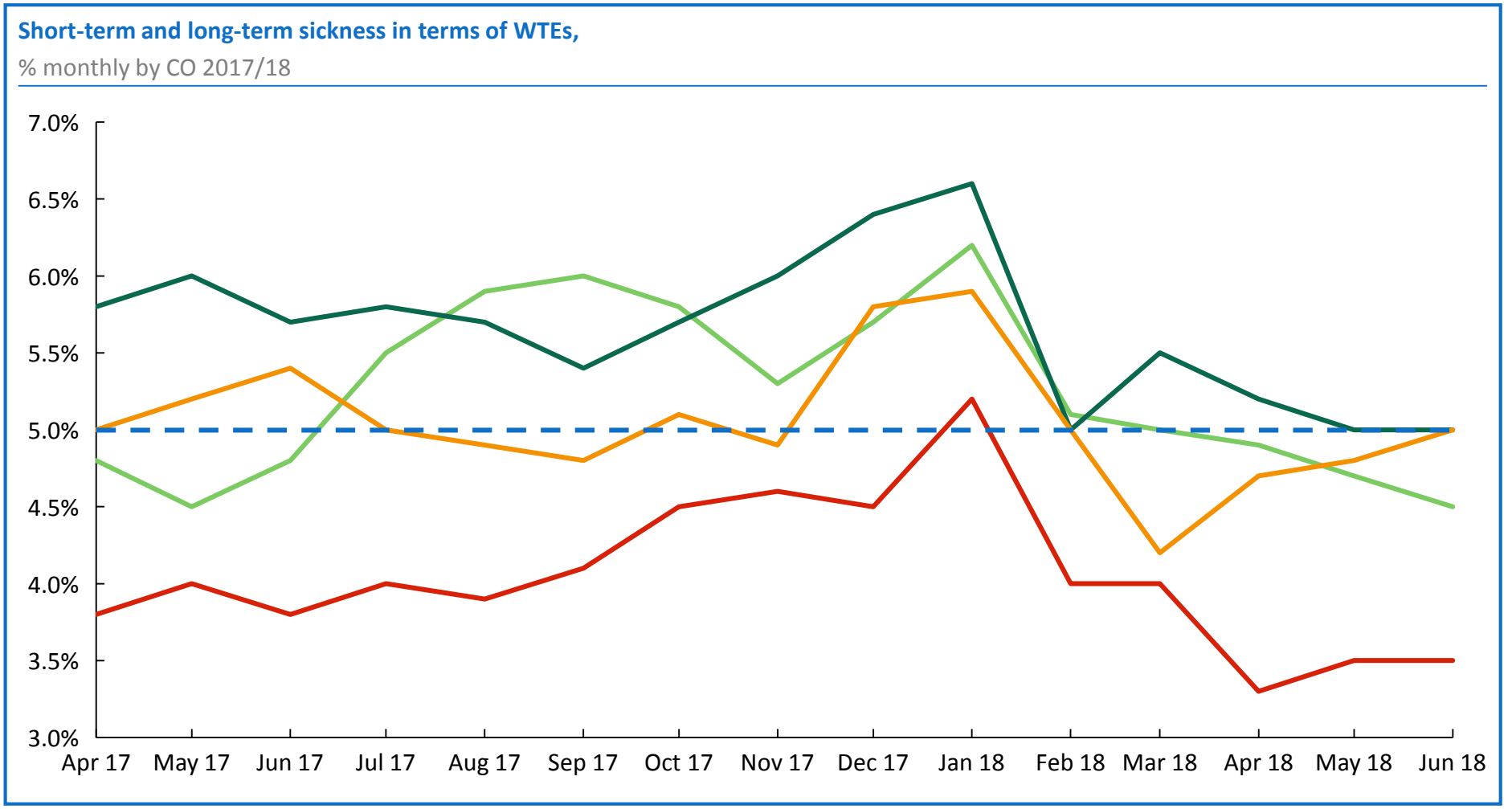
Both Oldham and Bury & Rochdale COs have seen declining cancer treatment waiting time performance



Bury & Rochdale CO covers ENT tumour groups

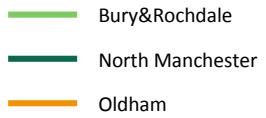
SOURCE: NCA CiC July 2018 pack

Sickness absence at Oldham and NM are now around the target while Salford and Bury & Rochdale are doing better



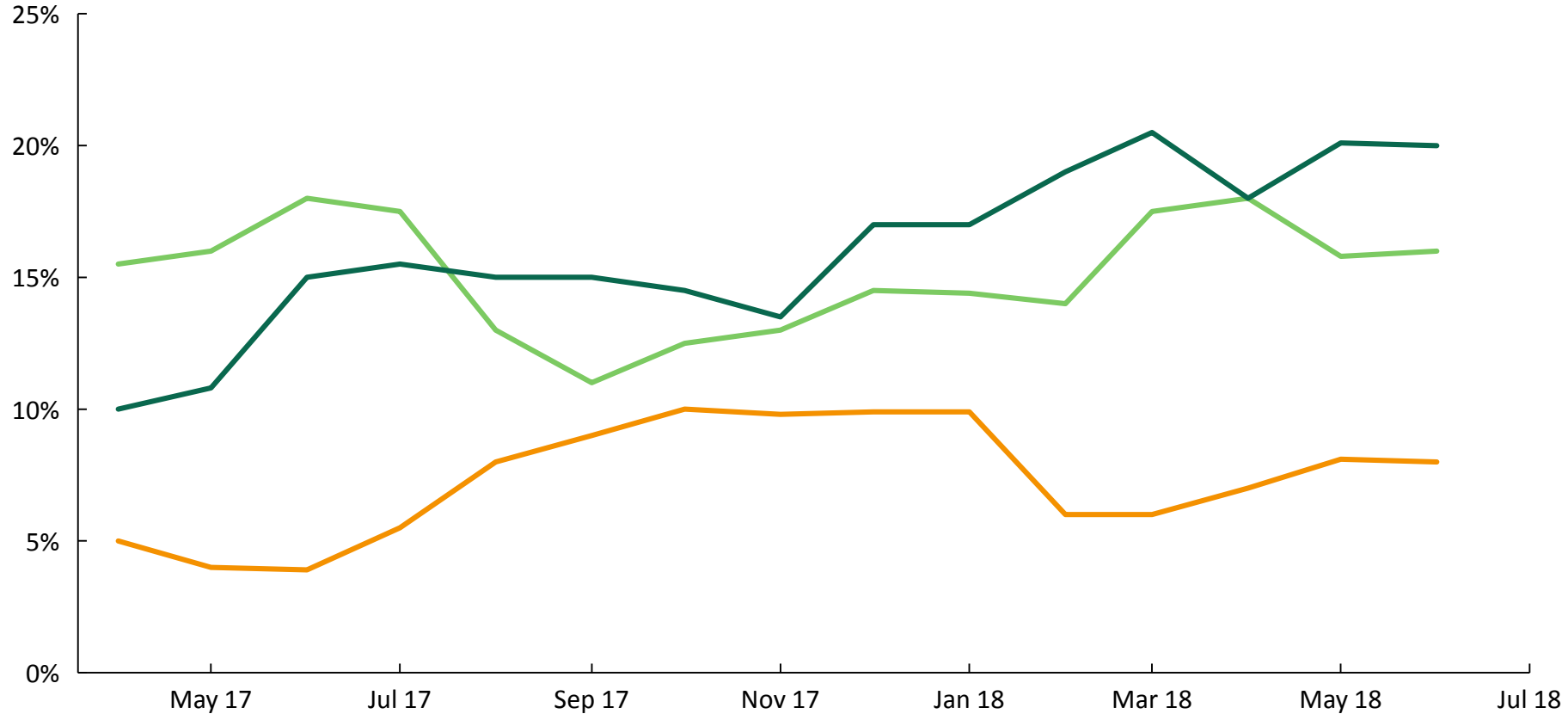
SOURCE: NCA CiC July 2018 pack

Vacancy rates for medical & dental staff roles are relatively high at NM and are trending upwards



Staff vacancy rates for medical & dental[1],

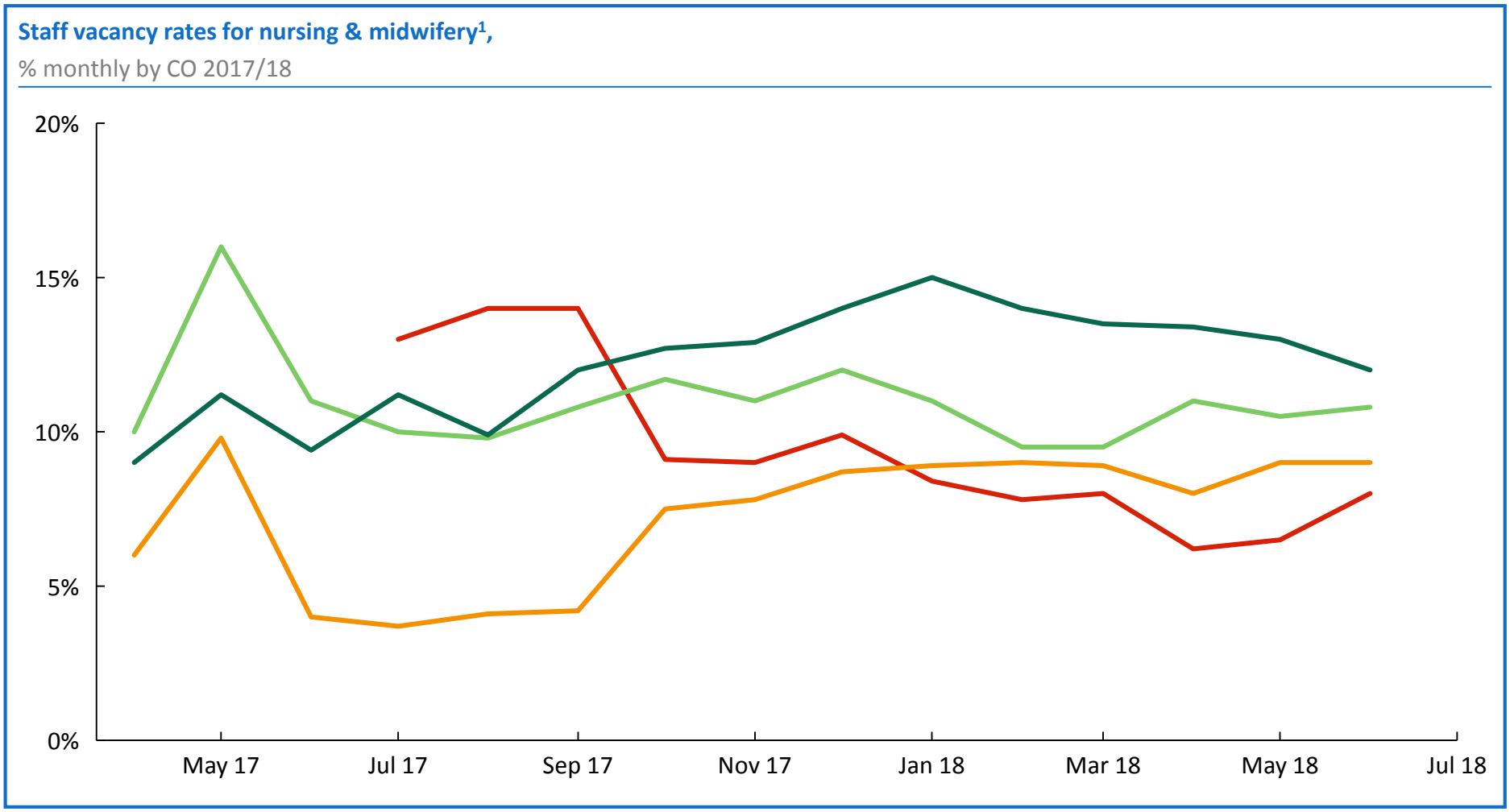
% monthly by CO 2017/18



1 Vacancy rates are primarily a function of staff turnover
Data for Salford were unavailable as of August 2018 but are undergoing validation

SOURCE: NCA CiC July 2018 pack

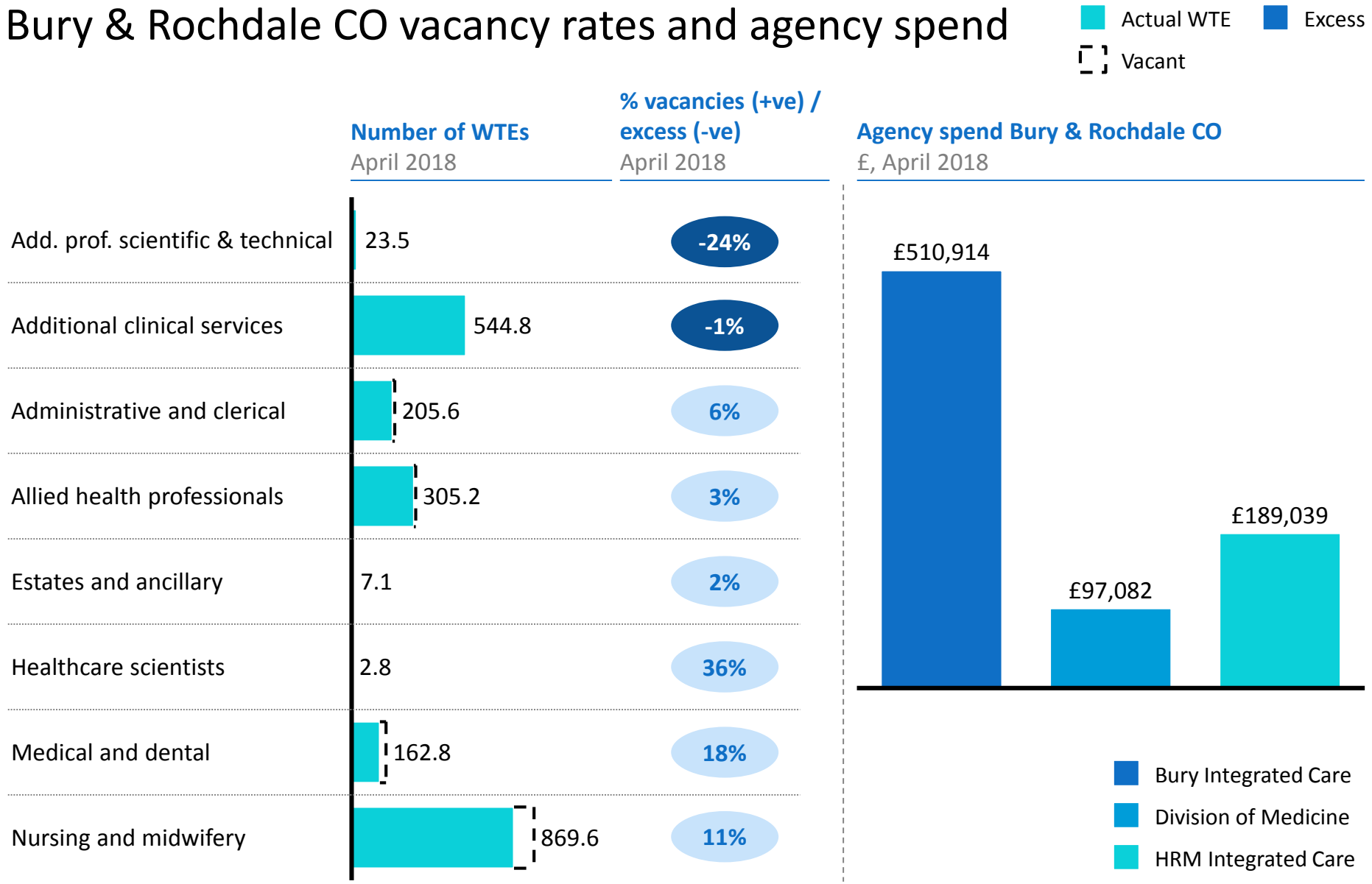
Vacancy rates for nursing & midwifery staff roles are highest at NM



1 Vacancy rates are primarily a function of staff turnover

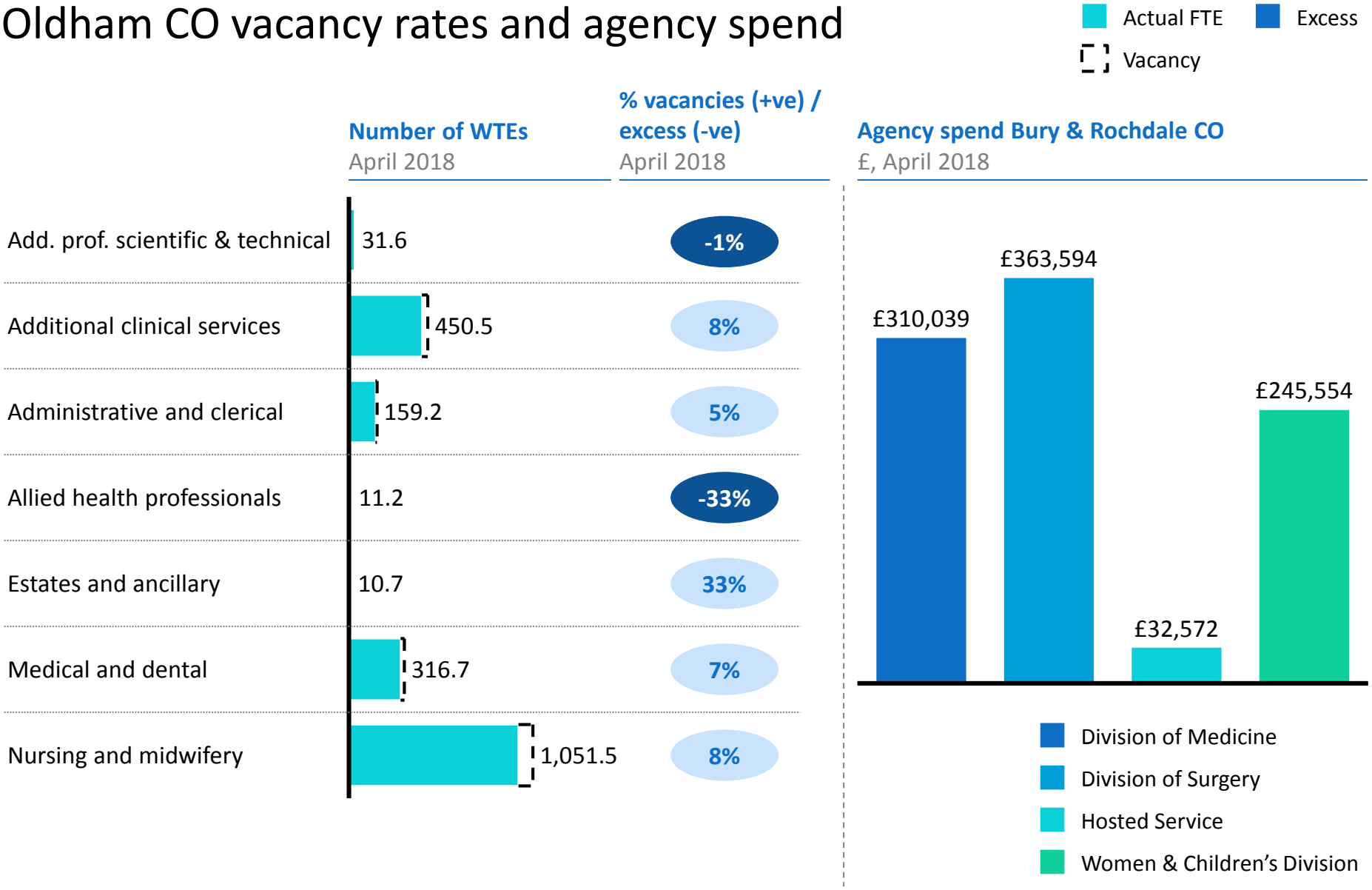
SOURCE: NCA CiC July 2018 pack

Bury & Rochdale CO vacancy rates and agency spend



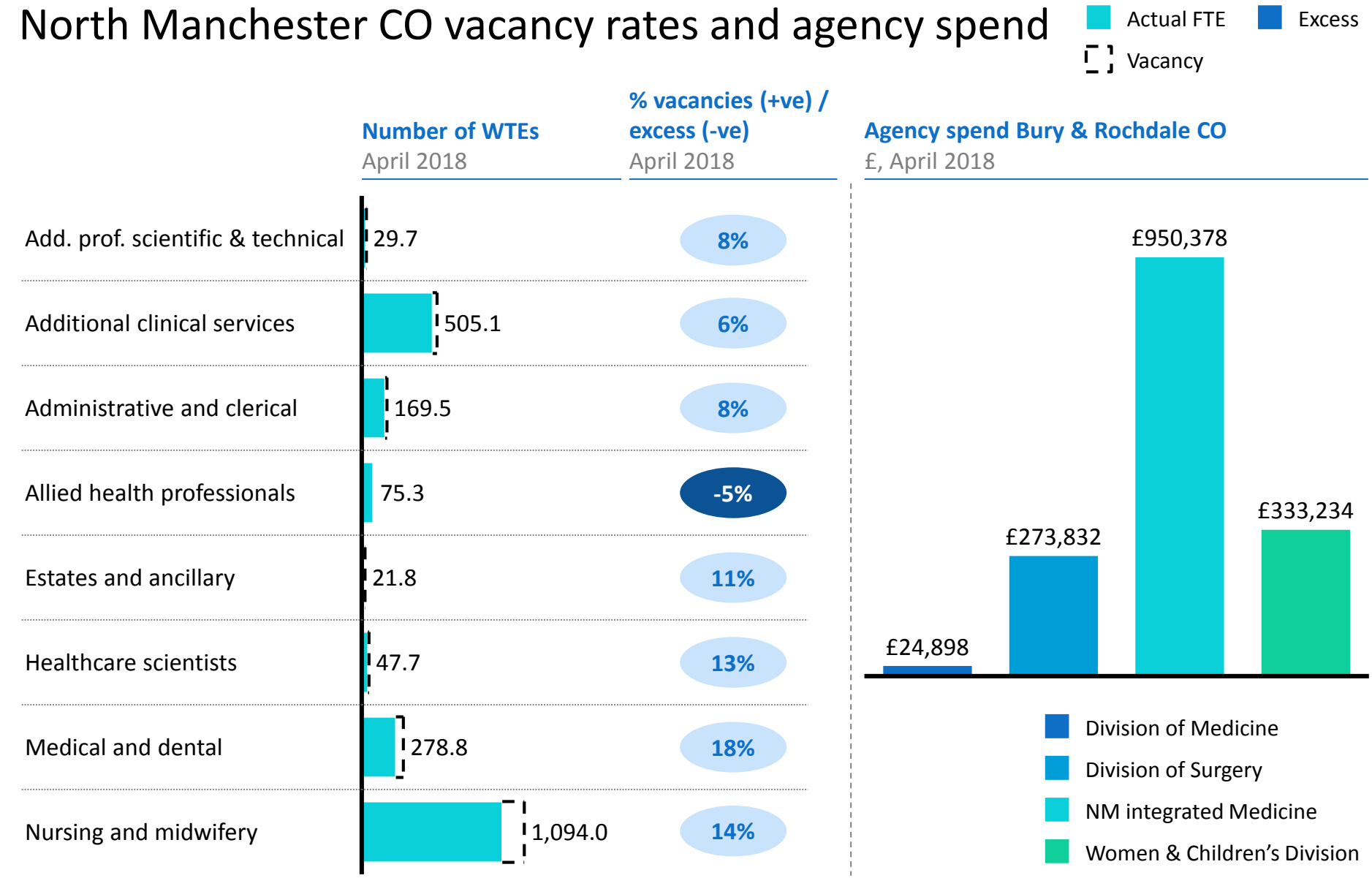
SOURCE: Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust, 2018

Oldham CO vacancy rates and agency spend



SOURCE: Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust, 2018

North Manchester CO vacancy rates and agency spend

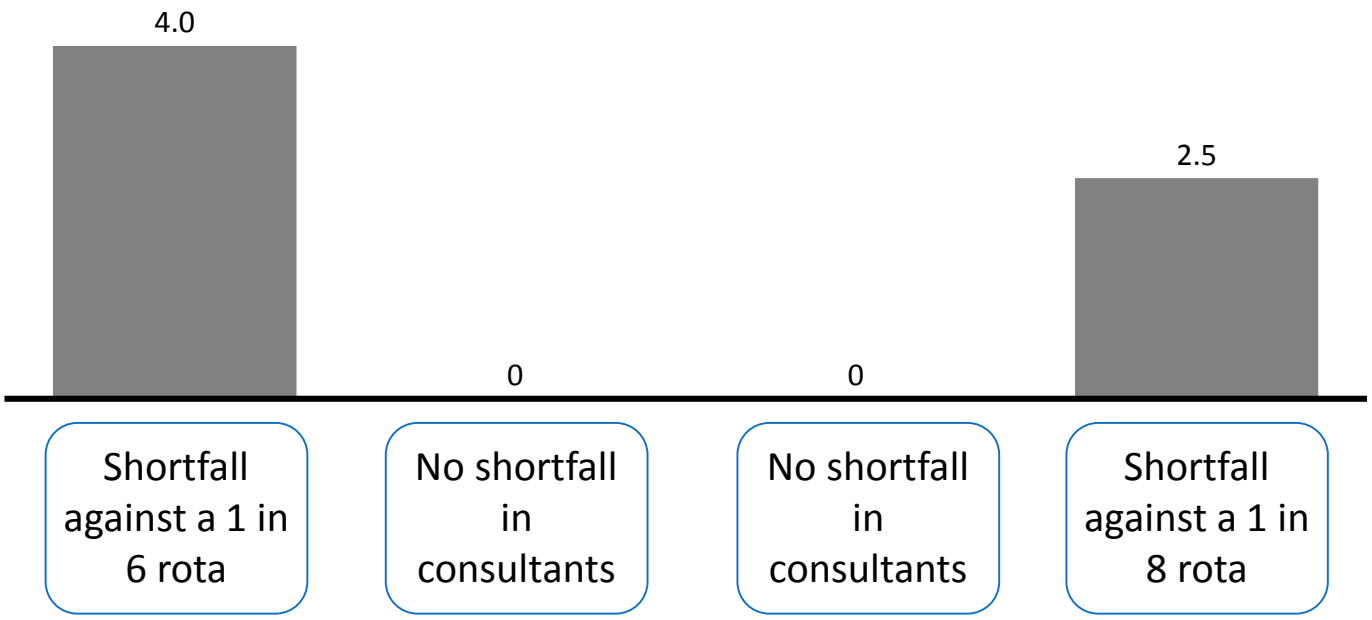


SOURCE: Joint Health Overview and Scrutiny Committee for Pennine Acute NHS Trust, 2018

Staffing levels for critical care

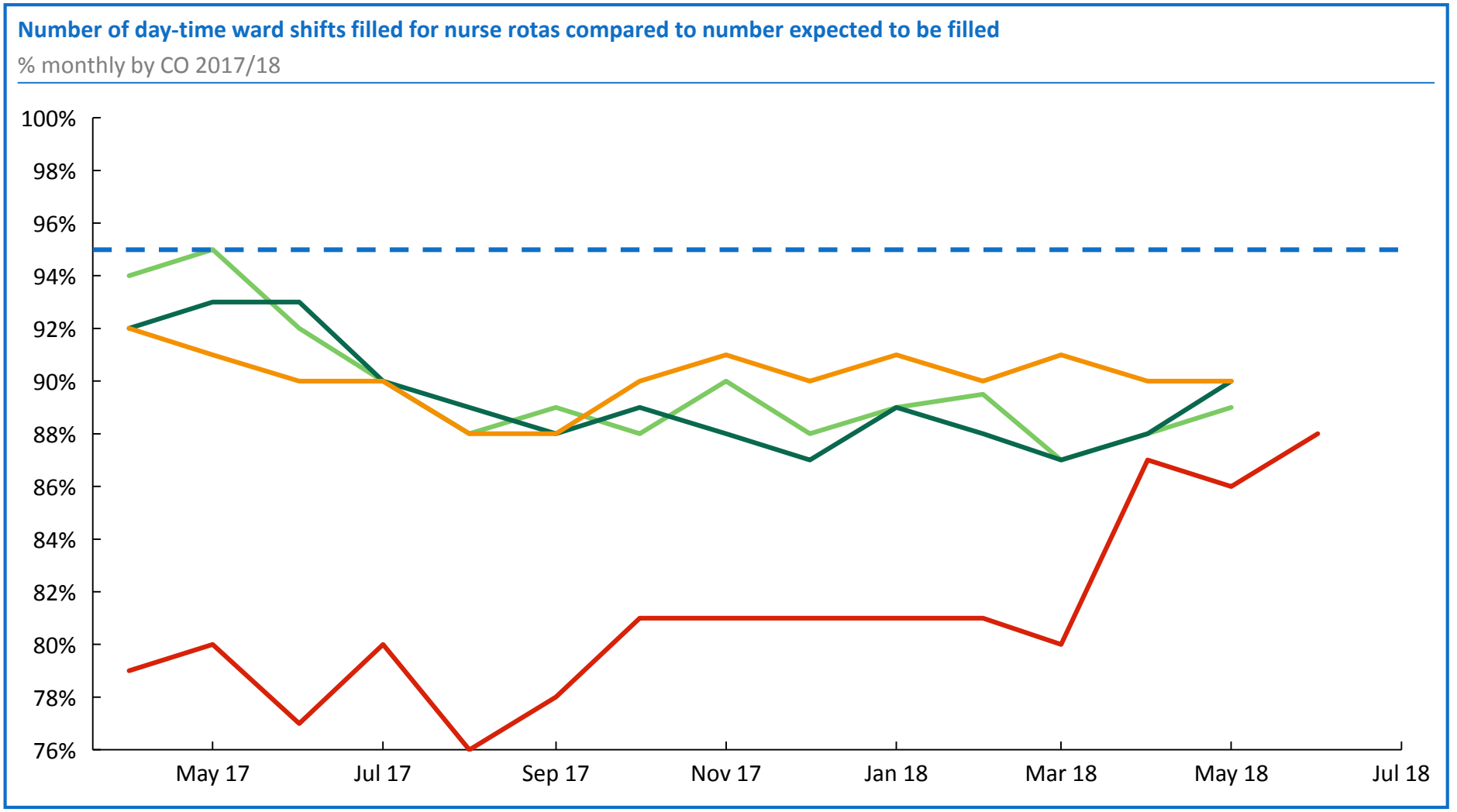
Consultant shortfall for critical care

Number of WTEs, September 2018



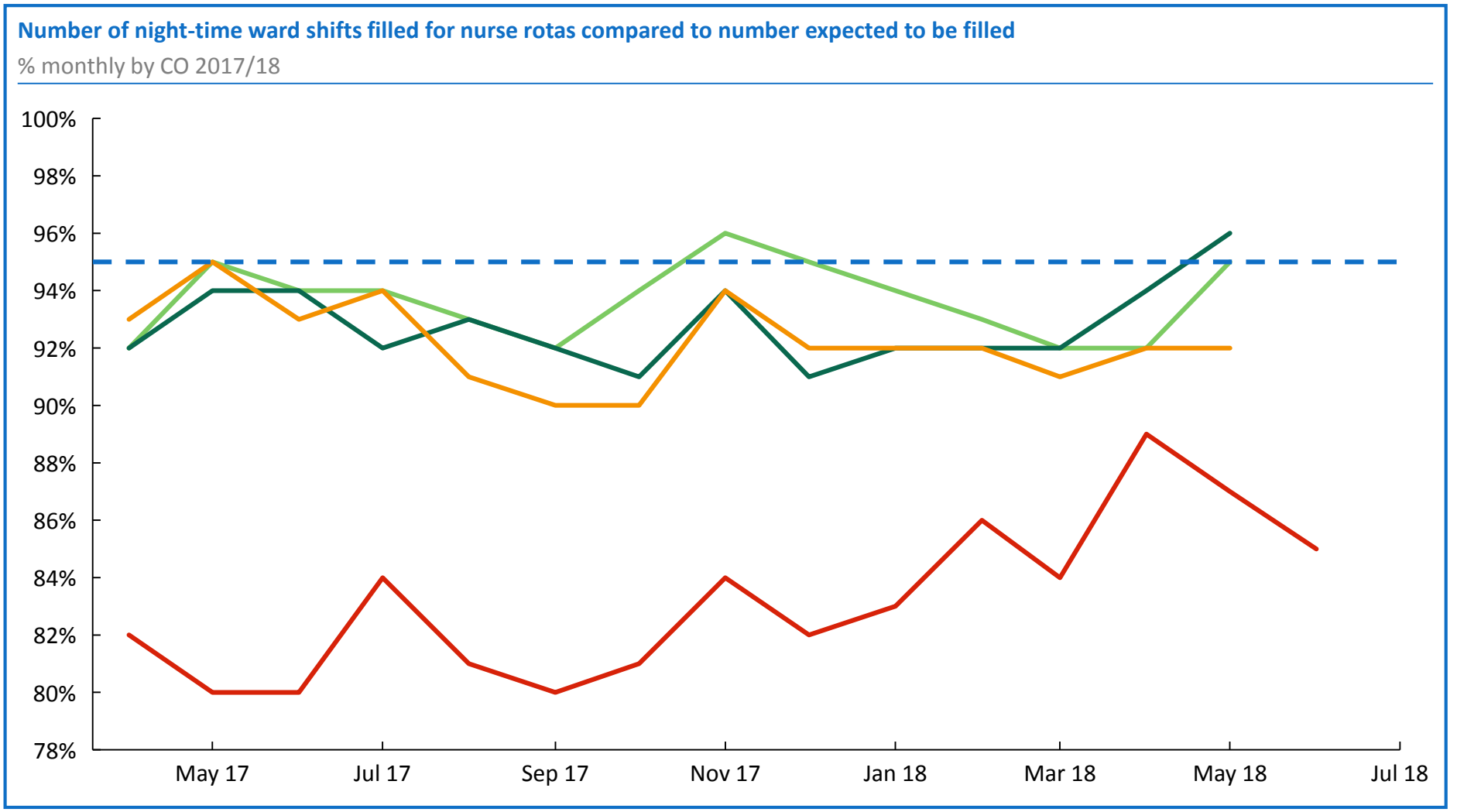
SOURCE: Trust ESR data 2018

Staffing levels for day-time nursing shifts are below the optimal staffing target at all COs



SOURCE: NCA CiC July 2018 pack

Staffing levels for night-time nursing shifts are below the optimal staffing target at Oldham and Salford



SOURCE: NCA CiC July 2018 pack

T&O and some GM wards at FGH are below optimal levels – there are also very low care staff fill rates for critical care

- Above or at 95% optimal staffing level target
- Below 95% optimal staffing level target but at or above 85%
- Below 85% optimal staffing level

			Day		Night	
Hospital	Main specialty	Ward	Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
Fairfield General Hospital	Cardiology	Ward 2 CCU	99.20%	76.70%	95.80%	98.40%
	Critical care	Ward 10 (ITU/HDU)	101.60%	55.00%	101.70%	56.70%
	General medicine	Ward 21	85.40%	91.20%	94.40%	97.80%
		Ward 5	92.20%	112.90%	80.00%	141.30%
		Ward 7	78.70%	93.30%	81.50%	88.00%
		Ward 8	87.00%	102.50%	87.50%	100.90%
	General surgery	Ward 14	100.00%	106.60%	120.80%	145.80%
	Geriatric medicine	Ward 20	83.30%	104.20%	96.70%	106.70%
	Trauma & orthopaedics	Ward 9	74.30%	78.10%	78.90%	101.70%
	Rehabilitation	Ward 11a	65.30%	106.30%	87.80%	99.30%
		Ward 11b (Stroke)	87.60%	105.00%	97.80%	130.60%
Rochdale Infirmary	General medicine	Clinical Admissions Unit	112.10%	97.10%	100.00%	118.10%
		Oasis Unit – RI	104.20%	99.40%	96.70%	121.90%
	Intermediate Care	Wolstenholme Unit - RI	98.30%	101.20%	100.00%	97.90%
	Rehabilitation	Floyd Unit	104.10%	108.10%	98.30%	130.80%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

Certain general surgery and ob-gyn wards at ROH are below optimal staffing levels

- Above or at 95% optimal staffing level target
- Below 95% optimal staffing level target but at or above 85%
- Below 85% optimal staffing level

			Day		Night	
Hospital	Main specialty	Ward	Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
Royal Oldham Hospital	Cardiology	Ward CCU	95.80%	220.00%	88.30%	0.00%
	Critical Care	Critical Care	93.70%	89.20%	100.00%	121.90%
	General Medicine	A&E Observation Ward	100.00%	285.70%	100.00%	214.30%
		Ward AMU	78.20%	97.40%	86.70%	108.60%
		Ward FIO	100.00%	112.70%	91.10%	155.90%
		Ward F7	92.90%	100.40%	101.10%	104.60%
		Ward F8	105.80%	98.30%	100.00%	113.80%
		Ward F9	105.00%	88.80%	90.00%	141.10%
		Ward G1	90.60%	107.10%	66.70%	141.30%
	General Surgery	Ward 62	92.30%	91.70%	87.50%	100.00%
		Ward T3	89.50%	100.00%	82.20%	127.40%
		Ward T4 STU	94.80%	115.40%	98.90%	130.20%
		Ward T5	88.30%	101.10%	92.20%	136.10%
		Ward T6	78.10%	74.10%	72.70%	86.20%
		Ward T7	78.80%	106.40%	86.20%	103.30%
	Gynaecology	Ward Fl	84.50%	78.00%	97.00%	100.00%
	Haematology	Ward Fli	89.90%	161.60%	94.50%	173.40%
	Obstetrics	Antenatal Ward	113.30%	126.20%	111.70%	90.00%
		Labour Ward	100.20%	85.80%	105.60%	85.00%
		Neonatal Unit	82.30%	25.80%	76.30%	0.00%
		Postnatal Ward	102.40%	88.50%	115.00%	87.50%
	Paediatrics	Childrens Unit	81.50%	109.20%	90.70%	68.20%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

Certain obstetrics, general surgery and paediatrics wards at NMGH are below optimal staffing levels

- Above or at 95% optimal staffing level target
- Below 95% optimal staffing level target but at or above 85%
- Below 85% optimal staffing level

			Day		Night	
Hospital	Main specialty	Ward	Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
North Manchester General Hospital	Cardiology	Ward CCU 64	84.70%	93.30%	100.00%	100.00%
	Critical Care	Critical Care	94.20%	96.70%	97.00%	106.70%
	Gastro-enterology	Ward D5	93.30%	104.20%	98.30%	100.00%
		Ward D6	92.80%	102.50%	101.50%	100.00%
	General Medicine	Ward C5	102.20%	113.00%	95.00%	133.70%
		Ward C6	97.40%	90.30%	100.00%	101.80%
		Ward E1	93.70%	111.10%	103.30%	205.40%
		Ward F4	95.90%	153.30%	106.70%	138.50%
		Ward H3	96.00%	108.10%	100.00%	129.60%
		Ward I6	98.30%	131.00%	93.30%	121.30%
		Ward J6	97.80%	105.80%	98.30%	135.00%
	General Surgery	Ward C3	104.70%	102.50%	105.00%	146.90%
		Ward C4	58.70%	77.50%	68.30%	76.70%
		Ward F3	89.40%	97.50%	113.30%	101.70%
		Ward F5	89.90%	94.20%	118.30%	96.70%
		Ward F6	92.40%	96.70%	103.30%	101.70%
	Infectious Diseases	Ward J3J4	91.80%	107.50%	97.30%	102.20%
	Obstetrics	Antenatal Ward	84.30%	83.30%	83.30%	106.70%
		Labour Ward	94.60%	58.10%	96.00%	62.70%
		Neonatal Unit	76.70%	89.70%	75.60%	-
		Postnatal Ward	98.70%	96.10%	97.10%	91.10%
	Paediatrics	Childrens	88.50%	49.40%	92.20%	123.50%
	Trauma & Orthopaedics	Ward I5	75.60%	89.80%	101.10%	135.00%
	Urology	Ward STU	71.00%	88.30%	100.00%	96.70%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

Salford Royal has staffing challenges for registered nurse rotas, in particular, across several specialties

- Above or at 95% optimal staffing level target
- Below 95% optimal staffing level target but at or above 85%
- Below 85% optimal staffing level

		Day		Night	
Hospital	Main specialty	Average fill rate - registered nurses	Average fill rate - care staff	Average fill rate - registered nurses	Average fill rate - care staff
Salford Royal Hospital	Acute Stroke Unit	64.85%	91.75%	70.00%	95.74%
	Acute Trauma	89.52%	140.37%	72.69%	175.22%
	Cardiology	78.57%	90.91%	100.00%	125.00%
	Care of the elderly	79.44%	107.58%	100.00%	118.45%
		84.46%	104.88%	91.75%	132.50%
	Critical Care Unit	92.96%	55.90%	78.57%	126.67%
	Dermatology	97.28%	100.00%	100.00%	100.00%
	Emergency Assessment Unit	96.67%	100.00%	95.00%	96.67%
	Gastroenterology	76.99%	90.42%	69.77%	177.27%
	General Surgery	69.62%	80.15%	68.54%	108.40%
		86.36%	140.00%	75.00%	230.00%
		83.45%	95.00%	78.26%	108.33%
	Haematology	64.00%	178.26%	65.22%	1742.86%
	Heart Care Unit	86.22%	88.89%	70.25%	97.44%
	Intestinal Failure Unit	106.91%	79.41%	98.33%	115.87%
	Medical / diabetes	101.31%	98.60%	93.90%	104.65%
	Medical HDU	90.94%	95.26%	81.37%	127.27%
	Neuro Rehab	123.19%	58.93%	92.18%	67.45%
	Neuro surgery & ENT	90.61%	95.24%	74.71%	142.86%
	Neurology	72.15%	83.56%	70.09%	107.44%
		100.00%	101.67%	100.00%	100.00%
		93.30%	87.73%	89.66%	115.79%
	Neurosurgery	110.26%	100.60%	75.56%	102.16%
		59.06%	77.32%	89.66%	97.99%
	Programmed Investigation Unit	80.96%	105.68%	86.54%	110.65%
	Renal	86.12%	97.01%	100.00%	100.00%
	Respiratory	79.44%	87.22%	75.83%	133.90%
	Stroke	70.33%	84.07%	76.52%	114.86%
	Stroke Rehab Unit	71.43%	91.30%	100.00%	98.98%
	Sub-Acute Care (Pendleton Suite)	-	-	-	-
	Surgery	93.41%	103.85%	97.78%	109.68%
	Surgical HDU	66.43%	90.66%	86.67%	100.81%
	Surgical Triage Unit	100.00%	98.31%	100.00%	100.00%
	Trauma Orthopaedics	97.91%	93.21%	96.67%	100.00%
	Trauma Rehab	83.63%	105.68%	100.00%	93.18%
	Urology	65.66%	118.92%	71.11%	132.97%

Fill rates are calculated as the percentage of day / night-time ward shifts expected to be filled that are actually filled, and averaged over the month for each ward. This is a function of vacancy and sickness rates, as well as admissions

SOURCE: NCA CiC July 2018 pack – June 2018 data

North West Ambulance Service quality assessment

Requires improvement · Inadequate · Outstanding · Good

NWAS – covers Greater Manchester, Cheshire, Merseyside, Cumbria & Lancashire

Latest inspection in Jun 2016, reported Jan 2017

Overview

Overall **Requires Improvement**

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well-led?	Requires improvement

Ratings of specific services

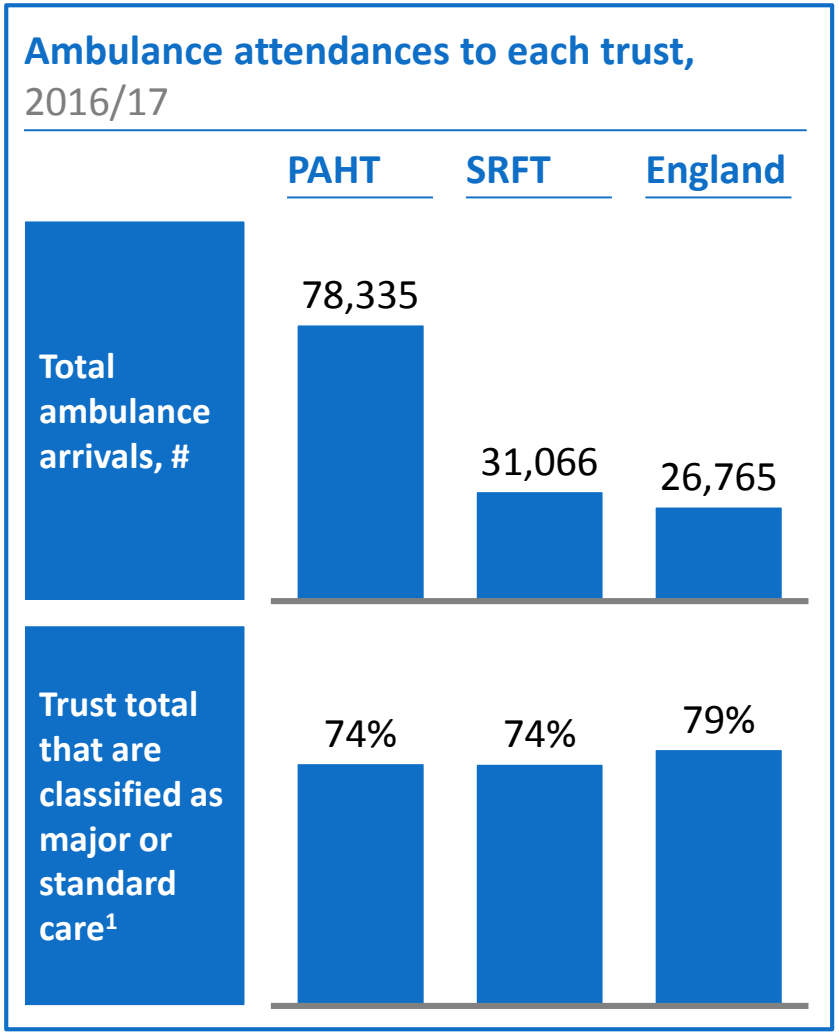
	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and urgent care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Patient transport services (PTS)	Good	Good	Good	Good	Requires Improvement	Good
Emergency operations centre (EOC)	Requires Improvement	Good	Good	Good	Good	Good
NHS 111 service	Good	Good	Good	Good	Good	Good

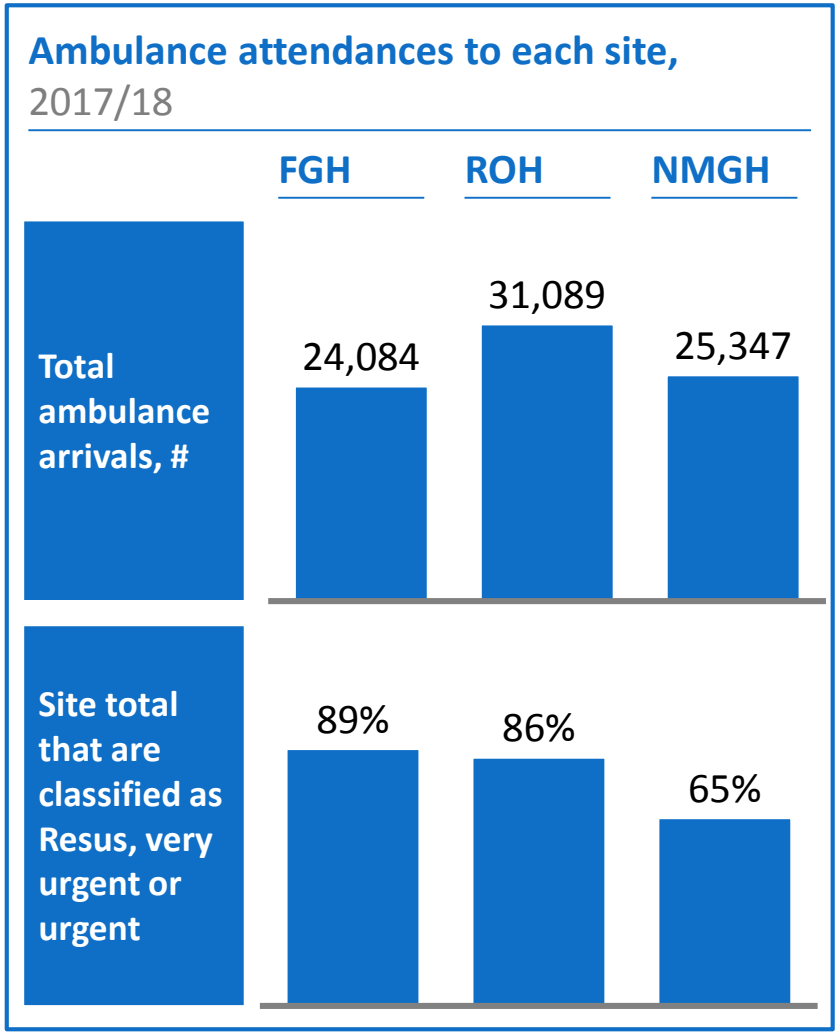
Specific recommendations

- Review the process for pre-alerting hospital accident and emergency departments to make sure that communication is sufficient for the receiving department to be made fully aware of the patient's condition
- Make sure that emergency operations centre staff across all three emergency operation centres (EOCs) are consistently identifying and recording incidents as
- Improve access to clinical supervision for all clinical staff
- Ensure all staff receive the mandatory training necessary for their role

SOURCE: CQC website

Ambulance activity to each of the NES and Salford sites

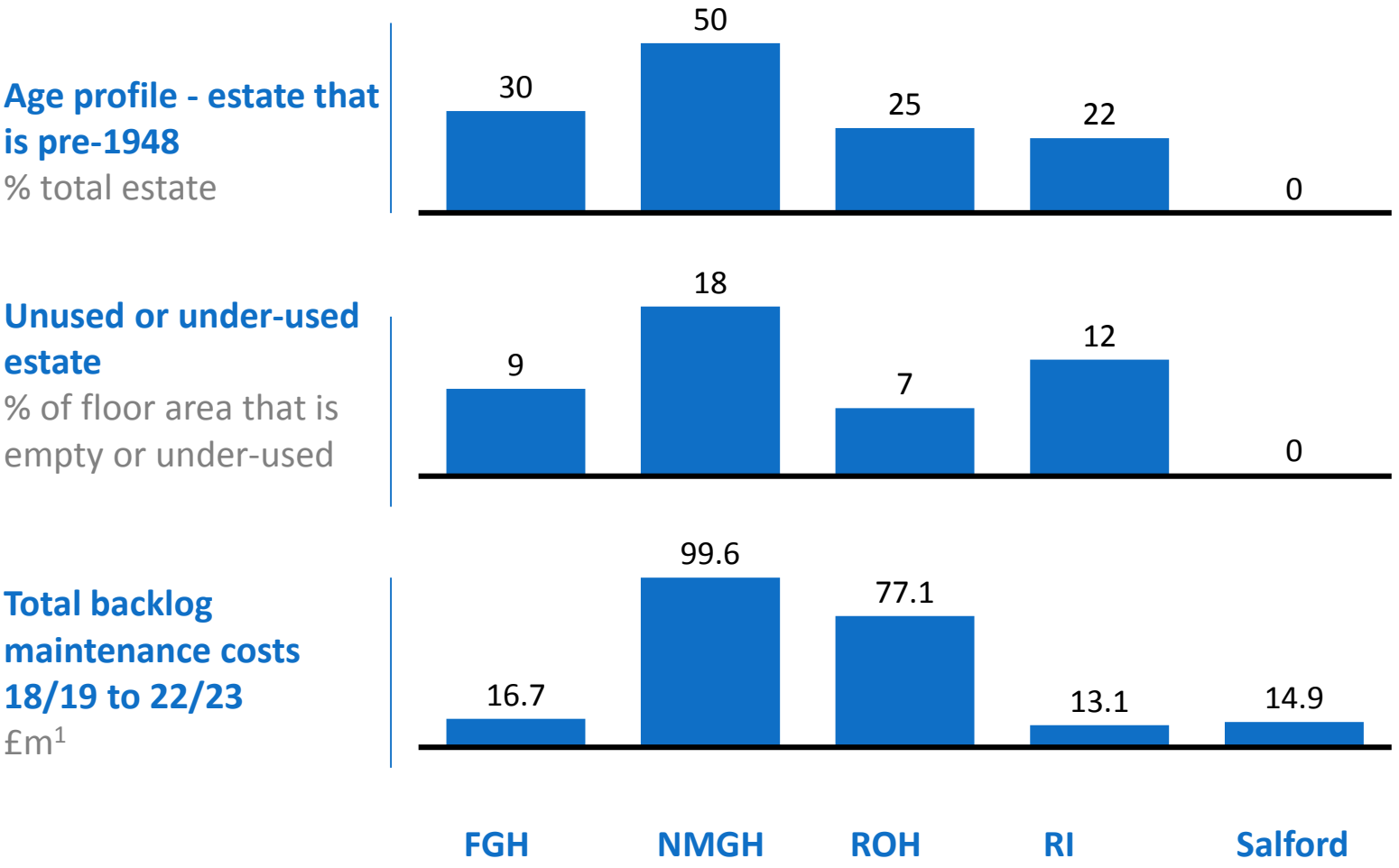




1 Defined for Salford, PAHT overall and England average based on HRGs VB01Z-VB08Z

SOURCE: Pennine Acute Trust data, 2018; HES A&E M13 2016/17 data, c/o NHS Digital

NM, in particular, does not use estate as efficiently as other sites, and has substantial backlog maintenance costs of nearly £100m



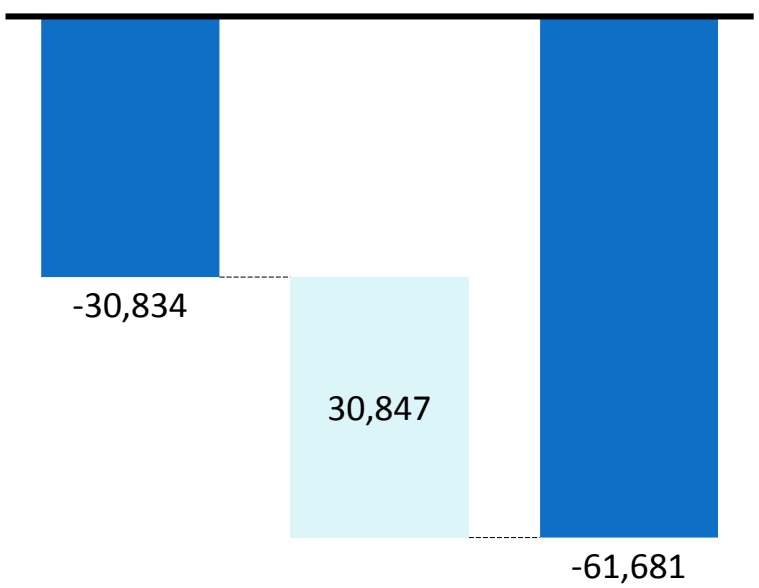
1 Data for Pennine sites is based on a Capita review for backlog over the next six years; data for Salford site is based on ERIC 17/18 returns

SOURCE: ERIC 17/18 and Capita review of Pennine sites

Both Trusts have underlying financial deficits

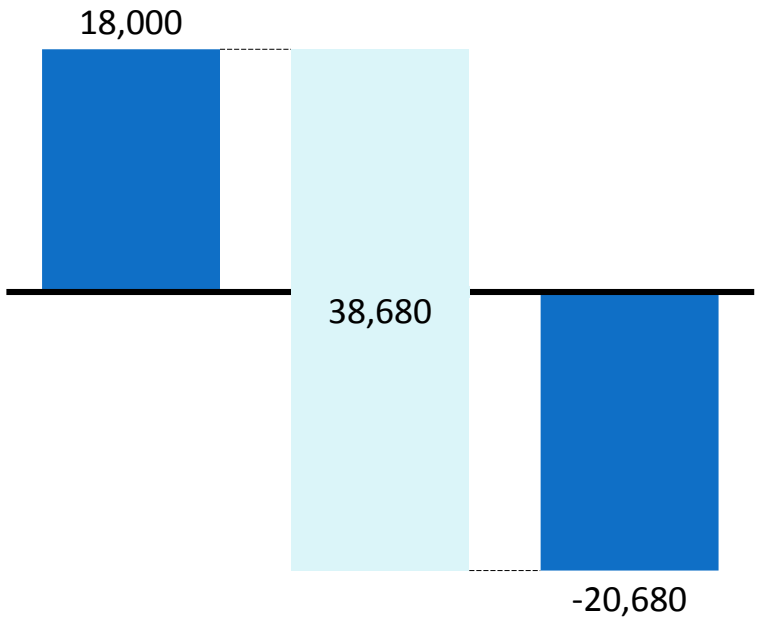
Baseline I&E for PAHT

£000s, 2017/18



Baseline I&E for SRFT

£000s, 2017/18



SOURCE: Provider and Commissioner model, GM Theme 3

Contents

Section summary

Focus of today's discussions

- Changes to consolidate activity at sites have already been agreed for certain services
- The Healthier Together business case (2015) has already recommended that some services, e.g. general surgery, move in order to capture the benefits to clinical quality, workforce and financial sustainability from delivering services at scale
- Further consolidation may deliver similar improvements in other fragile services as well as the use of estate that provides a better care experience for both patients and staff

Fairfield General Hospital profile

Current situation

- Fairfield General Hospital (FGH) is part of the Bury & Rochdale CO
- FGH has already been significantly reconfigured
- It predominantly provides medical and elective surgery and specialises in stroke, cardiology, ENT and orthopaedics, providing these services for the PAHT (Pennine Acute Hospital Trust) element of the NCA (Northern care Alliance)
- FGH does not provide acute or non-elective surgery, trauma, inpatient paediatrics or maternity, or gastroenterology

Rationale for change

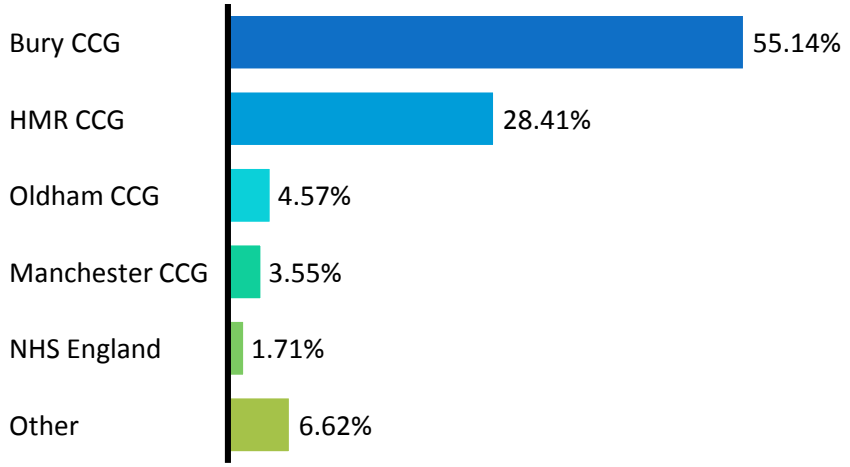
- Bury, Oldham and Rochdale locality plans and Transformation Fund bids propose major shift of activity away from FGH, which could reduce activity to a level that could potentially result in:
  - Lower quality of care due to a lack of opportunity for workforce to maintain skills
  - Higher costs due to underutilised estate and workforce
- Critical care service is provided at both FGH and ROH, where rotas are linked, and which has seen both quality and workforce sustainability issues with a consultant shortfall and very low care staff fill rates
- There is an opportunity to maximise use of capacity at FGH as part of shared hospital services across NCA

Key facts about the site

Fairfield key facts, 2017/18

Number of beds	282 acute beds; 0 other beds & trolleys[1]
Inpatient spells	NEL: 35,434; EL: 2,234
A&E attendances	71,449
Number of day cases	15,006
Number of outpatients	117,162

Fairfield activity split, all activity[2], 2016/17, NES = 87%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

Rochdale Infirmary profile

Current situation

- Rochdale Infirmary is part of the Bury & Rochdale CO and has a partnership with Rochdale Health Alliance to support the delivery of improved primary care services
- Rochdale was significantly reconfigured as part of the Healthy Futures reconfiguration across Pennine Acute and the North East Sector including North Manchester
- It now provides an urgent care centre and clinical assessment unit, a small number of inpatient medical beds, 23-hour day case provision, ophthalmology for the North East Sector, rheumatology and respiratory services and range of outpatient services. It has developed an innovative rehabilitation service with intermediate care, integrated community teams (neighbourhood based), the OASIS unit which is an inpatient facility for people with acute illness and dementia
- It no longer provides NEL Surgery, Trauma, A&E, Paediatrics, or Maternity and has a very small number of inpatient medical beds

Rationale for change

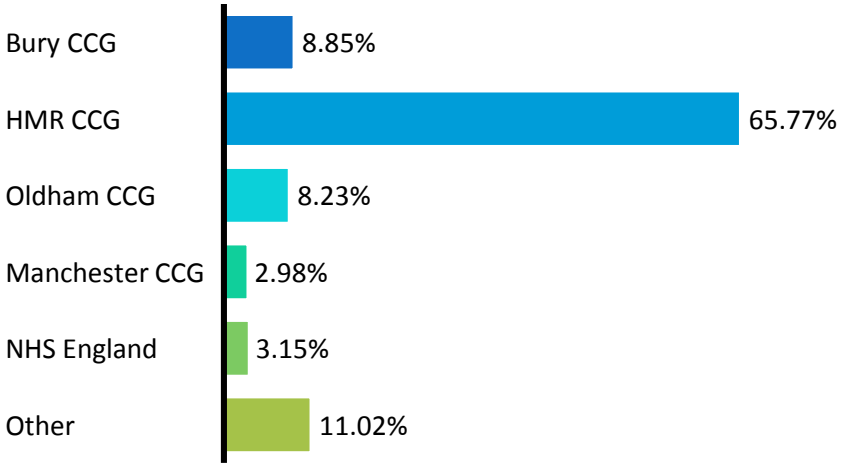
- Significant change has already happened at RI and the site currently functions well
- The Bury and Rochdale Care Organisation will host the Rochdale Local Care Organisation and this presents further opportunities to integrate health and social care community and acute services more effectively, manage patients with long-term conditions more effectively and further strengthen the partnerships with primary care, the VCSE and mental health services
- Innovative models such as the OASIS unit and the Wolstenholme unit could be replicated across other sites in NCA

Key facts about the site

Rochdale key facts, 2017/18

Number of beds	16 acute beds; 51 other beds & trolleys[1]
Inpatient spells	NEL: 3,373; EL: 178
A&E attendances	51,666
Number of day cases	25,533
Number of outpatients	137,764

Rochdale Infirmary activity split, all activity[2] 2016/17, NES = 83%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

Royal Oldham Hospital profile

Current situation

- The Royal Oldham Hospital (ROH) is part of the Oldham CO
- ROH will be a high acuity site inclusive of a trauma unit in addition to being a local general hospital, with a revised front end with A&E, streaming to primary care, AMU and ambulatory care
- It is the designated Healthier Together hub site for the North East Sector (NES) and will therefore see an increase in General Surgery emergency and high-risk patients – for which it has received capital investment
- Christie services are available from ROH as well as full critical care, maternity, centralised pathology for the NES, gynaecology services and paediatrics including a NICU

Rationale for change

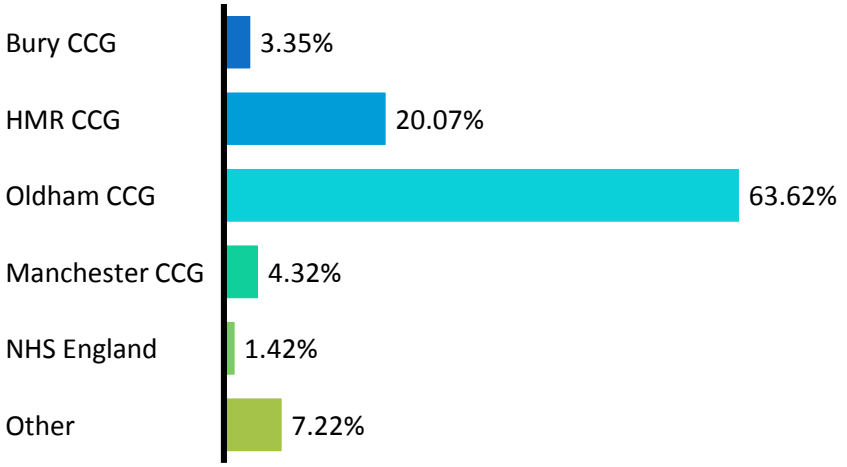
- Locality plans and Transformation Fund bids propose deflecting activity away from acute services at ROH through a greater focus on preventing ill health and delivering more out-of-hospital care
- This will be great for improving population health outcomes in Oldham; however, it may result in subscale activity in certain acute service lines. This in turn could result in:
  - Lower quality of care due to a lack of opportunity for workforce to maintain skills
  - Higher costs due to underutilised estate and workforce
- In particular, critical care, which shares rotas with FGH, is already experiencing quality challenges as revealed by a recent CQC inspection and ICNARC report

Key facts about the site

Royal Oldham key facts, 2017/18

Number of beds	382 acute beds; 181 other beds & trolleys[1]
Inpatient spells	NEL: 60,554; EL: 4,683
A&E attendances	106,924
Number of day cases	17,287
Number of outpatients	204,480

Royal Oldham activity split, all activity[2] 2016/17, NES = 87%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

North Manchester General Hospital profile

Current situation

- North Manchester General Hospital (NMGH) is part of the North Manchester CO
- The NMGH site is due to be acquired MFT, and will no longer be part of PAHT
- MHCC intend to utilise the site for much of its current provision as well as a health and well-being hub and mental health services. The site is undergoing master planning to identify other potential uses including educational facilities and housing options
- Its services are used by Manchester residents as well as by Bury and HMR patients as well. Some services on the site provide services to all the Pennine population such as diagnostics and urology. About 57% of activity on the site is outside of North Manchester

Rationale for change

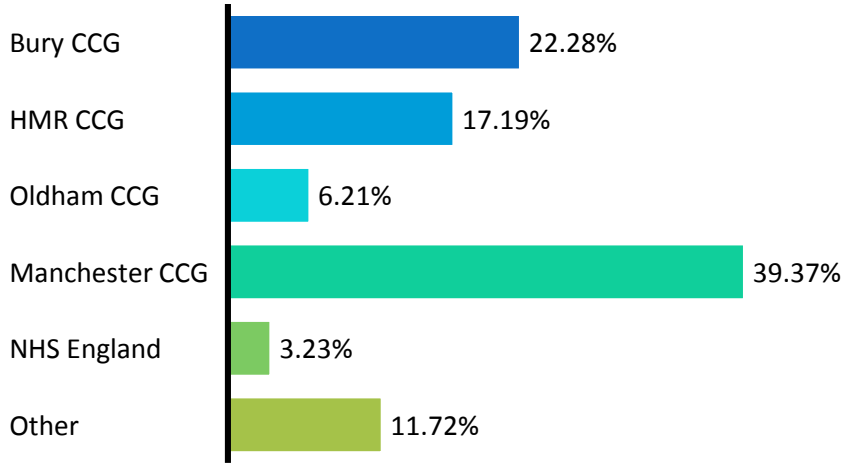
- There have been challenges with estate at NM:
  - In June, four theatres in the older part of the hospital were closed for safety reasons with most displaced activity being absorbed within the remaining nine theatres
  - A further two theatres will be in need of replacement in 18 months
- However, change at this site will be out of scope of the NES service strategy – nonetheless, agreed and possible future changes will impact PAHT sites
- For example, all high acuity general surgery activity will transfer to ROH as agreed in the Healthier Together consultation while other services are part of the GM Theme 3 review and will be reconfigured as a result of new care models

Key facts about the site

North Manchester key facts, 2017/18

Number of beds	370 acute beds; 137 other beds & trolleys[1]
Inpatient spells	NEL: 45,351; EL: 4,740
A&E attendances	101,645
Number of day cases	12,534
Number of outpatients	227,207

North Manc General activity split, all activity[2] 2016/17, NES = 46%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: Pennine Acute Hospitals NHS Trust annual report 2016/17; Pennine Trust Bed Stock 2018

Salford Royal Hospital profile

Current situation

- Salford Royal is part of a fully integrated care organisation, Salford CO, which brings together adult social care, mental health, community and acute services
- Provides medical and surgical services for the local Salford population with elective orthopaedic services at the Manchester Elective Orthopaedics Centre
- Designated Healthier Together high acuity site for General Surgery for the North West Sector (NWS)
- Provides a range of GM services including GM Neurosciences Centre; GM Major Trauma services (adult); GM Comprehensive Stroke Centre; and specialised services in Dermatology, Renal, and Intestinal Failure
- Designated GM site for the Oesophageal Cancer surgery and is one of the two North West providers of bariatric surgery
- Hosts The Christie Radiotherapy services
- Does not provide maternity, IP paediatric, elective breast surgery services or opthamology – these are provided at Bolton

Rationale for change

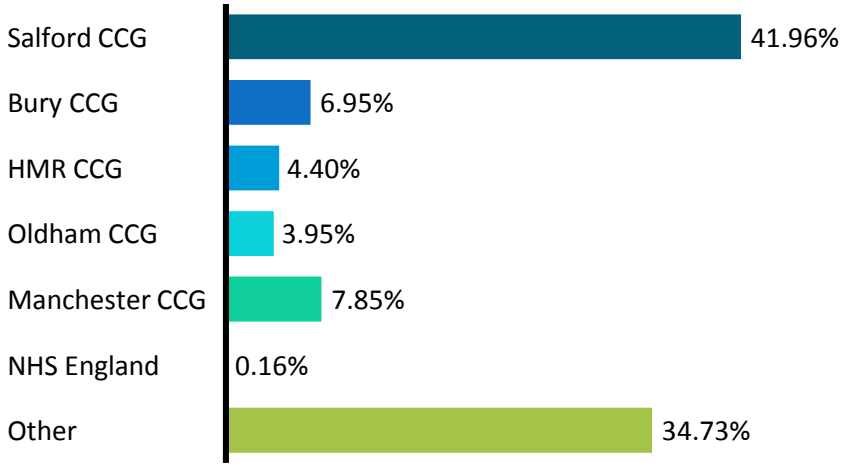
- Salford Royal has scored outstanding on its recent inspection by the CQC for the second time
- However, the site is facing some challenges, particularly operational and workforce challenges:
  - Operational: A&E waiting time and diagnostic waiting time performance has been deteriorating
  - Workforce: ward shift fill rates for registered nurses are consistently below target levels

Key facts about the site

Salford Royal key facts, 2017/18

Number of beds	792 acute beds; 32 other beds & trolleys[1]
Inpatient spells	NEL: 68,527; EL: 10,971
A&E attendances	100,586
Number of day cases	47,831
Number of outpatients	556,630

Salford Royal activity split, all activity[2] 2016/17, NES = 15%



1 Includes maternity beds, paediatric beds, and daycase trolleys
2 Includes OP attendances, A&E attendances and admissions
SOURCE: NCA CiC July 2018 pack; Bed Availability and Occupancy, NHS England Q1 2018/19; NCA activity model