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AGENDA PAPERS FOR

HEALTH AND WELLBEING BOARD MEETING

Date: Friday, 15 July 2016

Time: 9.30 a.m.

Place: The LifeCentre, 235 Washway Rd, Sale M33 4BP

	A G E N D A	**PART I**	**Pages**
1.	**ATTENDANCES**		
	To note attendances, including officers, and any apologies for absence.		
2.	**MEMBERSHIP OF THE BOARD 2016/17, INCLUDING CHAIRMAN AND VICE-CHAIRMAN**		
	To note the membership including Chairman and Vice-Chairman of the Health and Wellbeing Board for the Municipal Year 2016/17.		1 - 2
3.	**TERMS OF REFERENCE FOR THE BOARD 2016/17**		
	To note the Board's Terms of Reference as agreed at the Annual Meeting of the Council held on 25 May 2016.		3 - 8
4.	**REVISED HEALTH AND WELLBEING BOARD GOVERNANCE ARRANGEMENTS**		
	To consider a report of the Director of Public Health, setting out the Health & Wellbeing Board's revised governance arrangements for the 2016/17 municipal year.		9 - 12
5.	**MINUTES**		
	To receive and, if so determined, to approve as a correct record the Minutes of the meeting held on 15 April, 2016.		13 - 16

6. **DECLARATIONS OF INTEREST**

Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

7. **STRATEGIC CONTEXT**

To receive an update of the Chairman and the Chief Operating Officer, Trafford CCG on the following:

(a)	Greater Manchester Devolution Update	Verbal Report
(b)	Single Hospital Service Review	17 - 66

8. **LOCAL STRATEGY**

To receive a presentation of the Interim Corporate Director, Children Families and Wellbeing and the Chief Operating Officer, Trafford CCG, providing an update on the Trafford Locality Plan and the Trafford Programme of Work. 67 - 76

9. **PUBLIC HEALTH WORKING GROUP TERMS OF REFERENCE**

To consider a report of the Chairman. 77 - 78

10. **HEALTH AND WELL BEING PERFORMANCE DASHBOARD 2016-17**

To receive a report of the Head of Partnerships and Communities, Trafford Council. 79 - 92

11. **KEY SUCCESSES, CHALLENGES AND RISKS FOR THE LUNCHTIME SESSIONS AND TRAFFORD PARTNERSHIP BOARD**

The Chairman will lead a discussion on the key successes, challenges and risks for the lunchtime sessions and Trafford Partnership Board.

12. **URGENT BUSINESS (IF ANY)**

Any other item or items which by reason of special circumstances (to be specified) the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

THERESA GRANT
Chief Executive

Membership of the Committee

Chief Inspector V. Bellamy, R. Bellingham, Councillor K. Carter, J. Colbert, S. Colgan, A. Day, Dr N. Guest, G. Heaton, Councillor M. Hyman, G. Lawrence, M. McCourt, S. Nicholls, B. Postlethwaite, A. Razzaq, S. Webster, Councillor A. Williams and A. Worthington

Health and Wellbeing Board - Friday, 15 July 2016

Further Information
For help, advice and information about this meeting please contact:

Chris Gaffey, Democratic and Scrutiny Officer
Tel: 0161 912 2019
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This agenda was issued on **Thursday 7 July, 2016** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall, Talbot Road, Stretford M32 0TH.

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TRAFFORD COUNCIL

MEMBERSHIP OF COMMITTEES 2016/17

Notes on Membership:

(1) The Council Membership is nominated by the Leader of the Council.

(2) The chairmanship for the Health and Wellbeing Board will rotate on an annual basis between Trafford Council and NHS Trafford Clinical Commissioning Group.

(3) * Denotes that this position must be represented on the HWB as per the Health and Social Care Act 2012 (Note: at least one Councillor, one member of each relevant CCG, a representative of the local Healthwatch organisation plus any other members considered appropriate by the Council, must be appointed.)

COMMITTEE	NO. OF MEMBERS
HEALTH AND WELLBEING BOARD	3 (plus the *Corporate Director of Children, Families and Wellbeing and 14 External Partners)

CONSERVATIVE GROUP	LABOUR GROUP	LIBERAL DEMOCRAT GROUP
Councillors:-	Councillors:-	Councillors:-
Executive Member for Adult Social Services and Community Wellbeing Executive Member for Children's Services	Shadow Executive Member for Adult Social Services and Community Wellbeing (or Deputy)	
TOTAL 2	**1**	**0**

Membership of the Health and Wellbeing Board shall also comprise of:

- NHS England representative
- *Director of Public Health
- Chief Accountable Clinical Officer NHS Trafford Clinical Commissioning Group
- Chief Operating Officer NHS Trafford Clinical Commissioning Group
- Chair of Health Watch
- Third Sector representative
- Independent Chair Children's Local Safeguarding Board
- Independent Chair Adult Safeguarding Board
- Chair of the Safer Trafford Partnership - GMP
- Chair of the Trafford Sports and Physical Activity Partnership
- Chief Executive Officers of health care providers: (Central Manchester University Hospital NHS Foundation Trust; University Hospital South Manchester NHS Foundation Trust; Pennine Care NHS Foundation Trust
  Greater Manchester West Mental Health NHS Foundation Trust)

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Terms of Reference

1. Functions of Health and Well Being Board

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.
- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

2. Regulations relating to Health & Well Being Boards: Statutory Instrument 2013 No. 218

The regulations relating to health and wellbeing boards have been published as Statutory Instrument 2013 No. 218 entitled, The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 http://www.legislation.gov.uk/uksi/2013/218/ contents/made

The regulations modify certain legislation as it applies to health and wellbeing boards and disapply certain legislation in relation to the boards. The provisions which are modified or disapplied are in the Local Government Act 1972 and the Local Government and Housing Act 1989.

Under section 194 of the Health and Social Care Act 2012, a health and wellbeing board is a committee of the council which established it and for the purposes of any enactment is to be treated as if appointed under section 102 of the Local Government Act 1972. It is therefore a 'section 102 committee', as it is sometimes called within local government. However, the regulations modify and disapply certain provisions of section 102 and other sections of the Local Government Act 1972 and also provisions of the Local Government and Housing Act 1989 in relation to health and wellbeing boards.

This means that it is best not to think of health and wellbeing boards according to the strict model of other section 102 committees, but to think of them as a basic section 102 committee with some differences. The sections below discuss the characteristics shared

by health and wellbeing boards with other council committees and where they do or may diverge under the new regulations.

The modifications and disapplications which apply to health and wellbeing boards within the regulations generally also apply to subcommittees and joint sub-committees of boards.

3. Membership of Health & Well Being Boards

The Health and Social Care Act 2012 indicates that health and wellbeing boards are different to other section 102 committees, in particular in relation to the appointment of members. Specifically, the Act:

- sets a core membership that health and wellbeing boards must include:
    - at least one councillor from the relevant council
    - the director of adult social services
    - the director of children's services
    - the director of public health
    - a representative of the local Healthwatch organisation (which will come into being on a statutory footing on 1 April 2013)
    - a representative of each relevant clinical commissioning group (CCG)
    - any other members considered appropriate by the council

- requires that the councillor membership is nominated by the executive leader or elected mayor (in councils operating executive arrangements) or by the council (where executive arrangements are not in operation) with powers for the mayor/ leader to be a member of the board in addition to or instead of nominating another councillor.

- under the regulations (Regulation 7) modifies sections 15 to 16 and Schedule 1 of the Local Government and Housing Act 1989 to disapply the political proportionality requirements for section 102 committees in respect of health and wellbeing boards – this means that councils can decide the approach to councillor membership of health and wellbeing boards.

- requires that the CCG and local Healthwatch organisation appoint persons to represent them on the board.

- enables the council to include other members as it thinks appropriate but requires the authority to consult the health and wellbeing board if doing so any time after a board is established.

- the NHS Commissioning Board must appoint a representative for the purpose of participating in the preparation of JSNAs and the development of JHWSs and to join the health and wellbeing board when it is considering a matter relating to the exercise, or proposed exercise, of the NHS Commissioning Board's commissioning functions in relation to the area and it is requested to do so by the board.

4. Trafford Health and Well Being Board additional locally agreed functions

In addition to the statutory functions outlined in section 1 above the governance task group, convened in November 2015, agreed the Board would:

- Provide oversight to the delivery of the Trafford (Locality) Plan (although accountability for the delivery of the Plan will remain with the Trafford Joint Commissioning Board, reporting into the GM Joint Commissioning Board).
- Maintain a positive relationship with the Joint Commissioning Board in order to help shape strategic commissioning decisions and those concerning structural reform in Health and Social Care sectors.
- Agree annually, a number of key priorities (5-10) based on those in the Trafford (Locality) Plan, the CAMHs strategy and relevant data sets such as the JSNAA, the indices of Multiple Deprivation and Public Health profiles, as well as reflecting GM agendas emerging from the GM Joint Commissioning and GM Early Intervention and Prevention Boards.
- Ensure delivery against these priorities either through Task and Finish (service reform) project groups or by delegating the priority to a relevant thematic partnership (e.g. Safer Trafford)
- Put in place a Performance dashboard to monitor progress against the agreed priorities and receive exception reports relating to progress as necessary.
- Receive written reports at regular agreed intervals from the Safer Trafford, Sport and Physical Activity Partnerships, from the two Safeguarding Boards and from the project groups.

5. Trafford Health and Well Being Board Membership

Following a review of the overall structures of the Trafford Partnership in 2015, it was proposed to amend the composition of the Board and the Council approved the membership as follows:

- Executive Member for Adult Social Services and Community Wellbeing
- Executive Member for Children and Families
- Shadow Executive Member for Adult Social Care and Community Wellbeing (or Deputy)
- NHS England representative
- Corporate Director of Children, Families and Well Being (Director of Children's Services)
- Director of Public Health
- Chief Accountable Clinical Officer NHS Trafford Clinical Commissioning Group
- Chief Operating Officer NHS Trafford Clinical Commissioning Group
- Chair of Health Watch
- Third Sector representative
- Independent Chair Children's Local Safeguarding Board
- Independent Chair Adult Safeguarding Board
- Chair of the Safer Trafford Partnership - GMP
- Chair of the Trafford Sports and Physical Activity Partnership
- Chief Executive Officers of health care providers:

  (Central Manchester University Hospital NHS Foundation Trust
  University Hospital South Manchester NHS Foundation Trust
  Pennine Care NHS Foundation Trust
  Greater Manchester West Mental Health NHS Foundation Trust)

6. Meeting Arrangements

Notice of Meetings

Meetings of the Board will be convened by Trafford Council, who will also arrange the clerking and recording of meetings (a member of the Council's Democratic Services Team will act as Clerk).

Chairmanship
The chairmanship for the Health and Well Being Board will rotate on an annual basis between Trafford Council and NHS Trafford Clinical Commissioning Group.

Quorum
The quorum for all meetings of the Board will be a minimum of 5 members with at least two Local Authority and two Clinical Commissioning Group members present.

Substitutes
Nominating groups may appoint a substitute member for each position. These members will receive electronic versions of agendas and minutes for all meetings. Members are asked to nominate a single named substitute who replace them in the event they cannot attend a meeting. Notification of a named substitute member must be made in writing or by email to the Clerk. . Substitute members will have full voting rights when taking the place of the ordinary member for whom they are designated substitute.

Decision Making
It is expected that decisions will be reached by consensus; however, if a vote is required it will be determined by a simple majority of those members present and voting. If there are equal numbers of votes for and against, the Chairman will have a second or casting vote. There will be no restriction on how the Chairman chooses to exercise a casting vote.

Meeting Frequency
The Health and Well Being Board will meet quarterly in line with the new schedule of dates agreed within the Trafford Partnership review.

Status of Reports
Meetings of the Board shall be open to the press and public and the agenda, reports and minutes will be available for inspection at Trafford Council's offices and on Trafford Council's website at least five working days in advance of each meeting. This excludes items of business containing confidential information or information that is exempt from publication in accordance with Part 5A and Schedule 12A to the Local Government Act 1972 as amended. The same principals will apply to information from NHS Trafford as a partner organisation on the board. Other participating organisations may make links from their website to the Board's papers on Trafford Council's website.

7. Members' Conduct

Where appropriate rules and regulations governing the Code of Conduct of Board members will apply. The Code in use will be the Trafford Council Code of Conduct. Board members will be expected to declare appropriate interests where necessary.

8. Amendment of the Constitution

The Health and Well Being Board may vary its constitution by a simple majority vote by the members provided that prior notice of the nature of the proposed variation is made and included on the agenda for the meeting.

9. Governance and Accountability

- The Health and Well Being Board will be accountable for its actions to its individual member organisations.

- There will be sovereignty around decision making processes. Representatives will be accountable through their own organisations for the decisions they take. It is expected that Members of the Board will have delegated authority from their organisations to take decisions within the terms of reference.

- Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations. However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies.

- It is expected that decisions will be reached by consensus.

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REVISED REPORT

TRAFFORD COUNCIL

Report to:	**Health & Well-Being Board**
Date:	**15th July 2016**
Report for:	**Information**
Report of:	**Jill Colbert, Interim Corporate Director Children, Families & Well Being - Trafford Council**

Report Title

Revised Health and Well Being Board Governance Arrangements

Purpose and Summary

This report updates the Health and Well Being Board on the revised 2016-17 municipal year governance arrangements.

Recommendation(s)

The Health and Well Being Board notes the revised governance arrangements for the municipal year 2016-17 outlined within this report outlined within this report.

Contact person for further information:

Name: Kerry Purnell Extension: 0161 912 2115

1 Revised Health and Well Being Board Governance Arrangements

1.1 As the Trafford Health and Well Being Board is a statutory committee of Trafford Council the revised Health and Well Being Board governance arrangements have been agreed at Annual Council for the municipal year 2016-17 are outlined below in this report.

2 Health and Well Being Board Chair and Vice Chair Arrangements

2.1 For the municipal year 2016-17 the Chair of the Health and Well Being Board will rotate to the lead elected member for Adults, Community & Well Being (Councillor Alex Williams) and the vice Chair will be the Chief Accountable Officer at NHS Trafford Clinical Commissioning Group (Dr Nigel Guest).

3 Shadow Executive Health and Well Being Board Arrangements

3.1 For the municipal year 2016-17 the Shadow Executive Health and Well Being Board members are Councillor Karina Carter as Shadow Executive (Adult Services and Community Well Being) or Deputy.

4 NHS England Representative

4.1 Communication has been received from NHS England Area Team (AT) that with effect from 1st April 2016 NHS England will no longer be represented at the Trafford Health and Well Being Board due to the new Greater Manchester devolution arrangements and the transfer of primary care commissioning to Clinical Commissioning Groups. A communication has been sent to the Greater Manchester Health and Social Care Partnership to ascertain whether there will be representation from them on the local Health and Well Being Boards. A response is awaited.

5 Voluntary and Third Sector Representative

5.1 The Health and Well Being Board agreed to a voluntary and third sector representative at the 6th June 2013 meeting and Trafford Council agreed to a named representative at their 10th July 2013 meeting. An appointment process was undertaken by the Partnerships Team and BlueSci attended the Health and Well Being Board meeting on 3rd December 2013. No set term was defined for the voluntary and third sector representation.

5.2 The arrangements for the Health and Well Being Board voluntary and third sector representative are now due for review. The representation on the Health and Well Being Board has been discussed at the newly established Voluntary and Third Sector Strategic Forum and options are being considered to refresh the representative membership from the next meeting on 21st October 2016.

6 Trafford Health Protection Forum

6.1 The notes of the Trafford Health Protection Forum to be included on the next agenda under a minutes for information heading and circulated to the Health and Well Being Board.

7 Trafford Joint Strategic Needs Assessment (JSNA) Group

7.1 The minutes of the Trafford Joint Strategic Needs Assessment (JSNA) Group to be included on the next agenda under a minutes for information heading and circulated to the Health and Well Being Board.

8 Recommendations

8.1 It is recommended that the Health and Well Being Board notes the revised governance arrangements for the municipal year 2016-17 outlined within this report.

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HEALTH AND WELLBEING BOARD

15 APRIL 2016

PRESENT

Cllr A. Williams (in the Chair)	Exec Member for Adult Social Services & CW
A. Day	Chairman of HealthWatch, Trafford
Dr N. Guest	Chief Clinical Officer, NHS Trafford CCG
Cllr J. Harding	Shadow Exec Member for Adult Social Services & CW
Cllr M. Hyman	Executive Member for Children's Services
G. Lawrence	Chief Operating Officer, NHS Trafford CCG
Supt J. Liggett	Greater Manchester Police
B. Postlethwaite	Chair of the Trafford Safeguarding Children Board
A. Razzaq	Director of Public Health
A. Worthington	Chair of the Sports & Physical Activity Partnership

In attendance

K. Ahmed	Director of All Age Commissioning
M. Barrett	Sport & Physical Activity Relationship Manager
M. Colledge	Chair, NHS Trafford CCG
J. Crossley	Associate Director of Commissioning, Trafford CCG
Cllr Mrs J. Lloyd	Shadow Lead Member for Integration of H&SC
K. Purnell	Head of Partnerships & Communities
Cllr B. Shaw	Lead Member for Integration of Health and Social Care
R. Spearing	Integrated Network Director, Pennine Care FT

Also in attendance

L. Dabbs	Partnerships Officer
C. Gaffey	Democratic & Scrutiny Officer

APOLOGIES

Apologies for absence were received from R. Bellingham, Chief Inspector V. Bellamy, J. Colbert, M. McCourt, S. Nicholls and S. Webster.

53. MINUTES

RESOLVED: That the Minutes of the meetings held on 17 March 2016, and 21 March 2016, be approved as a correct record and signed by the Chairman.

54. DECLARATIONS OF INTEREST

Interest was declared by Councillor Joanne Harding who is a Senior Manager at Self Help Services, a mental health crisis service which is commissioned in Trafford. Councillor Harding is also on the Board of Trustees for Trafford Carers.

Interest was declared by Councillor Mrs Judith Lloyd, who is a Trustee of Trafford Domestic Abuse Services.

55. GM DEVOLUTION: TAKING CHARGE - HEALTH & SOCIAL CARE UPDATE / TRAFFORD LOCALITY PLAN - UPDATE

The Board received a verbal report of the Chief Operating Officer, NHS Trafford Clinical Commissioning Group providing an update on the Locality Plan and Greater Manchester Devolution.

Following the Board's approval of the Trafford Locality Plan at the meeting on 21 March 2016, the Plan was then submitted to the GM Devolution Team. The feedback indicated that the Plan was strong on innovation, but required improvement around implementation and financial robustness. Work would begin on these aspects immediately, and consultancy support would be provided by the GM Devolution Team to assist at no extra cost to Trafford. The Board discussed the importance of the Trafford Care Coordination Centre (TCCC) in relation to the Locality Plan.

GM Devolution came into effect on 1st April 2016, with work on governance arrangements ongoing. The Board were advised that the Trafford Joint Commissioning Board were now meeting on a regular basis, and Members requested that the Health and Wellbeing Board be provided with a structure diagram detailing how different Boards were connected to allow them to understand how decisions were made.

RESOLVED: That the verbal update be noted.

56. BETTER CARE FUND 2016/17

The Board received a report providing an update on the progress of the Better Care Fund (BCF) for Trafford in 2015/16, as well as providing an overview of the planning process and content of the plan for 2016/17. Once complete, the new plan would need to be approved by the Health and Wellbeing Board.

It was agreed that a performance dashboard summary report relating to the BCF programme would be provided at future meetings, and a full reflection report on the 2015/16 BCF programme would be brought to the next meeting.

It was confirmed that Trafford Council and Pennine Care NHS Foundation Trust had recently entered a Strategic Partnership Agreement for Integrated All Age Community Health and Social Care Services. Pennine would now take lead responsibility for the day to day provision of children's services, while retaining their adult services responsibilities. Both organisations would continue to be responsible for their individual statutory obligations.

RESOLVED: That the report be noted.

57. JOINT LEARNING DISABILITY STRATEGY

The Board received a report of the Director of All Age Commissioning. The report offered the Board the opportunity to comment on the All Age Learning Disabilities Strategy, which aimed to develop an integrated all age approach with a shared commitment of creating independence and improving resilience.

It was noted that a large part of the adult social care budget was spent on the adult learning disability population, and one aim of the strategy would be to manage this spending more effectively. A reassessment of 77 adults with learning disabilities identified a number of principles for developing an approach to supporting people with learning disabilities which would improve outcomes within the available budget.

The Trafford Care Commissioning Group and other Board members welcomed the new strategy.

RESOLVED: That the All Age Learning Disability Strategy be approved.

58. PUBLIC HEALTH ANNUAL REPORT 2015

The Board received a report of the Director of Public Health providing the final version of the Public Health Annual Report for 2015 for their approval before its publication online.

Board members discussed adult education, child poverty and physical inactivity, and it was noted that a strategy around dementia would need to be developed. Members agreed that the Health & Wellbeing Board should be used as a vehicle to support reducing physical inactivity and improve health in general within Trafford. It was suggested that all partners should come together, possibly in a working group, to work on these issues.

RESOLVED: That the Public Health Annual Report for 2015 be approved for publication online.

59. INCREASING PHYSICAL ACTIVITY

The Board received a presentation of the Director of Public Health and the Sport & Physical Activity Relationship Manager providing Trafford's vision for reducing physical inactivity. The presentation provided the Board with Trafford's current position and advised of the next steps to be taken; to target the 28% of people that are physically inactive, and to create a vision that kept the message simple, united partner effort, and influenced delivery.

The Board discussed the importance of communicating the message effectively, as well as ensuring that key members of the Health and Wellbeing Board come together to drive the strategy forward. Discussions also took place around how children's physical inactivity could be reduced.

RESOLVED: That the Health & Wellbeing Board supports the vision laid out in the presentation to reduce physical inactivity within Trafford.

60. DOMESTIC ABUSE REPORT

The Board received a report of the Head of Partnerships and Communities providing an update on the Domestic Abuse work streams and the new Governance arrangements for Domestic Abuse.

Members were advised of the significant investment made at GM level to help combat domestic abuse. It was noted that Trafford now had sixteen volunteers, all of which had been vetted, risk assessed, and received the necessary training to assist domestic abuse victims and signpost them to relevant services. The Superintendent representing Greater Manchester Police explained how risks relating to domestic abuse reports were categorised.

RESOLVED: That the report be noted.

61. HEALTH AND WELLBEING PERFORMANCE DASHBOARD REPORTS

The Board received the Health and Wellbeing performance dashboard reports for information.

RESOLVED: That the Health and Wellbeing performance dashboard reports be noted.

62. TRAFFORD PHARMACEUTICAL NEEDS ASSESSMENT (PNA) REFRESH

The Board received a report of the Director of Public Health providing an update on the refresh of the Trafford Pharmaceutical Needs Assessment (PNA). The Board were reminded that the PNA was a statutory requirement, and work was underway to complete the new PNA by the 1st April 2017 deadline. A target date for completion was set for January 2017.

Board members discussed the government's proposed reductions in funding for pharmacy provision, and it was noted that this topic would be revisited at a future meeting.

RESOLVED: That the report be noted.

63. CHAIRMAN'S ANNOUNCEMENT

As per the annual rotation of the Health and Wellbeing Board's Chairmanship, it was confirmed that a Trafford Council representative would become Chairman for the 2016/17 municipal year, with an NHS Trafford Clinical Commissioning Group representative becoming Vice-Chairman.

The meeting commenced at 10.00 am and finished at 12.15 pm

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

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Summary

The first stage of the Single Hospital Service Review was considered by the Health and Wellbeing Board on the 27th 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 hosptial providers.

City of Manchester Single Hospital Service Review

Sir Richard Leese

Chairman

Manchester Health and Wellbeing Board

27th 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 8th 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 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 8th 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.

Sir Jonathan Michael, Independent Review Director

27th May 2016

Contents

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 27th 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

27th 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.[1] 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"[2]. 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

1 Taking Charge of our Health and Social Care in Greater Manchester, December 2015

2 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 stoke mortality by 10% and length of stay from 15 to approximately 11.5 days[3]. 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.

[3] 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[4]. 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[5].

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

[4] Source: NHS Bexley Clinical Commissioning group. Annual report summary 2014/15
[5] 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.[6]

[6] 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.[7]

[7] 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.[8]

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.[9]

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.[10,11,12]

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.

[8] Source: Monitor, Success at Wexham Park is a model for the rest of the NHS, 2 February 2016
[9] Source: The King's Fund, Foundation Trust and NHS Trust Mergers 2010 to 2015, September 2015
[10] 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,
[11] 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,
[12] 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

27th May 2016

Central Manchester University Hospitals NHS
NHS Foundation Trust

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

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

NHS Foundation Trust

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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

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

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The Pennine Acute Hospitals NHS Trust

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

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The Pennine Acute Hospitals NHS Trust

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

With best wishes

Yours sincerely

Jim Potter
Chair

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

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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:- • Good outcomes for hospital care • Good access to hospital care when needed • Care which is better connected to community services supporting people to live independently in the community • Resource shift to support investment in proactive and upstream care.
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.

Trafford Locality Plan

Trafford Future Operating Model (FOM)

- Trafford's vision

'A fully integrated and efficient health and social care system, which has the people of Trafford at its heart'

- Overarching Principles:
  - *Enabling the borough and the residents of the future to thrive*
  - *Agreed focus on shared outcomes which benefit the people of Trafford*
  - *Shared vision across all stakeholders*
  - *Integrated 'Trafford Community' Offer*
  - *Key partners involved in all who can contribute to key outcomes*
  - *Grow the number of Partners to the FOM as required to deliver the vision*
  - *Focus on shared outcomes not those of individual organisations or individuals*
  - *No one held back, no one left behind*
  - *Confidence in our differences*

The four planks

The Locality Plan will set out the main areas for transformation across the health social care system and how it will change by 2020.

Trafford has a strategic vision to have a whole system approach to make best use of the Trafford pound.

There are four main planks to the Trafford strategy:

1. The Trafford Care Co-ordination Centre creates an integrated IT and clinical system which offers whole system wide change;

2. Integration of Health and Social Care Commissioning;

3. Integration of Health & Social Care Provision;

4. Complete redesign of Primary Care (New Models of Care);

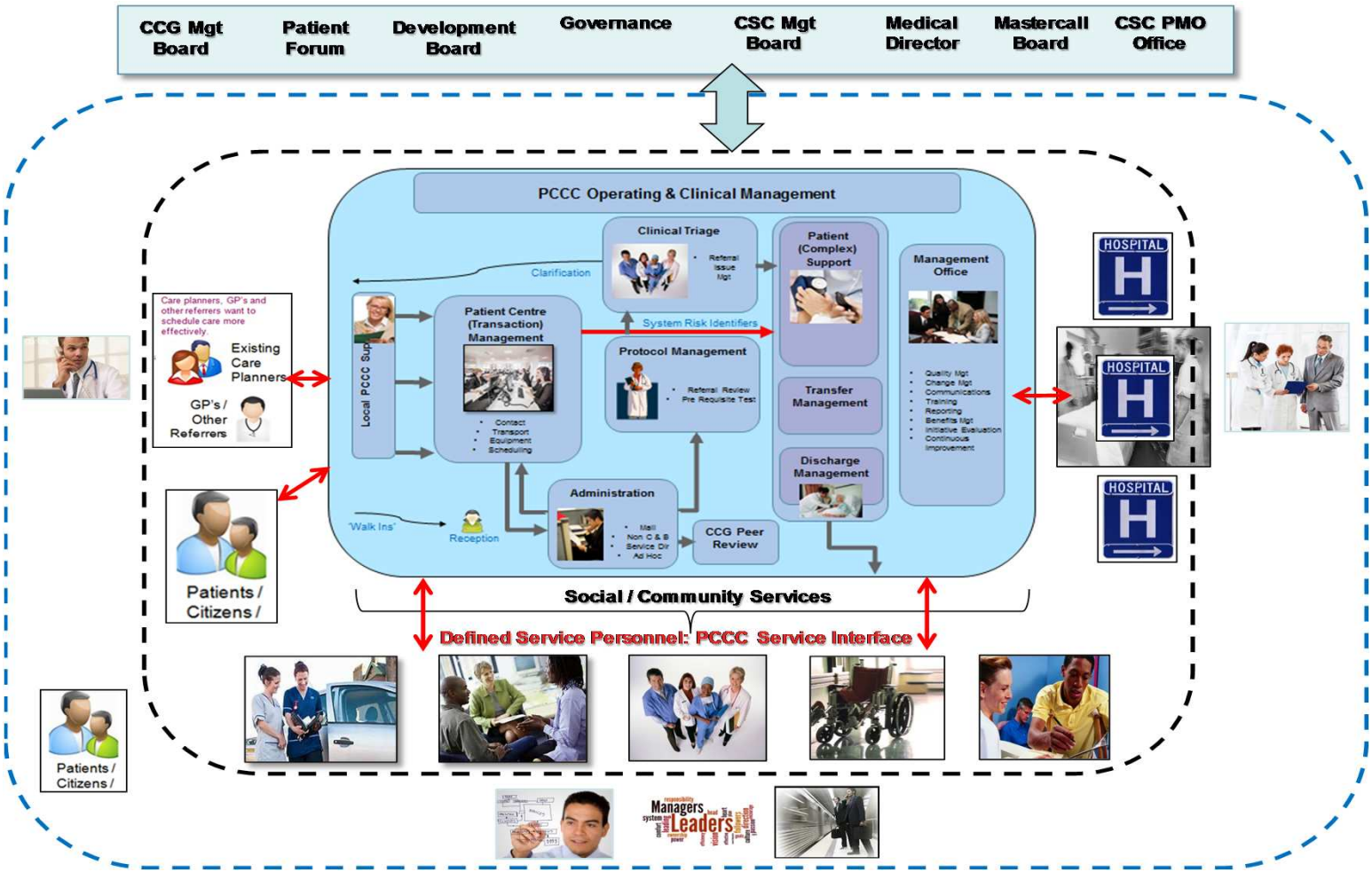
Plank 1: TCCC

The Trafford Care Coordination Centre (TCCC) has been designed to deliver multiple solutions to the challenges associated with effectively delivering integrated care in;

- Maximising the use of services, reduction in variation;
- Cutting down on waste (effectively managing supply and demand);
- Seamless delivery of services to patients;
- Developing a new, innovative, system wide approach to commissioning, and
- Replication

The service also has a full multi-disciplinary team in place who support clinicians and patients to ensure we maximise every patient contact to give the best clinical and patient satisfaction outcomes.

Plank 1: TCCC Model

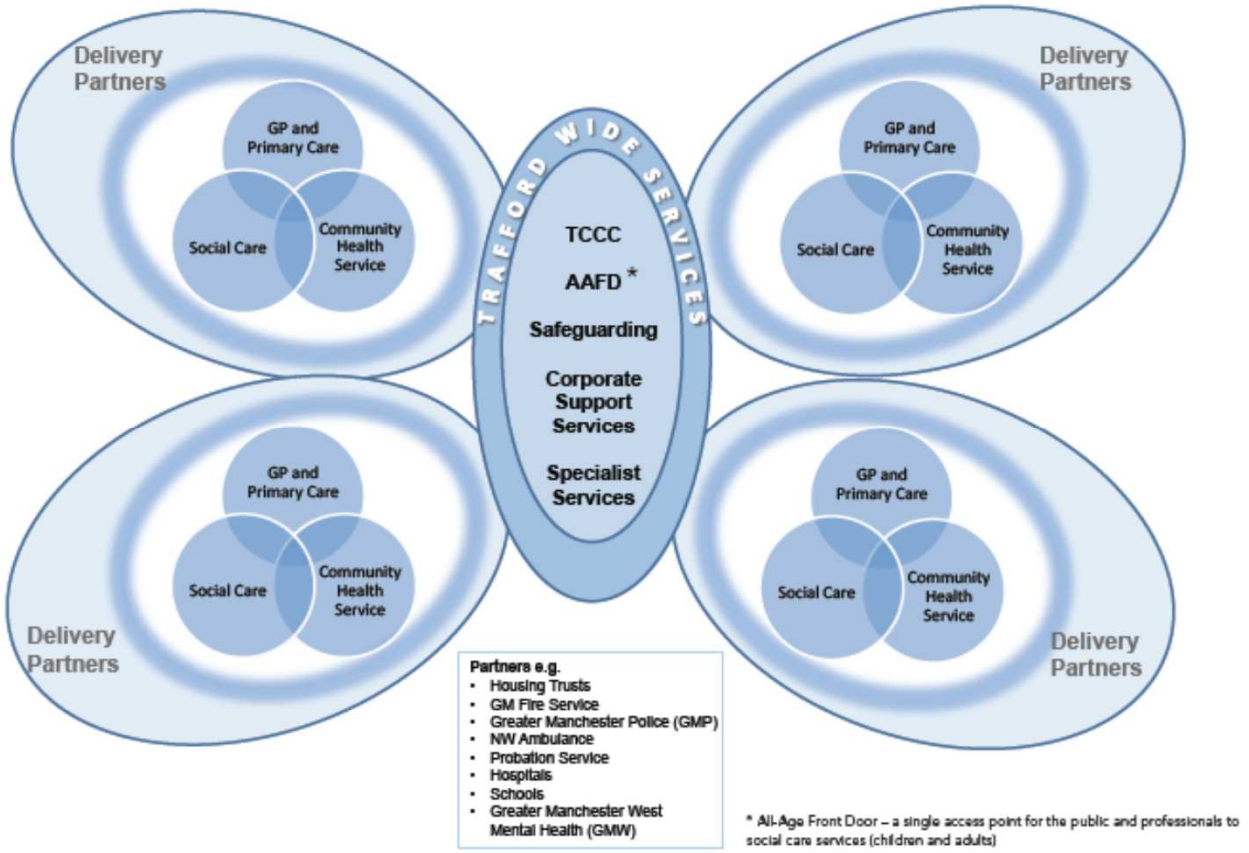


Plank 2: Integration of Health & Social Care Commissioning

Development of a integrated health and social care function

- New skills required for intelligent commissioning;
- Use of real time data for commissioning decisions;
- Integration of workforce

Plank 3: Integration of Health & Social Care Delivery



Out of Hospital services provided over 4 neighbourhood sites; north, south, central and west fully aligned to the TCCC:

- Health & Social Care Teams working closely with local GPs to ensure area needs are met
- Core services to include District Nursing, Specialist Palliative Care, Physiotherapy and a range of other facilities
- Allows for Integrated Care Pathways, Shared Case Management, IT Systems and processes

Plank 4: Primary Care - Principles of New Model

- Single system company format
- Stakeholder ownership
- Incentivisation
- Improved quality through local standards (QOF)
- Improved outcomes by agreed local operating procedures
- Performance management system in place
- Focus on staff retention/working environment – through flexibility, changes in responsibility and support through large team approach, portfolio working/developing nurturing skills
- Estates consolidation into integrated hubs with community services
- Back office centralisation

Next Steps

Locality working with Deloitte;

- Identification and quantification of locality financial gap
- Interview of organisational Trafford stakeholders
- Operating Models drafted
- Visioning Workshop
- Application to the GM Transformation Fund

Working towards considering a single organisational form

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Public Health Priorities Working Group
Terms of Reference

Name of Workstream:	Public Health Priorities Working Group
Accountable to:	Health and Well-Being Board
Purpose:	The Public Health Working Group will be a task and finish working group which will determine the future shape of public health investment based upon • agreed overall public health priorities which reflect local need and address health inequalities • evidence based intervention programmes to achieve the greatest impact on healthy life expectancy
Functions:	To hold a workshop and subsequent meetings as required to: • receive and understand relevant data, including any unmet and new/emerging need • review existing evidence and identify how we can have the biggest impact • consider the Health and WellBeing Strategy • agree a framework of priorities and outcomes for a refreshed approach for 2016 – 9
Membership:	Cllr. Alex Williams, Cllr Stephen Anstee, Cllr Joanne Harding, Cllr Karina Carter, Matt Colledge, Eleanor Roaf (Public Health Consultant), Richard Spearing (Network Director, Pennine Care), Julie Crossley (CCG Associate Director Commissioning), Karen Ahmed (Director All Age Commissioning, MBTC)
Duration of Membership:	For the life of the working group
Chair:	Cllr Alex Williams
Frequency of Meetings:	As determined by the membership

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TRAFFORD COUNCIL

Report to: **Health & Wellbeing Board**
Date: **15th July 2016**
Report for: **Discussion and Approval**
Report of: **Kerry Purnell, Head of Partnerships and Communities, Trafford Council**

Report Title

Health and Well Being Performance Dashboard 2016-17

Purpose

To outline the performance dashboard to be used in 2016-17 which relates to the Health and Well Being (improving healthy life expectancy) priorities and the Safer Trafford Partnership priorities

Recommendations

The Board considers whether to include outcome measures for the Locality Plan and the Better Care Fund into the single performance dashboard.

The Board approves the approach to the performance dashboard and performance reports

Contact person for access to background papers and further information:

Name: Kerry Purnell, Eleanor Roaf and Martin Barrett

1. Background

When the Board discussed its new governance arrangements and where they fit with the new Trafford Partnership structures at its meeting in January 2016, the Board agreed it wished to receive a single performance report at its quarterly meetings. This performance report would include a single Dashboard capturing the outcome measures for the Health and Wellbeing priorities and those relevant to the partnerships and plans which report into the Board. The Board also agreed to receive progress updates from regarding the service areas which report into the Board for examples regarding:

- Locality Plan

- Better Care Fund
- Safer Trafford Partnership
- Sports and Physical Activity Partnership
- Trafford Safeguarding Children's Board
- Trafford Adult Safeguarding Board
- Health Watch

2. Performance Dashboard

Work is still being progressed to finalise the outcome measures for the five adopted Health and Wellbeing Priorities which aim to increase Healthy Life Expectancy across Trafford over the next 3 years. These priorities are:

- To reduce the impact of mental illness
- To reduce physical inactivity
- To reduce the number of people who smoke or use tobacco
- To reduce harms from alcohol
- To improve cancer prevention, and in particular the uptake of screening

The Mental Health Harm reduction work stream is to be discussed at the newly established Mental Health Strategic Group on 28th July 2016. A draft set of performance measures have been incorporated into the dashboard and are draft subject to adoption and/or amendment by the Mental Health Strategic Group.

The Physical Activity targets owned by the Sports and Physical Activity Partnership are incorporated into the dashboard.These measures mostly reflect statistics from the national Active Person's Survey which are only are available annually. Sport England release quarterly data but quite often there is a lag in time from that data being available to it being available at a Locality level. For example, for 3 of the measures the most up to date data is for the time period mid-Jan 2014 to mid-Jan 2015.

Further work is to be undertaken in the coming weeks to develop longer term targets (2020) for the 5 Healthy Life Expectancy priorities.

The Safer Trafford Partnership has set 4 high level targets for 2016-17 which are included in the Dashboard. Some measures are reported quarterly and some annually. Safer Trafford has a further set of outcomes related to each of the two sub-groups of the Safer Trafford Board. Progress against these will be presented to the Health and Well Being as part of regular update reports (see below).

Consideration should be given to including outcome measures for the Locality Plan and the Better Care Fund into the single performance dashboard.

3. Service areas

The following headline updates have been received:

Mental Health Harm Reduction

A programme of work and priorities on mental health harm reduction is being discussed with mental health commissioners at Trafford Council and NHS Trafford CCG based on existing work pertaining to Public Sector Reform (PSR) and complex dependency, integrated early intervention and prevention services, commissioned services on CAMHS, eating disorders, domestic violence, health and wellbeing in the workplace, adult mental health services in the statutory and voluntary/third sectors.

Physical Activity

- 22.3% of the Borough's adult population are physically inactive (undertaking less than 30 minutes of moderate intensity activity each week)
- SPAP continue to feed in to the creation of "Every Resident Active – A Health & Wellbeing Vision for Trafford" and are committed to more effectively positioning physical activity across the health, community and economic agendas. The draft vision will be presented at the September Health and Wellbeing Board.
- Active Early Years project progressing with a system-wide approach (eg. nurseries, health visitors, childminders, providers, Children's Centres) to increasing the proportion of physically literate children in Stretford and Partington underway
- Other outcome-focused SPAP projects include:
    - Recreational Running
    - Walking
    - Trafford Volunteer Inspire Programme
    - Active Key Stage 1

The Sports and Physical Activity Partnership Scorecard can be found at appendix B.

Safer Trafford Partnership

- The new voluntary Behaviour Change programme for those who cause harm through domestic abuse has been commissioned and the first cohort are expected through the service at the end of July.
- The partnership between GMW and the Safer Trafford Integrated Partnership team continues to strengthen. 2 Substance Misuse practitioners have been recruited and will be co-located frim mid-July at Stretford Police station.

4. Proposed Approach

The Performance dashboard will be presented at quarterly to the Health and Wellbeing Board.

Safer Trafford will provide detailed progress reports bi-annually with the next one due in September 2016

Annual reports will be provided by Health Watch and by the two Safeguarding Boards

5. Recommendations

The Board considers whether to include outcome measures for the Locality Plan and the Better Care Fund into the single performance dashboard.

The Board approves the approach to the performance dashboard and performance reports

Trafford Health and Wellbeing Board
April 2016 to March 2017

Increasing Healthy Life Expectancy – Performance measures

The table below gives the suggested performance measures for the five areas identified for their impact on increasing healthy life expectancy in Trafford (and reducing the inequalities within this measure). Please note that although indicative mental health harm reduction measures have been produced these have not yet been agreed by the Joint Commissioning Board Mental Health work stream. This agreement is required in order that the mental harm reduction work is embedded within this new governance architecture. The final mental health measures will be presented to the July 2016 HWBB meeting. For the physical activity measures, please note there is ongoing discussion about the data sources to be used as national datasets and collection methods are still to be finalised. There are also discrepancies between local and national datasets that need to be properly understood.

Ref	Theme	Aim	Performance Measure	Local/ National	Benchmark Score	2016-17 Outcomes	2020 targets	Comment
1.1	Physical Activity	To reduce the percentage of people in Trafford who are physically inactive	Percentage of adults undertaking less than 30 minutes of moderate intensity physical activity each week (Active People Survey – to become Active Lives Survey)	National	22.3% (2014)			20.6% considered sedentary (0 minutes per week). Chief Medical Officer guidelines target is 150 minutes per week.
1.2	Physical activity	To increase the number of people walking each week	Percentage of adults taking part in Recreational and/or Active Walking each week (Active People Survey – to become Active Lives Survey)	National	36.5% (2014)			
1.3	Physical activity	To increase the number of people running each week	Percentage of adults taking part in Athletics (Running) at least once each week (Active People Survery	National	4% (2014/5)			G Manchester data, not Trafford specific

Ref	Theme	Aim	Performance Measure	Local/ National	Benchmark Score	2016-17 Outcomes	2020 targets	Comment
			– to become Active Lives Survey)					
1.4	Physical Activity	To increase the number of people cycling each week	Percentage of adults taking part in Recreational and/or Active Cycling each week (Active People Survey – to become Active Lives Survey)	National	14.7% (2014)			
1.5	Physical Activity	To increase the number of people volunteering in sport and physical activity	Percentage of adults undertaking at least some sport and physical activity volunteering over the past 12 months (Active People Survey – to become Active Lives Survey)	National	13.20% (2014/15)			G Manchester data, not Trafford specific
1.6	Physical Activity	To increase physical literacy across the early years, at school and at home	Physical competence at school entry from school readiness assessment	Local	TBC			
2.1	Alcohol	Create an IT response to provide intelligence for Health Leads to assess licensing applications against health outcomes.	Alcohol Harm Mapping Tool used in 100% of alcohol license applications	Local	N/A			

Ref	Theme	Aim	Performance Measure	Local/ National	Benchmark Score	2016-17 Outcomes	2020 targets	Comment
2.2	Alcohol	Review application pathway to incorporate this process.	Licensing Application Pathway Reviewed with Health Element	Local	N/A			
2.3	Alcohol	An increased use of Health Checks by GP's and Pharmacies to screen for alcohol misuse	Number of NHS Health Checks delivered including completion of AUDIT alcohol screening questionnaire	National	5,367 (2014/15)			
2.4	Alcohol	Increase awareness and use Audit Alcohol Screening Tool in Primary Care (FAST or AUDIT-C)	Proportion of adults screened using an AUDIT alcohol screening questionnaire in primary care	Local	Not yet available			
2.5	Alcohol	Provider lead activities on National and Local Campaigns	A minimum of 3 campaigns: delivered across Trafford, amplified via the media and evaluated	Local	N/A			
2.6	Alcohol	Reduce number of Hospital Admissions for alcohol-related conditions	Number of alcohol-related hospital admissions (narrow definition)	National	1,384 (630 per 100,000) (2014/15)			PHOF 2.18
3.1	Tobacco	Prevention of illicit and illegal tobacco sales	Number of reports to Trading Standards regarding underage or illegal sales	North West	394 (Q1&Q2 2015/16)			
3.2	Tobacco	Reduction of smoking prevalence in routine and manual groups	Smoking prevalence in routine and manual group	National	27.8% (2014)			PHOF 2.14

Ref	Theme	Aim	Performance Measure	Local/ National	Benchmark Score	2016-17 Outcomes	2020 targets	Comment
3.3	Tobacco	Protecting children from exposure to second hand smoke	Prevalence of smoking at time of delivery	National	8.3% (2014/15)			PHOF 2.03
4.1	Cancer	To reduce the age-standardised rate of mortality from all cancers in persons under 75 years	Under 75 mortality rate from cancer (Persons) per 100,000 population	National	137.6 (2012/14)			PHOF 4.05i
4.2.i	Cancer	To increase the proportion of eligible patients attending for breast screening	Proportion of eligible patients attending for breast screening	National	70.50% (2014/15)			
					73.9% (2015)			PHOF 2.20i
4.2.ii	Cancer	To increase the breast screening uptake rate of the bottom 5 performing practices in Trafford	Average breast screening uptake rate of the bottom 5 performing practices in Trafford	Local	53.90% (2014/15)			
4.3.i	Cancer	To increase the proportion of eligible patients attending for cervical screening	Proportion of eligible patients attending for cervical screening	National	79.90% (30.9.15)			
					75.2% (2015)			PHOF 2.20ii
4.3.ii	Cancer	To increase the cervical screening uptake rate of the bottom 5 performing practices in Trafford	Average cervical screening uptake of the bottom 5 performing practices in Trafford	Local	72.90% (30.9.15)			

Ref	Theme	Aim	Performance Measure	Local/ National	Benchmark Score	2016-17 Outcomes	2020 targets	Comment
4.4.i	Cancer	To increase the proportion of eligible patients completing their bowel screening	Proportion of eligible patients completing their bowel screening	National	54.40% (2012/13)			
					56.6% (2015)			PHOF 2.20iii
4.4.ii	Cancer	To increase the bowel screening uptake rate of the bottom 5 performing practices in Trafford	Average bowel screening uptake of the bottom 5 performing practices in Trafford	Local	34.60% (2012/13)			
5.1	Mental Health	To increase employment for those with long-term conditions including adults who are in contact with secondary mental health services	1.08i - % point gap in the employment rate between those with a long-term health condition and the overall employment rate	National	8.9% (2014/15)			PHOF 1.08i
5.2	Mental Health	To reduce hospital admissions caused by unintentional and deliberate injuries in under 18s	2.07i – Hospital admissions caused by unintentional and deliberate injuries to children (0-14)	National	124.2 per 10,000 (2014/15)			PHOF 2.07i
5.3	Mental Health	To increase the emotional well-being of looked after children	2.08 – average difficulties score for all looked after children aged 5-16 years who have been in care for the last 12 months as at 31st March	National	10.2 (2014/15)			PHOF 2.08

Ref	Theme	Aim	Performance Measure	Local/ National	Benchmark Score	2016-17 Outcomes	2020 targets	Comment
5.4	Mental Health	To reduce excess Under 75 mortality rate in adults with serious mental illness	Excess under 75 mortality in adults with serious mental illness	National	404.7 (2013/14)			PHOF 4.09
5.5	Mental Health	To reduce the work sickness absence level	The percent of working days lost to reported sickness absence	National	1.5% (2011/13)			PHOF 1.09ii
			Reduce the level of sickness absence (Council-wide, excluding schools) (days).	Local	9.08 days (2015/16)	8.5 days		Trafford Annual Delivery Plan (ADP) target

Ref	Theme	Aim	Performance Measure	Local/ National	Benchmark Score	Target 2016/17	Q1 target/actual	Comment
6.1	Safer Trafford	Maintain the position of Trafford compared to other GM areas in terms of Total Crime Rate.	Maintain the position of 1st as defined by IQUANTA data	Local	1st (2015/16)	1st	1st	Trafford Annual Delivery Plan (ADP) target
6.2	Safer Trafford	Reduce the number of repeat demand incidents at addresses or locations by 15% that are linked to: • Domestic Abuse • Missing from home • Missing from Care • Alcohol or • Substance Misuse	Reduce the demand caused by repeat incidents at the same addresses	Local	75% repeat incidence (2015/16)	60% repeat incidence	Annual target	Trafford Annual Delivery Plan (ADP) target
6.3	Safer Trafford	To improve the public perception of how the police and the Council are dealing with ASB and crime by 5% across Trafford as a whole	Increase community confidence by partnership working within our town centres	Local	74% (2015/16)	79%	Awaiting Q1 data from GMP Due week commencing 11/7/16	Trafford Annual Delivery Plan (ADP) target

6.4	Safer Trafford	To increase the number of perpetrators of domestic abuse we work with through voluntary Behaviour Change programmes and to reduce the risk of those individuals repeating abusive behaviour.	Increase the number of perpetrators engaging with us through the Behaviour Change and Strive programmes.	Local	New work	40	0 (This programme has not yet begun)	Trafford Annual Delivery Plan (ADP) target New DA Behaviour Change courses begin end of July 2016

Trafford Strategic Sport & Physical Activity Partnership – Performance Scorecard

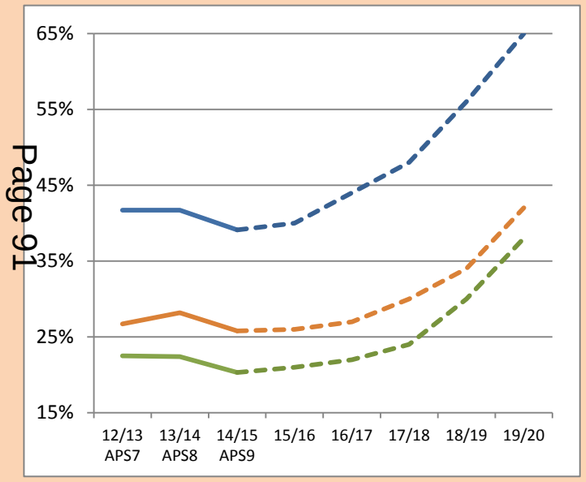
Outcome: More People, More Active, More Often

Population: All residents in Trafford

Our priorities:

- Increase 1 x 30 minutes participation in sport and physical activity across all ages (particularly from those who are currently characterised as inactive)
- Maximise opportunities of the use of green space infrastructure for physical activity in the borough such as running, cycling and walking
- Encourage workplace activity programmes
- Increase volunteering opportunities in sports
- Support links between school sport and the community

How well are we doing?

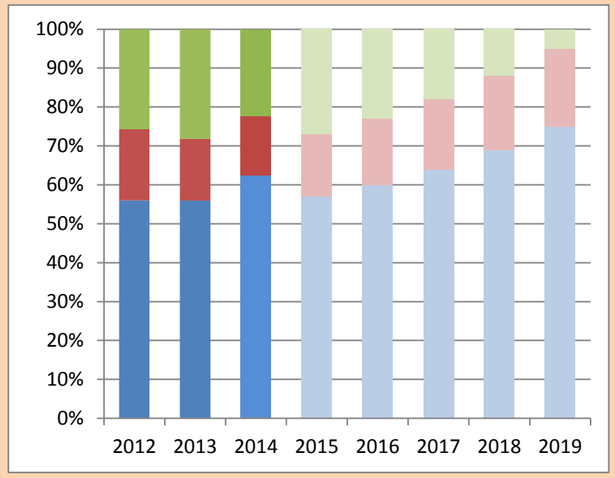


39.1% -2.60%

We know that 39.1% of the adult population (16+) in Trafford take part in sport at least once a week. With regards to regular participation we know that 20.3% take part in sport on three or more occasions each week, which increases to 25.8% participating three times a week or more under a broader sport and active recreation definition (NI8).

Furthermore, we know that women are less active. Similarly, but on a sub-regional level, we know that older people, people with a disability, people from a black and ethnic minority background, and people not in employment are also less active.

(Data source: APS9)



22.3% -5.90%

We know that 22.3% take part for less than 30 minutes each week with 20.6% considered sedentary (0 minutes per week). We also know that 62.5% of the adult population (16+) in Trafford take part in at least 150 minutes of moderate or vigorous intensity physical activity per week, which meets the Chief Medical Officer's physical activity guidelines.

As with sports participation we know that physical activity rates are generally lower among women, ethnic minorities, and those with a disability.

(Data source: PHE period 2014)

Our approach:

In order to deliver a population-level shift in sport and physical activity participation in Trafford the Partnership will look to:

- INNOVATE – Have a positive impact on health by activating cross-networks of expertise and promoting the benefits of sport within educational, workplace and community environments;
- COORDINATE – Promote borough-wide activity and target health inequalities in areas of deprivation, particularly focusing on vulnerable communities with lower life expectancy;
- ENGAGE – Help to optimise use of our assets and increase participation levels through partnership working and promotion; and
- DELIVER – Increase participation through evidence-based interventions that support behaviour change with an emphasis on areas where there are gaps in provision.

WALKING

35.2% +0.80%

34.8% of adults (16+) in Trafford have undertaken at least some active or recreational walking each week. Furthermore, 31.9% walk for at least 30 minutes each week.

Data source: PHE period 2014

RUNNING

9.18% -1.22%

9.18% of adults (16+) in Trafford have participated at least once in athletics /running over the past year. Additionally, 4% across Greater Manchester run at least once a week.

Data source: APS9

CYCLING

9.68% -0.15%

9.68% of adults (16+) in Trafford have participated at least once in cycling over the past year. Furthermore, 3.51% across Greater Manchester cycle at least once a week.

Data source: APS9

PHYSICAL LITERACY

7.6%

7.6% of reception aged children in Trafford do not meet the expected level within Early Learning Goal associated with Moving and Handling. 5.7% within Health and Self-Care.

Data source: Early Learning Goals 2015

VOLUNTEERING

13.2% +2.80%

13.2% of adults (16+) across Greater Manchester have volunteered in sport at least once over the past year. Furthermore, 3.37% have undertaken volunteer coaching.

Data source: APS9

Trafford Strategic Sport & Physical Activity Partnership – Project Tracker

RECREATIONAL RUNNING

Start date: 1/2/16 End date: 31/3/17

Project objective: *To increase the number of people running in Trafford.*

Performance indicators	Q1 – Feb-Jun 16		Q2 – Jul-Sep 16		Q3 – Oct-Dec 16		Q4 – Jan-Mar 17	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Parkruns established	1	1	2		2		2	
Weekly Parkrun runners	300	355	600		600		600	
Run leaders trained	24	16						
Beginner Running Groups established	2	1	4		5		6	
Weekly Beginner Running Group runners	30	9	60		75		90	
'3-2-1' routes mapped	2	0	6					
Sport Relief Mile events delivered	2	2						
Sport Relief Mile runners	300	306						
Trust10 event established	0	0	1					

ACTIVE EARLY YEARS

Start date: 1/4/16 End date: 31/3/17

Project objective: *To increase the proportion of children in Trafford leaving Key Stage 1 who demonstrate the requisite motivation, confidence, physical competence, knowledge and understanding to value and take responsibility for engagement in physical activities for life.*

Performance indicators	Q1 – Apr-Jun 16		Q2 – Jul-Sep 16		Q3 – Oct-Dec 16		Q4 – Jan-Mar 17	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Bespoke nursery training delivered	3	3	6		9		10	
Nursery staff trained		18						
Let's Play awareness training delivered	1	0	2					
Health Visitors trained	12	12						
Other professionals/deliverers trained	15	0	30					
Let's Play franchise sessions established	2	2						
Let's Play franchise session throughput		48						

TRAFFORD SPORTS CAPITAL GRANT SCHEME

Performance indicators	Q1 – Apr-Jun 16		Q2 – Jul-Sep 16		Q3 – Oct-Dec 16		Q4 – Jan-Mar 17	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Applications received		18						
Grants paid (awarded)		10 (15)						
Total grant funding awarded	£104k	£81k	£104k					

TRAFFORD VOLUNTEER INSPIRE PROGRAMME

Start date: 1/2/16 End date: 31/3/17

Project objective: *To increase the number of people volunteering in sport in Trafford.*

Performance indicators	Q1 – Feb-Jun 16		Q2 – Jul-Sep 16		Q3 – Oct-Dec 16		Q4 – Jan-Mar 17	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual
Active volunteers	100	25	200		300		500	
Volunteer profiles		27						
Provider profiles		12						
Volunteer opportunities posted		8						