Item No. 4

Greater Manchester Joint Health Scrutiny Committee submission to the NHS consultation on Healthier Together

31 October 2014

1. Key comments

In fulfilling its duty to scrutinise these proposals the Greater Manchester Joint Health Scrutiny Committee has developed an informed understanding. The Committee recognises it own role in contributing to a clear understanding of the proposals. The Committee therefore wishes to preface its response to the consultation with clear statements about how the proposals have been presented and understood:

1. The hospital element of Healthier Together is at the heart of the consultation but has not been well understood.
2. The Committee itself, and sections of the public, at first found it difficult to understand the consultation. At Committee meetings and public events clinicians supporting the programme often gave the clearest explanations. Following presentations by Martin Vernon (Consultant Physician) and Martin Smith (A&E Consultant), the Committee wishes to stress that:

- The proposals will not lead to the closure of any hospitals or Accident and Emergency Departments.
- The hospital element of the consultation is, at heart, about which operating theatre a small but significant number of patients have their specialist or more complex surgery in.
- The hospital proposals only relate to specific services for accident and emergency, acute medicine and general surgery in emergency circumstances.
- The proposals will create two types of hospitals for these services, 'Specialist' and 'General'. The proposals will create between 4 and 5 'Specialist' hospitals in Greater Manchester, but *only for the services* described above. In other words, the many different services provided in hospitals – urology, sexual health, cancer and others, are unaffected. For example, one hospital's website in the South of the city region lists *148* different services on its website. Hospitals' own *specialisms*, like neuro-rehab at Salford Royal Foundation Trust, or burns at University Hospital South Manchester, are unaffected. The Committee felt that use of 'specialist' and 'specialism' terminology had created unnecessary confusion.
- In the future, complex and high risk surgery will take place in the Specialist hospitals, and moderate to low risk surgery will take place locally. Once someone has received 'specialist' care in the Specialist hospital, they will return to their local General hospital.
- For most patients there will be little change. The Committee heard that for A&E 10% of all patients need specialist care which equates to 100,000 patients a year. Each local General A&E will still treat 90% of the patients they do currently, which means that 95% of A&E patients will continue to attend the same hospital. For general surgery 90% of patients will attend the same hospital they currently do.

- In the future, all the hospitals in Greater Manchester, Specialist and 'General', will work together within a single service model. Clinicians argued that achievement of the single service model is more important than the location of the specialist sites. Achieving the single service model, and ensuring that all hospitals meet the standards that have been agreed (currently no hospital meets all the standards) will save lives and improve patient care in Greater Manchester.
- The proposals have not been created in order to make savings, in fact they will slightly increase expenditure, but are driven by the desire to improve patient care.

3. The Committee recognises that the NHS is complex organisation and its own attempt to provide clear messages about the hospital elements runs to over a page. Moreover, at times public understanding has been muddied by the contributions of some politicians, pressure groups, and individual hospital trust boards. However, ensuring public confidence in hospital changes should be seen as of the utmost importance, and indeed is essentially a requirement of the statutory framework for consultation. Although the Committee feels there has been a genuine attempt to describe these proposals, Healthier Together should recognise the need to improve communication. Healthier Together have already begun to address these criticisms with the creation of 'Bite Size' fact sheets, and a leaflet sent to every household in Greater Manchester.

4. The Committee's understanding is that the final decision for Healthier Together will be made in the new year, and may well be made after the General Election. The Committee recommends ongoing communication by the Healthier Together team which seeks to address the comments made in this response.

5. Finally, the consultation recognises how dependent these hospital changes are upon primary care, particularly access to GP services, and local integration between health and social care. As discussed below, the Committee supports the overall strategic vision for reform, and particularly the need to improve primary care. The Committee particularly welcomes the primary care standards. The Committee recognises the value and ambition in a consultation which seeks to engage the public on the whole reform agenda and the interdependencies between the three key strands. However, it should be recognised that many individuals first concerns will be about changes to their local hospitals, and the Committee suggests that more can be done to address these concerns.

2. Background

During June 2014 the Committees of Common (CiC) of the Association of GM Clinical Commissioning Groups launched a consultation upon Healthier Together.

Under the Health Scrutiny Regulations the affected local authorities are required to appoint a Joint Scrutiny Committee for the purposes of responding to the Healthier Together consultation.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 set out the responsibilities upon local authorities with regard to consultations by the NHS:

- *In summary, where a responsible person has under consideration any proposal for a "substantial development of the health service in the area of a local authority", or for*

"a substantial variation in the provision of such service" the person must consult the authority.

- *The affected authority may report to the Secretary of State in writing where it is not satisfied that consultation on the proposal i) has been adequate, or ii) if it feels that the proposal would not be in the best interests of the health service in its area.*

GM local authorities agreed that the existing GM Health Scrutiny Panel be formally appointed as the Joint Scrutiny Committee for the purposes of the Healthier Together consultation. More recently, Derbyshire County Council were identified as an affected local authority and joined the Committee.

The Committee will continue to meet in order to produce a detailed Final Report once the CiC confirms the decision making timescale. The Committee was keen to provide initial comments at this stage in response to the consultation.

3. Evidence gathered

The existing GM Health Scrutiny Panel received updates on Healthier Together within regular briefings on issues of strategic importance to the NHS. Meetings of the GM Health Scrutiny Panel were held in April, May and June.

The revised Committee then held meetings in July, August, September and October to consider the following agenda items during the consultation period:

- The overall case for change and summary of the proposals.
- Finance.
- Workforce transformation.
- Patient and carer transport.
- Primary care.
- The single service model.

Colleagues representing NHS England, the CiC, Transport for Greater Manchester, the Patient Reference Group, ORS (the organisation supporting the consultation) and clinicians attended meetings.

Additionally, Committee members and supporting officers attended a number of the public consultation meetings, including patient engagement events, transport meetings, and the public engagement bus.

4. Comments on the overall programme

The Committee agrees with the underlying principles behind the Healthier Together consultation – that standards of care can be improved, that clinical expertise is sometimes spread thinly across Greater Manchester, and if possible care should take place in the community and not in hospital settings.

The Committee agrees that changes to services are needed, and recognises the joint principles agreed by AGMA and the CiC during 2013:

- At the local level integration between health and social care will help ensure that people who do not need to go to hospital can be seen in more appropriate settings, including their own home.

- The overwhelming majority of hospital treatment should be at a local General hospital. However, rare conditions and specialist treatments – 'once in a lifetime' instances – might be more appropriately addressed at specialist centres.

The Committee supports the main aim of Healthier Together to provide 'best care' for everyone in Greater Manchester. Healthier Together has made clear that there are too many variations in the quality of care in Greater Manchester – particularly within hospital emergency care but also within primary care. The Committee recognised that currently not one hospital in Greater Manchester meets all the national quality standards.

5. How primary care is changing

The Committee agrees that improvements to hospital services, and broader improvements to care and support rest upon the quality and accessibility of our primary care services. More patients need to be supported independently, avoiding hospital attendance and admissions. Members of the Committee highlighted the need to improve standards in primary care, and in particular to improve seven day access.

The Committee heard how Greater Manchester's primary care demonstrator sites are making progress, with 6 sites now covering a population of 377,000 citizens. Four of the six sites include a specific focus on extended GP access over 7 days.

The Committee agrees with the standards set out in the consultation document. The Committee suggests that the Primary Care Strategy focuses upon:

- Mental Health.
- Patients with established conditions and the large number of patients receiving optimal treatment.
- Patients with conditions that they are unaware they have and attending accident and emergency services too late.
- Patients on the "cusp" of developing conditions and although accessible via data bases there is currently an inability to focus on these individuals.
- Individuals who do not take up free analysis i.e. bowel cancer screening.
- The current disjointed services provided to vulnerable people i.e. the elderly.

6. Joining up healthcare

The Committee agrees with the proposals for joining up the health and care system. The Committee had agreed to focus its work plan upon the in-hospital elements and accordingly gathered less information on this aspect of Healthier Together.

In exploring improvements to primary care and integrated care, the Committee identified risks. If partners plan to re-invest strategically into primary care this has the potential to destablise hospitals. The Committee thought that it was essential that funding and staff flows are handled in a correct manner.

The Committee recognised the interdependencies of primary care, integrated care and hospital reform. It was felt that the partners are not used to governing as a whole system in partnership, but there is increasing appetite to work in this way.

The Committee felt that the parts of the system that back up hospital improvements had not been presented clearly enough (although recognised the difficulties in achieving this whilst ensuring the appropriate focus on the in-hospital element). Without the

commitment to get the primary and community elements in place, the public will not believe that there is the will to make these changes. The Committee felt that some quick moves into community settings need to be described visibly as success stories.

7. How hospital services could change

The Committee received a presentation on finance and agrees that the hospital proposals are based upon improvements in quality and patient safety, not about making savings.

In its introduction to this response the Committee describes its understanding of the in-hospital proposals. The Committee agrees that the shared service model is at the heart of the proposals, but this has been lost in the consultation. The Committee agrees that we cannot make improvements to meet the standards without the single service model.

In principle, the Committee supported hospitals co-operating to meet the standards. Committee members were aware of initial proposals to collaborate advocated by the NW and southern sectors. The Committee agreed that these collaborations have the potential to provide clinical excellence and service provision that is sustainable and affordable. However, the Committee felt the need to stress that if collaboration leads to sharing of services beyond the scope of Healthier Together, it is extremely important that these developments are also consulted upon. Failure to do so will be damaging to public trust.

The Committee recognised that even following the completion of Healthier Together all GM Trusts will remain in financial deficit, and that the savings resulting from Healthier Together are relatively small in the context of overall financial challenge. The Committee acknowledged that Healthier Together had set out very clearly its aim to address quality and improve standards in in-hospital care, and not to primarily address financial challenge. The Committee noted that separate plans were in place to meet the financial challenge.

The Committee recognised that patient transport has been consistently raised at public engagement events. Healthier Together had assured the Committee that all the proposed options meet the standards. The Committee acknowledges that once patients have received care in a Specialist hospital they will be repatriated back to their local hospital.

Despite the presentation, the Committee had ongoing grave concerns about this area, particularly emphasising the impact upon relatives and carers. Some members of the Committee were left with little confidence as to the travel times and robustness of the information provided. The Committee suggested that further analysis was required, and in particular to consider information on peak period travel times, rather than an analysis between the hours of 10am and 4pm. As discussed below, the Committee requested further information upon the impact on residents in High Peak.

The Committee discussed the workforce aspects of the hospital proposals and recognised that these issues would be explored in more detail closer to implementation. However, the Committee recommends that the following areas are addressed in workforce planning:

- Lack of emergency consultants.
- Issues around GP recruitment

- Shortfalls in nursing.
- The need to understand what future models of care look like, upskilling existing workforce and identifying new ways of working/new roles.

At its last meeting members discussed the impact of the proposals upon High Peak, as an additional member from Derbyshire County Council had joined the Committee. There was felt to be a history of disappointing NHS consultation in the area. Derbyshire had not been involved early in this consultation and presentations subsequently given had been to felt to be 'Manchester-centric'. The Committee heard that between 70-80,000 Derbyshire residents look out to Stockport and Wythenshawe for their hospital services. There was concern that these patients would not be able to access urgent care within the 45 minute standard. The Committee agreed that these patients should be taken into account within patient modelling and requested further information at a future meeting.

8. Initial comments on the consultation process

The Committee's Final Report will make detailed comments on the consultation process itself.

The Committee is broadly supportive of the consultation that has been carried out, recognising the complexities of consultations of this sort, and Healthier Together's wish to engage the public in a more positive 'conversation'.

The Committee, at its own meetings and public events, identified some misunderstandings on the nature of the consultation. The consultation document presents the overall health and social care public service reform programme, incorporating in-hospital reform, integrated health and social care, and primary care. The Committee felt that while it has been important to describe the wider narrative, the statutory consultation focused more specifically on the in-hospital changes, in particular the single service model and the development of General and Specialist Hospital sites for A&E, acute medicine and general surgery.

Although the Joint Health Scrutiny Panel had supported the consultation document, it was noted that at public meetings there had been confusion about the scope of the proposals. This may have been due to unhelpful misreporting of the proposals which inaccurately introduced the threat of hospital closure. The Committee acknowledges that Healthier Together, and the consultation document, stress very clearly that no hospitals will close as a result of these proposals.

The Committee felt that the CiC and NHS hospital trusts had been discussing Healthier Together for two years and therefore there should be no misunderstanding about what these proposals are trying to achieve. The Committee was concerned at the possibility that hospital Trust Boards and by extension hospital staff may have contributed to misunderstanding about the proposals.

The Committee has yet to discuss the proposals in detail with hospital Chief Executives, which has been scheduled for its November meeting. The Committee's concern about these issues rested upon members' participation in public consultation events and how Healthier Together has been reported in the media.

The Committee discussed the consultation process with representatives of the External Reference Group and the research organisation supporting the consultation process. The Committee identified the following issues that were arising at public meetings:

- Although support was given for joined up health and social care plus GP 7/7 access, concern was being raised regarding the feasibility of recruitment and access to patient records
- That proposals were driven by financial necessity as opposed to clinical needs
- Concerns about travel and access to specialist hospitals in relation to visitor access.
- Clarification of terminology was required in respect of General and Specialist hospital/"Specialisms". People think that if a hospital is not designated as specialist, it is going to lose its specialism.
- Training and support for GPs and hospitals involved in order to meet the needs of patients with hearing, learning disabilities etc
- The practicalities and costs of staff working and moving across multiple sites.

The Committee agrees that indication of support for a particular option should not be seen as a 'numbers game'. Although the CiC should note the outcome, one hospital receiving the most responses would not necessarily mean that it was the best option.

As suggested above, the Committee discussed issues around public perception and negative assumptions/press coverage. It was believed that it was important to ensure that clear messages were made on the gains to be achieved, in particular, that standards in GM hospitals would be raised and no A&E service would close. Building public confidence remains a key task and the Committee recommends that following the consultation process Healthier Together publish a "You said…. We did…" document.

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