SUMMARY OF REPORT:

This paper is an update and follow up to the paper presented to the Strategic Partnership Board on 28 October 2016, and sets out the proposed approach to developing a GM strategy for hospital based services under Theme 3, Standardising Acute and Specialised Care.

This paper is the first step in a series of papers which will build the strategy for hospital based services. This paper is complementary to and should be read in conjunction with the governance paper (Theme 3 – Revised Governance to deliver the Theme 3 Strategy for Hospital Based Services), which outlines what governance arrangements are needed to support the strategy work and the inputs to it.

KEY MESSAGES:

This paper describes an approach and framework for developing a strategy for hospital based services, and describes how this will be achieved such that all the work under Theme 3 is brought together and delivers under a single process.

The development of this paper marks the start of working and engaging differently with our stakeholders across the GM Health and Social Care system. We have widely shared our thinking within the health and social care system as the basis for discussion and feedback in preparing this paper.

This paper has been discussed and supported by the Strategic Partnership Board Executive on the 12th April 2017 and the Joint Commissioning Board on the 18th April 2017.

PURPOSE OF REPORT:

The purpose of the report is to set out the proposed approach and process for developing a GM strategy for hospital based services; to describe how this will be achieved such that all
the work under Theme 3 is brought together and delivers under a single process, with the involvement and engagement of all key stakeholders across the Greater Manchester Health & Social Care system, including service users, carers and the public.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Approve the approach described above to develop a hospital based services strategy.
- Note the additional documentation to follow.

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1.0 INTRODUCTION

1.1. Theme 3 Standardising Acute & Specialist Care was set up by the GM Health and Social Care Partnership to deliver commitments outlined in the GM 5 year strategic plan ‘Taking Charge’. It brings together hospitals from across GM to work together across a range of clinical services, to make sure expertise, experience and efficiencies can be shared widely so that everyone in GM can benefit equally from the same high standards of specialist care.

1.2. Why do we need a strategy for hospital based services?

1.2.1. Strategically we want to ensure that decisions about services result in the delivery of improved and equitable services for patients across GM and the wider area that GM hospitals serve; and that these services are clinically sustainable and financially affordable across GM. This is a huge challenge for the GM Health and Social Care System and how we work together as partners to achieve this. It means we need to ensure that decisions about hospital based services in GM are not taken in isolation, and that across the GM system we develop a coherent range of hospital based services based on a ‘single service’ approach but that clinical interdependencies are understood and recognised. We need to have a single way of ensuring that, as a system, we understand the full impact of changes on patients and carers; on wider health and care services; on our hospital infrastructure and estate; on our organisations; and in each locality, such that the costs of service change can be minimised and the benefits for patients are maximised. The strategy will provide a GM wide framework for hospital based services. Individual commissioners, Trusts and localities will then commission and provide services within the agreed framework.

1.2.2. The Theme 3 projects that were prioritised in September 2016, cover services that account for two thirds of all hospital activity and represent 61% of in scope acute costs in GM (in scope services represent £1.6bn of £2.7bn of in scope spend). The prioritised projects also represent all key components of hospital care (medicine, surgery, women’s and children’s, and specialised services). There are also a number of programmes of work that are very closely linked to Theme 3, for example the development of the Single Hospital Service across the City of Manchester; the establishment of Group arrangements between Salford Royal and Pennine Acute; and the Greater Manchester cancer plan. Change in these areas will deliver significant elements of the strategy.

1.2.3. More widely, many programmes of work connect to Theme 3 and will influence and determine the future shape of hospital based services. This includes the transformation of adult social care; cross-cutting work to deliver the GM mental health strategy; work on maternity services; work to standardise clinical support and corporate functions (Theme 4); place driven change in each of the 10 localities; the transformation of community based care (Theme 2); and population health and prevention (Theme 1). Hospital trusts are also working towards national requirements such as the delivery of the 10 clinical standards for urgent and
emergency care, and the delivery of 7 day services. Each and all of these will impact upon the shape of what care needs to be delivered in our hospitals in the future.

1.2.4. The GM Mental Health and Wellbeing Strategy calls for greater integration across mental and physical health and social care services within each of the ten GM localities as well as across the wider GM conurbation; and for responsive and clear access arrangements connecting people to the support that they need. With the approach to developing a strategy for hospital based services described in this paper, there is a clear opportunity and a need to ensure the links between physical and mental health are considered in the design process; and that new models of care in hospital based services pick up on patients mental health needs in a holistic way that enables them to access the care that they require.

1.2.5. To effectively deliver the scale of change described above, making the links across a complex system whilst maintaining patient safety and performance is a significant challenge. Not only will this will require strategic co-ordination, it will also require detailed operational coordination.

1.2.6. In addition, and crucially, a coherent message will need to be given to patients and carers and staff about any potential change, what this means for them and how this step on the journey contributes to delivery of the overall strategy. Therefore a GM strategy for hospital based services is needed to provide the strategic direction, oversight and planning described above.

1.3. Context

1.3.1. The Greater Manchester 5 year plan – ‘Taking Charge’ describes 5 themes or programmes of change. These are shown below.

1.3.2. Theme 3 is Standardising Acute & Specialist Care and is described as “The creation of “single shared services” for acute services and specialist services to
deliver improvements in patient outcomes and productivity, through the establishment of consistent and best practice specifications that decrease variation in care; enabled by the standardisation of information management and technology.

1.3.3. The current transformation priorities for Theme 3 were developed with clinicians, providers and commissioners over a number of months culminating in a proposal from the Theme 3 Steering Group which was endorsed by the Association Governance Group (AGG), Provider Federation Board, the Strategic Partnership Board Executive on the 12th September 2016, and the Strategic Partnership Board on the 28th October. The current transformation priorities are:

- Paediatrics (including specialised children's services), and maternity
- Respiratory and cardiology
- Benign urology
- MSK and orthopaedics
- Breast services
- Neuro-rehabilitation
- Vascular
- HIV*
- Ophthalmology*.

*Note that HIV and ophthalmology (specialised services) have been prioritised but will be initiated as part of a second wave.

1.3.4. A number of acute and specialised projects were previously underway some at implementation stage; these have also been brought within the oversight and leadership of Theme 3:

- A&E, Acute Medicine and General Surgery (Healthier Together)
- OG cancer
- Urology cancer.

1.3.5. The standardisation of GM hospital services is one part of a much larger system change driven by each of the 10 localities delivering improved primary, community and social care services, with the interface between the two critical to delivering improved care. The hospital based services strategy will not only need to describe the impact of changes on GM hospital based services as a whole, but also what this means in each of the 10 localities. The transformation priorities in Theme 1 (population health and prevention), Theme 2 (the transformation of community based care) and Theme 4 (standardisation of clinical support and corporate
functions) will also drive changes that will impact in some way on hospital based services and vice versa. At the appropriate point the impact on cornerstone services such as critical care and diagnostics will also need to be understood, planned for and implemented. These connections are illustrated in the diagram below:

1.4. **The purpose of this paper**

1.4.1. From early on in our discussions it became very clear that there are many different views about what a GM strategy for hospital based services means to different people and what it should and should not include.

1.4.2. The purpose of this paper is to set out our proposed approach for the strategy and how it will be developed; and to describe how this will be achieved such that all the work under Theme 3 is brought together and delivers under a single process, pulls in the same direction, and does so with the involvement and engagement of all key stakeholders across the Greater Manchester Health & Social Care system. Governance and Decision making processes need to be clear and understood.

1.5. **How we have developed this paper**

1.5.1. The development of this paper has marked the start of working and engaging differently with stakeholders across our GM Health and Social Care system. In early February we developed a core presentation which outlined our thinking on the content of a strategy for hospital based services, and a process for developing this. We have widely shared this as the basis for discussion and feedback in 1:1s with individuals and with key stakeholder groups across GM. These conversations have shaped the slide presentation, and the content behind this paper. A full list of those who have contributed to date can be found in the appendix. A summary is provided below of the key groups we have engaged with or have scheduled.
<table>
<thead>
<tr>
<th>Group</th>
<th>Date</th>
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<tbody>
<tr>
<td>Theme 3 Delivery Board</td>
<td>22nd February / 29th March 2017</td>
</tr>
<tr>
<td>GM Association of Clinical Commissioning Groups (AGG)</td>
<td>7th March 2017</td>
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<tr>
<td>Finance Executive Group</td>
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<tr>
<td>CCG Chief Officers</td>
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<tr>
<td>Provider Transformation Leads for Theme 3 projects</td>
<td>10th March 2017</td>
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<tr>
<td>Theme 3 Clinical Reference Group</td>
<td>16th March 2017</td>
</tr>
<tr>
<td>GM Health and Social Care Partnership Senior Management Team</td>
<td>4th April 2017</td>
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<tr>
<td>Provider Federation Board</td>
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<td>Strategic Partnership Board Executive</td>
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<td>Joint Commissioning Board Executive</td>
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<tr>
<td>Strategic Partnership Board</td>
<td>28th July 2017</td>
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2.0 WHAT NEEDS TO CHANGE

2.1. The GM Health and Social Care system is complex, with 37 different partner organisations, each with different strategic priorities and statutory responsibilities. Coupled with this is a considerable amount of transformation work that is already underway across GM to deliver the strategic plan. Yet there is currently no single way in which changes that impact on hospital based services can come together and be understood as part of a single direction of travel that all stakeholders are working towards. This has led to a lack of clarity about who should be doing what; duplication of tasking in the system; and understandable frustrations about how to navigate the governance at local, sector, and GM levels.

2.2. Our ambition is that all the work under Theme 3 impacting hospital based services is brought together and delivers under a single process. This process will have the involvement and engagement of all key stakeholders across the Greater Manchester Health & Social Care system at its core.

2.3. As previously described, we are not starting from scratch, and are able to build on existing work and decisions made. However, in order to achieve this ambition the following issues need to be addressed.

2.4. Issues to address

2.4.1. Clear strategic context and approach

There is a need to ensure that the strategic context within which Theme 3 sits is clearly described, including re-articulating the challenges set out in the strategic plan, what Theme 3 needs to achieve to address these challenges, and the implications of this for the system. There is also a need to clearly set out how we intend to do this (this paper).

2.4.2. Where Theme 3 fits and links to other themes

Since Taking Charge was published in December 2015, locality plans have been published, and much work has happened to define the priorities and work programmes of each of the Themes (population health and prevention; transformation of primary and community based care; transformation of clinical support and corporate functions; as well as the cross cutting work streams mental health, adult social care transformation etc.). There is a need now to describe this context and the connections between these pieces of work so that it is clear where Theme 3 and a hospital based services strategy fits.

2.4.3. The reconfiguration of A&E, Acute Medicine and General Surgery

The reconfiguration of A&E, Acute Medicine and General Surgery (Healthier Together) is an integral part of Theme 3 and there is a strong commitment to delivering the Healthier Together outcomes. The clinical case for change for Healthier Together is strong, and the programme has not only provided the basis for
devolved working across GM, but the single service model of care has laid the 
foundations for the development of new models of care within Theme 3, and 
provides a building block for the strategy. It is also recognised however that the 
changed environment requires that the reconfiguration of A&E, Acute Medicine and 
General Surgery is taken forward in a pragmatic manner which allows for a 
continued interaction with broader service reconfiguration plans so as to make 
Healthier Together more affordable. Theme 3 is placing a high priority on this 
through this work to develop the hospital based services strategy. A number of 
governance issues will also need to be resolved quickly in order to support progress 
on both Healthier Together and Theme 3, so that the two programmes are fully 
brought together. Activities in both now need to be unified through a single 
governance structure. The Theme 3 governance paper sets out how this will be 
done.

2.4.4. Range of services in Theme 3

The prioritisation of services under review by Theme 3 took place in August and 
September 2016. Since then questions have rightly been asked about connected 
services, and whether there are any gaps in what Theme 3 should cover. 
Considerations could include the ‘cornerstone’ services such as critical care, and 
diagnostics and services that have been already identified as Theme 3 priorities but 
were not part of ‘wave 1’ for example Ophthalmology and HIV. We propose that a 
full assessment of the gaps is undertaken as part of the early work on the strategy, 
and the range of services under Theme 3 may increase. A paper will be produced 
explaining any proposed changes.

2.4.5. Services outside of Theme 3

Hospital services are part of a dynamic system and business as usual must 
continue whilst the strategy is being developed. It is therefore critical that we 
understand what changes to services outside of Theme 3 are happening that will 
impact upon hospital services and vice versa. We also need to be really clear how 
and where decision making happens for such changes where a strategically 
significant impact on hospital services is anticipated. It is important that progress is 
not halted where this is required, but that changes are strategically aligned and 
contribute to the overall direction of travel. Work is underway to ensure that decision 
making and governance processes are clear so that short and medium term actions 
are consistent with the strategic direction of travel.

2.4.6. Links with other work

Theme 3 needs to interface closely with Themes 1, 2 and 4 so that developments 
and proposals emerging from these Themes are shared, and the implications for 
hospital based services can be understood and addressed.

2.4.7. Current technology capability of organisations and desired future state

Hospitals across GM have a wide range of digital maturity levels and capability to 
deliver digital transformation. Critical information flows will vary across GM from
paper processes through to electronic transfer of structured data. Any service redesign that impacts across multiple hospitals (or any organisation) will have an associated information flow. For high quality service redesign, this flow will need to be digital; sufficient; of high value (concise); and standardised. Future service capabilities will depend on further technological innovation, for instance, the ability to automatically detect deteriorating patients, the ability to guide clinical staff through standardised pathways and the ability to rapidly change a pathway and its adoption in response to new evidence. Digital technology can help reduce variation in standard processes and procedures, and there is an opportunity within Theme 3 to build such changes in at the design stage.

2.4.8. Workforce capability and capacity

Associated with service redesign and increasing digital maturity, it is important that the hospital workforce also has a strong digital capability.

2.4.9. Workforce Strategy

The emerging clinical strategy for hospital based services will articulate changes that will impact upon the workforce. At this stage, there is insufficient detail regarding care models and new service models to provide a clear understanding of the future workforce requirements. However, emerging locality workforce plans have started to develop on the shape of future workforce models and new ways of working to support the proposed changes.

The emerging GM Workforce Strategy will help identify workforce challenges and opportunities such as expanding and developing the GM workforce; developing and maximizing flexibility and inter-organisational mobility; introducing training and development programmes to support new ways of working and/or preparing the workforce for the future. Additionally, robust system leadership and organisational development programmes supported by excellent people management processes to support staff through changes will be critical to achieving success.

The establishment of a Workforce Reference Group involving key stakeholders including trade union colleagues and clear strategies to engage staff in the co-designing/co-creating the future workforce will be a vital part of the workforce programme necessary to support Theme 3.

3.0 PROPOSED APPROACH TO DEVELOPING A STRATEGY FOR HOSPITAL BASED SERVICES

3.1. Guiding principles

3.1.1. The approach we have developed to produce the strategy is underpinned by the following guiding principles, formed out of our learning so far:

- We build on existing good practice and approaches taken to date where we have this experience already within the system. Good examples of this include
the Single Hospital Service work led by Sir Jonathan Michael and Healthier Together. Further information on the learning from these programmes is in the appendix.

- **We take account of existing commitments** where service decisions have already been made and commitments have been given to the public.

- **We allow momentum to be maintained.** This could mean for example identifying and supporting ‘quick wins’ for implementation and investment that are clearly aligned to strategic direction alongside the development of the strategy.

- **We position acute change as part of locality plans** and recognise that while some hospital based services may need to operate on a GM footprint, our hospital services are fundamentally at the heart of the places in which the people of GM live and work – the 10 localities.

- **We operate in a ‘real world’ context** meaning that we must develop services that are ambitious, but we must recognise the constraints in which we are operating as our starting point: standards cannot be developed in isolation of questions of affordability, understanding the limitations of our workforce and maximising the use of our estate. Such constraints however can be seized as an opportunity to think differently and innovate.

- **We share our proposed approach with all stakeholders** so that everyone is clear how they can input into the process. This paper has been the starting point for this new way of working and a demonstration of how we intend to continue.

- **We take advantage of new and existing digital technologies** to maximise clinical benefits and patient experience while reducing costs. Digital information must be shared effectively to reduce duplication and improve quality. Digital pathways will guide users in appropriate care and alert them to deteriorating patients or actions that must be completed.

3.2. **Scope of the strategy**

3.2.1. The approach that we outline in the rest of this paper sets out the steps we believe are needed to produce a strategy for hospital based services.

3.2.2. The scope of the strategy will include all acute hospital sites and services; this includes the post-acute neuro-rehabilitation units. Acute mental health inpatient facilities will also need to be considered from an estates perspective as part of this work. This is illustrated on the map below:
3.3. Developing the Strategy – Hospital based services strategy framework

Set out below are the elements of work we believe are needed to produce a coherent strategy for hospital based services. Together these form a “framework”. Each element is explained in detail in the rest of the paper.

**Hospital based services strategy framework**

1. **Strategic context and the strategic intent for Theme 3**
2. **Reminder of the case for change, process to date, decisions taken, and progress so far (stock take)**
3. **Identification of any gaps**
4. **Design of Theme 3 services (specialty projects including existing priorities and any gaps identified)**
5. **Development of options for Theme 3 services**
6. **Construction of a commissioning strategy for hospital based services**
3.3.1. Strategic context, and the strategic intent for Theme 3

This is important to ensure that the strategic context of all of the Themes is properly understood and to describe and draw the connectivity between them in a way that everyone can understand: A separate paper will be produced, led by Warren Heppolette that will provide this context. The hospital based services strategy will link back to this overarching paper and will address where Theme 3 work fits, the strategic aims of Theme 3 and the success metrics against which Theme 3 will be measured.

3.3.2. Reminder of the case for change, process to date, decisions taken and progress so far (‘stock take’).

A piece of work will be undertaken to provide a ‘stock take’ of work to date. We propose that this is a paper that covers the following content in order to provide a firm foundation and understanding on which to base the next phases of work:

- A stock take of strategic decisions taken to date and progress in implementing these
- Outline existing site visions following from the reconfiguration of A&E, Acute Medicine and General Surgery (Healthier Together)
- A summary of the prioritisation process to used to identify current priority projects
- Progress with the current priority projects
- Exploration of working relationships with other themes and associated networks and groups
- Description of the emerging landscape
- Design principles developed and agreed by providers and commissioners.

3.3.3. Identification of gaps

Following on from the context paper and the stocktake, we will identify services that do not currently sit within Theme 3 but may need to be considered in order to complete the strategy work. We propose to identify the gaps; assess how these gaps should be considered by the programme; and incorporate any additional services into the design programme as required.

3.3.4. Design of Theme 3 priority services

This is the continuation of the design work already started on Theme 3 priority projects and any new work required from the assessment above. This design work will need to be completed (e.g. design of new models of care) so that strategic options can be developed. We propose that this work continues and completes late
2017. Providers and commissioners are developing a set of core design principles that will inform this work. These are set out in section 3.4.

3.3.5. Development of options for Theme 3 services

It is anticipated that following the completion of design work and new models of care a limited range of options will be identified that will need to be considered and assessed.

The culmination of this work will be the collation of options to understand the overall impact on hospital based services in GM.

3.3.6. The output from the process described above will be a GM wide commissioning strategy for hospital based services. The strategy will cover all services within Theme 3.

3.3.7. Enabler - Collaboration and engagement

A detailed collaboration and engagement plan will be developed, covering all members of the Partnership – providers, commissioners and local authorities – public, patients and carers, staff and politicians such that there is:

- Clarity on strategic intent
- Clarity on decisions already made and ‘anchor points’
- Meaningful input to key decisions
- Perspectives heard and responded to such that challenges are avoided
- Service users are appropriately informed, and have the opportunity to contribute appropriately and effectively as part of this process

3.3.8. Enabler - Governance and process

Governance and process will be reviewed, and a decision making framework produced to ensure:

- Decisions that are planned through this process can withstand challenge and are legally sound
- A record of engagement, assurance and decisions is kept such that should a challenge arise it can be robustly defended
- Compliance with regulatory assurance and other requirements
- Legal advice is sought where required.
- Further detail on this will be outlined in the governance paper.
3.4. **Commissioning priority principles**

3.4.1. The following priority principles have been developed following work completed by both the Provider Federation Board (see letter attached in appendix 4.6), and commissioners. We will use both to guide the development of the strategy:

- Creating a system that is capable of delivering consistent quality standards for all Greater Manchester patients, eliminating variation
- Meeting access expectations of local people and the NHS Constitution
- Delivering services at a population scale and geography that makes the best use of evidence and skilled workforce
- Creating an affordable, effective and financially sustainable system, that successfully reduces costs in the acute sector as planned in the GM Strategy. By, for example:
  - Providing care and support in the lowest intensity and lowest cost, clinically appropriate care setting, supporting patients to ‘choose wisely’
  - making best use of estates
  - ensuring consistency and reducing duplication
- Ensuring care in the most appropriate setting, and integration of physical, mental health and social care are supported through strong involvement with Local Care Organisations.

3.5. **How will we involve clinicians, patients and carers?**

3.5.1. Clinical and patient engagement is central to the approach outlined below. Our approach is based on a process of ‘co-design’ with both clinicians, patients and carers from the services concerned, and has been developed through our work on OG Cancer, and Healthier Together to develop a set of clinician and patient-designed deliverables that together will inform a future service specification and business case. This includes the development of a case for change, clinical and patient standards, a service access framework which describes all the service dependencies, a model of care, and resulting business case. Overall we will ensure that service users and the public are widely engaged with, appropriately informed, and have the opportunity to contribute appropriately and effectively as part of the process to develop the overall strategy.

3.5.2. In order for future decisions to stand up to scrutiny each element of the design needs to be developed and then overseen by an appropriate group. Clinical engagement is based around a wide and representative group of clinicians brought together from across Greater Manchester in a Design Oversight Forum. This will be the place where each of the design elements is developed and shared over the
course of a series of workshops. Independent clinical advice is sought in order to
test the clinical outputs from this group, while patients and carers who use the
service are engaged and involved in shaping proposals.

3.5.3. Once draft deliverables have been developed, oversight and assurance is required
from a number of different groups, including the Workforce Reference Group as a
key element of this change programme will be to engage the workforce in the
development of the new care models/services. Our approach is illustrated in
summary below, and will be outlined in full in a Clinical Approach Paper to be
developed by the Theme 3 Clinical Reference Group:

**Approach to clinical engagement and patient and carer involvement**

3.5.4. Involvement and participation of the population in decisions that affect them is at the
cornerstone of the NHS Constitution: Principle Four states that “the patient will be at
the heart of everything the NHS does”. Involvement is critically important in any
service redesign or service transformation due to the legislation in the Health Social
Care Act (2012) “Duty to promote involvement of each patient” and NHS England’s
Four Tests for Service Reconfiguration which include “strong public and patient
engagement. The graphic below illustrates the different levels of how the population
can be involved in every service transformation project.

*NHS England’s ladder of participation (Transformation Participation in Health and
Care Guidance, 2013):*
3.5.5. Our approach to the involvement of patients and carers in the design of services has been developed through the transformation process for OG and Urology cancer services under Theme 3. Patients and carers co-designed and developed a set of patient standards as part of a new service specification. This approach promoted the involvement of patients and carers; was endorsed by the GM Joint Health Overview and Scrutiny Committee and led to a more efficient, faster, and robust decision making process. This will be a core part of the design work on Theme 3 priority services.

3.5.6. For services to be truly patient-centred, patients and carers must be involved at the design and planning stage. Engagement and participation mechanisms will be used to listen to and involve patients and carers. This strengthens accountability to local communities and creates more patient-responsive services. It is also promotes transparency of decision making ensuring that changes to services focus on standards that are important to patients, and carers.

3.5.7. In this way commissioners are enabled to meet their statutory duties regarding population involvement and can confidently meet any legal challenge.

3.6. **What governance is needed to support the development of this strategy?**

3.6.1. Straightforward and transparent governance will be needed to support decision making on the strategy, oversee this work, and the different inputs to it. A separate paper outlines the proposed governance to support the strategy, and details how Healthier Together and Theme 3 can be brought together in a common governance structure.

3.7. **Timescales**

3.7.1. There is a significant amount of work involved to develop the strategy including the completion of the clinical design work, and the development of options for activity, workforce, finance and estates modelling. The outline timeline for the elements of the framework is proposed as follows over the next 18 months:
3.8. Who will deliver this?

3.8.1. The diagram below shows the key elements of work that will need to be resourced to deliver the Theme 3 programme. The first three elements – 1) Development of the Strategy Approach, 2) Development of clinical models for Theme 3 priorities and 3) Modelling of activity, estate, workforce and finance - should run in parallel and are then brought together and options developed. This work will be underpinned throughout by robust programme management.
3.8.2. It is important that each group are clear about their respective roles and responsibilities and this is set out in further detail below.

3.9. In house capability

3.9.1. We propose that the NHS Transformation Unit will continue to provide primary support to the GM Health and Social Care Partnership to deliver the requirements of Theme 3, working with colleagues across the Partnership, together with Provider Transformation Leads and Commissioners. This support will need to be supplemented by working with chosen external partners as well, where this expertise is not available within the GM Health and Social Care Partnership or the NHS.

3.10. Leadership

3.10.1. Overall leadership of the Theme 3 from the GM Health and Social Care Partnership will be provided by Sarah Price, Executive Lead for Commissioning and Population Health, and Diane Whittingham, Associate Lead for Theme 3.

3.11. Partners

3.11.1. A number of external partners will need to be appointed to support key elements of the Theme 3 work. We propose support will need to be secured in the following areas:

- Overall leadership
  - A credible experienced senior leader and clinician to act as advisor to Theme 3
Leadership, development and expert facilitation

- Clinical leadership:
  - Overall clinical lead for Theme 3
  - Clinical leads for Theme 3 priority projects (for which an appointment process is already underway, jointly led by Provider Transformation Leads and the GM Health and Social Care Partnership)

- Clinical assurance:
  - Independent clinical advice for clinical deliverables— in the past this has been sought via Royal Colleges, Senates and other national bodies
  - Assessment of clinical safety of options proposed – a partner would need to be sought (akin to National Clinical Advisory Team) in order to provide this assurance

- Development and deployment of a dynamic activity, estates, finance and workforce model- an external partner with significant experience in modelling work will be commissioned

- Legal advice for governance and decision making

- Procurement advice

- Financial assurance of deliverables

- Patient involvement and engagement – appointment of patient involvement and engagement facilitators to work with the NHS Transformation Unit lead to co-ordinate the alignment of existing resources (e.g. established patient groups), and to supplement this where necessary.

3.12. Links between Theme 3 and the Single Hospital Service

3.12.1. The GM Strategy for Hospital Based Services will provide the framework against which the City of Manchester Single Hospital Service will develop plans for the delivery of clinical services. This will include two specific areas of work; realisation of the benefits described in the Sir Jonathan Michael Reports and the benefits set out in the submission to the Competition and Markets Authority in support of the proposed merger of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust. Post-Merger Integration Plans necessary to enable the establishment of a new NHS Foundation Trust will embrace the principles set out in the GM Strategy for Hospital Based Services without compromising the inherent responsibilities of the Board of Directors to run the new organisation efficiently and safely in line with commissioning plans and regulatory requirements. In essence the Single Hospital
Service will cooperate fully with the design and delivery of the GM Strategy for Hospital Based Services for the benefit of Greater Manchester.

3.12.2. Given the significant scale of transformation required to deliver the Single Hospital Service, and the fact it will impact on 40% of acute service provision across Greater Manchester, collaborative effort between the GM team and the Single Hospital Service is seen as essential. Access to intelligence, data and clinical expertise will be a vital prerequisite to success. The Single Hospital Service is committed to this degree of partnership and will strive to work with the GM team and other stakeholders to avoid duplication and potentially contradictory strategic planning.

3.13. Links between Theme 3 and the Salford Royal and Pennine Group

3.13.1. Salford Royal has set out a clear strategy to develop a health and care Group, leveraging a ‘standard operating model’ to deliver safe and sustainable care across the north of Greater Manchester. The establishment of the Group model will enable the provision of high quality acute services and the development of Local Care Organisations, underpinned by a clear strategy, more rapid decision-making and effective partnership arrangements within each Locality. This is entirely consistent with focus of Theme 3 to deliver significant improvements in acute and specialist care through the consistent application of best practice, as well as the commitment in Theme 2 (the transformation of community based care) to develop Local Care Organisations across GM.

3.13.2. The first step in this journey started last year, with Salford Royal NHS Foundation Trust supporting the services provided by Pennine Acute, initially through a management contract. Significant work has been undertaken with commissioners in the North East sector to support stabilisation and improvement of services, which will provide the foundation for the transformation of acute care and the implementation of new models of care (consistent with Locality Plans).

3.13.3. Work is currently underway to develop an acute service strategy for the North East sector, which will be aligned to both Theme 3 and local commissioning intentions. This will complement the agreed programme of change that has been developed in the North West sector, with partners in Bolton and Wigan. This work builds on and supports the establishment of Healthier Together single services and the designation of Salford Royal and Royal Oldham as high acuity hubs, which provides the cornerstone for acute care reconfiguration. The Group’s standard operating model will be used to support the delivery of the GM Strategy for hospital based services and meet the requirements of local commissioners, with a focus on ensuring the provision of high quality, resilient acute and specialist services and supporting the provision of local integrated care arrangements. Salford Royal’s designation as a Centre of Global Digital Excellence will be used to support the application of digital solutions that transform the model of care, reduce variation and improve productivity. The Group will work in close partnership with the GM team to ensure this capability is leveraged across the city region.
3.14. **Success factors**

3.14.1. Achievement of the following will demonstrate the success of the strategy:

- Entire pathways are considered and care is delivered in the most appropriate setting
- Variation is minimized and improvement is seen across Greater Manchester
- Services are operationally deliverable and clinical services are coherent in that interdependencies are understood and managed
- Alignment of GM vision with locality and organisation vision such that all change is pulling in the same direction
- Stakeholders feel truly involved in the process and are able to offer meaningful input to decisions
- Ensuring that service users and the public are widely engaged with, appropriately informed, and have the opportunity to contribute appropriately and effectively as part of the process to develop the overall strategy.
- Governance and decision making processes are clear
- The implications for sites of new models of care are fully articulated and understood
- Change in the acute sector does not have unintended negative consequences in primary / community and vice versa
- Decisions are taken in timely manner whilst maintaining transparency such that implementation can be achieved as quickly as possible
- Estate is optimised and utilised.

3.14.2. Further detail on how we think these can be achieved is given in the appendix.
4.0 APPENDICES

4.1. Learning from the Single Hospital Service Review

4.1.1. Key features of the Single Hospital Service review are highlighted below:

- Key role played by Local Authority CEs and leaders in supporting programme as part of health and social care services as a whole
- Senior independent leadership
- Oversight from the SHS Review Steering Group and the SHS Clinical Advisory Group
- Full clinical stock take (long list of services) and selection of 8 exemplar services based on criteria: Duplicated service / Quality / Financial / Size of service line / Deliverability
- Large plenary sessions held with all clinicians (120+) to review the exemplar services, develop cases for change and collate all outputs
- Qualitative input to reviews sought through interviews with key stakeholders
- 2 reporting points where work brought together from the review, and communication to wider stakeholders at these key junctures.

4.2. Learning from Healthier Together

4.2.1. Key features from pre consultation, and from the decision making process are highlighted below:

- Partnership between locally elected politicians and NHS leaders allows change in the acute sector to be part of a coherent whole that makes sense to local places and the people who live there
- Series of clinical congresses held to develop the future model of care individual specialities, a Future Model of Care group to collate to a coherent model and a Clinical Reference Group to sign off
- Consultation clinically-led (clinical champions)
- Consultation delivered by a whole team managing logistics etc.
- Criteria for option appraisal developed in consultation with public and stakeholders
- Completion of NHSE Assurance processes including external clinical panel of nationally recognised clinicians to check safety of proposals
- Decision making plan and timescales agreed with the commissioners 9 months in advance of decisions and shared with all stakeholders

- All inputs to decision making overseen by a specific governance group e.g. quality assessment overseen by Clinical Advisory Group, Transport data analysis developed by Transport Advisory Group. All decisions of groups minuted

- All inputs to decision making shared in advance with commissioners to familiarise with the data sets (series of 7 workshops over 2 months)

- Robust and well documented processes, backed up through governance

- Workforce issues debated and discussed in conjunction with Trade Union colleagues leading to the development of jointly agreed protocols designed to support consistency of approach and application of people management arrangements.

4.3. How we agreed the current priorities

4.3.1. The steps taken to agree the current Theme 3 priorities are illustrated below, together with the clinical prioritisation matrix that was developed by clinical experts through the Theme 3 Clinical Reference Group in June 2016:
4.3.1.1. Clinical prioritisation matrix:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of criteria</td>
<td>Assessment of the opportunity to save lives e.g. through prevention, or addressing gaps in population health needs</td>
<td>Assessment of clinical variation between providers to understand where there is high variation and improvement required</td>
<td>Judgment of the CRG based on known risks</td>
<td>High-level estimate of financial opportunity</td>
</tr>
<tr>
<td>Proposed scoring</td>
<td>High/medium/low</td>
<td>High/medium/low</td>
<td>Binary value based on whether previous CRG meetings have highlighted service as an area of concern</td>
<td>High/medium/low</td>
</tr>
<tr>
<td></td>
<td>High = Service gap identified and immediate opportunity to improve outcomes</td>
<td>High = High variation across GM and below average performance</td>
<td></td>
<td>High = largest financial opportunity when ranked</td>
</tr>
<tr>
<td></td>
<td>Low = Excellent outcomes already</td>
<td>Low = Low variation across GM and above average performance</td>
<td></td>
<td>Low = smallest financial opportunity when ranked</td>
</tr>
<tr>
<td>Key inputs</td>
<td>Right Care data (data does not directly align with service lines and gaps exist, but included to inform discussion)</td>
<td>Standardised HED data for: hospital mortality; readmissions; long length of stay</td>
<td>Minutes from previous CRG meetings</td>
<td>Provisional estimate based on Better care Better Value efficiencies and Carter review findings</td>
</tr>
</tbody>
</table>

4.3.1.2. Strategy RACI matrix

<table>
<thead>
<tr>
<th>Key strands of work</th>
<th>Theme 3 CCG</th>
<th>Theme 3 #CC</th>
<th>Patient user group</th>
<th>Portfolio Board</th>
<th>SP / E</th>
<th>PRB</th>
<th>AEG</th>
<th>ICB / E</th>
<th>GM Estates</th>
<th>FIG</th>
<th>Trust Boards</th>
<th>CCG Boards</th>
<th>SCDC</th>
<th>Lead / Project</th>
<th>Provider teams</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Identification of any gaps in current work*</td>
<td>A</td>
<td>R</td>
<td>R</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>C</td>
<td>R</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Strategic context</td>
<td>A/R</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
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<td>I</td>
<td></td>
</tr>
<tr>
<td>Stocktake</td>
<td>A/R</td>
<td>I</td>
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<td>I</td>
<td>I</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Current vision for each site</td>
<td>A</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>R</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Estates baseline</td>
<td>R</td>
<td>I</td>
<td>R</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>A</td>
<td>C</td>
<td>R</td>
<td>C</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Develop Decision Making Framework</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>I</td>
<td>C</td>
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<td>C</td>
<td>C</td>
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<td></td>
</tr>
<tr>
<td>Develop dynamic estates model</td>
<td>R</td>
<td>I</td>
<td>A</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>C</td>
<td>C</td>
<td>R</td>
<td>C</td>
<td>R</td>
<td>C</td>
<td>C</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>Project design Inc. gaps identified</td>
<td>A</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>R*</td>
<td>R</td>
<td></td>
</tr>
<tr>
<td>Articulation of end vision</td>
<td>A</td>
<td>R</td>
<td>R</td>
<td>C</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>C</td>
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</tr>
</tbody>
</table>

A – Accountable  
R – Responsible  
C – Consulted  
I – Informed

* Specialised services projects only
4.4. How success factors will be achieved

<table>
<thead>
<tr>
<th>Success Factors</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarity and transparency of process, responsibility and criteria for decision</td>
<td>Approach paper sets out process and responsibilities, decision making framework developed via consultation with key groups and shared</td>
</tr>
<tr>
<td>making</td>
<td></td>
</tr>
<tr>
<td>Stakeholders including services users and the public are widely involved in the</td>
<td>Comms plan with each stakeholder group throughout the process, stakeholders are consulted on key elements of strategy</td>
</tr>
<tr>
<td>process and are able to meaningful input to decisions – challenge is avoided</td>
<td></td>
</tr>
<tr>
<td>Clarity of proposal – which services are proposed to be delivered on which</td>
<td>End vision articulates clearly what services are delivered where – tested with stakeholders to ensure clarity</td>
</tr>
<tr>
<td>footprint, which services are to be delivered on which site, what is meant by</td>
<td></td>
</tr>
<tr>
<td>‘single service’, ‘lead provider’ etc.</td>
<td></td>
</tr>
<tr>
<td>Alignment of Greater Manchester vision with locality and organisation vision</td>
<td>Strategic intent and decisions to date communicated. Current site visions used to test alignment of thinking</td>
</tr>
<tr>
<td>such that all change is pulling in the same direction</td>
<td></td>
</tr>
<tr>
<td>Services are operationally deliverable, affordable, and clinical services are</td>
<td>CRG to oversee work to determine interdependencies and offer on each site</td>
</tr>
<tr>
<td>coherent in that interdependencies are understood and managed</td>
<td></td>
</tr>
<tr>
<td>Estate is optimised and utilised</td>
<td>Dynamic estates modelling to ensure best estates solution determined</td>
</tr>
<tr>
<td>Variation is minimized and improvement is seen across Greater Manchester</td>
<td>Best practice used to determine standards and model. Monitoring through implementation</td>
</tr>
<tr>
<td>Entire pathways are considered and care is delivered in the most appropriate</td>
<td>Included in 1) Assessment of speciality models and 2) Decision making criteria</td>
</tr>
<tr>
<td>setting</td>
<td></td>
</tr>
<tr>
<td>Change in the acute sector does not have unintended negative consequences</td>
<td>Included in 1) Assessment of speciality models and 2) Decision making criteria</td>
</tr>
<tr>
<td>in primary / community and vice versa</td>
<td></td>
</tr>
<tr>
<td>Decisions are taken in timely manner such that implementation can be achieved</td>
<td>Decision making process clearly set out at start as well as decision making timetable</td>
</tr>
<tr>
<td>as quickly as possible</td>
<td></td>
</tr>
<tr>
<td>Should a challenge to changes proposed arise it is robustly defended</td>
<td>Robust governance, record keeping and audit of involvement/legal advice throughout.</td>
</tr>
</tbody>
</table>

4.5. Provider Federation Board principles can be viewed at this [Link](#).

4.6. Stakeholders engaged to develop the strategy approach

The table below lists all of the individual stakeholders who we have also engaged with to develop the approach for the strategy:

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Organisation</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew Foster</td>
<td>Chief Executive, Wrightington Wigan and Leigh NHS Foundation Trust</td>
<td>14th March 2017</td>
</tr>
<tr>
<td>Ann Barnes</td>
<td>Chief Executive, Stockport NHS Foundation Trust</td>
<td>8th March 2017</td>
</tr>
<tr>
<td>Ann Gibbs</td>
<td>NHS Improvement</td>
<td>21st February 2017</td>
</tr>
<tr>
<td>Anthony Hassall</td>
<td>Chief Officer, NHS Salford Clinical Commissioning Group</td>
<td>16th February 2017</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Date</td>
</tr>
<tr>
<td>-----------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Bev Humphrey</td>
<td>Chief Executive, Greater Manchester West Mental Health NHS Foundation Trust</td>
<td>22nd March 2017</td>
</tr>
<tr>
<td>Donna Hall</td>
<td>Chief Executive Wigan Council</td>
<td>15th May 2017</td>
</tr>
<tr>
<td>Darren Banks</td>
<td>Director of Strategy, Central Manchester University Hospitals NHS Foundation Trust</td>
<td>14th February 2017</td>
</tr>
<tr>
<td>Ian Williamson</td>
<td>Chief Officer, NHS Central Manchester Clinical Commissioning Group</td>
<td>14th March 2017</td>
</tr>
<tr>
<td>Jackie Bene</td>
<td>Chief Executive, Bolton NHS Foundation Trust</td>
<td>1st March 2017</td>
</tr>
<tr>
<td>John Wilbraham</td>
<td>Chief Executive, East Cheshire NHS Trust</td>
<td>1st March 2017</td>
</tr>
<tr>
<td>Jon Rouse</td>
<td>Chief Officer, GM Health and Social Care Partnership</td>
<td>13th February 2017</td>
</tr>
<tr>
<td>Karen James</td>
<td>Chief Executive, Tameside &amp; Glossop Integrated Care NHS Foundation Trust</td>
<td>21st March 2017</td>
</tr>
<tr>
<td>Mike Deegan</td>
<td>Chief Executive, Central Manchester University Hospitals NHS Foundation Trust</td>
<td>8th February 2017</td>
</tr>
<tr>
<td>Nicky O'Connor</td>
<td>Chief Operating Officer, GM Health and Social Care Partnership</td>
<td>13th February 2017</td>
</tr>
<tr>
<td>Ranjit Gill</td>
<td>Chair, NHS Stockport Clinical Commissioning Group</td>
<td>23rd March 2017</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Date</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Richard Jones</td>
<td>Executive Director for Adult Social Care, GM Health and Social Care Partnership</td>
<td>21&lt;sup&gt;st&lt;/sup&gt; February 2017</td>
</tr>
<tr>
<td>Kiran Patel</td>
<td>Chair, NHS Bolton Clinical Commissioning Group</td>
<td>27&lt;sup&gt;th&lt;/sup&gt; March 2017</td>
</tr>
<tr>
<td>Dr Richard Preece</td>
<td>Executive Lead for Quality, GM Health and Social Care Partnership</td>
<td>13&lt;sup&gt;th&lt;/sup&gt; February 2017</td>
</tr>
<tr>
<td>Sarah Price</td>
<td>Executive Lead for Commissioning and Population Health, GM Health and Social Care Partnership</td>
<td>6&lt;sup&gt;th&lt;/sup&gt; March 2017</td>
</tr>
<tr>
<td>Roger Spencer</td>
<td>Chief Executive, The Christie NHS Foundation Trust</td>
<td>22&lt;sup&gt;nd&lt;/sup&gt; March 2017</td>
</tr>
<tr>
<td>Silas Nichols</td>
<td>Chief Executive, University Hospital of South Manchester NHS Foundation Trust</td>
<td>8&lt;sup&gt;th&lt;/sup&gt; March 2017</td>
</tr>
<tr>
<td>Sir David Dalton</td>
<td>Chief Executive, Salford Royal NHS Foundation Trust and Pennine Acute Hospitals NHS Trust</td>
<td>27&lt;sup&gt;th&lt;/sup&gt; February 2017</td>
</tr>
<tr>
<td>Steve Wilson</td>
<td>Executive Lead for Finance and Investment, GM Health and Social Care Partnership</td>
<td>13&lt;sup&gt;th&lt;/sup&gt; February 2017</td>
</tr>
<tr>
<td>Steven Pleasant</td>
<td>Chief Executive, Tameside Metropolitan Borough Council</td>
<td>10&lt;sup&gt;th&lt;/sup&gt; May 2017</td>
</tr>
<tr>
<td>Su Long</td>
<td>Chief Officer, NHS Bolton Clinical Commissioning Group</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; March 2017</td>
</tr>
<tr>
<td>Dr Tracey Vell</td>
<td>Associate Lead in Primary and Community Care, GM Health and Social Care Partnership</td>
<td>31&lt;sup&gt;st&lt;/sup&gt; January 2017</td>
</tr>
</tbody>
</table>
5.0 RECOMMENDATIONS

5.1. The Strategic Partnership Board is asked to:

- Approve the approach described above to develop a hospital based services strategy
- Note the additional documentation to follow.