Main paper

Complex Services Pennine Acute Disaggregation

1 Background

In 2021, Manchester Foundation Trust (MFT) acquired the North Manchester General Hospital (NMGH) site, and Salford Royal Foundation Trust (SRFT) acquired the remaining sites of PAHT, creating the Northern Care Alliance FT (NCA). Since then, due to the way in which digital systems and clinical rotas operate, there are some services that operate across the two providers that have not yet been 'disaggregated'. This means that the services still need to be split between the two organisations using an agreed set of principles: including splitting of the workforce, budget and waiting lists. In September 2022 the first phase of cmplex services were disaggregated (Fetal Medicine, Clinical Haematology and Sleep Services), these were considered by Scrutiny Committees in July 2022. A second phase (Cardiology, Gastronterology, Rheumatology and Urology (6 low volume pathways)) will be disaggregated in September 2023. Scrutiny Committees considered these proposals in January 2023.. The final phase of dissagregation is due to take place between January 2024 and March 2024 and includes Dexa (bone density) scanning, Ear, Nose & Throat (ENT), Trauma & Orthopaedics (T&O) and Urology. This paper concerns this final phase, and in particular scrutiny's approval of the substantial variation assessments that have been developed to assess the scale of impact of these changes.

2 Recommendations

Oldham Scrutiny Committee is asked to receive the report updating on the progress to disaggregate services from PAHT between the NCA and MFT, and to support the substantial variation assessments for the four services which recommend that these changes do not constitute a substantial variation.

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3 Introduction and Purpose

This document provides an update regarding the dissolution of the former Pennine Acute Hospitals Trust (PAHT) and re-provision of services by both Manchester University NHS Foundation Trust (MFT) and the remainder of the PAHT sites into the Northern Care Alliance (NCA). In particular, planned service changes in the context of previously agreed decisions taken in Greater Manchester to disaggregate services from the legacy PAHT and integrate North Manchester General Hospital (NMGH) into MFT and the remainder of the PAHT sites into the NCA.

The paper provides the following:

- A reminder about the background to the acquisition of the Pennine Acute Hospitals Trust
- An overview of the disaggregation approach and context of complex services
- An overview of the engagement undertaken with patients to gain feedback and insights to inform these plans
- The likely impact on Oldham patients
- A summary of the substantial variation assessment for each specialty

3.1 Strategic Context to the Pennine Acute Transaction

In January 2016, healthcare partner organisations in Manchester commissioned an independent review of the disposition and organisation of hospital services. This review concluded that the most effective route to achieve clinical, safety and efficiency benefits was to create a single hospital trust for Manchester. The findings of the report were endorsed by all the participating organisations.

At the same time, PAHT was facing significant challenges. Following many years of financial difficulties, a CQC inspection identified material problems with standards of care, and in August 2016 the Trust was rated as Inadequate. The NHS Improvement regional team undertook an option appraisal in respect of the long-term future of PAHT, and this concluded that the preferred option was for NMGH to be acquired by MFT, and for the other PAHT sites to be acquired by SRFT. MFT formally acquired the NMGH site and services through a commercial transaction on 1 April 2021, and SRFT acquired the remaining elements of PAHT through a statutory transaction on 1 October 2021 and became the Northern Care Alliance (NCA).

MFT and the NCA developed business cases to support the acquisitions, and these recognised the potential to deliver benefits through integrating former PAHT clinical teams into larger single services operating across the Manchester and NCA footprints respectively. However, both business cases also identified the significant legacy challenges in the former PAHT services, particularly in relation to financial sustainability and the need to invest in infrastructure (including Estate and Digital).

In its 15 years of independent operation there was some significant integration of services across the PAHT sites. The process of disaggregating these is therefore complex. MFT and the NCA have strong post-transaction joint working arrangements with significant progress-to-date and are continuing to work through these structures to agree the most appropriate timing and approach for disaggregation of these complex service arrangements.

NCA and MFT are progressing their plans for investment in the former PAHT sites and services, including new and improved buildings, equipment and information systems. On digital investment, MFT successfully rolled out the new electronic patient record (EPR) across the Trust (including NMGH) in September 2022.

3.2 Overview of disaggregation

At the time of the transaction, it was agreed to minimise any changes in clinical/patient pathways for 'Day 1' as a means of ensuring a safe and smooth transition. To support this agreement, a series of Service Level Agreement (SLA) arrangements were put in place to oversee the delivery of patient pathways across the North Manchester, Bury, Oldham and Rochdale hospital sites. However, both MFT and the NCA agreed that these SLA arrangements should be gradually wound down and accompanied by the sustainable integration of NMGH services into MFT and Bury/Oldham/Rochdale services into the NCA. This process is often referred to as the 'disaggregation' of legacy PAHT services and has been ongoing since the transactions were completed in 2021.

The process of disaggregation has required significant collaboration and co-operation between NCA and MFT. It has involved splitting services between the two organisations using an agreed set of principles. This includes separating of the workforce, budget and waiting lists and is a complex and wide-ranging piece of work that has implications across a variety of areas including IM&T, finance and governance. The work to disaggregate services must be handled carefully and with due regard to minimising the impact on patients, and staff. The initial work to disaggregate services was overseen by the legacy PAHT Board and was also evaluated by NHSEI as part of the Transaction Review process.

For each specialty or pathway that is being disaggregated, a working group of clinical experts in that specialty is convened to review the current service and develop the best clinical model, whilst a range of information including patient feedback, clinical outcomes and equality analysis is analysed to understand which options will deliver the best model for patients.

3.3 Progress of disaggregation: phases one and two

At the time of the transactions, approximately ninety SLA arrangements were in place across a range of clinical and corporate areas. Now more than half of these arrangements have been stood down. The SLAs that have been concluded to date represent the most straightforward disaggregation processes that have impacted low numbers of staff and have not required any changes to patient pathways.

In the main, service provision remains the same however there will be some elements of service change to ensure alignment of services to each respective organisation. Furthermore, in the majority of cases services will be provided within both the NCA and MFT offering patients the choice of which service to access.

Since summer 2022 NCA and MFT have been developing plans for the disagregation of 'complex services'. These are services that will potentially require a change in location or change in patient flows. As such, there has been strong engagement and early discussions with all relevant commissioners / localities[1] through a series of large-scale meetings and close working with all partners to ensure a collaborative approach to developing service change proposals. A group established of lead commissioners from each Locality, chaired by the nominated GM ICB lead Mike Barker (Place Based Lead for Oldham) has overseen MFT and NCA's development of this work.

In September 2022, the first phase of complex services was dissagregated; Clinical Haematology, Sleep services and Foetal Medicine pathways. This was prior to 'go live' of MFT's new electronic patient record system EPIC.

The second phase of changes, will come into effect in September 2023 and includes some Cardiology, Gastroenterology, Rheumatology and Urology pathways. These changes were considered by the HMR locality Board in February 2023 and followed the agreed GM Service

[1] Manchester, Bury, HMR, Oldham, Trafford, Salford and Specialist Commissioning

Change Framework – see appendix 1. MFT and NCA are working closely to develop safe transition plans for this next phase of changes, as well as working closely with Localities to ensure that GPs and referrers are aware of the new options and changes to pathways.

3.4 Which services are affected in phase three?

The final phase three complex service changes are planned to be implemented between January and March 2024 and affect the following specialties;

- DEXA or bone density scanning
- Ear, nose and throat (ENT) pathways
- Inpatient Urology
- Trauma & Orthopaedic surgical pathways

The integration of these services into MFT and NCA single services respectively, maximises the opportunity to realise the benefits envisaged in the organisational restructuring of PAHT as determined by NHS Improvement. Moreover, it delivers safe and clinically sustainable services for the populations of Bury, Oldham, Rochdale and North Manchester.

For each service or clinical pathway, as with earlier phases, the following steps have been taken:

1. Clinical review
2. Patient engagement
3. Equality Impact Assessment
4. Travel analysis
5. Quality Impact Assessment

A joint working group of clinicians is established to oversee development and agreement of clinical models. This group works jointly to understand the options for safely integrating or re-providing services within MFT and NCA and develop proposals which support the following;

- ✓ Quality and safety
- ✓ Health inequalities
- ✓ Efficiency - reduction in waiting times as well as being delivered within existing costs
- ✓ Patient experience
- ✓ Deliverability e.g., we have the right workforce
- ✓ Travel and access for the population
- ✓ Strategic fit e.g., alignment with any wider clinical decisions such as GM Cardiac pathways

From this, detailed service change proposals have been developed. Patient engagement is then undertaken alongside equality impact analysis,travel analysis and quality impact assessment.

A detailed travel analysis has been undertaken to understand the impact of the proposed changes on the populations affected. This considers the impact for residents living in the affected catchment area on journey times by car and public transport (including bus, tram and a combination of the two). The analysis also includes an assessment of the costs of travel. This has been used to inform the completion of the ‘Substantial Variation Assessments’

A range of patient engagement approaches have been used including review of existing feedback on the services affected, as well as bespoke surveys and engagement events. These have included questionnaires or surveys in an outpatient setting, deliberative events and engagement with existing patient forums such as Healthwatch and locality patients groups where they are in place. Where appropriate deliberative events have been undertaken to understand more about how any potential changes to pathways should be made, and to consider mitigating actions MFT or NCA should make. This work has also been assured by the Greater Manchester Integrated Care System via their engagement team and considered by the GM Engagement and Inclusion Assurance Group (EIAG).

Table 1 Summary of engagement activities and themes

Engagement activity	Service changes	Summary	How has this informed the proposals
Outpatient setting surveys	ENT Urology T&O	~300 surveys completed in 8 different outpatient clinics. These have shown that most patients arrive for their care by car. These have also shown patient views on the impact of travelling to other sites.	For urology, patients expressed a preference for travelling to MRI over Wythenshawe. This has informed the selection of MRI as the preferred option.
Deliberative events	T&O	Two deliberative events held with a total of 13 attendees. Over 400 former patients invited to attend. These events demonstrated a preference for activity to be delivered at NMGH where possible. Patients who live near NMGH gave examples of travelling to Fairfield General and Rochdale Infirmary multiple times during their pathway.	T&O – the proposed model is to provide as much of the pathway at the local hospital as possible with only limited elements (elective surgery) to be provided at a dedicated elective hub.
Healthwatch feedback	DEXA ENT Urology T&O	Manchester, Trafford, Salford, Bury, Rochdale and Oldham Healthwatch met. Healthwatch groups recognised the case for change and welcomed the proposals and welcomed the planned patient engagement. Feedback from Rochdale Healthwatch suggested improvements to letters sent to patients in advance of Phase 1 changes.	Letters to be sent to patients for Phase 2 will be updated in light of feedback from Rochdale Healthwatch.
Manchester Patient & Public Advisory Group	DEXA ENT Urology T&O	The group understood the challenge of delivering services across IT systems and recognised the case for disaggregation to avoid this. The group felt that support should be offered for patients with travel and travel costs. The group identified concerns about patients travelling by public transport who need to arrive for surgery very early in the morning.	Options to support patients with travel and travel costs will be reiterated with GPs and Booking Teams in advance of the changes so these can be promoted to patients. MFT have confirmed that where appropriate later start times can be accommodated for patients travelling by public transport.

The feedback obtained through these routes will be used to inform how the planned changes will be implemented.

The table below summarises the current and future plans for each area. An accompanying slide pack is also provided to explain the changes in more detail. The changes impact the NMGH catchment area. This includes residents living in wards in Salford, Bury, Rochdale, Oldham and Manchester (see appendix 2 for NMGH catchment map).

In line with the Service Change Framework agreed by the Greater Manchester Integrated Care Board (GM ICB), for each area an assessment of whether the new pathways constitute 'substantial variation'. See appendix 1 for the Service Change Framework and appendix 3 for each 'Subtantial Variation Assessment'.

Table 2 Summary of phase three services and future plans.

Specialty	Current and future services	Substantial Variation Assessment
DEXA: This is a test that measures bone density (strength). Results provide helpful details about a patient's risk for osteoporosis (bone loss) and fractures (bone breaks)	**Current services** • Patients who receive care at NMGH and need a DEXA scan as part of their diagnosis must currently travel to Royal Oldham Hospital for their scan. Note this affects consultant referred DEXA scanning only. **Future services** the above refernced NCA service at Oldham remains, but in addition; • To make a change to current patient pathway so North Manchester residents access bone density DEXA scans at Manchester Royal Infirmary (Manchester University NHS Foundation Trust), rather than Royal Oldham Hospital (Northern Care Alliance NHS Foundation Trust).	It is recommended that this **change does not constitute substantial variation** because it affects a limited number of patients and travel and access is similar or better for most of the population.
ENT: These services deal with conditions affecting the ears, nose or throat. These can include hearing, dizziness or balance problems, conditions affecting the voice, breathing or swallowing, ear/sinus infections and tonsillitis, injuries to the nose, or cancers of the mouth or throat	**Current services** North Manchester catchment currently receive ENT services from NCA clinicians based at: • Fairfield General Hospital (FGH) for inpatient and day case care for adults • Royal Oldham Hospital (ROH) for inpatient and day case care for children • Outpatient clinics are provided by NCA clinicians at NMGH **Future services** • Above NCA services remain, but in addition; • MFT to take on delivery of ENT services for the NMGH catchment population • For adults, provide 23-hour inpatient, day case and outpatient services at NMGH • For children, provide day case and outpatient services at NMGH, with overnight stay services at Royal	It is recommended that this **change does not constitute substantial variation** because it increases choice for patients by creating a new service at NMGH. Patients will now be able to choose to access existing services at Fairfield General Hospital and Royal Oldham as well as NMGH. For the NMGH catchment this represents services closer to home.

	Manchester Children's Hospital	
Trauma and orthopaedics: These services are concerned with the diagnosis and treatment of conditions of the musculoskeletal system including bones and joints and structures that enable movement such as ligaments, tendons, muscles and nerves.	**Current services** National guidance and best practice recommends that trauma (emergency) and planned T&O surgery is delivered in separate surgical hubs. This has been shown to reduce waiting times and improve outcomes. The PAHT service model was to run two services as follows: • Royal Oldham Hospital (trauma) and Rochdale Infirmary (planned surgery) provide care for Oldham and Rochdale residents • NMGH (trauma) and Fairfield General Hospital (planned surgery) providing care for the NMGH catchment and Bury populations **Future services** NMGH and the patient flows for this catchment will come under MFT. The MFT elective hub is at Trafford General Hospital. Therefore North Manchester residents needing planned T&O surgery will attend this hub. All outpatients, diagnostics and follow up care will be provided at NMGH, residents would only need to travel to the hub for their surgery. FGH catchment residents will now access trauma care at the hub at Royal Oldham for inpatient trauma and at Rochdale Infirmary for ambulatory care. This means patients who attend FGH A&E with a T&O emergency will no longer be transferred to NMGH and instead be transferred to Oldham.	Elective orthopaedic care affecting the NMGH catchment population. It is recommended that this **change does not constitute substantial variation** because patients will be able to choose whether to access their care at either the elective hub at Fairfield General Hospital as they do now or at the MFT elective hub at Trafford General Hospital. Parts of the catchment are closer to Fairfield General Hospital and others are closer to Trafford General Hospital. Trauma care affecting the Fairfield General Hospital catchment population – travel analysis shows that Royal Oldham is closer for the Rochdale population but further for some part of the Bury population.
Urology: part of health care that deals with diseases of the male and female kidneys, bladder, and prostate.	**Current services** NMGH is the inpatient Urology site for the whole of PAHT. Outpatients and other aspects of the service are provided across the PAHT sites. MFT and the NCA propose that urology services fully separate in Jan 2024. **Future services** The NCA have previously proposed and agreed the following model to commissioners: • Bury residents will receive inpatient care at Salford Royal Hospital • Rochdale and Oldham residents will receive inpatient care at ROH	It is recommended that this **change does not constitute substantial variation** because it affects a limited number of patients and 95% of current activity will remain as it is now at NMGH. Of the patients affected, a proportion are elective patients who can choose to have their care at either Royal Oldham Hospital or Manchester Royal Infirmary.

	For the North Manchester catchment • NMGH will provide local care including outpatients, investigations, day case and short stay low complexity surgery (95% of current patient care) • Robust on call arrangements will ensure safe care for emergency patients A small number of patients having complex planned surgery (~150) and patients needing an emergency admission (~550) will have this care at the specialist hub at MRI.	

4. What does this mean for the Oldham population?

For the Oldham population, the majority of patients access their care at The Royal Oldham Hospital, part of the NCA. For some day case surgery they are seen at Rochdale Infirmary, and for some surgery and other investigations, such as cardiological treatments, they are seen at Fairfield General Hospital, also part of NCA.

A small number of the Oldham population on the border with Manchester access services at North Manchester General. Patients who are referred to a clinic at North Manchester General will be under the care of MFT and therefore some diagnostics or surgery required as part of their treatment may include services at other MFT sites, including Manchester Royal Infirmary. The changes being made will not affect where patients access outpatient clinics, but will affect where any follow on care as part of that pathway is delivered.

Table 3

Specialty/service	Estimated number of Oldham population affected
DEXA	~40 (10% of 420 affected)
ENT	~895 (10% of 8,950 affected)*
Trauma and Orthopeadics - Planned surgery	~150 (10% of 1,500 affected)*
- Emergency surgery (~650 people)	<10 (1% of 655 affected)
Urology	~70 (10% of 700 affected)

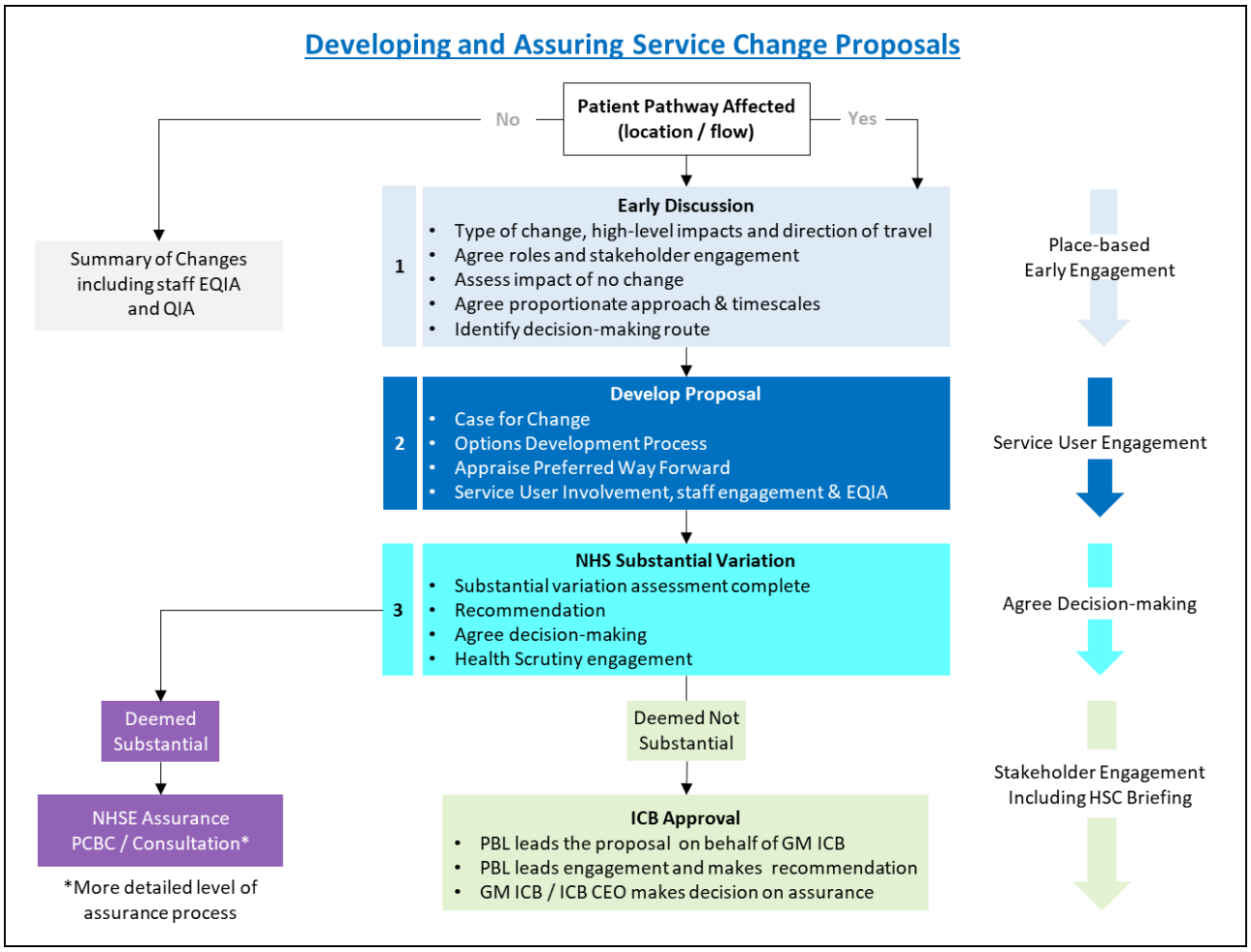
*This represents a proportion of the current patients. When implemented, Oldham residents may choose to have their elective orthopaedic / ENT care at Fairfield General / Royal Oldham and as such this figure may be lower.

5. Next steps and recommendation

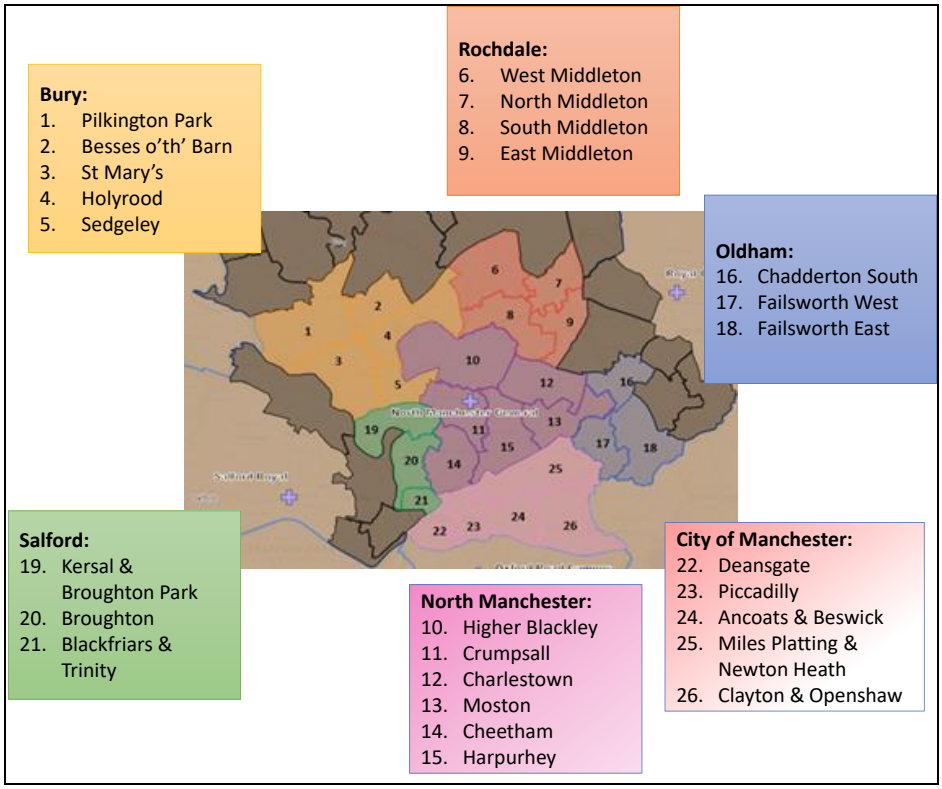
The preceding sections describe the background, progress to date and latest stages of disaggregation in order to provide Scrutiny with an overview of the phase three service changes and their impact. Further detail is available on request, however all of the above activities and developments have been overseen by a nominated group which includes representation from the Oldham locality

The Health Scrutiny committee is asked to endorse the assessment made by the sponsoring group that none of the changes identified in phase 3 constitute a ‘substantial variation’.

Appendix 1: Service Change Framework for GM ICB



Appendix 2: NMGH Catchment map



Appendix 3: Substantial Variation Assessments

Service Change Proposal for DEXA Scans

The proposal is that the management and provision of consultant referred bone density (DEXA) scans for NMGH and its catchment population should be transferred from the Northern Care Alliance NHS FT (NCA) to Manchester University NHS FT (MFT) and be provided at the Manchester Royal Infirmary (MRI) site.

DEXA scans are not provided at the NMGH site and at present, patients from the NMGH catchment area who are referred by NMGH consultants travel to Royal Oldham Hospital (ROH) for this scan. Common referring specialties are rheumatology, breast, orthopaedics and elderly care. Patients often receive the rest of their care at NMGH but must travel to ROH for this specific diagnostic test. This means that most of the patient care is delivered in the MFT EPR "Hive", but these specific tests are provided for under NCA systems. There is a risk that information is lost when transferring information between MFT and NCA systems. This proposed change would bring all aspects of patient care for this cohort into MFT systems.

Substantial variation assessment:

Domain		
Patient Population Affected	• The patient population affected is the NMGH catchment for the outpatient DEXA scan service. • The population affected is largely those patients resident in North Manchester. • Currently residents in this area travel to ROH for this scan, it is proposed that this will be provided at MRI. • Based on historic activity patterns the change of location will affect approximately 420 patients per year (Manchester ~230, Bury ~60, Rochdale ~40, Oldham ~40 and Salford ~40 per year based on historic activity. • Patient choice will be maintained or improved. • Overall capacity will be maintained.	Not Substantial Variation
Access	• A full travel analysis has been completed for the affected population. • Currently residents in this area travel to ROH for this scan, it is proposed that this will be provided at MRI. • Public transport times are improved for most residents in the NMGH catchment area when comparing travel to MRI compared to ROH. Some residents in the east of the catchment area will experience increased journey times. Similarly, car journey times are improved for residents in the east and south of the catchment with residents in the west experiencing longer journey times.	Not Substantial Variation

Domain		
Type / Rationale for proposed service change	• The change forms a part of strategic plans to integrate NMGH into MFT to maximise the benefits of single services. The strategic approach has previously been agreed through a robust and rigorous process, with this proposal being one of several changes to achieve the previously agreed vision for a single hospital service for Manchester. • The implementation of the Hive Electronic Patient Record (EPR) system at NMGH has further necessitated the changes as the service currently navigates the complexities of working across two separate digital environments. This involves access to more than one system with increased potential for human error. • The proposal is a partial change to existing service provision with local access retained. There is no change to the service for patients from the Bury, HMR and Oldham locality catchments and an equivalent service provision for NMGH catchment patients.	Not Substantial Variation
Wider community & other services	• Limited/no impact on co-dependent services. • The proposal forms part of large-scale plans to deliver patient benefits through the creation of single services within a single hospital trust for Manchester. Benefits include the use of the new electronic patient record system across every MFT site and close digital integration with primary care. • There are no wider community impacts. • There is no adverse impact on health inequalities as current service provision will be maintained.	Not Substantial Variation
NHSE Four Tests & Stakeholder Views	• Support from clinical commissioners to be progressed alongside the development of plans. • Proposal supported by key stakeholders and will be further progressed alongside the development of plans. • Strong consultant staff engagement, input and support. • Communication with patients will explain the changes and offer the opportunity for further engagement. However, as patients are expected to receive care at their current location, and remain under their current Consultant, it is not intended to undertake an active Patient Choice exercise.	Not Substantial Variation

Recommendation:

It is recommended that the service change proposals for Dexa scanning **does not constitute substantial variation** and that decision-making on the assurance of the change proposal should be taken through the Greater Manchester Integrated Care Board.
Key aspects of the rationale for this recommendation include:

- This change represents a small number of patients who already travel for this specific diagnostic test.
- This proposed change means an improvement in journey times for most of the catchment population.

Service Change Proposal - ENT

Electively, the ENT service for NMGH catchment residents includes outpatients (at NMGH and FGH), day case and inpatient elective care (FGH for adults, ROH for children). ENT cancer surgery is undertaken at MRI. Non-elective ENT presentations at NMGH for adults are treated on site (in the limited cases when immediate surgery is required) or transferred to FGH for adults or transferred to ROH for children.

ENT is typically a core service of a District General Hospital, however, there has not been a full ENT offer at NMGH for some time. This means that some NMGH catchment residents may need to travel to FGH or ROH for routine ENT outpatients and all minor procedures. Through the disaggregation of the service, MFT propose to create an enhanced ENT service at NMGH. This service would be provided for adults by the ENT Managed Single Service which is led by MRI. For children the NMGH service would be provided by RMCH clinicians. This will also allow emergency ENT provision at NMGH to be enhanced, through a locally based team of surgeons; at present, on call and inpatient care is provided on a visiting basis from FGH.

Disaggregation of the service and creation of this service at NMGH requires the following pathway changes:

Patient catchment	Pathway	Current Delivery Site	Proposed Delivery Site	Catchment Activity
NMGH	Adult acute inpatients	FGH	NMGH	250 NEL
NMGH	Adult day case and elective procedures	FGH	NMGH	350 DC, 110 EL
NMGH	Adult outpatient procedures	NMGH/ FGH	NMGH	6,000
NMGH	Paediatric acute inpatients	ROH	NMGH	25 NEL
NMGH	Paediatric day case and elective procedures	ROH	NMGH	200 DC, <5 EL
NMGH	Paediatric outpatient procedures	NMGH/ ROH	NMGH	1,500-2,000

*Excludes ENT cancer resections, which are currently and will remain undertaken at MRI

There are no planned changes for the NCA population and therefore this paper and assessment is only for the NMGH catchment.

Substantial Variation Assessment:

Domain	Assessment	Assessment
Patient Population Affected	• Based on an initial review of 2019 activity patterns the change proposal will affect c.950 inpatients per year and ~8,000 outpatients from the **NMGH catchment.** This is broken down in the table above. For a locality breakdown see appendix 1. • This means that these patients will be able to access care for this core service closer to home whereas currently many adults and children need to travel – often for routine care. • Children within the NMGH catchment currently being referred to RMCH will also be able to access their outpatient and elective day case procedures at NMGH. • In addition, patient choice will be a key feature of the proposal, ensuring that these patients will still be able to choose to continue to access the existing provider/site for planned activity should they wish to do so.	Not substantial variation

Domain	Assessment	Assessment
	• Based on an initial review of 2019 activity patterns the change proposal will affect no patients from the **NCA catchment**. • The proposal ensures that there is no reduction in total capacity levels for the system.	
Access	**For NMGH catchment residents** • A full travel analysis has been completed. • Journey times to NMGH are shorter or considerably shorter for the NMGH catchment population compared to both FGH and ROH by both car and public transport. • When compared to FGH public transport journey times are the same or up to 60 minutes shorter to NMGH. • Journey times are improved to NMGH compared to ROH for the majority of the NMGH catchment population except for wards in Oldham – residents in these wards may wish to choose the NCA for their ENT care. • Travel costs are expected to decrease in all cases.	Not substantial variation
Type / Rationale for proposed service change	• The change forms a part of previously agreed plans to integrate NMGH into MFT to maximise the benefits of single services. This has been previously agreed through a robust and rigorous process with the service change proposal one of several changes to achieve the previously agreed vision for a single hospital service for Manchester. • The proposal changes existing service provision to significantly improve local access. • Emergency ENT provision at NMGH will be enhanced, through a locally based team of surgeons; at present, on call and inpatient care is provided on a visiting basis from FGH. Adult patients will no longer need to be transferred to FGH for their procedure. • There is no reduction in overall system capacity. • A full Quality Impact Assessment has been undertaken. Patient experience will be improved, and risks reduced. No adverse impacts were identified across any domain.	Not substantial variation
Wider community & other services	• There is no impact on any co-dependent services. • The proposal forms part of large-scale plans to deliver patient benefits through the creation of single services within a single hospital trust for Manchester. • There are no known wider impacts across the community. • A full equality impact assessment has been completed. The proposal will benefit the diverse and relatively deprived population of North Manchester, which should contribute to narrowing of health inequalities. No negative impacts of the proposed changes were identified. There will be a continuous review of the changes to ensure no negative impacts to any patients and rapid mobilisation of mitigations in the event impacts are identified.	Not substantial variation
NHSE Four Tests & Stakeholder Views	• Patients will continue to be able to choose where they would like to access care and can choose either an MFT or NCA pathway. • The proposals will be presented to the Patient and Public Advisory Group (PPAG) of Manchester Health and Care Commissioning, NCA Healthwatch and Manchester and Trafford Healthwatch. • A patient survey is also planned. • The proposed changes and new service provision are clinically led seeking to deliver consistently high-quality care. Care will be delivered to the same standards as at present, as a minimum. The future pathways will	Not substantial variation

Domain	Assessment	Assessment
	provide enhanced options for diagnostic pathways for patients. • ENT staff have been substantially engaged on plans and progress for the proposals through a combination of routine and extraordinary forums. Clinical and operational leadership are involved in all discussion and decision making with regard to the changes and have therefore been responsible for communicating with staff.	

Recommendation:

It is recommended that this change **does not constitute substantial variation.**
This proposal is to create a core ad comprehensive service at NMGH provided care closer to home with significant improvements in journey time and cost of travel for NMGH catchment residents.

This proposal allows for creation of safer emergency provision to the busy NMGH A&E and a more robust on call / out of hours rota. The ENT emergency service will be equitable to other Manchester ENT patients.

Table: estimated number of affected patients per locality per annum based on historic activity.

Locality	ENT
Manchester	4923
Bury	1343
Rochdale	895
Oldham	895
Salford	895
Total	**8,950**

Substantial Variation Assessment – Urology

NMGH is currently the inpatient Urology site for the former PAHT footprint. Outpatients and other aspects of the service are provided at ROH, FGH and RI. NCA and MFT have agreed that full disaggregation of the service is the preferred exit strategy in line with other complex services. This would mean that ~30% of activity is retained by MFT (the NMGH catchment population) and ~70% would be provided by NCA for its population.

The NCA have previously agreed a model of care for Urology with commissioners through a prior decision-making process. The model is as follows:

- Bury residents to receive inpatient urology care at Salford Royal Hospital
- Rochdale and Oldham residents to receive inpatient urology care at Royal Oldham Hospital

Therefore, the scope of **this paper is focused on the changes for the NMGH catchment.**
Once the service is disaggregated the service at NMGH will be considerably smaller than currently and it will no longer be viable to maintain the full current model of care at NMGH. Instead, it is proposed that NMGH provides a comprehensive suite of local care including outpatients, urological investigations, day case and short stay, high volume low complexity surgery. A robust on call arrangement is proposed to ensure safe care for patients presenting with urological emergencies. Complex inpatient urology surgery is proposed to be delivered at MRI.

This represents phase 1 of the urology single service model development within MFT. Wider discussions are underway to determine the longer-term model for urological care across MRI, Wythenshawe, NMGH and Trafford.

Substantial variation assessment:

Domain	Assessment	Assessment
Patient Population Affected	• The NMGH catchment is affected by the proposal, this includes Manchester residents in the Northern part of the city, as well as a proportion of Bury (typically Prestwich and Whitefield) and HMR (typically Middleton) residents, who consider NMGH as their local district general hospital. • Most patients will continue to access care at NMGH for outpatient (~14,500 appointments per annum), day case (~1,350 procedures per annum) and high-volume low acuity urology surgery (~800 procedures per annum) and diagnostic services. • The activity data shows that approximately ~150 elective and ~550 non-elective inpatients (~4% of NMGH urology patients; of these an estimated ~385 are Manchester residents, ~105 Bury residents, ~70 residents from Oldham, Rochdale and Salford respectively) will be affected by the proposed changes and would receive care at MRI. These represent patients needing more complex inpatient care– likely once in a lifetime surgery. All outpatient care related to this surgery will continue to be provided at NMGH. • The proposal will include a review of patient pathways to ensure effective access to a full range of pathways designed to optimise care within MFT. • Patient choice will be a key feature of the proposal, ensuring that patients have a choice in which organisation to access for planned activity. The	Not substantial variation

Domain	Assessment	Assessment
	NHS constitution emphasises patient choice, and the patient will have access via the applicable DOS provisions.	
Access	• For the small number of urology patients who would receive their care at MRI, journey times to MRI compared to NMGH are longer by public transport and car for a proportion of the population affected. MRI is closer for a smaller proportion of the population. • However, MRI and NMGH are relatively close (~5 miles) and there are good transport links to the MRI for much of the population. • Patients will only need to travel for their inpatient care. All outpatient activity will be provided at NMGH.	Not substantial variation
Type / Rationale for proposed service change	• The proposed change forms a part of previously agreed plans to integrate NMGH into MFT to maximise the benefits of single services. This has been previously agreed through a robust and rigorous process. The service change proposal is one of several changes to achieve the previously agreed vision for a single hospital service for Manchester. • The proposal is a partial change to existing service provision with local access retained for outpatient, day case and high-volume low complexity urology and diagnostic services. • The proposal will see North Manchester catchment patients accessing inpatient care at established MFT services. • There is a strong focus on outcomes and clinical quality as phase 1 of the proposal forms part of the urology single service model development within MFT. • A key part of the proposal is to maximise care closer to home through the strengthening of ambulatory pathways. Intended benefits include a greater proportion of patients seen, treated and discharged without the requirement to be admitted to a bed. • There is also a strong focus on safety as phase 1 of the proposal will enable North Manchester catchment and NCA patients to receive care from one organisation and in one digital system. This will mitigate risks associated with the transfer of MFT and NCA patients and information between systems. • A QIA and EQIA have been completed and these support the principle of ensuring that incorporation of activity into MFT will have no negative impact on quality	Not substantial variation
Wider community & other services	• The changes release capacity at NMGH which could be reprofiled to support other North Manchester catchment activity. • The proposal forms part of large-scale plans to deliver patient benefits through the creation of single services within a single hospital trust for Manchester. Benefits include the use of the new electronic patient record system across every MFT site. • The patients who will access MFT services will be absorbed into the current MFT infrastructure • There are no known wider impacts across the community.	Not substantial variation

Domain	Assessment	Assessment
	• A full equality impact assessment and quality impact assessment has been completed.	
NHSE Four Tests & Stakeholder Views	Strong clinical evidence base • The proposal forms part of large-scale plans to deliver patient benefits through the creation of single services within a single hospital trust for Manchester. Benefits include the use of the new electronic patient record system across every MFT site. • Similar hub and spoke models already exist and the model of care aligns to GIRFT recommendations including Urology Area Network developments Strong public and patient engagement • Public and patient engagement forms a key component of developing the service change proposal with continued activities to further enhance service user engagement. This includes bespoke surveys to be undertaken in outpatient settings, discussion of proposals at MHCC Public and Patient Advisory Group, Healthwatch presentations the development of a QIA and EQIA and full consideration of patient choice in terms of which organisation to access for planned activity. Strong staff engagement, input and support • There is strong engagement from clinical and operational staff involved in the service across MFT. A series of MFT urology workshops have been held to identify how the service at NMGH could be developed and delivered in the short, medium and long term. Clinical discussion to advance aspects of the clinical model are continuing and this includes clinical lead discussion with members of the Urology team, NMGH, MRI Medical Directors and inputs from Group Strategy and the WTWA Senior Leadership Team. • MFT and the NCA also have strong post-transaction joint working arrangements and continue to work through these structures to coordinate disaggregation of the more complex services which includes Urology. A bipartite clinical working group, workforce group and disaggregation group provide oversight, leadership and support for the phase 1 proposal which will see complete disaggregation of the historical PAHT footprint for urology as the NMGH urology service will fully separate from the NCA urology service.	Not substantial variation

Recommendation:

It is recommended that the service change proposals for Urology **does not constitute substantial variation** and that decision-making on the assurance of the change proposal should be taken through the Greater Manchester Integrated Care Board. Key aspects of the rationale for this recommendation include:

- This change is a consequence of previously agreed decisions taken on the formation of a single hospital service for Manchester (with NMGH to be integrated into MFT) and for the formation of the Northern Care Alliance with both organisations seeking to optimise patient benefits through the delivery of integrated single services.
- Most patients will continue to access care locally at NMGH for outpatient, day case and high-volume low acuity urology and diagnostic services. Patients needing to access MRI will do so for once in a lifetime inpatient surgery.

Domain	Assessment	Assessment
	This model aligns with GIRFT recommendations. • The change proposal has followed a structured approach with full support from commissioners/localities and clear evidence of service user involvement that will continue through to and beyond implementation of changes.	

Service Change proposal - Trauma & Orthopaedics

Before transaction, Trauma and Orthopaedics (T&O) operated as a single service across the former PAHT footprint delivered from North Manchester General Hospital (NMGH), Royal Oldham Hospital (ROH), Fairfield General Hospital (FGH) and Rochdale Infirmary (RI).
Under PAHT, the Trust operated a two-axis model whereby NMGH and FGH served as one axis (with trauma surgery delivered at NMGH) and ROH and RI served as the other (with trauma surgery at ROH). All electives for the totality of PAHT were centralised at FGH with several day case operating lists at RI.

As part of the overall Transaction, NCA and MFT agree that full disaggregation of T&O services for North Manchester is the preferred exit strategy and agree for this to happen in line with other complex services by the 31 March 2024.

Once disaggregated, MFT will provide an orthopaedic elective and trauma service for NMGH catchment patients, and the NCA will provide an elective and trauma service for the FGH catchment patients, connecting into their wider organisational models.

Elective
The elective orthopaedic service on the NMGH/FGH axis consists of outpatients delivered locally and elective day case and elective inpatient procedures largely provided out of FGH, with some daycase procedures at RI.

After disaggregation, MFT will provide elective services to North Manchester catchment GP referrals and all NMGH A&E arrivals. The MFT site where day case and inpatient procedures are provided will be Trafford General Hospital (TGH). Patients will be able to choose whether to access their elective care at TGH or FGH. NCA will continue to provide elective service for Bury catchment GP referrals as well as FGH A&E arrivals. FGH A&E patients requiring Trauma surgery will be redirected to Royal Oldham Hospital (ROH).

A breakdown of proposed delivery sites following disaggregation is shown in the table below.

Trauma
The non-elective/trauma service consists of virtual fracture clinic (VFC), fracture clinic (FC), day case trauma, and inpatient trauma. This is serviced by a trauma rota covering each axis. Patients arriving at FGH requiring a trauma procedure are transferred by ambulance to NMGH for treatment. It is assumed that NWAS will continue to convey trauma patients to NMGH and ROH and current volumes are not expected to change.

After disaggregation, patients arriving at FGH A&E for treatment will no longer be transferred to NMGH for trauma care but instead will transfer (or be conveyed directly by ambulance) to ROH for inpatient trauma and RI for ambulatory trauma. There will be no change to the delivery of fracture clinics, these will remain at FGH.

There will be no change for residents living in the NMGH catchment area – these residents will continue to access trauma care at NMGH as they do now.

A breakdown of proposed delivery sites following disaggregation is shown in the table below.

Category	Service	Current site of delivery	Proposed site of delivery for (NCA)	Proposed site of delivery for (MFT)
Trauma Services	Fracture Clinic	FGH & NMGH	FGH (no change)	NMGH (no change)
	Day case	NMGH & RI (low volue)	RI	NMGH (no change)
	Inpatient	NMGH	ROH	NMGH (no change)
Elective services	Outpatients	FGH & NMGH	FGH (no change)	NMGH (no change)
	Day Case	FGH & RI	FGH & RI (no change)	TGH
	Inpatient	FGH	FGH (no change)	TGH

Substantial variation assessment:

<table>
<tr><th>Domain</th><th>Narrative</th><th>Assessment</th></tr>
<tr><td>Patient Population Affected</td><td>
The patient population affected by the proposed service change will predominately be those that live in the NMGH and FGH catchment areas.

Trauma – affects FGH catchment residents

The trauma planning assumption indicates that activity derived via an A&E attendance will be served by the Trust associated with that A&E. Currently, Fairfield General Hospital (FGH) arrivals (NCA) are transferred to NMGH (MFT) for trauma procedures/treatment.
Initial modelling (2019/20) has identified that approximately 650 patients are transferred from FGH A&E to NMGH per year for a trauma. The distribution by locality is as follows:
<table>
<tr><th>Locality</th><th>Estimated maximum number affected per annum</th></tr>
<tr><td>Bury</td><td>~400</td></tr>
<tr><td>HMR</td><td>~200</td></tr>
<tr><td>East Lancashire</td><td>~20</td></tr>
<tr><td>Bolton</td><td>~10</td></tr>
<tr><td>Oldham</td><td><10</td></tr>
<tr><td>Manchester</td><td><10</td></tr>
<tr><td>Other</td><td>~10</td></tr>
<tr><td>Total</td><td>~650</td></tr>
</table>

Of these patients, 296 have an inpatient trauma procedure at NMGH, 170 have a day case procedure at NMGH and the remaining 188 patients are discharged without procedure
Under the new clinical model, FGH patients will no longer be transferred to NMGH but instead will transfer (or be conveyed directly by ambulance) to ROH for inpatient trauma and RI for ambulatory trauma.
There will be no change to the delivery of Fracture Clinic, these will remain

</td><td>Not substantial variation</td></tr>
</table>

Domain	Narrative	Assessment
	at FGH. • It is assumed that NWAS will continue to convey trauma patients to NMGH and ROH and current volumes are not expected to change. • People living in the NM catchment area will continue to access trauma services at NMGH as per the current service model, and there will be no change. **Elective** • For the NM catchment most people requiring planned / elective care will continue to receive a significant element of their care at NMGH, including outpatients, tests and diagnostic procedures. • Where patients require an operation/procedure, patients will be able to choose whether to access this care at the NCA elective hub at FGH as they do now or at the MFT elective hub at Trafford General Hospital. • This is expected to impact ~1,500 patients per year based on 2019 activity profile (it is estimated this could affect ~825 Manchester residents, ~225 Bury residents and ~150 residents from Oldham, Rochdale and Salford respectively). • The elective pathways for the NCA population will remain unchanged. • Patient choice will be a key feature of the proposal. The NHS constitution emphasises patient choice, and the patient will have access via the applicable DOS provisions. Some people who reside in the North Manchester General Hospital catchment area may choose FGH (Bury) for their surgery and this will mean that they will also have outpatient appointments and diagnostics at FGH. Others may choose to have their surgery at TGH. If so, they would have outpatient appointments and diagnostics at NMGH, and just the surgery element of their pathway at TGH.	

Access	**Trauma**
	• Residents in the NMGH catchment area will continue to access trauma services at NMGH. All elements of the trauma pathway will continue to be delivered from NMGH and little will change from a patient access perspective for patients in this area.
	• People living in the FGH catchment area, under the new service model, will no longer be transferred to NMGH for their trauma surgery but instead will transfer (or be conveyed directly by ambulance) to ROH for inpatient trauma and RI for ambulatory trauma. There will be no change to the delivery of Fracture Clinic, this will remain at FGH. NCA have sufficient capacity to take on this volume of trauma activity from FGH arrivals supported by pathway improvement and efficiency opportunities.
	• The key headline messages for trauma are related to the change in travel time for patients travelling/being conveyed to ROH or RI instead of NMGH under the new proposed clinical model:
	  ○ The average journey time by car for NCA patients overall is approximately 5 minutes shorter on average travelling to ROH instead of NMGH and 3 to 4 minutes shorter on average when travelling to RI instead of NMGH.
	  ○ For the likely FGH catchment mostly impacted by the change, the
		Not substantial variation

Domain	Narrative	Assessment
	average journey time by car is longer by 1-2 minutes for Bury residents and shorter by 5-6 minutes for Rochdale residents when travelling to ROH rather than NMGH. When travelling to RI rather than NMGH by car, Bury residents will see a 2-3 minute longer journey and Rochdale residents will see a 1-2 minute reduction. ○ The average journey time by public transport for NCA patients overall is approximately 12 minutes shorter on average travelling to ROH instead of NMGH and 12 minutes shorter when travelling to RI instead of NMGH. ○ For the likely FGH catchment mostly impacted by the change, the average journey time by public transport is longer increasing from 51 to 83 minutes for Bury residents and shorter by 20 minutes for Rochdale residents when travelling to ROH rather than NMGH. When travelling to RI rather than NMGH by public transport, Bury residents will see a 14-15 minute longer journey and Rochdale residents will see a 5-6 minute reduction. Some Bury residents may already choose to go to a different hospital site that is closer e.g., Bolton or Salford. ○ The patient survey conducted with 88 patients using NCA services indicated that 83% of patients travelled by car or taxi and 5% travelled by public transport to FGH. **Elective** • Outpatient and diagnostic activity will continue as per the current service model, both at NMGH and at FGH. More outpatient activity is likely to be delivered at NMGH than currently to ensure that people from the NMGH catchment area do not have to travel to FGH but can receive that element of their care at NMGH (patients can still make a choice). • However, people from the NMGH catchment area requiring an elective planned surgical procedure/operation will now be able to choose whether to access this at FGH in Bury or Trafford General Hospital. • Access for elective planned surgical procedure/operation for the NCA population will remain unchanged. • A detailed travel analysis has been undertaken. The key headline messages for elective are related to the change in travel time for patients travelling to TGH instead of FGH under the new clinical model: ○ The average journey time by car for the overall catchment area (North Manchester) is 3 minutes longer to TGH than to FGH (19 minutes compared to 16 minutes). ○ Average journey times by public transport are, on average, 12 minutes longer to TGH than FGH (76 minutes compared to 63.9 minutes) but are more direct with fewer interchanges. As such the cost of public transport is marginally lower. ○ Residents in the south of the catchment are closer to Trafford General; residents in the north of the catchment are closer to Fairfield General. Patients may therefore choose to attend their closest hospital.	

Domain	Narrative	Assessment
Type / Rationale for proposed service change	**Elective** • The service change forms a part of previously agreed plans to integrate NMGH into MFT to maximise the benefits of single services and is part of the transaction process. • It is paramount that a long-term and sustainable service model for the ongoing provision of trauma and orthopaedic services at NMGH is established for the NMGH catchment area. • The rationale for offering orthopaedic elective surgery at Trafford General Hospital as well as FGH for the NMGH catchment area is to maintain access to high quality, safe and highly reliable care, and to benefit from the treatment outcomes associated with a 'high volume, low complexity' clinical model, based on recommendations from GIRFT, which Trafford General delivers. These models of care are associated with a better patient experience, less variation and better patient outcomes. The models are reflective of recommendations made through GIRFT and TGH already operates a GIRFT type Surgical Hub for Orthopaedics, and this service would increase capacity to accommodate the transfer of NMGH patients. • The new clinical model for orthopaedics for the NMGH catchment area will benefit from the Single Service model rolled out across MFT, delivering high quality and good outcomes for patients, in a more effective and efficient way, sustaining services now and into the future. The NMGH service will benefit from the scale of the MFT T&O service and the size of the workforce. **Trauma** • Equally, changes to the provision of trauma care to the FGH catchment area will enable the NCA to scale up and benefit from a Trust wide single service model across multiple sites for T&O services • Consolidation of trauma activity will lead to better outcomes and shorter lengths of stay for patients in a more effective and efficient way. Patients will benefit from the strong T&O patient quality indictors at ROH (i.e. LoS and readmissions) • Patients will also benefit from improved treatment outcomes associated with a 'high volume, low complexity' clinical model at RI based on recommendations from GIRFT. These models of care are associated with a better patient experience, less variation and better patient outcome.	Not substantial variation
Wider community & other services	• The proposal forms part of large-scale plans to deliver patient benefits, high quality, and sustainable care with better outcomes through the creation of single services for NCA and MFT. For example, the recent deployment of a single electronic patient record across all MFT sites will derive significant benefits to the standard and quality of care. It means that patient records will be contained in one space and will not cross multiple digital systems in different organisations. • There are no other known wider implications or co-dependencies across	Not substantial variation

Domain	Narrative	Assessment
	the communities of the proposed changes.	
NHSE Four Tests & Stakeholder Views	Strong clinical evidence base • The proposal forms part of large-scale plans to deliver patient benefits through the creation of single services for NCA and MFT. Benefits include the use of the new electronic patient record system across every MFT site. • Delivering a planned elective orthopaedic service adopting the HVLC (high volume, low complex) clinical delivery model will deliver a service that is high quality, highly reliable, effective, and sustainable. • Consolidation of trauma activity will lead to better outcomes and shorter lengths of stay for patients in a more effective and efficient way. Strong public and patient engagement • Public and patient engagement forms a key component of developing the service change proposal with continued activities to further enhance service user engagement. This includes, patient surveys and engagement events, discussion of proposals at Manchester Public and Patient Advisory Group, Healthwatch presentations the development of a QIA and EQIA and full consideration of patient choice in terms of which organisation to access for planned activity. The NHS constitution emphasises patient choice, and the patient will have access via the applicable DOS provisions. Support from clinical commissioners • Some of this work includes reorganising or restructuring services, and a process of engagement and dialogue with commissioners is being maintained to manage these changes. The proposal is being reviewed by Integrated Care Boards / Localities with the process led by the Place Based Lead for Oldham on behalf of the Integrated Care Board. The proposal has and will continue to be developed through a collaborative process with system partners. Strong staff engagement, input, and support • There is strong engagement from clinical and operational staff involved in the service across MFT and the NCA. A series of workshops have been held to identify how the service at NMGH and FGH could be developed and delivered in the short, medium, and long term. Clinical discussion to advance aspects of the clinical model are continuing with both organisations and this includes clinical lead discussion with members of the T&O teams and Leadership Teams. • MFT and the NCA also have strong post-transaction joint working arrangements and continue to work through these structures to coordinate disaggregation of the more complex services which includes T&O. A bipartite clinical working group, workforce group and disaggregation group will provide oversight, leadership and support which will see complete disaggregation of the historical PAHT footprint for T&O as the NMGH T&O service will fully separate from the NCA T&O service.	Not substantial variation

Domain	Narrative	Assessment

Recommendation:

It is recommended that the service change proposals for trauma and orthopaedic single service model development within MFT **does not constitute substantial variation** and that decision-making on the assurance of the change proposal should be taken through the Greater Manchester Integrated Care Board. Key aspects of the rationale for this recommendation include:

- This change is a consequence of previously agreed decisions taken on the formation of a single hospital service for Manchester (with NMGH to be integrated into MFT) and for the formation of the Northern Care Alliance with both organisations seeking to optimise patient benefits through the delivery of integrated single services.
- The key change for elective planned (inpatient/daycase) care affects residents in the NMGH catchment area. Patients will be able to choose whether to have their procedure at TGH or FGH. The travel analysis has demonstrated that the travel time, both by car and public transport to TGH is longer than to FGH, but not substantially. Travel to TGH by public transport is more direct with fewer changes. Travel by car is slightly more expensive, however, the cost of public transport is lower. The south of the catchment is closer to TGH; the north closer to FGH. There are existing mechanisms for patients and their carers to access support with travelling to hospital and the costs of travel. These will be promoted to patients through patient letters, MyMFT and referral / booking teams.
- The key changes for trauma care (patients presenting at A&E) affects residents in the FGH catchment, predominantly Bury. These residents will transfer from FGH (or be conveyed directly by ambulance) to ROH for inpatient trauma and RI for ambulatory trauma. The travel analysis has demonstrated that the travel time by car for Bury patients is minimally higher and for Rochdale residents is significantly low. By public transport, for all Bury residents is higher but lower for Rochdale residents. Some Bury patients may already choose to go to a different hospital site that is closer.