

GREATER MANCHESTER ACUTE SERVICES RECONFIGURATION



HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue Manchester is embarking on what may be a major restructuring of its acute services, with public consultation due by spring 2013.

Context Manchester has 10 acute trusts, running 14 hospitals. The numbers of surgical rotas and emergency departments in the city are widely seen as unsustainable. A combination of clinical evidence supporting the concentration of services, financial austerity and the creation of a city-wide commissioner has created the environment to take action.

Outcome The city's clinical commissioning groups are working with senior hospital clinicians to establish the "best clinical model" before exploring the consequences for organisations. Some trusts may not survive in their current form.

Introduction

Some time this summer NHS Trafford will go to the public with proposals for the future of Trafford Healthcare Trust. The consultation is widely expected to include radical options for the hospital where Nye Bevan marked the 1948 birth of the NHS, including that most politically flammable of changes, the reduction or removal of accident and emergency services.

However, if Greater Manchester's commissioners have their way, Trafford will be just the first step in a major restructuring of services across the city's acute hospital trusts. Working alongside Manchester's emergent clinical commissioners, the NHS Greater Manchester "cluster" of primary care trusts is determined to use its final year in existence to develop wide-reaching plans for reconfiguration of the city's acute services.

The possibilities under consideration are expected to include further reduction in the number of hospitals running full-blown A&E departments, the transfer of significant chunks of secondary care to GP and community services, and the consolidation of surgical specialties onto fewer sites.

Commissioners have much to do in little more than a year – they aim to be ready for public consultation by spring 2013. For some trusts, it may

even pose a threat to their continued existence as independent organisations.

This week's HSJ Local Briefing looks at the Greater Manchester "Safe and Sustainable" programme, and asks how it might reshape the city's hospital services in the future.

Why is it happening?

Commissioners and providers believe hospital services in Greater Manchester have been spread too thinly to ensure the best possible care at all times, on all sites. With a population estimated by the cluster at around 2.6m, the metropolitan area has 10 acute trusts – including three teaching trusts – running 14 hospitals. Specialties are duplicated across a number of sites, and all providers – with the exception of cancer specialist The Christie Foundation Trust – offer full emergency services on at least one site. The belief that services need to attain a "critical mass" of patients has hardened with restrictions on junior doctors' working hours, increased surgical specialisation, and emerging evidence in favour of 24-hour access to highly trained staff.

Salford Royal FT chief executive David Dalton is among those who believe Manchester cannot continue to sustain its current number of surgical rotas. "If you look at the evidence from the Royal College of

Surgeons and elsewhere of the need to assure high standards of care for the public 24 hours a day, seven days a week, then it's quite obvious that nowhere in the country should be able to continue in its current form unless they have that assurance of high standards," he says. Given the number of medical emergencies in the city, you would "struggle to make sense" of the number of overnight trauma and orthopaedic rotas it operates, says Pennine Acute Hospitals Trust chief executive John Saxby. He adds: "There has been a general acceptance in many surgical areas that needs to be looked at."

However, the hospitals face a prisoner's dilemma. While many believe there are benefits to concentrating services on fewer sites, none would wish to lose their own services – particularly if that meant they could no longer support a full emergency department. Apart from the loss of status, the loss of income could leave a trust financially unviable as an independent organisation. Unlike London, nearly all the city's acute providers are foundation trusts, and their regulatory regime requires them to place organisational survival before collaboration.

There are three reasons commissioners believe some of these barriers can now be overcome. The first is the weight of emerging clinical evidence for the benefits of weekend working and major trauma networks, and optimal catchment populations for acute surgery. The second is that last year Manchester's 10 PCTs were "clustered" into NHSGM, in anticipation of their abolition in 2013. Ironically, this process has apparently succeeded in creating – briefly – a bargaining unit capable of addressing deeper issues across the health economy. "Since the creation of NHSGM you've got something that a lot of people have been asking for,

for a long time," says Wrightington, Wigan and Leigh FT chief executive Andrew Foster, "somebody that will genuinely tackle some of the structural reconfiguration issues in Greater Manchester".

The third is that providers face years of unprecedented austerity. Greater Manchester will have to make £1.3bn of the £20bn NHS savings needed across England between now and 2015, and public finances suggest there will be little growth after that. "The providers have come very willingly and enthusiastically into Safe and Sustainable, and I think that's clearly being driven by the financial challenge," says NHSGM service transformation director Leila Williams. Acute trust executives say there is only so far they can go to safely reduce costs in their hospitals. After that, they believe savings will have to come either through transferring care into the community, or through consolidating or sharing services between providers. Commissioners fear that, without reconfiguration, money that could be used improving preventive care will be diverted to support hospitals – Trafford last year needed a £10m bailout to break even.

"Smaller FTs are going to find it increasingly difficult as standalone organisations to deliver the type of cost reductions required of them to maintain a safe set of services," says NHSGM chief executive Mike Burrows. "We are already seeing within Greater Manchester – Trafford being the prime example – that that phenomenon is manifesting itself."

What happens now?

The strategy adopted for Safe and Sustainable is based on the Making it Better reconfiguration, which recently finished consolidating Manchester's inpatient maternity services onto eight hospitals, down

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from 12. Those involved in Making it Better – Ms Williams included – share a view that such controversial change was only politically possible because it was developed and championed by clinicians, not managers. At the start of the last decade obstetrics and midwifery heads from across Greater Manchester were brought together to discuss whether the city could sustain 12 separate units. After concluding it could not, they developed a clinical model based on the population's needs, and the critical mass of patients needed to ensure units were practiced at treating complex cases.

The first stage of Safe and Sustainable will be to investigate the "case for change" across seven service areas, including urgent and emergency care, surgery, cancer, and stroke services. The team is pulling together baseline data on the current state of Manchester's services and has already begun convening groups of clinicians to discuss whether change is needed. This began in January, when the chairs of the city's 13 clinical commissioning groups met with medical and nursing directors from all its acute and community trusts, according to Raj Patel, chair of the clinical commissioning board.

He began this discussion by looking at Dr Foster evidence on variations in care quality between providers, and asking whether these variations could be addressed without collective action. Manchester had four of the 31 trusts identified by Dr Foster as the worst performers for hip fracture patients in 2011, and one of nine across England where death rates rose above average only at weekends.

"Generally the clinicians who came to these meetings came to the conclusion that if we have working hours directives, limitations in how

we train staff, limitations in how we use on-call rotas, then having 13 different [hospitals] across greater Manchester working in 13 different ways doesn't work very well," says Dr Patel. "We haven't got to the point where we've said how many sites we need or which sites should deliver what, but we're at the point where clinicians are saying, almost unanimously, that we need change, and we need some fairly radical change in the way we're delivering services."

What those changes might be is, says Mr Burrows, a matter for debate between clinicians, politicians, and the public. "We genuinely, at the moment, haven't got a blueprint," he insists. But he believes the "big stuff" in the planned consultation is likely to concern "cancer surgery, major trauma, acute surgical rotas, the implications for how we develop A&E services, and the implications for some tertiary specialties".

According to Ms Williams, the planned first stage of SaS is to establish the "best clinical model for Greater Manchester, without discussing how that affects our individual providers". That begins with clinicians across the system working to establish if and where there is a case for change. The team hopes to be ready to test the proposed model with patients and the public this summer, and then to refine it based on their views. If they get past that first stage, she explains, they would then look at how proposed service changes might affect providers.

Support in principle

The process seems designed to prevent the discussion from being politicised early on, by establishing support for first principles before broaching questions of organisational survival. "This is about services, it's not about

organisations," says Mr Burrows. "Questions have been asked around... 'do you want trusts to merge?' That's not on the agenda at all." However, he adds that, as a "by-product", reconfiguration might affect the viability of some trusts. "We need to deliver services from all hospital sites in Greater Manchester," he says. "But it's quite clear that we do have to change the configuration of services that are delivered from each of those sites. By implication, there won't be as much activity on some sites as there is at present, if we're successful."

How well the two-stage process will defuse controversy is open to question. One senior provider source told HSJ: "As soon as it becomes reasonably clear what is going to happen, or even what might happen, those organisations that feel threatened will be telling their staff about it, staff will be talking to their royal colleges and you will get a political escalation of the whole process."

Possibly the most politically sensitive area of the coming debate will be whether the city needs and can sustain its current number of A&E departments. Privately, some sources on both the provider and commissioner sides believe that it cannot.

In common with the rest of England, Greater Manchester has developed plans to reduce the number of sites treating major trauma patients. This is likely to have implications for the remaining A&E departments, says Dr Patel. At the same time, he says, significant parts of the work done by some A&E departments are "effectively, primary care services for the worried well". "There is something about reforming those services to say let's make sure major trauma is dealt with in the way it should be, let's make sure secondary care A&E is delivered

in way it should be and let's make sure primary care is optimised to deal with those people who shouldn't have to go to secondary care," he continues. He adds that clinicians are currently examining whether "we need a smaller number of units doing specialised accident and emergency and a smaller number of units simply offering a walk-in service".

Trauma collaborative

This initial work will also consider how many sites in Greater Manchester should provide major trauma care, says Dr Patel. Whereas some parts of England have chosen one major trauma centre for the region, Greater Manchester has agreed a "collaborative" between its three teaching hospitals: Salford, Central Manchester University Hospitals, and University Hospitals of South Manchester. No single site had all the services needed for major trauma. "It is recognised that this solution is different to other parts of the country," says Mr Burrows. "It reflects where we have come from as a set of organisations, not necessarily where we should be in the future." It is, however, unlikely that Safe and Sustainable will lead to any further consolidation of these services. Privately, commissioners say that while this should be a long-term ambition, it would be politically extremely difficult in the short to medium term.

The extent to which this programme becomes a power struggle between hospitals and commissioners will depend on how far the concrete proposals go. Providers HSJ spoke to were supportive of the programme's principles. They have their own reasons for wishing to see some consolidation of services, and many have begun to form alliances with neighbouring trusts in the hope that it can be done on a voluntary basis.

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Mr Dalton says he can see “no reason” why the reorganisation he wishes to see in the city should threaten any organisation’s viability. “What it means is people like me thinking about different organisational models... You can have a service which is shared across a number of organisations, where the rota might be shared, where inpatient beds might be shared and consolidated.” Mr Saxby says organisations had to go into Safe and Sustainable recognising that they may gain as well as lose activity. “I think there’s an acceptance, certainly in the chief executive community, that, well, that may happen. There may be people with unrealistic expectations about what it might mean for their own organisations, but that will all come out in the wash.”

It will also depend on which trusts are most threatened by the proposed clinical model. Those in the strongest position, clinically and financially, would clearly find it easiest to enlist political support if they opposed the plans. Conversely, funding pressure alone may force some of the financially weaker providers to merge and consolidate services. The most obvious case is Trafford Healthcare Trust, now in the final stages of a takeover by Central Manchester FT. Trafford had hoped to form an integrated care organisation with the area’s community and social services. It believed this would allow the health economy to meet rising demand by shifting resources into preventative and community care. But it put itself up for takeover when the government set a 2014 deadline for all trusts to become FTs, realising it could not make it in time. The healthcare trust’s commissioners have been developing options for reconfiguration in parallel with the takeover negotiations, and aim to go to public consultation in early

summer.

Asked of the extent of the proposals, Trafford Clinical Commissioning Group chair Nigel Guest says only that they are “open minded” about the “most efficient and optimal way of providing services in the future, including A&E”. However, NHS sources widely expect they will include options for reducing the level of emergency services on the site. The NHS Cooperation and Competition panel’s report on the takeover notes that in 2010 Greater Manchester primary care trusts removed Trafford’s inpatient maternity and paediatric services, as part of Making it Better. It states: “Given this recent decision by local commissioners, and the proximity of alternative accident and emergency departments in Greater Manchester, it seems likely that future commissioners may reconsider the current accident and emergency provision at Trafford.” It is also likely any changes agreed will happen fairly fast. As part of the takeover deal, NHSGM has agreed to provide what it expects to be a “fairly substantial package” of transitional funding to ensure Central Manchester does not lose money on Trafford in the period between acquisition and reconfiguration; it does not expect the funding to last beyond 2013.

Under strain

Beyond Trafford, providers show varying degrees of strain. The name most regularly cited in Manchester is Tameside Hospital FT. With a turnover of around £140m, it is the smallest acute provider in the city after Trafford, and its three year plan (see attached table) anticipates cost cutting measures well above the average for the city’s FTs. In 2012-13 it aims to reduce its non-private finance initiative operating expenses by 11 per cent, against an average of 5.2 per cent for all Manchester

foundations. In February 2011 foundation trust regulator Monitor found Tameside in significant breach of its terms of authorisation, after the trust recorded an unplanned deficit of £1.2m for the first half of the financial year. The regulator continues to ascribe Tameside the highest risk ratings for both finance and governance.

Some in the North West have also raised questions about Pennine Acute Trust. The trust is certainly not too small – it serves a population of around 850,000 – but it has struggled for the past year or so to meet some key performance targets. As HSJ reported earlier this month, Department of Health documents show that NHS North West has “real concern” about the trust’s ability to meet its December 2012 deadline to apply for FT status. Various NHS sources in Manchester believe that if the trust cannot make it independently it is likely to be split up. One well placed source says that while no Manchester FTs would want to merge with the trust in its entirety, there were a number who would be interested in taking on parts of the organisation.

But Mr Saxby says anyone who thought that was a possibility needed to “have some of their strategic instincts questioned”. He argues that in the past five years Pennine, which was formed through the 2002 merger of four general hospitals, had already carried out major reconfiguration. By the end of this month the trust will have centralised the “big two” services – acute surgery and trauma and orthopaedics – onto two sites, each serving a population of around 420,000. This, he says, brought them in line with RCS guidance that these services should have a catchment population of 400,000 to 500,000 people. It has also centralised its pathology lab, and surgical specialties including

vascular, gynaecology and urology on a single site, and closed the A&E department at Rochdale Infirmary.

“We believe our surgical specialties are of the right size, the right population, and the right generation of workload to justify us being able to keep them,” he explains. “If you look around some of the other trusts in Manchester, you will see that the base population that they serve is significantly less.” He adds: “Organisations that have got services that are not clinically viable need to address the clinical viability issues in their own backyard before they start poking around with other people.”

He says that the high risk rating for Pennine’s FT application was due to missed performance targets for referral-to-treatment waiting times and cancer waiting times. He believes its cancer performance would be up to standard by April, and its RTT performance by the end of June. Pennine is due to put its FT application in to the Department of Health in December.

Among Manchester’s four district general hospital foundation trusts, Tameside serves a core population of around 250,000, WWL 300,000, Bolton 310,000, and Stockport 350,000.