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<tr>
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<td>Project Lead</td>
<td>Clare Powell, Programme Director, Healthier Together</td>
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<td>Jessica Boothroyd</td>
<td>Finance, economic and commercial case</td>
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Approved by: Clare Powell (version 1.7 final) 15.09.2017
HEALTHIER TOGETHER JOINT COMMITTEE

Date: 19 September 2017
Subject: Healthier Together Business Case - Supporting Paper
Report of: Lee Hay, Deputy Programme Director – Healthier Together

PURPOSE OF REPORT:

The following paper is a summary report to accompany the Greater Manchester (GM) business case for Healthier Together (HT).

The purpose of bringing the business case to the Healthier Together Joint Committee is two-fold:

- To provide assurance to commissioners that the model of care and sector implementation plans remain consistent with the previously approved Decision Making Business Case; and
- To provide GM level oversight of the business case prior to submission to the Treasury, DH and NHSI as part of the formal process to access national capital monies.

This paper summarises the key issues contained in the business case and in particular highlights:

- The continued strength of the clinical case for change and the clinical benefits that will be realised through implementation of the new models of care;
- The economic case which demonstrates the value for money of the agreed model of care;
- The current status of the funding agreements in each sector;
- The management action that is taking place to manage the remaining programme risks and issues;
- The actions required to complete the commercial case such that it meets the requirements of the national capital allocation process.

RECOMMENDATIONS:

The Joint Committee is invited to:

- Note that the Healthier Together Business Case is consistent with previously agreed Joint Committee decisions in respect of HT;
- Note the management action being taken to manage the residual risks in the implementation of the model of care;
- Note the sponsorship and support of the Business Case by the Theme 3 Executive and the Finance Executive Group; and
- Approve the Greater Manchester Business Case for Healthier Together.

CONTACT OFFICERS: Lee Hay, Healthier Together Lee.Hay@nhs.net
Introduction

The business case (BC) for Healthier Together (HT) has been developed to follow the HM Treasury Five Case Model. The case is profiled at Greater Manchester (GM) level, with supporting appendices to articulate sector specific information.

The document is designed to serve multiple purposes:

- To provide assurance at a GM level that the business case for HT remains strong and coherent.
- To fulfil the national capital (Treasury) requirements for a Full Business Case (FBC). The contents of the working draft BC were utilised in the STP capital funding submission that resulted in the successful allocation of the full capital amount (£63M) in July 2017.
- Where necessary, to provide the basis for business cases that need to be approved by organisations within HT sectors.

The business case sets out the five cases as follows:

- **Strategic case** – demonstrating the case for change for HT is strong and strategically aligned with GM priorities.
- **Economic Case** – providing information about the preferred option for the HT model of care and its value for money.
- **Commercial case** – demonstrating a viable procurement and well-structured ‘deal’ i.e. providing a high-level summary of the estates requirements and procurement options at sector level including current cost estimates.
- **Financial case** – demonstrating the affordability and funding of the preferred option i.e. high level financial impacts of Healthier Together versus current service provision, and detail of funding agreements made to date (capital, transitional and revenue).
- **Management case** – demonstrating that robust arrangements are in place for the delivery, monitoring and evaluation of the HT scheme; this case demonstrates that risks are sufficiently mitigated and profiles the expected benefits of implementation.

Development of the FBC

The Full Business Case for Healthier Together has been compiled in collaboration with clinical and managerial representatives from all sectors associated with the programme. The robust governance architecture for HT has ensured scrutiny and assurance of all aspects of the business case through the appropriate forum, culminating in a coherent and assured plan for the implementation of Healthier Together, in line with the Decision Making Business Case (DMBC) as agreed at the Committees in Common (CIC) 2015.

The content of the business case was used to form the Strategic Outline Case submitted to the Treasury that led to the award of the full capital request of £63 million and has been supported by the Theme 3 Executive and Finance Executive Group (FEG) for approval at the Joint Committee in September 2017.
1. Strategic Case

1.1 Alignment of Healthier Together with GM Strategy

In 2012, Health and Care Leaders across Greater Manchester (GM) identified the need to address the variation in care and outcomes for patients across GM. A formal programme of change resulted in the 12 GM Clinical Commissioning Groups (CCGs) supported by the GM Combined Authority (GMCA) proposing changes to primary care, community care and some hospital services (A&E, Acute Medicine and General Surgery).

Healthier Together (HT) forms an integral part of the five-year vision for GM, as articulated in the Sustainability and Transformation Plan (STP) document ‘Taking Charge’; this establishes a strategic narrative following engagement with NHS commissioners, providers and local authorities, alongside best practice from national and international experts, to identify five key areas for transformational change in GM:

*Figure 1: Transformational Change Five Key Areas in GM*

HT is a key programme in the process of implementation and is the first programme of scale to implement through devolution. It forms a core and integrated component of the Theme 3 work programme “Standardising Acute and Specialised Care”, demonstrating GMs ability to make real transformational change across the region.

The changes implemented through the HT programme will provide a significant building block for the emerging Hospital Based Services Strategy and are complementary to the development of Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust into a Single Hospital Service.
The HT programme was led from the outset by GM CCGs. A case for change was developed through 84 clinical congress/workshop sessions attended by over 370 clinicians. Clinicians described a consistent cohort of standards that, if adopted across the conurbation, would significantly reduce variation in outcomes and improve performance and quality. This led to a proposal that each of the GM hospitals should change to meet these standards, and a new operating model was developed.

The design work involved patients, carers and members of the public throughout, culminating in a full public consultation covering 2.8m people in the summer of 2014. Over 29,000 residents formally responded and many more attended events and heard about the proposals.

Post-consultation, public feedback was collated into themes and considered by a number of governance groups, for example, Finance and Estates, and Clinical Advisory Groups. Each significant theme from the public feedback was responded to in a comprehensive and publicly available Decision Making Business Case. As an example, feedback suggested that travel data was out of date and could be improved. This was captured in a consultation feedback table and reviewed by the Transport Advisory Group. As a result, a decision was then taken to update the data prior to decision making.

Furthermore, a full Equality Impact Assessment was undertaken, assessing the impact on patients and the reach of the consultation to protected groups and the wider public.

The HT Joint Committee assessed the proposals together with the public response and unanimously agreed the implementation of HT and the preferred hub sites in late 2015, subject to a number of implementation conditions as a direct consequence of the feedback from the public and equality impact assessment. A subsequent judicial review, which was publically reported, was successfully defended.

The economic case for change involved a long list of seven key options in relation to the configuration of single services, articulated in the Pre-Consultation Business Case (PCBC). It was agreed and signed off by the HT Committees in Common (CIC) that due to the geography of the region, and associated key principles required the Decision Making Business Case would consider four shortlisted options.

Rigorous appraisal and analysis was undertaken, with sensitivity analysis of all four options and on 15th July 2015 CIC members voted unanimously in favour of option 4.4a as the preferred options for implementation (illustrated in Figure 2), based on criteria of quality and safety, transition, affordability and value for money, with the key differentiator determined to be travel and access.

*Figure 2: Preferred option CIC members voted unanimously for in 2015*
The programme has developed and adhered to a comprehensive assurance framework to ensure that the local design complies with the HT model and standards of care, outlined during consultation. The process includes a number of agreed implementation and equality conditions that must be met.

1.2 Clinical Case for Change

Healthier Together (HT) was initiated due to the unacceptable variations of care, and lack of compliance with national standards that exist in Greater Manchester (GM) for General Surgery, Emergency Medicine and Acute Medicine. The case for change (December 2013) highlighted the need to improve quality and safety in these services and the development of the clinical standards supports this improvement in order to improve outcomes.

Since the establishment of the CCG’s, the Association Governing Group (AGG) has taken on the GM wide governance arrangements for strategic change programmes. In March 2017, the AGG endorsed and supported:

- A refreshed clinical case for change, which in light of more recent guidance is even more compelling; and
- A report on the developing sector models of care, and compliance against the original model of care consulted upon. This report identified any variations to the original model of care, and the rationale for any changes. None of the variations were determined to be either significant or material.

1.2.1 General Surgery

Nationally, surgical morbidity and mortality rates for high-risk elective and emergency general surgical patients compare unfavourably with international results, with evidence of higher mortality and morbidity in these cohorts of patients.

Key indicators of the variation in outcomes across GM include patients undergoing emergency laparotomy surgery, with 30-day risk adjusted mortality rates ranging from 6.8% - 13.7% against a national average of 11% (Figure 3), and patients undergoing major elective cancer resection operations with 2-year adjusted mortality rates ranging from 13.8% - 42.9% against a national average of 20.9% (Figure 4):

<table>
<thead>
<tr>
<th>Trust</th>
<th>30-day Risk-Adjusted Mortality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>University Hospital of South Manchester NHS Foundation Trust</td>
<td>6.8</td>
</tr>
<tr>
<td>Stockport NHS Foundation Trust</td>
<td>6.9</td>
</tr>
<tr>
<td>Central Manchester University Hospitals NHS Foundation Trust</td>
<td>8.4</td>
</tr>
<tr>
<td>North Manchester General Hospital</td>
<td>9.3</td>
</tr>
<tr>
<td>Bolton NHS Foundation Trust</td>
<td>10.3</td>
</tr>
<tr>
<td>Royal Oldham Hospital</td>
<td>10.4</td>
</tr>
<tr>
<td>Salford Royal NHS Foundation Trust</td>
<td>11</td>
</tr>
<tr>
<td>Wrightington, Wigan and Leigh NHS Foundation Trust</td>
<td>13.3</td>
</tr>
<tr>
<td>Tameside Hospital NHS Foundation Trust</td>
<td>13.7</td>
</tr>
<tr>
<td><strong>National Average</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>
Table 2: National Bowel Cancer Audit: 2-year adjusted mortality

<table>
<thead>
<tr>
<th>Trust</th>
<th>Adjusted 2-year mortality (%)</th>
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<tbody>
<tr>
<td>Stockport NHS Foundation Trust</td>
<td>13.8</td>
</tr>
<tr>
<td>Wrightington, Wigan and Leigh NHS Foundation Trust</td>
<td>18.4</td>
</tr>
<tr>
<td>University Hospital of South Manchester NHS Foundation Trust</td>
<td>19</td>
</tr>
<tr>
<td>Bolton NHS Foundation Trust</td>
<td>21.7</td>
</tr>
<tr>
<td>Central Manchester University Hospitals NHS Foundation Trust</td>
<td>22.5</td>
</tr>
<tr>
<td>Salford Royal NHS Foundation Trust</td>
<td>24</td>
</tr>
<tr>
<td>Pennine Acute Hospitals NHS Trust</td>
<td>24.9</td>
</tr>
<tr>
<td>Tameside Hospital NHS Foundation Trust</td>
<td>42.9</td>
</tr>
<tr>
<td>National Average</td>
<td>20.9</td>
</tr>
</tbody>
</table>

A myriad of publications in recent years (Appendix 2) have continued to highlight the variation in surgical practice at national level, with Chana et al (2016) highlighting 7 and 30-day mortality, readmission rates and length of stay performance measures worse in English units than those in Australia and USA.

In GM, performance for high-risk emergency and elective general surgery reflects this national picture. Emergency general surgery is carried out in nine acute hospitals in GM with significant challenges, caused by variation in the number of consultant general surgeons, anaesthetists and supporting diagnostic services available. Examples of the variation in surgical practice relate to:

- Review by a consultant surgeon within 14 hours of emergency admission to hospital;
- CT scan performed and reported by Consultant radiologist;
- Timeliness of emergency laparotomy; and
- Post of length of stay,

The variation in the attainment of quality and safety standards still exists, and whilst improvements have been made since the original baseline assessment in 2013, the challenge of non-compliance remains a significant issue. Healthier Together aims to bring Greater Manchester surgical outcomes in line with the best hospitals in the UK, meaning that we have the opportunity to save the lives of up to 300 residents of Greater Manchester every year.

1.2.2 Emergency and Acute Medicine:

The NHS is experiencing unprecedented demand for urgent and emergency care and in GM demand for emergency departments is increasing year on year.

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1 Tameside Hospital FT has provided further clinical data to the National Bowel Cancer Audit team in respect of the mortality data used in this audit (see Appendix 1).
There is significant variation in the attainment of quality and safety standards, with lower than national average performance against the 4-hour A&E waiting time target and variable staffing levels, with key aspects of non-compliance against clinical standards including:

- Defined pathways including ambulatory care systems;
- Radiology standards (24/7 access to Consultant led in house reports within 1 hour);
- Multi-disciplinary care for the frail elderly;
- Access to support services essential for discharge;
- Interventions to reduce chronic attenders; and
- Variable delivery of the 12-hour consultant cover standard, as recommended by the Society for Acute Medicine.

1.3 Model of Care

The aim of the HT programme is to deliver a clinically led transformation of acute services which improves outcomes for patients; and which is operationally and financially sustainable. The programme forms part of the wider GM strategy “Taking Charge”, which through the devolution of health and social care in GM, aims to standardise acute care across the region to improve services for the benefit of patients.

As the first programme of scale to implement through devolution, the programme will demonstrate the ability to make real change across the region. The HT programme will ensure care is delivered in a new way and improve outcomes for patients by centralising high risk elective and emergency general surgery onto 4 “hub” sites (from 9 sites) to maximise the presence of senior decision makers and enable quality and safety standards to be consistently met.

In addition, all hospitals in GM will make a series of improvements to the way that they deliver Acute Medicine, Emergency Medicine (A&E) and General Surgery by adhering to quality and safety standards for these services; this will include increasing consultant led care and delivering care in a different way, such as through the expansion of ambulatory care (with patients seen the same day in a clinic rather than being admitted for a lengthy stay on a ward). Once implemented, GM will be at the forefront of providing high quality and safe care through collaborative, clinical operational networks as described in the Five Year Forward View and the Keogh Review.

1.4 Benefits

The HT programme will improve and sustain performance across GM in the key priority services of General Surgery, Emergency Medicine and Acute Medicine.

For general surgery, the consolidation of high risk elective and emergency general surgery services onto 4 “hub” sites will increase consultant presence at hub sites, improve access to theatres and critical care and enable quality and safety standards to be met. Healthier Together aims to bring Greater Manchester surgical outcomes in line with the best hospitals in the UK, meaning that we have the opportunity to save the lives of up to 300 residents of Greater Manchester every year. For the vast majority of patients, they
will continue to present or be taken by ambulance to their local A&E, which could be a non-surgical hub site; at all sites clear protocols will be followed by all A&E medical staff.

Enacting these protocols in liaison with the lead consultant at the hub site, will ensure appropriate transfer of patients, appropriate access to ambulatory care and the appropriate management of risk. This will ensure demand across the sector is effectively managed. GPs will also have access to senior medical opinion from the consultant at the hub site, upon the need to refer a patient.

The demand for transfer of emergency patients has been estimated by sector and used by the North West Ambulance Service (NWAS) to determine the investment in additional vehicles required; this has been incorporated into the business case. The demand for surgical ambulatory care services has been estimated at between 20%-30% of current admissions.

For emergency and acute medicine, demand is expected to be managed through the increase in senior decision makers at the front door, signposting to primary care, management of chronic attenders, management of the frail elderly, timely diagnostics and the enhancement of ambulatory care.

Recent review by the Emergency Care Improvement Programme (ECIP) anticipates, if the HT model is completely, effectively and consistently implemented there will be a “significantly positive effect on flow and therefore performance” within GM A&Es.

Figure 3: Summary of the model of care and expected benefits of implementation
1.5 Clinical Standards

The clinical case for change highlighted the need to improve quality and safety across GM for patients. The development of the clinical standards for General Surgery, Acute Medicine and A&E supports this improvement. Standards have been derived from national best practice guidance. Achieving full compliance with the standards will enable Trusts to achieve performance outcomes above and beyond national average, targeting upper quartile performance for a range of key metrics, for instance, length of stay and readmissions.

To manage ongoing performance, sectors will be monitored against quality and safety standards against which a baseline was taken in November 2016. Further monitoring will include review of available national and local audit data (see Appendix 3), hard copy evidence and peer-review.

1.6 Assurance Process

Further clarification on the Future Model of Care was provided to the four sectors in April 2016 by the Chief Medical Officer and Clinical Champions; the sectors have since been developing local models of care over the past 18 months.

An assurance process was established to ensure that the local implementation of HT complies with the HT model and standards of care and that the implementation conditions and equalities implementation conditions set out by the Committees in Common in July 2015 are met.

The stage 2 (Design of model of care and pathways) reviews were designed to achieve clinical assurance, focusing on the design of the sector’s models of care, to ensure they will deliver the standards and principles of the HT model of care.

The stage 2 review was split into three parts:

- Stage 2a: Presenting the model of care (clinical teams);
- Stage 2b: Actions and follow up on the model of care and presentation of the medical model of care (clinical teams);
- Stage 2c: Sector Senior Responsible Officer and Programme Director sign off.

Each sector has worked to develop detailed models of care that fit with the model outlined in the DMBC, and meets the Healthier Together standards whilst addressing any emergent factors potentially impacting the original model of care identified during the detailed design phase and assured through the review process.

A key example is that in the DMBC it was envisaged that the North West Ambulance Service (NWAS) would develop a pathfinder tool to determine the most appropriate place for patients to receive their care. This assumption has been rigorously tested through audits as part of the assurance process, with experts concluding there were not sufficient medical differentiators to identify emergency general surgical patients (operative and conservatively managed) at pre-hospital stage.

Therefore the current pattern of attendance for emergency general surgery patients is expected to continue. Through the development of local care models, clinical pathways and A&E consultant staffing levels have been iterated accordingly. For example, multiple non-hub sites have extended the hours of A&E consultant presence to reflect anticipated demand, in addition to an increase in General Surgical consultant presence at non-hub sites beyond a 3-4 hour hot clinic provision as initially deemed suitable for such a site.
result is more robust consultant level cover across GM to ensure senior decision making and timely patient review.

Other examples include:

- Better defining the activity codes that are considered to be “high risk” and producing local pathways (such as ambulatory care) in order to refine the level of activity that will transfer to the HT hub site in that sector;
- Refining the outline estimates of implications for beds and capital at each site and, based on that;
- Refining the outline workforce modelling, to describe the numbers of staff and coverage that will be provided within that sector;
- Establishing a more detailed understanding of the volume of activity transferring to the hub sites, in turn informing the on-site presence requirements to meet demand; and
- The National Major Trauma Service specification requires consultant general surgeon response within 30 minutes. This enables the resident hubs to now become non-resident depending on their assessment of demand during the stage 2 review.

1.7 Implementation Roadmap

He current phased implementation plan is described in the following roadmap:

*Figure 4: Implementation roadmap*
1.8 Progress to date

The full implementation of HT is dependent on capital investment, transitional funding and recurrent revenues agreed by providers and commissioners. There has however been significant progress across a range of areas associated with HT as sector teams have progressed improvements where possible. For example:

- The development and delivery of sector based MDTs for colorectal cancer, enhancing the decision making for patients with bowel cancer with more rigour and scrutiny for the ultimate benefit of our patients.
- Implementation of evolving best practice such as Enhanced Recovery after Surgery (ERAS+).
- Clinical pathways further clarified and defined clinical standards developed for related specialties such as radiology, gastro-intestinal haemorrhage and paediatric emergency general surgery.
- Additional consultants for general surgery and emergency and acute medicine since the original workforce baseline figures were assessed.
- Development of ambulatory care systems across GM.

2.0 Economic Case

2.1 Value for Money

The 2015 Healthier Together Decision Making Business Case considered four short listed options for service configuration:

- Option 1: ‘Do nothing’.
- Option 2: ‘Do Minimum’. All 10 hospitals increase their workforce to deliver the Healthier Together clinical standards.
- Option 3: Designate five hospitals as ‘specialist’ sites.
- Option 4: Designate four hospitals as ‘specialist’ sites.

The net present value\(^2\) (‘NPV’) of the options was calculated, including a separate NPV for each of the sub-options considered within Option 3 and Option 4. The net present value for four sites was higher than the net present value for five sites for all sub-options.

On 15th July 2015, all 12 Greater Manchester CCGs came together as a “Committees in Common” (‘CiC’) to select a preferred option for implementation. CiC members received information and presentations for all the criteria (Quality and Safety; Travel and Access; Transition; and Affordability and Value for Money). The CiC concluded that most of the criteria did not distinguish between the sub options; the key differentiator

\(^2\) Net Present Value (NPV) is a formula used to determine the present value of an investment by the discounted sum of all cash flows expected from the project. It allows comparison of different options at today’s prices, to determine which option represents the best value for money.
between options was travel and access. In light of the evidence, **CiC members voted unanimously in favour of option 4.4a (a sub option of Option 4) as the preferred option for implementation.**

Following the unanimous decision to implement option 4.4a, sector teams have worked to operationalise the clinical model and to refine costs. The economic case in the Greater Manchester full business case has been updated to incorporate these revised costs.

The September 2017 business case demonstrates that:

- Option 1 remains clinically unacceptable.
- When compared to the do minimum option (Option 2), Option 4 has a higher Net Present Value and therefore demonstrates value for money.

In conclusion, the economic case demonstrates that the preferred option, as decided by the Joint Committee in 2015, still demonstrates value for money at a GM level.

### 3.0 Commercial Case

#### 3.1 Further work required to meet Treasury BC requirements

The receipt of capital funding is contingent on completion of an appropriate Full Business Case. This includes a full Commercial case with detailed estates design work and a comprehensive section describing the approach which will be taken to procurement and contract management.

Due to the significant costs involved, Trusts did not commence detailed design work at risk prior to the identification of a capital funding source. Consequently, detailed design work did not begin in earnest until the 2017/18 financial year.

All sectors are now underway with commercial case development. The Manchester and Trafford sector and the South East sector anticipate completing their commercial case content by December 2017, whilst for the North East and North West sectors, where the capital schemes are more ambitious, full commercial case completion is not anticipated until early in the 2018 calendar year.

The Greater Manchester Health & Social Care partnership (GMHSCP) is seeking urgent clarity from NHS England /NHS Improvement on the expected timescales and approval routes for the release of the national capital which will include the submission of the current Full Business Case with the commercial case completed to the detail required.

### 4.0 Financial Case

#### 4.1 Funding and Financial Agreements

Implementing Healthier Together will have capital, transitional and recurrent revenue financial impacts. These are further described below, along with the funding agreements identified.

##### 4.1.1 Capital

The capital requirement for Healthier Together (HT) amounts to up to £63 million across Greater Manchester (GM). This is detailed below in Table 1.
Table 3: Capital Requirement

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<th>Sector</th>
<th>Requirement</th>
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<td>Manchester and Trafford</td>
<td>2 wards</td>
</tr>
<tr>
<td></td>
<td>3 critical care beds</td>
</tr>
<tr>
<td></td>
<td>1 theatre</td>
</tr>
<tr>
<td>North East Sector</td>
<td>2 wards</td>
</tr>
<tr>
<td></td>
<td>4 critical care beds</td>
</tr>
<tr>
<td></td>
<td>2 theatres</td>
</tr>
<tr>
<td>North West Sector</td>
<td>2 wards</td>
</tr>
<tr>
<td></td>
<td>6 critical care beds</td>
</tr>
<tr>
<td></td>
<td>2 theatres (one elective and one non-elective)</td>
</tr>
<tr>
<td>South East Sector</td>
<td>Equipping 1 ward</td>
</tr>
<tr>
<td></td>
<td>Equipping critical care beds</td>
</tr>
<tr>
<td></td>
<td>Equipping theatre</td>
</tr>
<tr>
<td></td>
<td>Expanding A&amp;E</td>
</tr>
<tr>
<td></td>
<td>Expanded CT</td>
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<td></td>
<td>Expanded Endoscopy</td>
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The GMHSCP submitted a bid for the full £63 million (alongside a capital bid of £30m for Major Trauma) to NHS England in May 2017.

In mid-July, the GMHSCP were informed that Greater Manchester has been awarded the full capital requested for both the Healthier Together and Major Trauma programmes. This is made up partly of STP funding and partly from DH Capital.

The receipt of capital funding is contingent on completion of an appropriate Full Business Case.

4.1.2 Transitional (non-recurrent revenue)

Transitional costs of implementation totalling £11.7m as set out below in Table 2 below, will be funded by the Greater Manchester Transformation Fund.
Greater Manchester Programme Management costs of £809k will be met through Greater Manchester CCGs, and IT costs relating to the implementation of Datawell have already been funded or are expected to be met through the GM Digital Fund.

In addition to the transitional costs described above, there is a risk that non-contracted pay costs of up to £5.0m could be required non-recurrently pending the substantive recruitment of new staff. It is expected that this risk will be partially mitigated through both local and STP level action, and that any non-mitigated element will be funded locally in sectors. This risk is most material in the North East sector where non-contracted pay costs are estimated at up to £4.2m.

Sectors will seek to fully mitigate these costs by only appointing to substantive posts and by bringing forward the timing of recruitment. Whilst this would eliminate the financial risk, it should be noted that any failure to recruit would risk delaying implementation of the model of care and therefore the achievement of the quality standards.

### 4.1.3 Stranded costs

During the transitional period, there is a risk that stranded costs will arise at non-hub sites. Stranded costs would arise if the loss of general surgery income at a non-hub site could not be matched by the immediate removal of equivalent cost (for example, overhead costs).

Stranded costs resulting at non-hub sites have been estimated at £18.5m across Greater Manchester, following application of a consistent calculation methodology. This methodology assumes that stranded costs will taper down over time following local mitigation action. There is a risk that providers are unable to reduce stranded costs in line with this profile.

The £18.5m stranded costs will be 75% underwritten through Greater Manchester sources. This leaves a further risk relating to the 25% (£4.6m) which is not underwritten.

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3 Datawell is an innovative and secure digital infrastructure that enables doctors and care professionals to share and view patient information to enhance care and decision making.
There are opportunities for providers to mitigate these costs e.g.:

- Organisations are working to identify and implement local solutions which would address stranded costs. The transitional monies set aside to underwrite stranded costs can be used instead to implement these solutions as required.
- Greater Manchester is currently reconfiguring more than half of its acute services under Devolution, providing an opportunity to mitigate stranded costs at acute provider sites.

4.1.4 Recurrent Revenue

The recurrent revenue impact of Healthier Together consists of:

- Activity moves – impact at hub: This is the income relating to the general surgery activity which is transferring from non-hub sites to hub sites, offset against the related operating expenditure required to deliver that activity to current clinical standards.
- Healthier Together Standards: This is the cost required to meet the Healthier Together clinical standards, and includes consultant cost, other staff cost and some non-staff costs.
- Revenue consequences of capital: This is the annual PDC and depreciation charges associated with the capital investment required for the programme.
- Ambulance costs: These are the costs of the additional ambulance conveyances from non-hub to hub sites.

The recurrent revenue impacts by sector are set out below in Table 3.

Table 5: Recurrent Revenue

<table>
<thead>
<tr>
<th>Recurrent Annual Revenue Impact (£’000)</th>
<th>Activity moves – impact at hub</th>
<th>HT stds</th>
<th>Revenue cons. of capital</th>
<th>Ambulance Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manchester and Trafford</td>
<td>(1,561)</td>
<td>2,200</td>
<td>693</td>
<td>225</td>
</tr>
<tr>
<td>North East sector</td>
<td>-</td>
<td>6,747</td>
<td>1,728</td>
<td>228</td>
</tr>
<tr>
<td>North West sector</td>
<td>1,569</td>
<td>3,197</td>
<td>2,073</td>
<td>148</td>
</tr>
<tr>
<td>South East sector</td>
<td>172</td>
<td>1,916</td>
<td>1,258</td>
<td>228</td>
</tr>
<tr>
<td>TOTAL</td>
<td>180</td>
<td>14,060</td>
<td>5,752</td>
<td>829</td>
</tr>
</tbody>
</table>

PDC is a form of long-term government finance provided to NHS trusts to enable them to purchase the Trust’s assets from the Secretary of State. Public dividend capital (PDC) represents the Department of Health’s (DH’s) equity interest in defined public assets across the NHS.
Ambulance costs will be funded by commissioners as part of the GM ambulance commissioning round.

In Manchester and Trafford and the North East sector, providers and commissioners have reached agreement on the funding of the other recurrent revenue impacts. These agreements will require ratification through local Trust Boards and CCG Governing Bodies following Greater Manchester approval of the Healthier Together Business Case.

In the North West sector and in the South East sector, providers and commissioners have reached partial agreement on the funding of the recurrent revenue impacts. Work continues to urgently complete and finalise these agreements.

4.1.5 Summary

- Capital funding has been fully identified, contingent on completion of an appropriate Full Business Case.
- Transitional funding has been fully identified for all transitional costs, other than:
  - Stranded costs: Funding sources have been identified to underwrite the majority of stranded costs should these eventuate.
  - Non-contracted workforce costs: These are expected to be partially mitigated through both local and STP level action, with any non-mitigated element funded locally in sectors.
- Ambulance costs will be funded by commissioners as part of the GM ambulance commissioning round.
- Recurrent revenue funding agreements have been reached in two of the four sectors and partial agreements have been reached in the remaining two, with work to urgently finalise these currently ongoing. The full business case which supports the DH submission will need to detail the final agreements reached for all recurrent revenue impacts of the programme.

5.0 Management Case

5.1 Governance

To oversee the implementation of HT, sectors have developed Programme Boards to oversee progress. These boards are represented by all stakeholders across the sector ensuring providers and commissioners play an active part in implementation; individual sector risk registers are managed here. Any risk that requires escalation would be raised at the HT Delivery Board, which has provided system wide oversight and governance of the programme. Development of a HT dashboard will ensure that performance is monitored in a structured and robust way with sectors reporting monthly on progress and achievement.

5.2 Risks and Issues

The following table provides a summary of the key risks and mitigations being managed in the HT programme. The risks are described in the Programme Risk Register and are reported routinely at the Delivery Board and escalated through the Theme 3 architecture as required.
### Table 6: Key risks and mitigations

<table>
<thead>
<tr>
<th>Key Risks</th>
<th>Mitigating Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workforce:</strong></td>
<td>GM Workforce Reference Group to develop strategies focussing on key aspects of programme deliverables including recruitment, assessment of pipeline consultants within the GM system, terms and conditions and consistent application of policy and principles.</td>
</tr>
<tr>
<td>Ability to recruit required number of consultants to deliver the HT standards</td>
<td>Collaboration with Health Education England to ensure attractive training propositions for junior medical trainees across GM balanced with service stability for all sites.</td>
</tr>
<tr>
<td>Changes to working patterns with new model may ability to retain and recruit staff</td>
<td>Established sector workforce and HR groups reviewing recruitment strategies linking to the wider GM picture, with robust staff communication and engagement strategies.</td>
</tr>
<tr>
<td>Impact of training requirements of junior medical staff due to HT impacting service provision at non-hub sites</td>
<td>Phased implementation plan across GM facilitates a sequential approach to recruitment where appropriate.</td>
</tr>
<tr>
<td><strong>Radiology:</strong></td>
<td>GM review of clinical pathways to maximise efficient use of the workforce.</td>
</tr>
<tr>
<td>Workforce challenges to delivery core requirements of HT</td>
<td>Clinical Champions input to lead early engagement with staff groups, Unions, colleges etc.</td>
</tr>
<tr>
<td>Sub-specialty delivery of interventional radiology</td>
<td>Readiness assessment focusing on cultural aspects of change, supplementary to systems and structural change requirements.</td>
</tr>
<tr>
<td>Existing reporting pressures</td>
<td>Radiology Clinical Advisory Group and Vascular Intervventional Radiology sub groups established with strong links to HT and pathway development, in additional to sectors developing local models to ensure 7 day delivery of level 1 competencies.</td>
</tr>
<tr>
<td>Radiology standards agreed.</td>
<td>Collaborative Image Sharing business case in development to enhance efficiencies and reporting capability.</td>
</tr>
<tr>
<td>GM Workforce Group focussing on Radiology workforce requirements linked to wider Theme 3 requirements.</td>
<td></td>
</tr>
</tbody>
</table>
### Transfer of Patients:

Potential clinical dis-benefit of double ambulance transfers of patients from a non-hub to a hub.

The potential dis-benefit of double ambulance journeys continues to be reviewed by the NWAS task and finish group with senior clinicians addressing any potential risks and issues. The evidence from NHS Lothian will continue to be explored in more detail as well as GM initiatives that transfer patients from a receiving A&E site to a specialist centre, such as Neurosurgery, Stroke, PCI, Major Trauma and existing Fairfield & Trafford models.

NWAS business case provides sufficient capacity for the transfer of all patients from a non-hub to a hub site, using Optima modelling system to account for additional resources required.

Similar models to Healthier Together exist such as NHS Lothian, where patients are transferred from an A&E receiving site to a specialist colorectal site for emergency laparotomy intervention, with excellent patient outcomes such as mortality rates for emergency laparotomy.

Examples of existing pathways that transfer patients from one A&E to another, such as Fairfield model for emergency general surgery, Neurosurgery, Stroke, Major Trauma and PCI.

### Delivery of standards & benefits

Healthier Together standards and benefits of the programme not being achieved.

Benefits baseline completed in April 2017. Shared with sectors. Review and audit process to be developed and agreed with board linking to external independent support to facilitate process with use of audit data, hard copy evidence and peer-review.

Clinical Benefits dashboard developed and agreed via delivery board and reporting to commence from November 2017.

### Critical Care Compliance:

Critical Care services in 2/4 sector hubs not being compliant with National Critical Care Guidance. This is due to workforce shortage of ICM consultants.

Compliance being managed by Critical Care Network across GM. Risk highlighted to AGG on 21st March 2017. Programme Team to liaise with CC Network.

### Equalities:

Risk that HT model creates inequity and fails to ensure patient voice heard through the planning and implementation stages.

Equalities advisory group established alongside the development of Integrated Impact Assessment (IAA) implementation condition with reporting function through the HT delivery board.

Delivery of sector level equality impact assessments and patient voice groups and inclusion of patient in various working groups in addition to strengthening links with wider Theme 3 changes.
### GI Bleed Patients:
The risk that patients with life threatening gastrointestinal haemorrhage arriving in ED at non hub sites. Sectors not compliant with NICE/CEPOD standards.

NWAS medical pathfinder has GI haemorrhage included as indication for divert. GI Bleeds pathways under development and shared with sectors via Clinical Alliance. To be assessed as part of go-live plan and readiness asst. Clinical Lead to assure sectors approach. GI Bleeds workshop to be held following sector specific meetings on 26th October 2017

### Funding:
- Risk of failure to secure capital via national route
- Risk of lack of transitional funding to support implementation
- Stranded costs
- Risk of failure to agree recurrent revenue impact of delivering Healthier Together

The treasury allocated full capital request of £63m on 19 July 2017. Following GM approval the FBC will be submitted to national authorities for final approval and release of capital. The commercial case component will be completed now sectors are moving at risk ahead of the release of national funds through the procurement stages to complete the detailed design phase.

Transformation Oversight Funding Group decision delivered on 28 June 2017 to support £17.2m and GM CCG monies to the value of £5.5m made available to support the transitional process.

A large percentage of the TFOG funding supports any unmitigated stranded costs, with the expectation that organisations and sectors will work to mitigate their available assets. For example linking Theme 3 changes, looking to agreements around reciprocal activity flows, explore independent sector opportunities to deliver work referred to private sector back to the NHS, links with integrated programmes and wider estates strategies.

Recurrent revenue agreements in place in two sectors, North West Sector expected to conclude imminently and the GM HSCP to support conclusion of negotiations in South East Sector.

Funding oversight provided by the Finance Executive Group.

### System Assurance:
The system needs assurance, through the FBC that HT is affordable and deliverable (e.g. that workforce can be put in place) before funding and implementation is agreed

Production of a full FBC agreed with sectors.

Governance process approved and Executive function process established.

Production of accompanying paper to provide assurance on risks, funding, case for change and value for money to be presented at the Theme 3 executive and finance executive group prior to final approval at the Joint Committee.
6.0 Recommendations

The Joint Committee is invited to:

- Note that the Healthier Together Business Case is consistent with previously agreed Joint Committee decisions in respect of HT;
- Note the management action being taken to manage the residual risks in the implementation of the model of care;
- Note the sponsorship and support of the Business Case by the Theme 3 Executive and the Finance Executive Group; and
- Approve the Greater Manchester Business Case for Healthier Together.
7.0 Appendices

7.1 Appendix 1

Tameside Hospital NHS Foundation Trust Outlier Communication as per appendix 1 of the National Bowel Cancer Audit 2016

Outlier Communication

Tameside & Glossop Integrated Care NHS Foundation Trust received a potential outlier notification for higher than expected rate of 2 year mortality scheduled to be published in the December 2016 National Bowel Cancer Audit Report.

The Trust is concerned as the NBOCA mortality position is related to a historic dataset and will continue to repeat itself until the 2018 report, despite actions taken by the Trust to address the issues of incomplete and poor data quality. In addition to the data review, an MDT review of the 21 mortality patients identified from the 2013 data set was completed. This was to provide an assurance of the care delivered, to identify any areas of concern and establish any areas where lessons could be learned. The review also gave the level of understanding as to what had caused the higher than expected mortality rate and, whether the deaths were expected/unexpected and avoidable/unavoidable.

Methodology:

Following identification of all the patients in the cohort who had died, a retrospective case note review was completed using a specific mortality review proforma for the patients with bowel cancer aligned to the Trust Mortality Review process. The proforma incorporated identification of ASA, Charlson Score and T stage.

Outcomes:

Data Quality The review of these historic cases identified areas of data weaknesses in both the HES data (clinical coding of co-morbidities) populating Somerset and the quality of data submission to the audit platform. The team concluded that these weaknesses have affected the inclusion of risk factors for this cohort of patients, influencing the Trusts 2 year mortality outcomes performance.

Clinical Reviews:

- 0 of the patient deaths identified were avoidable.
- Average age of patients reviewed was 72 years; (49–90), with only 3 patients being under the age of 60 years.
- Average survival days for the 21 patients reviewed was 288.1 days, with a range of 0 – 705 days.
- ASA classifications; a large percentage ASA 2, 42.9% (9/21), case note review challenged the accuracy of the ASA recording.
- 38.0% (8/21) were emergency procedures.
- 37.5% (3/8) of emergency procedures had an average age of 83 years and expected mortality ranging from 76.8% – 94.3% prior to surgery. All but 1 had multiple co-morbidities; the 1 remaining patient presented with severe sepsis and died of multi organ failure.
- Of the remaining deaths these were attributed to unexpected complications, natural causes due to age group of patients, and other primary focus of cancer(s).
• 28.6% (6/21) of patients had metastases at time of surgery, despite surgery and treatment 50% of patients developed metastatic disease.

• 2 of the patients reviewed had previous cancer primary focus elsewhere.

• 52.4% (11/21) of the patients reviewed had the tumour staged as T4.

**Actions:**

As a Trust we consider that the MDT review and resulting actions put in place are an appropriate way to address the outlier issue. The Trust is confident that its outlier status will resolve with the addition in time of these dataset time periods. It needs to be noted that the mortality reviews have not identified any issues in way clinical care was delivered.

The latest report outcomes have already been discussed internally and brought to the attention of the Service Quality & Governance Group, a further in depth report and action plan is to be completed to assure the quality of the data submitted prior to lock down.

Validation of data submitted to NBCA has been further strengthened in collaboration with Clinical audit and Clinical coding teams with the clinicians to assure the validation of HES data with NBOCA data to assure the accuracy of future data submissions, with measures in place to prospectively monitor progress.

7.2 **Appendix 2**

Evidence of variation in surgical practice can be seen in published National Surgical Audit Programmes:

- National Bowel Cancer Audit (2014, 2015 and 2016)

A number of national publications that incorporate GM data also demonstrate ongoing clinical challenges:

- NCEPOD, "Treat the cause", 2016
- NCEPOD, " Time to Get Control", 2016

Variation in practice remains a priority for professional surgical bodies and this is recognised as pivotal to improving surgical outcomes, including mortality. Evidence includes:

- The National Bowel Cancer Audit Programme
- National Emergency Laparotomy Audit Programme 2014 onwards
- NICE October 2016: Molecular testing strategies for Lynch syndrome in people with colorectal cancer

Consistent quality improvement themes drawn from research include:

- Standardising of clinical pathways, including the value of post-operative planned critical care (Swart M, Carlisle JB, Goddard J Br J Anaesthesia 2017;118:100-104, Chana P, Joy M, Casey N et al BMJ Open 2017;e014484); and
7.3 Appendix 3:

Audit data:

- National Emergency Laparotomy Audit (NELA)
- GM Critical Care and Trauma Network’s peer review report
- Society for Acute Medicine Benchmarking Audit (SAMBA)
- National Bowel Cancer Audit (NBOCA)
- National Cardiac Arrest Audit (NCAA)
- National Oesophago-Gastric Cancer Audit (NOGCA).