

Clinical Senate Independent Clinical Review of Recommendations made by NCAT on 13th December 2013 for Healthier Together

Date of Report: 19th June 2014

Chair's foreword:

Greater Manchester's 12 clinical commissioning groups are fully committed to supporting the reform of Greater Manchester's Health and Care system, and the Healthier Together Programme is the vehicle for that reform. The transformation programme is a commendable and ambitious whole system approach to quality improvement that is clinically driven and based upon agreed clinical standards. The clinical standards embedded in the programme aim to improve system and process reliability, reducing high morbidity and avoidable mortality.

The National Clinical Advisory Team (NCAT) carried out a formal review of the Healthier Together Programme between September and December 2013. The subsequent formal report focussed on clinical assurance and recommendations, with the panel fully endorsing the programme's ambition, vision and scope; describing it as 'an exemplar for the NHS and its partners'.

In April 2014, the newly formed Greater Manchester, Lancashire and South Cumbria Clinical Senate received a commission by the Senior Responsible Officer for Healthier Together to provide clinical advice to commissioners that would support assurance of the recommendations made by the NCAT within the report of the review.

In accepting this commission, the challenges for the Clinical Senate in carrying out a review of this kind quickly became apparent. The sheer scale and size of the transformation programme, the likes of which has not before been seen within the NHS, meant navigating through a wealth of data and documentation in order to find specific evidence. Nonetheless, with the support and help of the Healthier Together Programme Director, Medical Director and wider team, the Clinical Senate was able to reach its conclusions.

This report sets out the process of review, evidence sourced and findings of the Clinical Senate. In recognition of work that is in progress and planned for Healthier Together programme, the Clinical Senate has provided additional specific and general advice that aims to enhance the delivery of the programme further.

Finally, it is important to note that throughout the process of this review I have been impressed by the richness and depth of discussions enabled by the diverse nature of the members of our Clinical Senate, as well as the approach to team working from our working groups. In recognition of their hard work, dedication and support, I would like to also thank the Clinical Senate management team for their role in the production of this report and the ongoing facilitation of the Clinical Senate.



A handwritten signature in black ink that reads "Donal J. O'Donoghue". Below the signature is a horizontal line.

Professor Donal O'Donoghue
Senate Chair
Greater Manchester, Lancashire & South Cumbria Senate

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Relevant documents:

1. National Clinical Advisory Team (NCAT) Formal Review (17th December 2013) : Report and Recommendations -

https://healthiertogethergm.nhs.uk/files/7413/9704/0809/Appendix_13_NCAT_formal_review.pdf
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1. Table of Summary Findings and Clinical Senate Advice

| NCAT recommendations | F/P/N | Clinical Senate Advice |
|---|-----------------|--|
| <p>Recommendation 1 <i>Some evidence of insufficient clinical and management ownership at the institutional level. An issue which needs to be addressed with some urgency.</i></p> | <p>F</p> | <p>The Healthier Together Programme has increased clinical engagement and raised awareness of the programme in as far as it is possible to do so. It is always difficult to assess, in such circumstances, the effect that the increased awareness has had and if this has translated into greater ownership. Having said that, the steps taken by the Healthier Together programme have satisfied the Clinical Senate that they have improved and increased engagement and ownership by evidence of activities provided.</p> |
| <p>Recommendation 2 <i>The current standards are divided into 'in' and 'out' of hospital standards and currently are mostly focused on hospital care. Whole service reform requires a whole system approach to standard setting with a chief focus on the care of the individual patient and outcomes of the whole patient journey. For instance most of children's care is delivered outside of the hospital.</i></p> | <p>P</p> | <p>There is evidence of progress with these recommendations. Whilst there are clear job descriptions for clinical leadership roles this would further benefit from being placed within a leadership structure that describes how these roles are embedded both for in and out of hospital care settings to enable a whole pathway of care approach.</p> |
| <p>Recommendation 3 <i>Timeliness and responsiveness of services are most valued by patients and need to be a key component of a set of standards.</i></p> | <p>P</p> | <p>Current variation in timeliness and responsiveness of services was evidenced through a facilitated peer review process. It is the Clinical Senate's view that it is the responsibility of Providers to review findings of this process and to develop actions that will implement improved standards of timeliness and responsiveness at this time. Secondly, caution is urged in the use of evidence from trauma as a proxy for the basis of system wide travel times for undifferentiated patients.</p> |
| <p>Recommendation 4 <i>Workforce development must be of the whole system not just of hospitals. Development that encompasses cultural issues, workforce involvement in service improvement, education, training and developing new roles and ways of working is of the utmost importance. These issues apply to all new and existing staff and for all grades as for instance Healthcare Assistants provide much of the care of patients. Developing and meeting educational standards including time set aside for staff learning is as important as the setting and meeting of other standards.</i></p> | <p>P</p> | <p>The Healthier Together programme has provided evidence to demonstrate that they are making efforts to engage widely with the workforce within the system. It can improve this further by targeting a wider range of middle and lower grade frontline staff. The Clinical Senate consider that it would be beneficial for the Healthier Together programme to draw learning from other reconfiguration programmes, in particular in terms of impact of reconfiguration on workforce, where shared rotas or new roles were developed and to avoid any obvious pitfalls.</p> |
| <p>Recommendation 5 <i>More focus on patient outcomes, in particular patient determined outcomes</i></p> | <p>P</p> | <p>There is an acknowledgment that patient and carer involvement can be improved, there is evidence of steps being taken to achieve this through activities that are being implemented through the pre-consultation stakeholder and public engagement events.</p> |
| <p>Key: F = Fully met; evidence shows that progress has been made as far as possible P = Partially met; evidence shows that some progress made with further focus required N = Not met; no evidence of progress made</p> | | |

2. Background

2.1 Healthier Together¹ is an ambitious service transformation programme sponsored by the Greater Manchester Association of Clinical Commissioning Groups and forms part of the Greater Manchester's Programme for Health and Social Care reform. The Future Models of Care described by Healthier Together aim to drive up standards and create a 'single service' concept with multi-disciplinary teams responsible for Specialists and Local Services for a population of Greater Manchester. The programme focusses on three key areas, these are: Integrated and Primary Care, Community Based Care and In-Hospital Care.

2.2 In December 2013, the National Clinical Advisory Team (NCAT) was invited to review the Healthier Together Programme, specifically the standards and evidence of current compliance with the standards. NCAT produced a report² following the review that was overwhelmingly supportive of the programme, and confirmed that the models of care proposed are consistent with best practice. NCAT made a number of recommendations within the report for the transformation programme to further consider.

2.3 In April 2014 the Clinical Senate received a request³ from the Healthier Together's Senior Responsible Officer, Mr Ian Williamson, Accountable Officer for Central Manchester Clinical Commissioning Group, to review the recommendations made by NCAT and to provide independent clinical advice in relation to five priority recommendations and support the assurance process associated with the recommendations.

Figure 1. NCAT Recommendations under review

Recommendation 1: Some evidence of insufficient clinical and management ownership at the institutional level. An issue which needs to be addressed with some urgency.

Recommendation 2: The current standards are divided into 'in' and 'out' of hospital standards and currently are mostly focused on hospital care. Whole service reform requires a whole system approach to standard setting with a chief focus on the care of the individual patient and outcomes of the whole patient journey. For instance most of children's care is delivered outside of the hospital.

Recommendation 3: Timeliness and responsiveness of services are most valued by patients and need to be a key component of a set of standards.

Recommendation 4: Workforce development must be of the whole system not just of hospitals. Development that encompasses cultural issues, workforce involvement in service improvement, education, training and developing new roles and ways of working is of the utmost importance. These issues apply to all new and existing staff and for all grades as for instance Healthcare Assistants provide much of the care of patients. Developing and meeting educational standards including time set aside for staff learning is as important as the setting and meeting of other standards.

Recommendation 5: More focus on patient outcomes and in particular patient determined outcomes.

3. Methods

3.1 The Clinical Senate set up four working groups⁴ with a range of clinicians to examine specific recommendations (Figure 1) and to review the recommendations made by NCAT (Figure 2). An initial request was made to Healthier Together for a formal report with supporting evidence for each of the recommendations⁵. Information was received by way of details of the Pre-Consultation Business Case available on the Healthier Together website, at: <https://healthiertogethergm.nhs.uk/resources/pre-consultation-business-case-pcbc/f/>. This was further reviewed

¹ Details of the Healthier Together Programme can be found www.healthiertogethergm.nhs.uk

² National Clinical Advisory Team (NCAT) Formal Review (17th December 2013) : Report and Recommendations

³ Letter to Prof Donal O'Donoghue, Senate Chair (9th April 2014)

⁴ List of members of working groups

⁵ Senate Council Letter to Healthier Together (26th March 2014)

by each of the working groups in light of the recommendations. The working groups developed a number of questions that arose from review of the information that were collated and sent in to Healthier Together⁶.

3.2 The Medical Director for Healthier Together, Dr Chris Brookes, attended a Clinical Senate Council meeting on the 14th May 2014 to present a response to the questions sent in advance. At the meeting, the working groups leads and wider council were given an opportunity to pose the questions directly to Dr Brookes. Following this a record was made of key discussions⁷, and Healthier Together was asked to supply further evidence⁸ to support the narrative provided. The working groups reviewed the evidence and developed statements that provided an assessment of the extent to which questions had been answered and recommendations had been progressed to implementation. The statements form the basis of the clinical advice developed by the Clinical Senate Council.

Figure 2. Objectives of Working Groups

1. Review the extent to which the recommendations made in the NCAT formal review of the 17th December 2013 have been implemented, by
2. Formulating questions and making a clinical assessment of the supporting evidence in order to identify improvements that can be made in light of the NCAT recommendations made, and to
3. Provide a consensus statement of clinical advice; highlighting outstanding issues.

4. Outcomes of review by Clinical Senate Council

4.1 NCAT Recommendation 1: Some evidence of insufficient clinical and management ownership at the institutional level. An issue which needs to be addressed with some urgency.

4.2 Evidence reviewed: The Clinical Senate requested evidence of clinical engagement and details of meetings and events that aimed to achieve clinical and managerial ownership. Healthier Together sent details of the Provider Reference Group, their Terms of Reference, Details of Clinical Champions as well as details of Clinical Engagement Attendance that provides a breakdown of attendees from Hospital Trusts in Greater Manchester invited to clinical events, an appendage of the Pre-Consultation Business Case.

4.3 Clinical and managerial leadership is essential in ensuring ownership for the effective redesign of services in line with the desired model of care. The role of Medical Director was created in order to develop and enhance this specific area and Dr Brookes has taken steps to engage widely across the system to achieve this.

4.4 This has included a programme of visits to organisations, Trust boards, Webinars with staff and sharing events with a range of stakeholders from across the conurbation. The programme has secured senior management engagement by way of the Provider Reference Group that has membership of each of the Chief Executive Officers of Trust's.

4.5 The Clinical Senate understand that the purpose of engagement is to promote awareness and not necessarily achieve consensus in relation to the programme's aims. Moreover, it does not necessarily follow that improving engagement and raising awareness achieves ownership and the programme Leaders should be aware of this.

4.6 Conclusion of the Clinical Senate Council: recommendation fully met; The Healthier Together Programme has increased clinical engagement and raised awareness of the programme in as far as it is possible to do so. It is always difficult to assess, in such circumstances, the effect that the increased awareness has had and if this has translated into greater ownership. Having said that, the steps taken by the Healthier Together programme have satisfied the Clinical Senate that they have improved and increased engagement and ownership by evidence provided.

5. NCAT Recommendation 2: The current standards are divided into 'in' and 'out' of hospital standards and currently are mostly focused on hospital care. Whole service reform requires a whole system approach to

⁶ Questions collated by working groups during review of evidence provided by Healthier Together

⁷ Notes of discussions at Clinical Senate meeting 14/5/14

⁸ List of evidence provided by Healthier Together

standard setting with a chief focus on the care of the individual patient and outcomes of the whole patient journey. For instance most of children’s care is delivered outside of the hospital.

5.1 Evidence reviewed: Presentation by Dr Brookes to Senate Council, Provider Reference Group agenda, Pre-Consultation Business Case, Primary Care Commissioning Strategy, Community Based Care Standards, DRAFT Social Care Standards, GM Vision for Primary Care and Trauma Network Governance Structure.

5.2 To date, the Healthier Together Programme focus has largely been on the hospital pathways and it is in that area where plans are most well developed. The programme is using similar methods to develop plans in Primary, Community and Integrated Care and where appropriate is using a joint approach between Local Authority and the NHS. This is forming part of discussions at the provider reference group and leadership has been identified for these work streams.

5.3 Achieving improved standards and reducing variation of care for the ‘single system’ care model proposed will require consistency of leadership across the organisations. It was acknowledged that leadership roles within the programme are key to drive a whole system approach, and will require being representative of both in and out of hospital services. Job descriptions for clinical champions exist and insights from other reconfigurations, i.e. Trauma are being engendered into system wide governance structures.

5.5 Conclusion of the Senate Council: recommendation partially met; there is some evidence of progress with these recommendations. Whilst there are clear job descriptions for leadership roles this would further benefit from being placed within a leadership structure that would describe how these roles are embedded both for in and out of hospital care settings.

6. NCAT Recommendation 3 – Timeliness and responsiveness of services are most valued by patients and need to be a key component of a set of standards

6.1 Evidence reviewed: The Clinical Senate requested example of actions plans from sites following peer review. Healthier Together provided details of quality and safety standards, definition of fixed points, Transport analysis statement 45 minutes.

6.2 The Healthier Together team facilitated an audit by way of self-assessment and peer review for all provider organisations with the purpose of using the information to inform the case for change. Self assessment and peer review methodology offers an opportunity to compare differences between organisations by making an assessment of comparison of performance between teams and organisations. This can provide valuable data that can allow for identification of areas for improvement.

6.3 The audit provided a baseline in relation to Provider Trusts achievement or otherwise with access and timeliness standards. This information can be used to form the basis of action plans that aim to improve the current position.

6.4 The Healthier Together programme is a transformation programme and so it is not a responsibility of the programme to hold Providers to account for performance against standards. The Healthier Together team had briefed Providers and Commissioners with the results of the audit.

6.5 A key component of the standards in relation to timeliness and responsiveness is the assessment of patients into ‘urgent’ and ‘less urgent’ in order to understand progress on the two hour access standard for primary care. This would be determined following clinical assessment by appropriately trained clinical staff.

6.6 A standard transfer time for undifferentiated patients of 45 minutes is suggested, this is to ensure that patients will not have to travel more than this timeframe for specialist services. In addition, there was a 20 minute transfer time to a ‘place of safety’ which would be the nearest District General Hospital. At this time, there is no clinical evidence base from which to support the timeframe for patients presenting with undifferentiated symptoms. The standard has been adapted from evidence available from Trauma services. It can be strongly argued that presentation of Trauma patients would lend itself to more rapid immediate diagnostics and triage than that of undifferentiated patients.

6.7 Conclusion of the Clinical Senate Council: NCAT Recommendation partially met; Current variation in timeliness and responsiveness of services was evidenced through a facilitated peer review process. It is the Clinical Senate's view that it is the responsibility of Providers to review findings of this process and to develop actions that will implement improved standards of timeliness and responsiveness at this time. Secondly, caution is urged in the use of evidence from trauma as a proxy for the basis of system wide travel times for undifferentiated patients.

7. NCAT Recommendation 4. Workforce development must be of the whole system not just of hospitals. Development that encompasses cultural issues, workforce involvement in service improvement, education, training and developing new roles and ways of working is of the utmost importance. These issues apply to all new and existing staff and for all grades as for instance Healthcare Assistants provide much of the care of patients. Developing and meeting educational standards including time set aside for staff learning is as important as the setting and meeting of other standards.

7.1 Evidence reviewed: Presentation to the Clinical Senate Council by Dr Brookes, Stakeholder and Public Engagement Record, Healthier HR&WF Group Terms of Reference, Clinical Engagement attendance, DRAFT clinical engagement plan.

7.2 The Clinical Senate were reassured by Dr Brookes that the Healthier Together programme has been gathering information in relation to workforce. Though the Clinical Senate feel that it is important to note that in assessing workforce requirements an audit of workforce size serves to inform the process and is not an answer in itself. Transforming the workforce will require winning the 'hearts and minds' of the people working in the system and to enable them to understand how this relates to their personal roles and place of work.

The Clinical Senate fully supports the effective utilisation of a highly skilled and sparse workforce as a major driver for change.

7.3 The Healthier Together team acknowledge that the engagement of frontline staff is key to success of the programme and to date they have facilitated roadshows and communications that aim to achieve this. Questionnaires highlighted concerns amongst staff about the understanding of the programme at the macro level, and the implications for individual working patterns and job security.

7.4 The sharing events have been important in engaging staff and moving forward a more targeted approach to staff from a range of grades and professions will be necessary. Currently, attendance lists show selected high level managers, nursing and medical staff, with nominal middle grade doctors that are not truly representative of all staff grades and can be improved.

7.5 Information has been provided that shows attendance at the events and it would be beneficial to carry out further analysis of this, for example percentage attendance by group per Trust, in order to highlight areas of low engagement. Further, it is important for engagement to demonstrate that views gathered at events are acted upon; there is some evidence that this is being achieved and it is an area that the team can further build upon.

7.6 A reported component of the new ways of working and developing new roles is the Advance Nurse Practitioner role. It would be useful to demonstrate how this specifically helps with Consultant numbers and the ability to deliver a high quality 24 hour service. In terms of new roles there are not currently any examples beyond that of the Advance Nurse practitioner and is an area that requires considerable further development.

7.7 The Healthier Together programme has commissioned work from Health Education England to examine workforce further and the implications for training and development of roles. This work has not concluded and so was not presented for review.

7.8 A number of large scale reconfigurations have taken place in the last 10 years; examples can be drawn from Stroke, Vascular and Cardiac. The programme would benefit from learning from the experience of such programmes in relation to workforce, particularly where shared rotas or new roles were developed.

7.9 Conclusion of the Clinical Senate Council: Recommendation partially met: The Healthier Together programme has provided evidence to demonstrate that they are making efforts to engage widely with the workforce within the system. It can improve this further by targeting a wider range of middle and lower grade frontline staff. The Clinical Senate consider that it would be beneficial for the Healthier Together programme to draw learning from other reconfiguration programmes, in particular in terms of impact of reconfiguration on workforce, particularly where shared rotas or new roles were developed and to avoid any obvious pitfalls.

8. NCAT Recommendation 5. More focus on patient outcomes, in particular patient determined outcomes

8.1 Evidence reviewed: Presentation by Dr Brookes to the Clinical Senate Council, Stakeholder and Public Engagement Record.

8.2 Dr Brookes presented to the Clinical Senate Council and described involvement of patients and carers in the models of care as something that HT is striving to achieve and acknowledge it as an area that needs improvement. This in some way will be addressed in the public consultation.

8.3 Dr Brookes discussed the importance of leadership in effecting cultural change and the appointed clinical champions will have responsibilities in this area. Specific details in terms of achieving this remain unclear and it would benefit from further focus.

8.4 It will be important to involve patients and carers in development of the outcome frameworks, specifically in terms of patient defined outcome measures. It has been acknowledged that this is an area that requires further strengthening. This is more evident in the discussions at primary care level and form part of the stakeholder events.

8.5 A challenge for all services is to ensure the engagement of 'hard to reach' patients to ensure equity of access. This is being reviewed to an extent in the Committees in Common where priority groups have been listed, it has been part of the pre-consultation process and plans to share information in other languages in recognition of the diversity of population. It would be helpful to engage the seldom heard patients who have typically got issues accessing mainstream services and build this into the pathway discussions, especially around patients who are more vulnerable and less able or willing to travel to access care.

8.6 Conclusion of the Clinical Senate Council: Recommendation partially met; There is an acknowledgment that patient and carer involvement can be improved, there is evidence of steps being taken to achieve this through activities that are being implemented through the pre-consultation stakeholder and public engagement events.



Greater Manchester



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Donal O'Donoghue
Chair
Clinical Senate
NHS England (Greater Manchester,
Lancashire & South Cumbria)

9 April 2014

Dear Donal

**Clinical Senate Review of National Clinical Assessment Team (NCAT)
Recommendations**

I am writing to you in my capacity as the Senior Responsible Officer of the Healthier Together programme to seek the support of the Senate in assuring the programme of work we are undertaking. You will be aware that during 2013/14 the (NCAT) undertook a further review of the Healthier Together programme of work which was overwhelmingly positive. The report however highlighted a number of recommendations and indicated that these issues would need to be addressed as part of the Healthier Together programme. I attach a copy of the NCAT report.

As you will be aware NCAT has now been disbanded and my purpose in writing to you is to seek the support of the Greater Manchester, Lancashire & South Cumbria Senate in taking on the assurance associated with these recommendations. I have included herewith the specific NCAT recommendations that we would like the Senate to review. It is our anticipation that the additional recommendations contained within the report will be addressed through the NHS England Assurance process.

I believe Mike Burrows has already discussed this with you and it would be helpful if we could meet at the earliest possible convenience to work with you to determine what evidence we need to pull together to satisfy these recommendations.

Yours sincerely

Ian Williamson

Cc: Dr Chris Brookes
Leila Williams
Alex Heritage

Appendix II – List of members of working groups

| No | Recommendation | Working Group |
|----|--|---|
| 1 | Some evidence of insufficient clinical and management ownership at the institutional level. An issue which needs to be addressed with some urgency. | Group 1 Irfan Chaudry – Lead Dr Carole Gavin Angela Douglas Helen Hurst Dr Steve Watkins |
| 2 | The current standards are divided into ‘in’ and ‘out’ of hospital standards and currently are mostly focused on hospital care. Whole service reform requires a whole system approach to standard setting with a chief focus on the care of the individual patient and outcomes of the whole patient journey. For instance most of children’s care is delivered outside of the hospital. | |
| 3 | Timeliness and responsiveness of services are most valued by patients and need to be a key component of a set of standards | Group 2 Dr Graham Spratt – Lead Mohammed Sawar Mr Nigel Scott Dr Jane Wilcock Dr Martin Hogg |
| 4 | Workforce development must be of the whole system not just of hospitals. Development that encompasses cultural issues, workforce involvement in service improvement, education, training and developing new roles and ways of working is of the utmost importance. These issues apply to all new and existing staff and for all grades as for instance Healthcare Assistants provide much of the care of patients. Developing and meeting educational standards including time set aside for staff learning is as important as the setting and meeting of other standards. | Group 3 Bob Coward – Lead Ian Trodden Nicola Cooke Dr Ian Donaldson |
| 5 | More focus on patient outcomes and in particular patient determined outcomes. | Group 4 Claire Maguire – Lead Dr Jaydeep Sarma Dr Darren Kilroy Kate McNulty Dr Ivan Bennett |



Greater Manchester, Lancashire & South Cumbria
Clinical Senate

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Dear Dr Brooks & Ms Williams

Re: National Clinical Advisory Team (NCAT) Formal Review, 17th December 2013

The Greater Manchester, Lancashire & South Cumbria Clinical Senate have received a request from Greater Manchester CCG's to review progress to date on the response made by the Healthier Together programme in relation to recommendations from NCAT, set out on pages 10 – 12 of the review paper dated 17th December 2013.

Specifically, the Clinical Senate have been asked to:

1. Review the extent to which the recommendations made in the NCAT formal review of the 17th December 2013 have been implemented, by
2. Making an assessment of the supporting evidence for remedial action taken by Healthier Together in light of the NCAT recommendations made, and to
3. Provide independent clinical advice; highlighting issues where further thinking is required. This will provide assurance to CCG's in relation to the extent to which recommendations have been taken on board.

In order to achieve this, we are formally writing to request a report with supporting evidence for each of the recommendations, outlining specific actions, progress made and the named lead with responsibility for implementation of the recommendations. It would be beneficial to have the contact details of the named leads so that lead Senate members can contact individuals directly should they need to clarify any points from the supporting information.

In addition it would be most helpful if a senior member(s) of your team could attend the next Senate Council meeting on the 14th May 2014 at 2.30pm at the Reebok Stadium in Bolton (exact venue to be confirmed) to provide a brief outline of the response made by the Healthier Together Programme and to take any questions.

The Senate Council will aim to expedite this process as quickly as possible in light of the timeline for the public consultation, and to this end we suggest the following timescales:

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| Report & documents from Healthier Together | 18 th April 2014 |
| Initial response and clarification by Senate members | 10 th May 2014 |
| Presentation to Senate Council | 14 th May, 2.30pm |

Report prepared by Senate Council

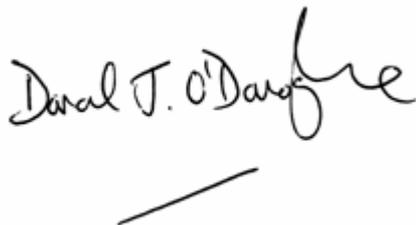
29th May

Many thanks with your co-operation and attention to this, if you could forward information and key contacts requested to Juliette Kumar, Senate Manager at Juliette.kumar@nhs.net

I enclose a document outlining the specific recommendations the Senate Council are asked to review, and named Council Members responsible for specific recommendations.

I am confident that with your collaboration we will be able to complete this process as efficiently as possible.

Yours Sincerely

A handwritten signature in black ink that reads "Donal J. O'Donoghue". The signature is written in a cursive style. Below the signature is a single horizontal line.

Prof Donal O'Donoghue

Senate Chair
Greater Manchester, Lancashire & South Cumbria Clinical Senate

Collated responses from working groups for assurance of Healthier Together, questions presented verbatim for consideration at Clinical Senate Council meeting 14th May 2014.

Working Group 1

Dr Irfan Chaudry

Dr Carole Gavin
Angela Douglas
Helen Hurst
Dr Steve Watkins

| Recommendation – Standards | |
|-----------------------------------|---|
| 1. | Some evidence of insufficient clinical and management ownership at the institutional level. An issue which needs to be addressed with some urgency. |
| 2. | The current standards are divided into ‘in’ and ‘out’ of hospital standards and currently are mostly focused on hospital care. Whole service reform requires a whole system approach to standard setting with a chief focus on the care of the individual patient and outcomes of the whole patient journey. For instance most of children’s care is delivered outside of the hospital. |
| No | Questions |
| 1 | Has Clinical and Managerial Leadership roles been identified and embedded for each of the services? |
| 2 | Have Terms of Reference been agreed by all providers for the provision of Leadership for each service review? |
| 3 | Can we have assurance that all Leadership roles are representative of both “in” and “out” of Hospital services? |
| 4 | Is Leadership Governance the same across all services and what evidence are we able to see of this? |

Working Group 2

Dr Graham Spratt

Mohammed Sawar
Mr Nigel Scott
Dr Jane Wilcock
Dr Martin Hogg

| Recommendation – Timeliness and responsiveness of services | |
|---|---|
| 3. | Timeliness and responsiveness of services are most valued by patients and need to be a key component of a set of standards |
| No | Question |
| 1 | The baseline position has been established through self-assessment and further validation. To what extent have there been reliability and validity checks of the data to establish robustness? a. There is a clear difference in opinion between the trusts and the external reviews as to compliance with the measures; Wigan and Pennine are the |

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| | <p>clearest examples?</p> <p>b. Mostly the measures found to be not compliant seem to be associated with review times and hence clinical staffing?</p> |
| 2 | <p>Presumably within the ownership of each self-assessment there is a degree of commitment to an action plan? To what extent can we evidence explicit action plans that are projecting improvements in the current position and the associated timeline of this?</p> <p>a. Radiology provision seems to be a consistent theme in terms of a service struggling to meet the criteria.</p> <p>b. Timelines for children's worst in terms of compliance</p> |
| 3 | <p>Do we have explicitly agreed criteria for discriminating "urgent" from "less urgent" in primary care in order to understand progress on achieving the two hour access standard for cases in primary care?</p> |
| 4 | <p>Given the range of standards to be assessed for timeliness of response, is there a process for agreeing with individual services their prioritisation for action plans in relation to the standards?</p> <p>a. Timelines are not well met with most points addressed with partially compliant or no evidence submitted.</p> <p>b. How can challenges be met coupled with specific recommendations for how evidence is submitted so that degree of compliance can be fully assessed.</p> |

Working Group 3

Dr Robert Coward

Ian Trodden

Nicola Cooke

Dr Ian Donaldson

| | |
|----|---|
| | Recommendation – Workforce |
| 4. | <p>Workforce development must be of the whole system not just of hospitals. Development that encompasses cultural issues, workforce involvement in service improvement, education, training and developing new roles and ways of working is of the utmost importance. These issues apply to all new and existing staff and for all grades as for instance Healthcare Assistants provide much of the care of patients. Developing and meeting educational standards including time set aside for staff learning is as important as the setting and meeting of other standards.</p> |
| No | Question |
| 1 | <p>4a. Workforce development must be of the whole system - The audit of workforce size will simply serve to inform the process of workforce development and is not an answer in itself.</p> <p>Q. What mechanisms are in place to inform the workforce of progress of the project and relate this to their personal roles and place of work?</p> |
| 2 | <p>4b. Workforce involvement in service improvement</p> <p>Clearly large numbers of personnel attend these events - we have no evidence presented to us here that assures us their views are either representative of the healthcare system across the area or indeed their views have been incorporated.</p> <p>Q. How can you demonstrate that the views of all stakeholders have been fairly represented</p> |

| | |
|---|--|
| | <p>and can you give examples of the views expressed being acted upon?</p> <p>Q. Beyond senior clinical and senior management how have you engaged with “existing staff of all grades”?</p> <p>Q. Is there any analysis of response in relation to site or grade or specialty of respondents?</p> |
| 3 | <p>4c. Education, training and developing new roles and ways of working</p> <p>Development of Advanced Nurse practitioner role is clearly important, not sure how this helps with Consultant numbers all the time.</p> <p>Q. Are there any other examples beyond an ANP of how staff will be working differently?</p> <p>Q. How many A&E Departments have an ANP (You say most have them already)? How many of these Departments have the staffing issues mentioned despite the presence of an ANP? ie They are not the answer...</p> <p>Q. How many Consultants posts have been deemed not required as a result of an ANP?</p> <p>Q. Can we see the details of the planning done by Clinical Congress on the future staff modelling that is mentioned?</p> <p>Cross site working will be a challenge. In my experience staff do not embrace and many opt not to engage in this type of working.</p> <p>The evidence of staff engagement presented is in the form of a snapshot of comments.</p> <p>Q. Who selected and how were these comments selected for submission as evidence?</p> <p>Q. How can you assure me that the need for these new working patterns has the majority support of all staff involved?</p> <p>Q. Can you provide me with the output from the “Healthier Together HR & Workforce group” you are using to evidence this.</p> <p>Q. How will the creation of new multidisciplinary teams be supported both at the local and specialist centres?</p> |
| 4 | <p>5. Developing and meeting educational standards</p> <p>Q. How will the timing of change be communicated to HEE north west (the Deanery) to ensure curricular requirements are available at specific sites and training rotations can be adjusted within these time scales?</p> <p>Q. Is there any baseline audit data of present Health Care Assistants training in compassionate care and the duty of candour?</p> <p>Q. Will training opportunities be shared between both the local and specialist sites and travelling arrangements funded appropriately for all grades of staff with transparency between different sites?</p> |

Working Group 4

Claire Maquire

Dr Jaydeep Sarma

Dr Darren Kilroy

Kate McNulty

Dr Ivan Bennett

| | Recommendation – More focus on patient outcomes, in particular patient determined outcomes |
|-----|---|
| No | Question |
| 1 | How will the urgent care system work safely, especially for sick children, if they have to travel still further to a specialist centre? |
| 2 | How many specialist and general centres will there be and how will that be decided? |
| 3 | How will a 'single service' work between neighbouring Trust and why not simply merge into a single Trust with real economies of scale? |
| 4 | What are the risks and cultural barriers, and how will they be managed? |
| 5 | What guarantee is there that Primary Care will be in a position to manage care in a community setting, in order to transfer activity out of hospital, given that this sector is commissioned directly by the Area Team? |
| 6 | How will the Primary Care standards be achieved? |
| 7 | What is being done where services are only partially or non-compliant? Can they provide evidence of a clear action plans so that patient outcomes are achieved? |
| 8. | How is the variation in performance being managed? Can they provide evidence to provide assurance of a continuity of approach? |
| 9. | What evidence have the HT Team got of patient/carer involvement in the outcome frameworks in terms of patient defined outcome measures? |
| 10. | How are the team tackling issues of engagement of “harder to reach” patients to ensure equity of access? |
| 11. | What evidence is there that the HT team are involving patients/carers in co-production of service redesign? |
| 12. | How is Shared Decision Making being clearly embedded into future clinical training? |

Notes of presentation made by Dr Chris Brookes of the Healthier Together Programme in relation to the five recommendations and evidence requested

The Healthier Together (HT) Medical Director, Dr Chris Brookes attended a meeting of the Clinical Senate Council on the 14th May 2014 following a request for the Senate Council to review the recommendations made by NCAT for the programme of work. Dr Brookes was invited to present a response to questions developed and sent in advance of the meeting.

1. Recommendation 1 – Insufficient clinical and management ownership

1.1 Questions posed by the Clinical Senate:

- Has Clinical and Managerial Leadership roles been identified and embedded for each of the services?
- Have Terms of Reference been agreed by all providers for the provision of Leadership for each service review?
- Can we have assurance that all Leadership roles are representative of both “in” and “out” of Hospital services?
- Is Leadership Governance the same across all services and what evidence are we able to see of this?

1.2 Summary response

Dr Brookes outlined the steps taken to further engage and increase clinical and managerial ownership of the HT programme. Dr Brooke’s appointment last year was to achieve this aim and his role is to engage widely with people within the system of health and care.

Dr Brookes also described his visits and attendance at Trust boards and meetings with non-executive directors across the conurbation to discuss the work of the HT programme, and alluded to key meetings that allowed senior clinical and managerial input into HT, including the Provider Reference Group.

Dr Brookes described how the HT team facilitated Webinars with staff, held two sharing events with 100+ stakeholders at each event. These events were a specific attempt to reach frontline staff working in the system and not just senior clinical and managerial colleagues.

1.3 Evidence requested to support statement

1. TOR or minutes of Provider Reference Group
2. TOR for Leadership Groups
3. Exemplar governance for single site
4. Details of roadshows
5. Analysis of staff groups reached

2. Recommendation 2 – Whole system approach to standard setting

2.1 Questions posed by the Clinical Senate

- How are you approaching development of in and out of hospital standards of care?

2.2 Summary response

Dr Brookes described how work has been progressing for standards for access to community care and discussed how this was being taken forward using a joint approach between the Local Authority and the NHS. These standards will be engendered into the future models of care and Primary Care Strategy.

2.3 Evidence requested to support statement

1. Minutes of Committees in Common
2. Specific standards for Out of Hospital and Social Care
3. Primary Care Strategy

3. Timeliness and responsiveness of services

3.1 Questions posed by the Clinical Senate

- The baseline position has been established through self-assessment and further validation. To what extent have there been reliability and validity checks of the data to establish robustness?
- Presumably within the ownership of each self-assessment there is a degree of commitment to an action plan? To what extent can we evidence explicit action plans that are projecting improvements in the current position and the associated timeline of this?
- Do we have explicitly agreed criteria for discriminating “urgent” from “less urgent” in primary care in order to understand progress on achieving the two hour access standard for cases in primary care?
- Given the range of standards to be assessed for timeliness of response, is there a process for agreeing with individual services their prioritisation for action plans in relation to the standards?

3.2 Summary response

Dr Brookes was able to tell the Council that the standards of 45 minutes transfer time for undifferentiated patients to ensure that patients will not have to travel more than this timeframe for specialist services. In addition, there was a 20 minute transfer time to a ‘place of safety’ which would be the nearest DGH. A number of ‘fixed points’ were agreed, in other words – levels of service provision. Consideration was also given to travel time for families and friends visiting. This was reported to be an integral part of the options appraisal for the placement of services. Dr Brookes was able to describe how the development of the timeframes for response had been discussed and debated in the Committees in Common, the body that represents CCGs and which is a key part of the governance of the programme.

In relation to the ‘urgent and less urgent’ criteria, Dr Brookes acknowledged that this was a matter of clinical judgement. Such a decision to categorise could only be made by a qualified clinician assessing the individual. A debate was had around the 45 transfer standard which concluded in the acknowledgement that the transfer time was based upon a proxy measure taken from Trauma services that should be treated with caution as it was as yet untested.

Dr Brookes outlined that the Healthier Together programme was a transformational programme that was clinically led and involved a bottom up approach to change through engagement. Whilst it made an assessment based upon a peer review methodology, it was not the programmes aim to monitor improvements in individual Trusts but to gain a baseline assessment.

3.3 Evidence requested to support statement

1. Notes of committee’s in common
2. Statement regarding 45 minute transfer time
3. Evidence for ‘fixed point’ argument
4. Action plans made by providers following peer review

4. Recommendation 4 – Workforce

4.1 Questions posed by the Clinical Senate

- What mechanisms are in place to inform the workforce of progress of the project and relate this to their personal roles and place of work?
- How can you demonstrate that the views of all stakeholders have been fairly represented and can you give examples of the views expressed being acted upon?
- Beyond senior clinical and senior management how have you engaged with “existing staff of all grades”?
- Is there any analysis of response in relation to site or grade or specialty of respondents?
- How many Consultants posts have been deemed not required as a result of an ANP?
- Can we see the details of the planning done by Clinical Congress on the future staff modelling that is mentioned?
- Cross site working will be a challenge, how will you engage staff to embrace this type of working?
- How can you assure me that the need for these new working patterns has the majority support of all staff involved?
- Can you provide us with the output from the “Healthier Together HR & Workforce group” you are using to evidence this?
- How will the creation of new multidisciplinary teams be supported both at the local and specialist centres?

4.2 Summary response

Dr Brookes gave reassurance to the Senate Council that the process of evidence gathering in regards to workforce had been ‘forensic’ with information gained from Chief Executive’s and Medical Directors to understand the gap between current to future state for the models of care.

Dr Brookes described how the HT programme had commissioned a piece of work with Health Education England to examine this fully and the work was ongoing.

The models of care depend on working in new ways and it is key to get staff engaged. Dr Brookes acknowledged that it was a challenge to reach the ‘band 5 on the ward’ but that ongoing efforts were being made to achieve this with roadshows.

Dr Brookes was asked how the workforce analysis was being taken forward in primary and out of hours care. Again, the dialogue was taking place with Health Education England in regard to achieving this.

The meeting discussed learning from previous reconfigurations where there is evidence of complaints from trainees following service changes and discontinuity of training. Dr Brookes noted that it was important to learn from previous experience to avoid the same pitfalls.

4.3 Evidence requested to support statement

- TOR for workforce group
- Notes and minutes of workforce meetings
- Details of programme to reach frontline staff

5. Recommendation 5 - More focus on patient outcomes, in particular patient determined outcomes

5.1 Questions posed by the Clinical Senate

- What evidence have the HT Team got of patient/carer involvement in the outcome frameworks in terms of patient defined outcome measures?
- What evidence is there that the HT team are involving patients/carers in co-production of service redesign?
- What are the risks and cultural barriers, and how will they be managed?
- How are the team tackling issues of engagement of “harder to reach” patients to ensure equity of access?
- How is Shared Decision Making being clearly embedded into future clinical training?

5.2 Summary response

Dr Brookes described involvement of patients and carers in the models of care as something that HT is striving to achieve and acknowledge it as an area that needs improvement. Patients had been involved following development of the care models. Dr Brookes acknowledged that discussions had been had with patients but that they had not directly been involved in the development of the models during the design.

Dr Brookes pointed out that the Committees in Common meetings were public meetings and patients were able to attend. In addition, there are plans for the public consultation where patients and their families can input views.

5.3 Evidence requested to support statement

1. Clarity for paediatric services
2. TOR and minutes of meetings involving patients
3. Details of any communication strategy aimed at patient groups

Appendix VI – List of specific evidence supplied by Healthier Together

- 1. Provider Reference Group Terms of Reference and Agendas**
- 2. Clinical Champions Job Description**
- 3. Greater Manchester Vision for Primary Care**
- 4. Primary Care Commissioning**
- 5. Community Based Standards**
- 6. Social Care Standards**
- 7. Trauma Governance Structure – exemplar**
- 8. Minutes of Clinical Reference Group**
- 9. Healthier Together Committees in Common Terms of Reference**
- 10. Public Meetings Minutes**
- 11. Transport Analysis Standards**
- 12. Fixed Point Flow Chart**
- 13. Example of evidence supplied to apply for fixed point**
- 14. Draft Clinical Engagement Plan**
- 15. Clinical Engagement attendance**
- 16. Human Resources and Workforce Group Terms of Reference**
- 17. Stakeholder and public engagement record**
- 18. Plans for Consultation Engagement**
- 19. An independent perspective on Pre-Consultation plan by the Consultation Institute**
- 20. Summary of planned integrated impact assessment**
- 21. Contacts of programme leads for each workstream**
- 22. Greater Manchester Quality and Safety Standards**