NHS
Greater Manchester
Integrated Care

Complex Service Change on the previous Pennine Acute Hospitals footprint

15th March 2023

NHS Greater Manchester Integrated Care

MEETING:	***Integrated Care Board***
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AUTHOR/S:	
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PRESENTED BY:	Mike Barker, Place Based Lead, Oldham

PURPOSE OF PAPER:

Decision Requested:	**Yes** ☒	**No** ☐
For Discussion:	**Yes** ☒	**No** ☐
For Noting/Information:	**Yes** ☐	**No** ☒
Financial Implication:	**Yes** ☐	**No** ☒

PURPOSE OF REPORT:

The report provides an update regarding planned service changes in the context of previously agreed decisions taken in Greater Manchester to disaggregate services from the legacy PAHT and integrate North Manchester General Hospital (NMGH) into MFT and the remainder of the PAHT sites into the NCA.

The paper provides the following:

- A reminder about the background to the acquisition of the Pennine Acute Hospitals Trust by Manchester Foundation Trust and Salford Royal Foundation Trust (and the subsequent creation of the NCA)
- An overview of the disaggregation approach and context of complex services
- A reminder of the agreed approach to developing and assuring service change in Greater Manchester (agreed by JPDC in July 2022)
- A summary of phase 2 complex services namely Cardiology, Gastroenterology, Rheumatology and Urology (6 low volume pathways)
- Overview of engagement approach to date, and summary of estimated impact using service change assurance framework.

KEY MESSAGES:

- The agreed service change assurance process has been undertaken to assess the impact of phase 2 complex service disaggregation on the affected population

RECOMMENDATIONS:

- GM ICB is asked to discuss and support the approach to the Phase 2 complex service change proposals developed, and the Locality engagement undertaken
- GM ICB is asked to endorse the output of the substantial variation assessment undertaken for each of the phase 2 specialties and support the development of implementation plans.

1.0 BACKGROUND

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

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

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

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

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

2.0 DISSAGREGATION OF SERVICES BETWEEN MFT AND NCA

2.1. When MFT acquired NMGH in April 2021 there was a degree of disaggregation of Pennine services – namely all those services that were delivered solely on the NMGH site. For services which were delivered across the former Pennine footprint in order to minimise any changes in clinical / patient pathways for ‘Day 1’ as a means of ensuring a safe and smooth transition.

2.2. To support this agreement, a series of approximately 90 Service Level Agreement (SLA) arrangements were put in place to oversee the delivery of patient pathways across the North Manchester, Bury, Oldham and Rochdale hospital sites.

2.3. However, both MFT and the NCA have since been developing plans which would enable the SLA arrangements to be wound down as sustainable plans for the integration of NMGH services into MFT and Bury/Oldham/Rochdale services into the NCA are developed and enacted. This process is often referred to as the ‘disaggregation’ of legacy PAHT services and has been ongoing since the respective transactions were completed in 2021.

2.4. The SLAs that have been concluded to date represent the most straightforward disaggregation processes that have impacted low numbers of staff and have not required any changes to patient pathways.

2.5. The process of disaggregation has required significant collaboration and co-operation between NCA and MFT. It is a complex and wide-ranging piece of work that has implications across a variety of areas including workforce, IM&T, finance, and governance. The work to disaggregate services must be handled carefully and with due regard to minimising the impact on patients, and staff. The initial work to disaggregate services was overseen by the legacy PAHT Board and was also evaluated by NHS England as part of the Transaction Review process.

2.6. Whilst good progress has been made, there is a residual set of services that presents the most complex challenges in respect of service disaggregation. These are services that will potentially require a change in location or change in patient flows. As such, there has been strong engagement and early discussions with all relevant commissioners / localities[1] through a series of large-scale meetings and close working with all partners to ensure a collaborative approach to developing service change proposals.

2.7. Last summer 2022, prior to the official formation of the GM ICS, the GM Joint Planning and Delivery Committee (JPDC) was asked to consider an approach to a propose 'Framework for Developing and Assuring Service Change Proposals in Greater Manchester' (appendix 1). This was approved and Mike Barker, Place Based Lead for Oldham, was asked to sponsor a group constituting key representatives from the affected Localities, and leads from NCA and MFT, to over the development of the service change proposals and assessment of in line with the framework.

2.8. A key catalyst for first phase of complex service disaggregation was the introduction of MFT's new electronic patient record (EPR) programme in September 2022 which brought the North Manchester site, and other hospitals within MFT, together under one system called HIVE. Until that point, NMGH, while being run by MFT, was part of the previous digital infrastructure supporting PAHT.

2.9. Key services including Clinical Haematology, Sleep services and Foetal Medicine pathways were disaggregated prior to 'go live' of this new system to ensure that patients could be safely managed within one system. For patients accessing these services this has meant either remaining under the care of NCA or choosing to move under the care of a MFT clinical team. For example, Clinical Haematology services are based at the Royal Oldham Hospital, however some patients living in North Manchester were able to move their care to newly created pathways delivered from North Manchester General by MFT.

2.10. These changes were considered by Scrutiny committees in the affected localities in July 2022, as well as being agreed by Greater Manchester JPDC.

3.0 THE NEXT PHASE OF SPECIALITIES AFFECTED AND APPROACH

3.1. Since the changes enacted in September 22, MFT and NCA have continued to develop plans for the remaining area of complex disaggregation, overseen by the Locality leads group chaired by Mike Barker, Place Based Lead for Oldham.

3.2. The Locality leads group was constituted by nominations from Place Based Leads and Deputy Place Based Leads and meets monthly, though has met fortnightly recently to support a period of increased activity and engagement. The group has overseen NCA/MFT's development of service

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

change proposals, including the approach to travel time analysis, and production of the substantial variation assessments, as well as ensuring the appropriate level and timing of Locality engagement. The membership of this group is described in Figure 1.

Figure 1: Membership of 'Complex service change on previous PAHT footprint' group

Locality/Organisation	Locality representative
On behalf of GM ICB	Mike Barker, Place Based Lead for Oldham
Bury	Ian Mello, Director of Secondary Care Commissioning Karen Richardson, Deputy Director of Commissioning
Manchester	Julie Taylor, Locality Director of Strategy/Provider Collaboration
Oldham	Sophie Spilsbury, Head of Scheduled Care
Rochdale	Nadia Baig, Associate Director of Transformation and Delivery
Salford	Harry Goldby, Associate Director of Delivery and Transformation
Northern Care Alliance Foundation Trust	Moneeza Iqbal, Director of Strategy
Manchester University Foundation Trust	Sophie Hargreaves, Director of Strategy

3.3. This group is also overseeing an evaluation of the changes enacted in Phase 1 to understand any learning for later phases of disaggregation, and any unintended consequences.

3.4. The Phase 2 specialties which are planned to be disaggregated by September 2023 are listed below, including an estimate of the number of patients impacted;

- Cardiology - impacts ~ 650 patients per year
- Gastroenterology – impacts ~ 25 inpatients and ~225 outpatients per year
- Rheumatology impacts ~270 patients per year
- Urology – 6 low volume pathways -impacts ~5 to 60 patients per pathway (~210 in total across the 6 pathways)

3.5. For the Phase 2 services, in the main service provision remains the same, however there will be some elements of service change to ensure alignment of services to each respective organisation. Furthermore, all services will be provided within both the NCA and MFT offering patients the choice of which service to access.

3.6. The Phase 3 complex specialties which are in the process of being developed, for which the timescales will be after September 2023 are listed below. These areas have not been assessed against the service change framework yet, however colleauges will recognise that some of these specialties were previously part of the *Greater Manchester Improving Specialist Care programme;*

- Ear, nose and throat (ENT)
- Urology – further pathways
- Trauma & Orthopaedics
- Vascular Surgery

4.0 APPROACH TO ASSESSING THE IMPACT OF PHASE 2 SERVICE CHANGES

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

4.2. For each service or clinical pathway, the following steps are taken,

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

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

4.3. The process includes a review of a long list of options, followed by a detailed appraisal of shortlisted options, with clinical consensus on the preferred way forward. All service change proposals follow the Service Change Framework agreed by the Greater Manchester JPDC on 12th July 2022, including an assessment of whether they constitute 'substantial variation'. See Appendix 1 for the Service Change Framework.

4.4. A detailed travel analysis is undertaken to understand the impact of the proposed changes on the NMGH catchment population. This will consider the impact for residents living in the catchment area on journey times by car and public transport (including bus, tram and a combination of the two). The analysis also considers the impact on the cost of travel.

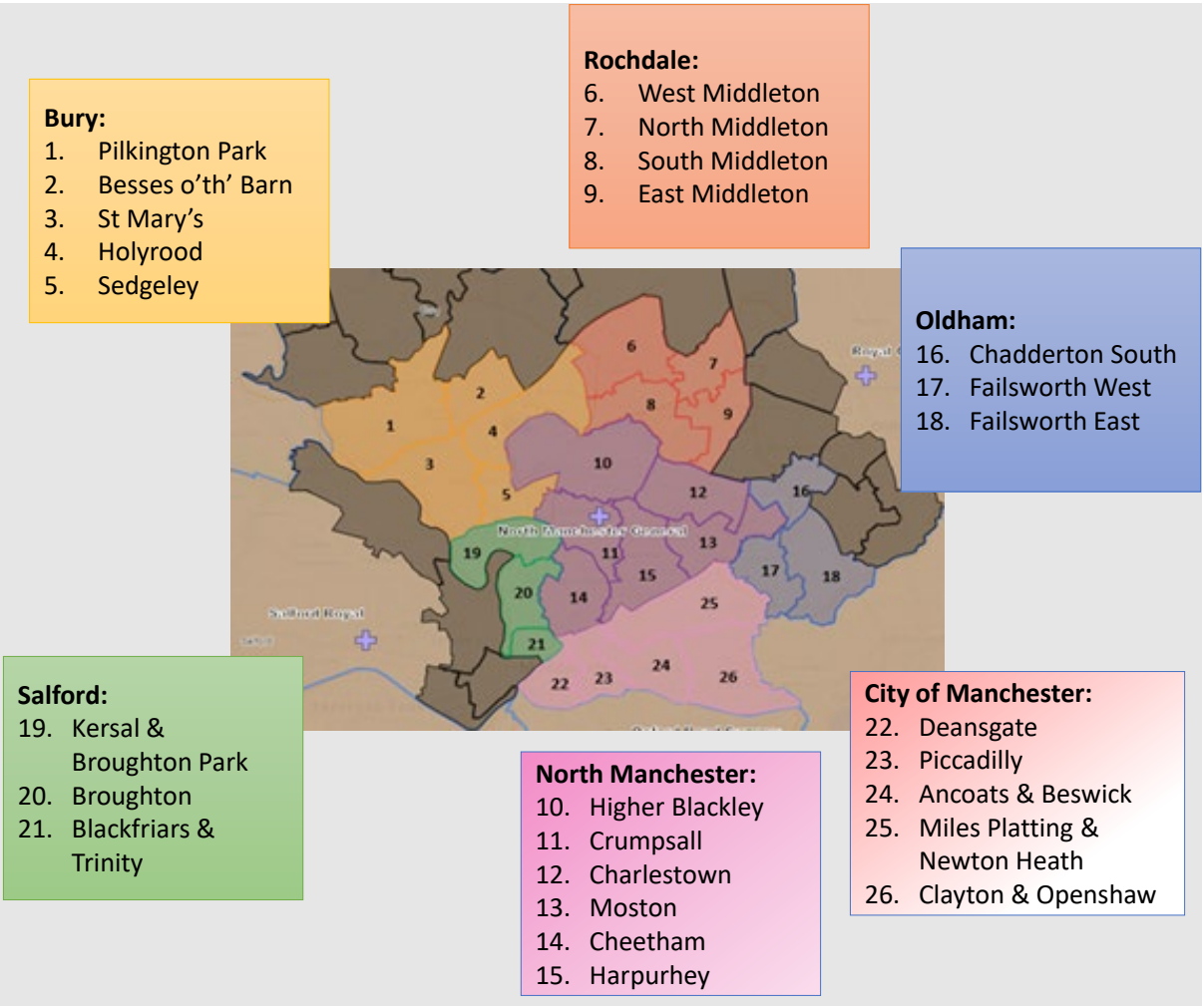
4.5. A programme of patient engagement is undertaken using a range of existing feedback on the services affected, as well as bespoke engagement activities with key patient groups to understand more about how any potential changes to pathways should be made, and how these can improve patient experience.

5.0 WHAT IS THE IMPACT OF THE PHASE 2 SERVICE CHANGES?

5.1. The service changes largely relate to disaggregating service and/or pathways from the North Manchester General Hospital (NGMH) site.

5.2. The NMGH catchment population is defined as those wards for whom NMGH is the closest hospital. The access impact of the proposals on this population has been considered. This does not mean that residents outside this catchment area cannot or do not use NMGH nor that residents in this care cannot and do not choose to attend NMGH. However, this methodology provides a good assessment of the impact on the patients and residents who are most likely to use NMGH and are therefore most affected by any proposed service changes. The map below shows the catchment area and constituent wards used in this analysis.

5.3. Figure 2: NMGH core catchment area and constituent wards



5.4. The tables below summarise the impact of the changes in Cardiology, Gastroenterology, Rheumatology and Urology (6 low volume pathways) on the NMGH catchment. Detailed substantial variation assessment against the likely options for service delivery is provided in Appendix 2.

5.5. Figure 3: Summary of substantial variation assessment for Phase 2 specialties

Specialty	Impact on the NMGH catchment
Cardiology	Patients from North Manchester, Bury, Rochdale and Oldham requiring Catheter Laboratory treatment are largely seen at Fairfield General Hospital's Silver Heart Unit. In the future, a patient who is referred to North Manchester General to see a cardiologist would receive their Catheter Laboratory treatment at Manchester Royal Infirmary, rather than at Fairfield General Hospital. This will affect circa 650 patients per year. Improvements in the patient pathway mean that approximately 20% of these patients can be assessed by a less invasive CT scan. **Substantial variation assessment** It is recommended that this **change does not constitute substantial variation** because it affects a limited number of patients and travel and access is similar or better for most of the population.
Gastroenterology	Plans are being developed to integrate the NMGH gastroenterology service within the MFT Group for NMGH catchment patients in four areas as follows:

<table>
<tr><th>Specialty</th><th>Impact on the NMGH catchment</th></tr>
<tr><td></td><td>
<table>
<tr><th>Pathway</th><th>Current site</th><th>Proposed site</th><th>NM Catchment volumes (pa)</th></tr>
<tr><td>Acute inpatients</td><td>ROH</td><td>NMGH</td><td>26</td></tr>
<tr><td>Specialist Endoscopy procedures (EMR/ESD)</td><td>ROH, FGH, RI</td><td>MRI</td><td>75</td></tr>
<tr><td>GI Physiology</td><td>RI</td><td>Wyth</td><td>222</td></tr>
<tr><td>Fibroscans (specialist test)</td><td>RI</td><td>MRI</td><td>141</td></tr>
</table>
In addition, a small amount of specialist endoscopy activity is still being delivered at NMGH for Oldham, Bury and Rochdale residents. These procedures require the use of the fluoroscopy suite at NMGH and are proposed to be delivered at Royal Oldham Hospital following the building of their new fluoroscopy suite.
<table>
<tr><th>Pathway</th><th>Current site</th><th>Proposed site</th><th>NCA Catchment volumes (pa)</th></tr>
<tr><td>ERCP procedures</td><td>NMGH</td><td>ROH</td><td>208</td></tr>
<tr><td>EUS procedures</td><td>NMGH</td><td>ROH</td><td>93</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
</table>
Substantial variation assessment: It is proposed that these changes do not constitute substantial variation because of the limited patient numbers affected per pathway.
</td></tr>
<tr><td>Rheumatology</td><td>
The vast majority of Rheumatological care is delivered in outpatient clinics (91%). Patients from North Manchester and surrounding areas access Rheumatology outpatient clinics at NMGH and this will not change. A small number of Rheumatology patients require more specialist treatments, including drug infusions and specialist therapy. Some of this is provided at NMGH, but about 270 North Manchester patients attend Rochdale Infirmary for this care. It is proposed that North Manchester residents will be able to access these services at either NMGH or Manchester Royal Infirmary.
Substantial variation assessment: It is proposed that this change does not constitute substantial variation. This is because of the limited patients affected – the key component of Rheumatology provision is provided via outpatients at NMGH, and this will not change. Travel and access are similar or better for most of the catchment population.
</td></tr>
<tr><td>Urology (6 low volume pathways)</td><td>
The urology pathways included in this wave are for low volume patient pathways including both treatment and diagnosis;
<table>
<tr><th>Pathway</th><th>Current site of delivery</th><th>Proposed site of delivery</th><th>2022/23 North Manchester catchment</th></tr>
<tr><td>Bladder chemotherapy</td><td>Fairfield General Hospital or</td><td>MRI - future aspiration to</td><td>48*</td></tr>
</table>
</td></tr>
</table>

Specialty	Impact on the NMGH catchment			
		Rochdale Infirmary	expand to NMGH	
	Andrology	Rochdale Infirmary outpatient injection Royal Oldham Hospital outpatient vacuum pump	MRI specialist regional centre for penile implants	14 14
	Urodynamics	Fairfield General Hospital or Royal Oldham Hospital	Trafford General Hospital future aspiration to expand to NMGH	58
	TULA	Fairfield General Hospital or Rochdale Infirmary (procedure only)	Trafford General Hospital - future aspiration to expand to NMGH	14
	Rezum	Rochdale Infirmary (procedure only)	Trafford General Hospital - future aspiration to expand to NMGH	5
	ESWL	Rochdale Infirmary	Wythenshawe Hospital - future aspiration to expand to NMGH	60
	Substantial variation assessment: It is proposed that these **changes do not constitute substantial variation** because of the limited patient numbers affected per pathway.			

6.0 ENGAGEMENT AND OVERSIGHT OF PHASE 2 AND 3 CHANGES

6.1. As described, NCA and MFT have jointly engaged with the affected Localities, in particular ensuring that respective Health Overview and Scrutiny Committees are updated and able to assess the impact on their population. Colleagues in each Locality have supported briefings with key council members and through key Locality governance;.

6.2. Figure 4: Formal Locality engagement relating to complex disaggregation

Locality	Scrutiny Committee & Locality engagement	Other engagement
Bury	▪ 18th January 22 (specifically relating to Urology) ▪ 25th January 23 ▪ Locality Board 25th January 23	▪ Bury Healthwatch at Joint NCA Healthwatch Board 7th February 23
Manchester	▪ 20th July 22 (phase 1 changes) ▪ 8th February 23	▪ Patient Public Advisory Group (PPAG) date ▪ Manchester Healthwatch 15th February 23
Oldham	▪ 17th January 23	▪ Oldham Healthwatch at Joint NCA Healthwatch Board 7th February 23

Rochdale	▪ Limited scrutiny dates available therefore engagement at Rochdale Locality Board 28th February 23	▪ Rochdale Healthwatch at Joint NCA Healthwatch Board 7th February 23
Salford	▪ Engagement with Health Scrutiny Chair ▪ Planned to brief the key councillors from affected Wards	▪ Salford Healthwatch at Joint NCA Healthwatch Board 7th February 23

6.3. This engagement has resulted in helpful feedback and support from the affect Localities which has been factored into the assessment of the disaggregation plans.

7.0 RECOMMENDATIONS AND NEXT STEPS

7.1. Greater Manchester Integrated Care Board (ICB) is asked to support the approach to the Phase 2 complex service change proposals developed, and the Locality engagement undertaken

7.2. With the endorsement of the GM ICB, the NCA and MFT will work together to develop safe plans for disaggregation. There is a tried and tested process to do this which has been developed over the last 3 years of working together to safely disaggregate services. Depending on the feedback from the affected Scrutiny Committees and decision of the ICB, the estimated timeline for disaggregation of these services is September 2023.

7.3. When disaggregated service models are implemented, patients will be provided with appropriate information to support in accessing new sites including travel options and parking information. This will be provided both via letter and digitally. The Equality Impact Assessment will inform the actions required to ensure that all patients are supported to access services.

7.4. Later this year, service change proposals for the services included in phase 3 will undergo the same process described in this report. This includes Trauma & Orthopaedics, Ear, Nose & Throat, Vascular and the remainder of Urology. Outcome reports from phase 1 changes will also be shared once available.

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Appendix 1: Previous GM JPDC engagement to agree a service change framework

Greater Manchester Health and Social Care Joint Planning & Delivery Committee

Date: 12th July 2022

Subject: A Framework for Developing and Assuring Service Change Proposals in Greater Manchester

Report of: Mike Barker, Place Based Lead for Oldham Integrated Care Partnership

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PURPOSE OF REPORT:

The following paper draws on guidance and good practice to present a framework for developing and assuring service change proposals.

REQUESTS OF JPDC:

The Greater Manchester Joint Planning and Delivery Committee are asked to:

- Note the content of the report.
- Support testing the framework as set out in this paper with the priority PAHT complex services for disaggregation and incorporate lessons learned to create a GM Framework for developing and assuring service change.

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1 Introduction / Purpose

The following paper draws on guidance and good practice to present a framework for developing and assuring service change proposals. It includes the following:

- Background and context including legal requirements
- A structured three-stage approach to developing service change proposals that includes:
    - Early discussions and planning between relevant stakeholders.
    - A proposal template that includes realistic and viable options development process.
    - A substantial variation assessment tool.
- An overview of decision-making in the context of GM ICB changes from July 2022

This paper emphasises the need for a pragmatic and proportionate approach. Service change proposals vary in scale and scope and the associated level of resource input, detail and assurance should therefore reflect the level of change to ensure timely and effective decisions are made in support of improving patient care.
The approach is currently being tested through the legacy Pennine Acute Hospital Trust (PAHT) complex services for disaggregation. It is recommended that any lessons learned are incorporated into the approach to create a GM framework for developing and assuring service change.

2 Background and Context

The following section sets out key context that has shaped the approach to developing service change proposals.

2.1 Legal Duties:

Service change is any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered (NHSE Guidance[2] pg. 10).

Legal requirements for public involvement and consultation state that the relevant body must make arrangements which secure that users of those services, whether directly or through representatives, are involved[3] in:

1. the planning of the provision of those services,
2. the development and consideration of proposals for changes in the way those services are provided[4], or
3. decisions to be made by that body affecting the operation of those services

When considering whether the above duty applies and to what extent, there are two key questions:

1. **Will the proposal for change have an impact on the manner in which the services are delivered or the range of services available?** *If the answer to question 1 is no, then there is no duty to involve service users. However, the relevant healthcare provider may wish to carry out some form of engagement. If the answer is yes, then question 2 must be considered:*
2. **What is the likely impact of the implementation of the proposals?**

Legal advice[5] suggests that if the impact is substantial then a more extensive engagement should be considered, (possibly including public consultation). If the impact is fairly minimal then a limited

[2] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
[3] Involved whether by being consulted or provided with information, or in other ways. The involvement/engagement duty is to involve individuals to whom the services are being or may be provided (capturing existing service users but also potential future service users).
[4] https://www.legislation.gov.uk/ukpga/2006/41/part/12/chapter/2
[5] Hill Dickinson shared with Manchester CCG

form of public engagement may be appropriate.

2.2 Substantial Variation:

NHSE guidance (pg. 7) states:
"Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority[6]. This is in addition to the duties on commissioners and providers for involvement and consultation, and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.
There is no legal definition of 'substantial development or variation' and for any proposed service change commissioners and providers should seek to reach agreement with the local authority on whether the duty is triggered. Regular local authority engagement should continue through the lifecycle of service change."
The Centre for Public Scrutiny[7] (CfPS) encourages NHS bodies and Health Scrutiny Committees (HSC) to reach agreement on what constitutes 'substantial' within their local context and suggests criteria and protocols based on legislation and the experience of HSC and NHS bodies.
Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider (NHSE Guidance pg. 11).

2.3 Assurance

All service change should be assured against the government's four tests:

- Strong public and patient engagement.
- Consistency with current and prospective need for patient choice.
- A clear, clinical evidence base.
- Support for proposals from clinical commissioners.

In April 2017, NHS England introduced a new test for any proposal that includes plans to significantly reduce bed numbers. One of three conditions must be met that demonstrates sufficient alternative provision, evidence of new treatments or therapies that will reduce admissions or a credible plan to improve performance.
A robust assurance process should be established that is proportionate to the scale of the proposed changes.

2.4 Key points:

- Where a service change is proposed that impacts on the manner in which services are delivered or the range of services available, it triggers a need for involvement of service users or representatives.
- The impact and scale of proposals can vary which in turn informs the level of engagement required.
- Proposals and associated assurance processes should be proportionate to the level of change proposed.
- NHS bodies should work with Local Authority to agree what constitutes 'substantial variation' (or not) using agreed criteria and protocols to inform decision-making and ensure an effective and timely process.

[6] Under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the 2013 Regulations") made under s.244 NHS Act 2006
[7] https://democracy.leeds.gov.uk/documents/s9540/Extracts%20cfps%20guidance%20document.pdf

- Service reconfigurations are a complex, non-linear processes. They can be costly and time consuming when obligations are not met, resulting in the potential for legal challenge or changes failing to be implemented[8].

3 Framework for Developing and Assuring Service Change Proposals

The following approach has been developed to create a structured process to developing service change proposals where there is a change to a patient pathway (location or flow). It sets out a three-stage process as follows:

1. **Early Discussion** – High-level statement of intent developed to support early discussions between relevant partners (e.g. providers, and ICB commissioners (including Place Based Leads) from relevant Local Integrated Care Partnerships (localities)) to review the scale and scope of any potential service change, agree the approach and clarify roles and responsibilities. It is important to clarify the impact and consequences to patients of 'no change', which should drive timescales and inform a proportionate approach.
2. **Proposal** – a change proposal is developed that incorporates service user involvement.
3. **Substantial Variation Assessment** – the proposal is assessed using a substantial variation assessment tool. The outcome determines whether the change is considered 'substantial variation' (or not), which in turn informs the proportionate level of assurance and approvals process required. If deemed 'substantial' there is a higher level of assurance required and potential requirement for a Pre-consultation Business Case (PCBC) and public consultation.

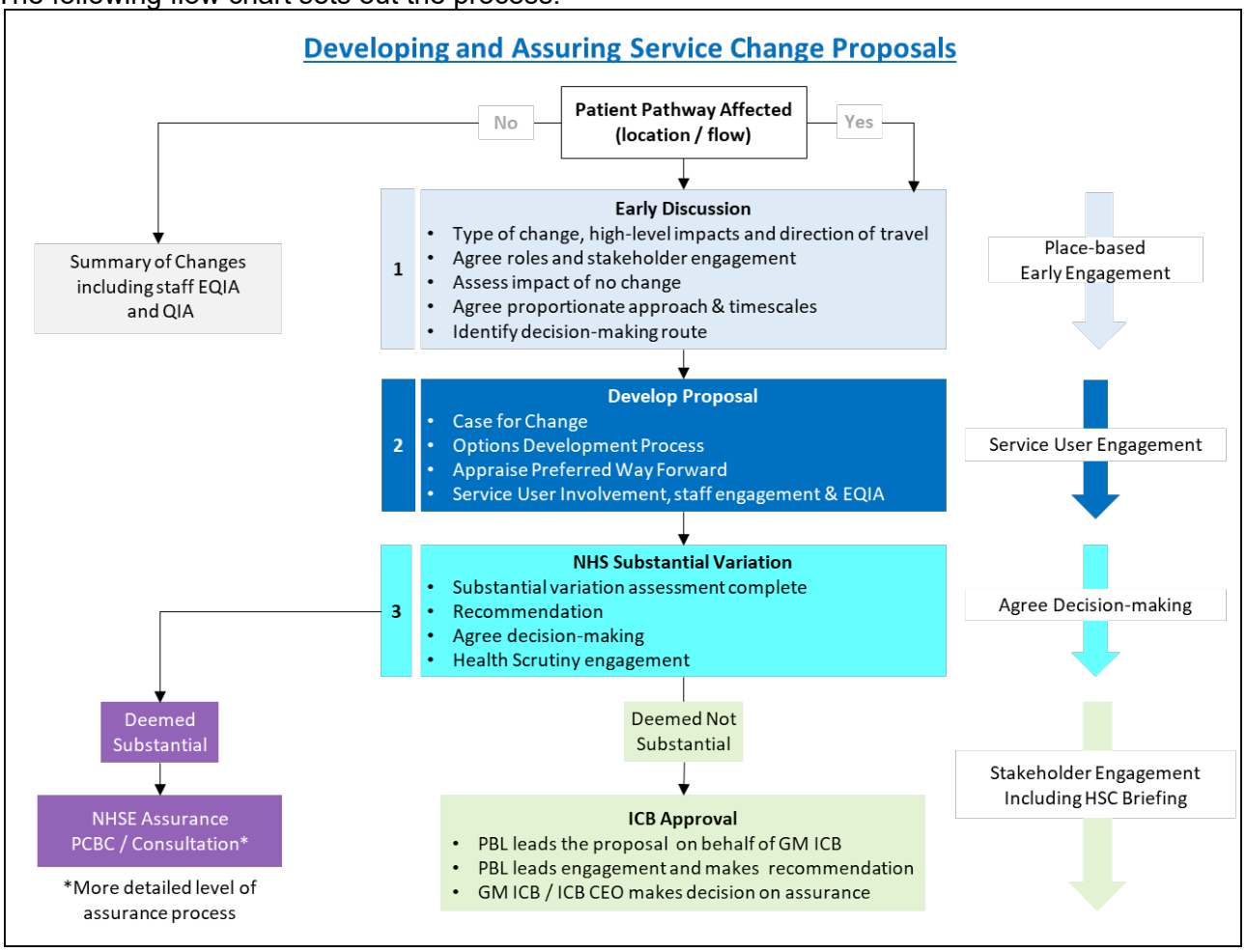
Change proposals will be typically stratified across three levels of impact:

1) Single locality
2) Multiple localities
3) GM wide impacts across the Integrated Care System

As GM transitions to new ICB arrangements from July 2022 the process for decision-making across all three levels has been agreed as a nominated Place Based Lead to lead the work on behalf of the GM ICB. This is explored in more detail in section 4.

[8] https://www.capsticks.com/assets/NHSEI_legislation_for_service_change_guide.pdf

The following flow chart sets out the process:



*Where it is identified that a Pre-Consultation Business Case (PCBC) and potential public consultation is required then naitonal guidance[9] should be followed supported by the recently published Major Service Change: Interactive Handbook[10] (NHS England, 2022).

The following sections provide further detail on each of the three stages.

3.1 Early Discussion

Key components of early discussions include:

- Overview of the potential proposal (initial thinking / statement of intent) including rationale and clinical case for change with a clear understanding of the impact/consequences to patients if status quo is maintained. This should inform timescales and be a key factor in determining a proportionate and timely approach.
- The type of change (patient flow/location or operational/clinical leadership).
- The number of patients potentially affected (by point of delivery) and the scale of change.
- Whether there is wholesale loss of an offer from a site or partial change in service provision (patient choice).
- Identification of relevant providers and localities potentially affected.
- High-level potential travel impacts (time, distance and transport factors).
- Assessment of potential financial implication/requirements upfront and early in the process.

[9] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/
[10] https://www.nwcsenate.nhs.uk/news-events/national-senate-news/nhse-major-service-change-interactive-handbook

- Likely level of stakeholder interest e.g. political, public.
- Alignment to strategy/previous commissioning decisions and service interdependencies
- Planning service user engagement and staff involvement.

Key Outputs at this stage include:

- Agree joint working, leadership and roles and responsibilities.
- Agree the rationale/clinical case for change with clear understanding of the impact/consequences to patients of 'no change'. This should inform timescales.
- Agree the scope and scale of potential change.
- Plan and organise service user involvement groups/process.
- Agree appropriate decision-making governance.
- Plan Health Scrutiny informal and formal briefings.
- Define demographics/equality analysis and travel impact assessment requirements.
- Flag potential change to NHSE via NHSE processes e.g. reconfiguration tracker.

3.2 Stage 2: Proposal Development

The proposal needs to articulate a compelling case for change with a structured and transparent approach to developing options and narrowing them down to a either a limited number of options or a preferred way forward. The proposed solution should be described with a clear understanding of patient impacts and benefits/risks etc.

It is important to adopt an agile[11] approach to developing options that ensures clear evidence of strong public and patient engagement[12]. Best practice approach to developing options includes involving staff and the public through a structured and transparent process. Options taken forwards should be sustainable in service, economic and financial terms and be deliverable.

Key elements of a proposal include:

1. **Context** – including background, current service provision, relevant demographics and strategic context.
2. **Case for change** – including current situation, the impact of 'no change' and establish the key drivers for change.
3. **Options** – options development process should not be over-engineered. An agile and timely approach is encouraged, and any options considered must be realistic and deliverable. In some instances there will only be a limited number of viable options for consideration or even just one viable option for comparison against a 'do nothing'.
4. **Preferred way forward** – appraisal of the preferred way forward. To include summary of proposed changes, benefits, clinical opinion, risks, QIA, travel analysis, dependencies and finance.
5. **Engagement** – involvement in developing the proposal to include service user involvement, EQIA and staff engagement.
6. **Recommendations and next steps** – implementation planning.

Appendix 1 provides a detailed template setting out the key features of a proposal and steps to develop options.

The level of detail and process needs to be proportionate i.e. balance a pragmatic approach that optimises valuable NHS resource, time and cost inputs through agile ways of working to advance proposals at pace whilst ensuring legal duties are satisfied e.g. service user involvement. The

[11] Agile approach to include desktop analysis, rapid collaboratives, workshops, virtual meetings, one-to-one discussions and e-mail correspondence.
[12] One of the four tests of service change.

consequences of ‘no change’ should be clearly understood and a key factor in driving timescales. Service user engagement forms a key part of developing proposals for services change. NHSE guidance (pg. 17) states:
It is critical that patients and the public are involved throughout the development, planning and decision making of proposals for service change. Early involvement with the diverse communities, local Healthwatch organisations, and the local voluntary sector is essential, as well as engaging NHS Improvement where appropriate…… Involvement should not be a standalone exercise; rather, it should be part of an ongoing dialogue taking place in stages as proposals are developed.… The most successful proposals ensure continuous discussion and involvement of the local population and key stakeholders throughout the process.

A range of approaches can be taken to developing a service user involvment process. This may include utilising existing and regular patient participation / expert patient groups, Healthwatch forums or establishing bespoke service user representative groups and delivery of patient surveys. The approach should be planned in the early discussion phase to allow time to organise relevant forums and materials.

Key Points:

- The proposal template is not exhaustive but equally not intended to add complexity for smaller-scale service change proposals. A proportionate approach should be agreed and sustained throughout the process and agreed by all parties.
- The key to developing options is to demonstrate a breadth of realistic options have been considered with a clear explanation as to how a preferred way forward was selected. In some scenarios there may only be a limited number of viable options available to explore.
- Service user involvement is a required and beneficial part of the process. A range of options are available to incorporate service user groups which should be agreed and planned in the early discussion stage.
- Staff involvement is key.

3.3 Stage 3: Substantial Variation

There is no legal definition of ‘substantial development or variation’. For any proposed service change, commissioners and providers should work with the local authority or local authorities Health Scrutiny Committee (HSC) to determine whether the change proposed is substantial.

Several regions use protocols/checklists to support NHS and HSC to work collaboratively to develop local agreement on what is considered ‘substantial variation’. Following a review of existing approaches, a substantial variation assessment tool has been developed. It sets out relevant factors/prompts across five domains to support an assessment of whether the proposal should be considered ‘substantial variation’ or ‘not substantial variation’.

The outcome of this review then informs the proportionate level of assurance. For example, if a proposal is considered ‘not substantial variation’ then it is suggested that assurance against the four tests of service change through agreed ICB governance will suffice without the need for formal public consultation.

The substantial variation assessment tool uses the following five domains (with some relevant examples included):

- **Patient population affected** e.g. number of patients affected
- **Access** e.g. travel impacts
- **Type / rationale for proposed service change** e.g. wholesale loss of service or partial change to existing service provision with local access retained
- **Wider community and other services** e.g. impact on co-dependent services
- **NHSE four tests and stakeholder views** e.g. strong public and patient engagement

The full substantial variation template is available in appendix 2.
The role of Health Scrutiny is an important part of the service change process. Recommended next steps in the application of the substantial variation assessment tool include:

- Test the approach using the priority PAHT complex service change proposals.
- Incorporate learning in conjunction with relevant health scrutiny committees and develop into a standardised protocol for GM.
- Include a resolution procedure in the event there is not consensus on the outcome.

4 Decision-making and Assurance

As GM transitions to new ICB arrangements from July 2022 the agreed process for decision-making is for a nominated Place Based Lead to lead the work on behalf of the GM ICB. This includes:

- Leadership of proposal development process through a partnership approach that includes relevant providers and locality leads
- Engagement with relevant Place Based Leads and key stakeholders.
- Presentation of proposals to GM Joint Planning and Delivery Committee (JPDC) seeking support for the proposals.
- Oversight of health scrutiny engagement/briefings.
- Recommendation made to GM ICB / ICB Chief Executive for final decision to approve and assure changes.

This process will be reviewed as based on further developments of the GM ICB scheme of accountability and delegation to ensure a streamlined process for decision-making. A stratified approach to decision-making will be developed across the following three levels of impact:

1. Single locality
2. Multiple localities
3. GM wide impacts across the Integrated Care System

5 Recommendations

The Greater Manchester Joint Planning and Delivery Committee are asked to:

- Note the content of the report.
- Support testing the framework as set out in this paper with the priority PAHT complex services for disaggregation and incorporate lessons learned to create a GM Framework for developing and assuring service change.

6 Appendices

6.1 Appendix 1 – Proposal Template

The following template acts as a guide to develop a proposal for service reconfiguration where there is a change to a patient pathway (location or flow). It sets out the typical information required and incorporates NHSE guidance (pg. 41) on core components of a proposal.
It includes a requirement to analyse the full range of potential service changes that can achieve the desired improvement in quality and outcomes and the development of a range of options. It is important to note that any options development process should not be over-engineered, and an agile and timely approach encouraged. Any options considered should be realistic and deliverable. In some instances there will only be a limited number of viable options for consideration or even just one viable option for comparison against a 'do nothing'.

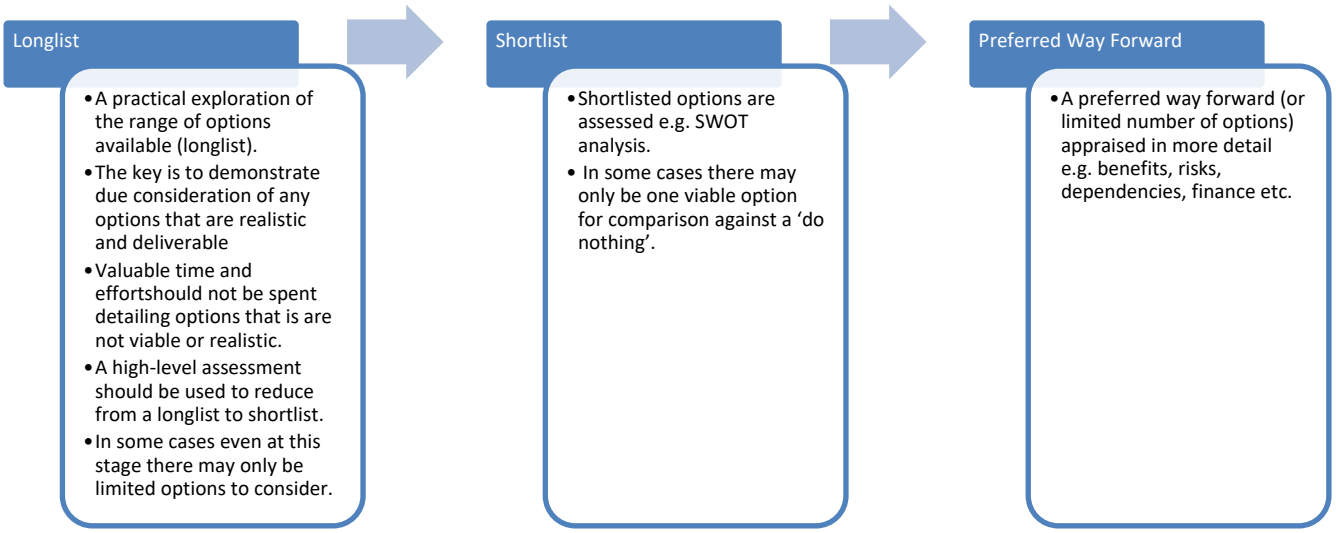
Once the template has been populated it can be used to inform a more detailed assessment of whether the change triggers locally agreed thresholds for 'substantial variation'.

Proposal Template (Supporting detail suggested in grey)

1. **Context**
   - Background – Organisations involved, generic overview
   - Current service – overview of service
   - Demographics – local population affected by the change. Can be generic high-level demographics but think specifically about those affected including equalities focus
   - Strategic context – any national/local context where relevant

2. **Case for Change**
   - Current situation – Describe the why? Identify the problem & issue(s) to resolve explaining why the current situation is no longer appropriate or sustainable. Be clear on number of patients affected
   - Impact of no change – explain why this isn't an option and the impacts/consequences to patients if there is no change (including risk associated with patient pathways that involve handovers between different healthcare digital systems).
   - Key drivers for change – Ensure focus on clinical case for change. Consider duplication, fragmented services, creation of enlarged single services, improved seven day working (equity across the week), better access to specialist care, increased subspecialisation, improved career development, reduced vacancies/turnover/use of locum and agency staff, reduction in variation, poor outcomes, poor patient experience, workforce, standards compliance, constraints, finance, health inequalities, access, improved continuity of care (including avoiding complex handover between different digital environments), improved digital functionality, R&I, staff development, education and training.

3. **Options**
   - Overview of the process for generating and evaluating options
   - Longlist – Process should not be over-engineered. It should demonstrate the breadth of thinking with regards to realistic options. For each option summarise with description, advantages, disadvantages and conclusions. Be clear on why options were not taken forward / rationale for narrowing options
   - Short list – Consider SWOT and narrative against criteria such as quality (clinical effectiveness and patient safety), health inequalities, patient experience (choice, access, travel), efficiency (include recovery, finance), deliverability, strategic fit, estates etc.
   - Preferred way forward and why / limited options for consideration



4. Preferred way forward / limited options

- Clear description of proposed solution including:
  - Summary of relocated services including number of patients affected (by point of delivery and catchment/area), capacity changes (linked capacity changes / dependencies) and access changes (physical and waiting times)
  - Staff changes (ways of working, number affected, changes to staff location)
  - Evidence base & clinical view
  - Key enablers (IT, digital, FM, communication plans)
  - Timescales and implementation plans
  - In line with strategic direction of travel (GM/local)
- Benefits / disbenefits
- Quality Impact Assessment
- Clinical opinion (understanding the clinical view is paramount and external clinical opinion (where relevant) provides additional assurance to commissioners and wider stakeholders that the preferred option is robust)
- Risks and mitigations (proposals to mitigate any negative impacts)
- Constraints and dependencies
- Finance (affordability) and workforce

5. Engagement

- Involvement in developing the proposal
- Equality Impact Assessment (EQIA)
- Patient survey
- Staff engagement

6. Recommendations and Next Steps

6.2 Appendix 2: Substantial Variation Assessment Tool

The following substantial variation assessment tool builds on existing approaches sourced through a review process[13]. Key points include:

- Using key information from the proposal (stage 2) the NHS provider and commissioner should complete the template and assess for substantial variation.
- The tool sets out relevant factors/prompts (in grey) for consideration across five domains to support an assessment on whether the change should be considered 'substantial' or 'not substantial'. These are intended as a guide to inform the assessment.
- Areas such as "number of patients affected" and "travel impacts" are not quantified in terms of what constitutes large or small impacts at present. This could be developed as part of the next steps.
- Clear recommendations should be documented with supporting rationale.

Domain	Substantial Variation	Not Substantial Variation
Patient Population Affected	• A large number of patients are affected A large proportion of the local population / catchment population are affected • Patient choice is reduced • Reduction in overall capacity and activity	• A small number of patients are affected • A small proportion of the local population / catchment population are affected • Patient choice is maintained or improved • Improved or sustained level of capacity and activity and demonstrate resilience to meet demand
Access	• For the identified population catchment a larger proportion of patients would experience an increased travel time compared with the previous service provision[14] • Reduced physical access (reduced public transport, limited parking, reduced hours) • Reduced access for some sections of the community (protected characteristics)	• For the identified population catchment a larger proportion of patients experience a decreased or neutral travel time impact and/or any negative travel impacts are identified and sufficiently mitigated • Improved physical access (better facilities, transport, parking, extended hours) • Minimal/positive impacts on specific sections of the community or mitigations identified
Type / Rationale for proposed service change	• Limited focus on quality e.g. improving patient experience and outcomes or improving clinical quality • Change driven by non-patient factors e.g. finance • Wholesale loss of a service offer from a site	• Strong focus on quality including patient experience, outcomes, clinical quality & safety and risk reduction • Patient focussed change e.g. service improvement • Partial change to existing service provision with local access retained • Introduction of technology or new roles
Wider community & other services	• High impact on co-dependent services • High impact on other health and social care services e.g. increased demand on other services	• Limited/no impact on co-dependent services • Proposal creates clinical benefits to existing services i.e. increased capacity for other services at current site (improvements to flow and access for other services

[13] A range of existing tools and protocols were reviewed and adapted for inclusion in this document
[14] Any travel impact assessment should be considered in the context of improved clinical quality

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Domain	Substantial Variation	Not Substantial Variation
	• Negative community impacts e.g. economic, regeneration, recovery • Widening health inequalities / Equality impacts not considered	• Limited/no wider community impacts e.g. economic, regeneration, recovery • Reduces health inequalities / Equality impacts considered
NHSE Four Tests & Stakeholder Views	• Limited public and patient engagement • Patient choice reduced • Limited clinical evidence base • Not supported by clinical commissioners • Not supported by key stakeholders • Poor staff engagement and level of input	• Strong public and patient engagement • Patient choice improved or impacts mitigated • Strong clinical evidence base • Support from clinical commissioners • Proposal supported by key stakeholders • Strong staff engagement, input and support
Recommendation:		

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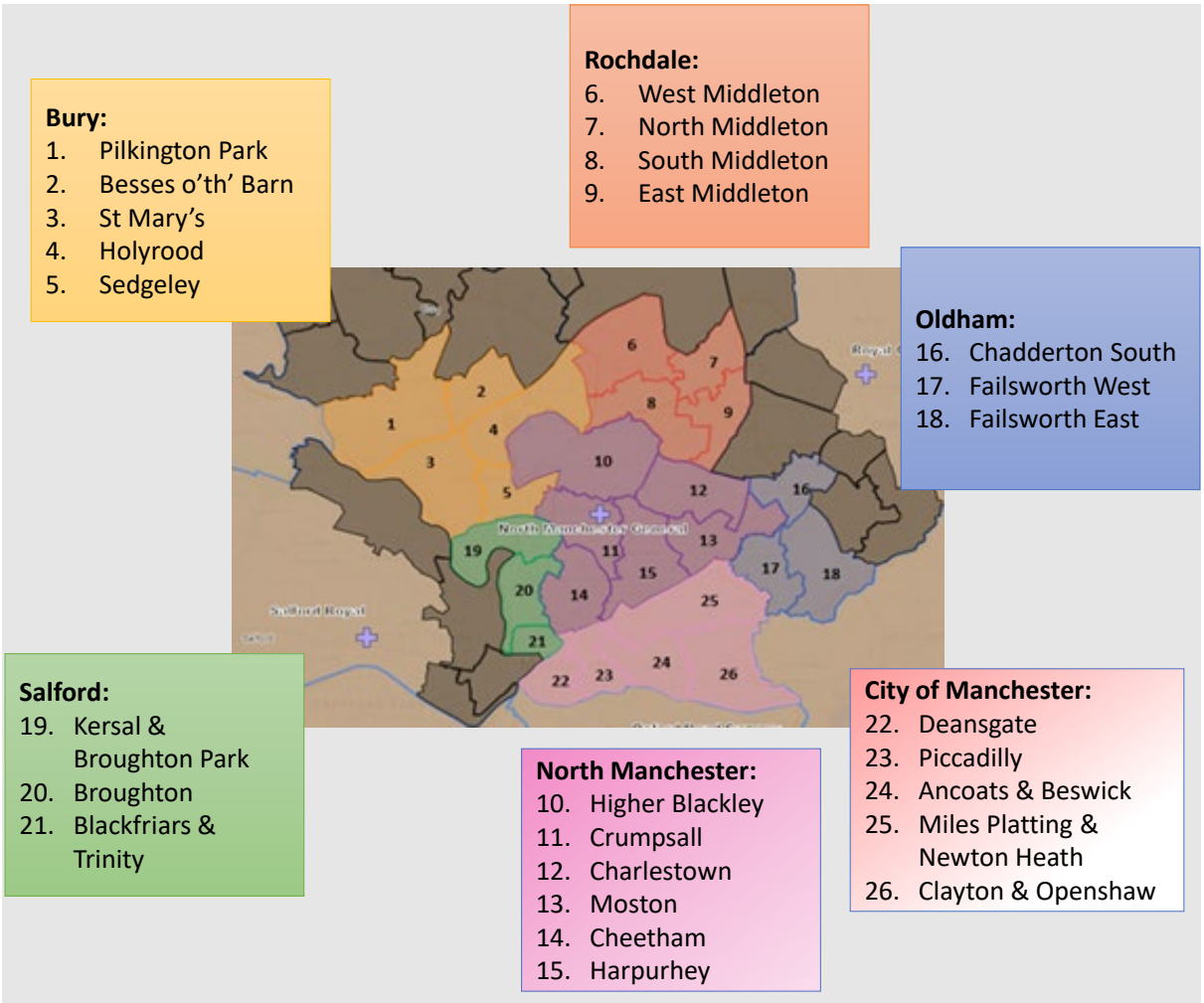
Appendix 2:Substantial variation assessment and impact on NMGH catchment population

The NMGH catchment population is defined as those wards for whom NMGH is the closest hospital. The access impact of the proposals on this population has been considered. This does not mean that residents outside this catchment area cannot or do not use NMGH nor that residents in this care cannot and do not choose to attend NMGH. However, this methodology provides a good assessment of the impact on the patients and residents who are most likely to use NMGH and are therefore most affected by any proposed service changes. The map below shows the catchment area and constituent wards used in this analysis.

Figure 1: NMGH core catchment area and constituent wards



The tables below summarise the impact of the changes in Cardiology, Gastroenterology, Rheumatology and Urology (6 low volume pathways) on the NMGH catchment.

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Table 1: Summary of changes and impact - Cardiology

Cardiology	Impact on the NMGH catchment
Summary of changes	A Catheter lab is a specialised area in the hospital where doctors perform tests and procedures to diagnose and treat cardiovascular disease. Patients from North Manchester, Bury, Rochdale and Oldham requiring Catheter Laboratory treatment are largely seen at Fairfield General Hospital's Silver Heart Unit. In the future, a patient who is referred to North Manchester General to see a cardiologist would receive their Catheter Laboratory treatment at Manchester Royal Infirmary, rather than at Fairfield General Hospital. This will affect circa 650 patients per year. Improvements in the patient pathway mean that approximately 20% of these patients can be assessed by a less invasive CT scan.
Patient feedback summary	The proposals were presented to the Patient and Public Advisory Group (PPAG) of Manchester Health and Care Commissioning and Manchester, Trafford, Salford, Bury, Oldham and Rochdale Healthwatch. No specific concerns were raised about the proposal itself, however, general issues regarding travel costs, transport access and car parking at hospital sites were mentioned. A survey has been undertaken of patients accessing the rapid access chest pain clinics at North Manchester General Hospital (NMGH) over a two-week period. This found a similar proportion of respondents would find it very easy or fairly easy to travel to MRI and FGH.
EQIA summary	A full Equality Assessment has been undertaken. Cardiovascular disease (CVD) is strongly associated with health inequalities, if you live in England's most deprived areas, you are almost four times more likely to die prematurely than someone in the least deprived. CVD is more common where a person is male, older or ethnicity of south Asian or African Caribbean15. The proposal to use non-invasive CT versus Catheter lab will improve pathways and outcomes for all groups. The proposed change creates no greater barriers than those that already exist and no specific disbenefits to people with protected characteristics.
QIA summary	A full Quality Impact Assessment has been undertaken. No adverse impacts were identified across any domain.
Travel analysis	A detailed travel analysis has been completed. The average journey time by car for the overall catchment is the same for MRI (16 mins) compared to FGH (16 mins). Public transport journey times are significantly less to MRI than FGH (average journey time is 43.6 minutes compared to 63.9 minutes). Travel costs are on average

[15] Health Matters: Preventing Cardiovascular Disease, Public Health England, February 2019

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Cardiology	Impact on the NMGH catchment
	cheaper for both car and public transport users. Car parking is broadly comparable.
Patient choice impact	As per current arrangements, patients wishing to choose an MFT or NCA pathway would need to do so for the whole pathway including their first outpatient appointment. A specific choice exercise will be undertaken to support the partial service change, and this will involve communication with NMGH patients who have a complex device, to ascertain their preferences for follow up care.
Substantial variation assessment	It is recommended that this change does not constitute substantial variation because it affects a limited number of patients and travel and access is similar or better for most of the population.

Table 2: Summary of changes and impact – Gastroenterology

<table>
<tr><th>Gastroenterology</th><th>Impact on the NMGH catchment</th></tr>
<tr><td>Summary of changes</td><td>Gastroenterologists diagnose, treat and work to prevent gastrointestinal (stomach and intestines) and hepatological (liver, gallbladder, biliary tree and pancreas) diseases.

Plans are being developed to integrate the NMGH gastroenterology service within the MFT Group for NMGH catchment patients in four areas as follows:

<table>
<tr><th>Pathway</th><th>Current site</th><th>Proposed site</th><th>NM Catchment volumes (pa)</th></tr>
<tr><td>Acute inpatients</td><td>ROH</td><td>NMGH</td><td>26</td></tr>
<tr><td>Specialist Endoscopy procedures (EMR/ESD)</td><td>ROH, FGH, RI</td><td>MRI</td><td>75</td></tr>
<tr><td>GI Physiology</td><td>RI</td><td>Wyth</td><td>222</td></tr>
<tr><td>Fibroscans (specialist test)</td><td>RI</td><td>MRI</td><td>141</td></tr>
</table>

In addition, a small amount of specialist endoscopy activity is still being delivered at NMGH for Oldham, Bury and Rochdale residents. These procedures require the use of the fluoroscopy suite at NMGH and are proposed to be delivered at Royal Oldham Hospital following the building of their new fluoroscopy suite.

<table>
<tr><th>Pathway</th><th>Current site</th><th>Proposed site</th><th>NCA Catchment volumes (pa)</th></tr>
<tr><td>ERCP procedures</td><td>NMGH</td><td>ROH</td><td>208</td></tr>
<tr><td>EUS procedures</td><td>NMGH</td><td>ROH</td><td>93</td></tr>
</table>
</td></tr>
</table>

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<table>
<tr><th>Gastroenterology</th><th>Impact on the NMGH catchment</th></tr>
<tr><td>Patient feedback summary</td><td>The proposals were presented to the Patient and Public Advisory Group (PPAG) of Manchester Health and Care Commissioning and Manchester, Trafford, Salford, Bury, Oldham and Rochdale Healthwatch. The groups supported the case for change and the proposed preferred way forwards. In wide-ranging discussions, the groups did not raise any specific concerns about the proposal itself. General issues regarding travel costs, transport access and car parking at Hospital sites were discussed as well as the need for clear patient information during implementation.</td></tr>
<tr><td>EQIA summary</td><td>A full equality impact assessment has been completed. This did not identify any negative impacts of the proposed changes.</td></tr>
<tr><td>QIA summary</td><td>A full Quality Impact Assessment has been undertaken. No adverse impacts were identified across any domain.</td></tr>
<tr><td>Travel analysis</td><td>A detailed travel analysis was undertaken. The outcome of this is summarised below:
<table>
<tr><th>Service</th><th>Car</th><th>Public transport</th><th>Cost</th></tr>
<tr><td>Acute inpatients</td><td>Reduced from 13.8 minutes to 10.2 minutes</td><td>Reduced by 25 minutes</td><td>Cheaper for car and public transport</td></tr>
<tr><td>Specialist Endoscopy EMR/ESD</td><td>Comparable journey times, +/-3 minutes on average</td><td>average journey times reduced by almost 30 minutes</td><td>Cheaper for car and public transport</td></tr>
<tr><td>Fibroscans</td><td>Marginal increase from 13.8 minutes to 16.4 minutes</td><td>Reduce from 52.7 mins to 43.6 minutes</td><td>Cheaper for car and public transport</td></tr>
<tr><td>GI Physiology</td><td>Increase of 3 minutes</td><td>Increase of 9 minutes</td><td>Increase of 44p for car users and £2.01 for public transport</td></tr>
</table></td></tr>
<tr><td>Patient choice impact</td><td>As per current arrangements, patients wishing to choose an MFT or NCA pathway would need to do so for the whole pathway including their first outpatient appointment.</td></tr>
<tr><td>Substantial variation assessment</td><td>It is proposed that these changes do not constitute substantial variation because of the limited patient numbers affected per pathway.</td></tr>
</table>

Table 3: Summary of changes and impact - Rheumatology

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Rheumatology	Impact on the NMGH catchment
Summary of changes	Rheumatology is the branch of medicine that deals with painful, typically inflammatory or infectious conditions of the joints and other parts of the musculoskeletal system. The vast majority of Rheumatological care is delivered in outpatient clinics (91%). Patients from North Manchester and surrounding areas access Rheumatology outpatient clinics at NMGH and this will not change. A small number of Rheumatology patients require more specialist treatments, including drug infusions and specialist therapy. Some of this is provided at NMGH, but about 270 North Manchester patients attend Rochdale Infirmary for this care. It is proposed that North Manchester residents will be able to access these services at either NMGH or Manchester Royal Infirmary.
Patient feedback summary	The workforce alignment processes have not yet been completed, but the most likely outcome is that the staff who currently provide the service will align to NMGH (MFT). This will mean that the patients continue to receive the same service, in the same location, and provided by the same staff. In this context it is not thought to be appropriate to undertake a patient feedback exercise. If there is a different outcome from the workforce alignment processes, a patient feedback exercise will be undertaken.
EQIA summary	A full Equality Impact Assessment has been undertaken. Given that the proposed change in the main does not impact on the service provision itself, only the location of the delivery, the equality impacts are likely to be fairly limited. Increased access to day case treatment at NMGH will be beneficial to the patient population as a whole. Rheumatological illnesses are more common amongst women, older people and the non-White population, so the beneficial effects will be experienced more by these groups.
QIA summary	A full Quality Impact Assessment (QIA) was completed. There are no adverse impacts expected across any domain.
Travel analysis	Patients would find that the average car journey time would decrease marginally from 19.6 minutes to 16.4 on average but would see journeys by public transport reduce significantly to 43.6 minutes from 72.7 on average. Travel costs are on average cheaper for both car and public transport users. Car parking is broadly comparable.
Patient choice impact	There will be no impact on Patient Choice, and patients will continue to be able to choose where they would like to access care including MFT or NCA pathways.
Substantial variation assessment	It is proposed that this change does not constitute substantial variation. This is because of the limited patients affected – the key component of Rheumatology provision is provided via outpatients at NMGH, and this will not change. Travel and access are similar or better for most of the

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Rheumatology	Impact on the NMGH catchment
	catchment population.

Table 4: Summary of changes and impact – Urology 6 low volume pathways

<table>
<tr><th>Urology</th><th>Impact on the NMGH catchment</th></tr>
<tr><td>Summary of changes</td><td>Urology is a part of health care that deals with diseases of the male and female kidneys, bladder, and prostate.

The urology pathways included in this wave are for low volume patient pathways including both treatment and diagnosis;

<table>
<tr><th>Pathway</th><th>Current site of delivery</th><th>Proposed site of delivery</th><th>2022/23 North Manchester catchment</th></tr>
<tr><td>Bladder chemotherapy</td><td>Fairfield General Hospital or Rochdale Infirmary</td><td>MRI - future aspiration to expand to NMGH</td><td>48*</td></tr>
<tr><td>Andrology</td><td>Rochdale Infirmary outpatient injection
Royal Oldham Hospital outpatient vacuum pump</td><td>MRI specialist regional centre for penile implants</td><td>14
14</td></tr>
<tr><td>Urodynamics</td><td>Fairfield General Hospital or Royal Oldham Hospital</td><td>Trafford General Hospital future aspiration to expand to NMGH</td><td>58</td></tr>
<tr><td>TULA</td><td>Fairfield General Hospital or Rochdale Infirmary (procedure only)</td><td>Trafford General Hospital - future aspiration to expand to NMGH</td><td>14</td></tr>
<tr><td>Rezum</td><td>Rochdale Infirmary (procedure only)</td><td>Trafford General Hospital - future aspiration to expand to NMGH</td><td>5</td></tr>
<tr><td>ESWL</td><td>Rochdale Infirmary</td><td>Wythenshawe Hospital - future aspiration to expand to NMGH</td><td>60</td></tr>
</table>
*2019/20 data utilised</td></tr>
</table>

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Urology	Impact on the NMGH catchment
Patient feedback summary	The proposals were presented to the Patient and Public Advisory Group (PPAG) of Manchester Health and Care Commissioning and Manchester, Trafford, Salford, Bury, Oldham and Rochdale Healthwatch. The groups supported the case for change and the proposed preferred way forwards. In a wide-ranging discussion, the group did not raise any specific concerns about the proposal itself. General issues regarding travel costs, transport access and car parking at Hospital sites were discussed as well as the need for clear patient information during implementation.
EQIA summary	A full equality impact assessment has been completed. This did not identify any negative impacts of the proposed changes.
QIA summary	A full Quality Impact Assessment (QIA) was completed. There are no adverse impacts expected across any domain.
Travel analysis	A detailed travel analysis has been undertaken. This found that: • Journeys to MRI (pathways 1 – 2) are on average shorter by car and considerably so by public transport compared to Fairfield General Hospital, Royal Oldham Hospital and Rochdale Infirmary • Journeys to Trafford General Hospital (pathways 3 – 5) are on average longer by car and public transport compared to Fairfield General Hospital and Rochdale Infirmary. However, there are 14 and 5 patients per annum on pathways 4 and 5 respectively. Car parking is also free at Trafford General for less than 3 hours. • Journeys to Wythenshawe (pathway 6) take slightly longer on average by car (3 minutes longer) and public transport (9 minutes). The travel analysis also includes an analysis of the cost of travel which found limited change for all pathways. Except for Trafford where car parking is free up to 3 hours, car parking charges are similar at all hospitals.
Patient choice impact	As per current arrangements, patients wishing to choose an MFT or NCA pathway would need to do so for the whole pathway including their first outpatient appointment.
Substantial variation assessment	It is proposed that these changes do not constitute substantial variation because of the limited patient numbers affected per pathway.

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