# Central Manchester University Hospitals / University Hospital of South Manchester merger inquiry

1. Declaration: I was a Consultant Surgeon at the University Hospital of South Manchester (UHSM) between 2012 and 2016. I left for professional reasons and now work in Scotland. The changes proposed between Central Manchester University Hospital NHS Foundation Trust (CMFT) and UHSM have no personal effect on my current or future career.

2. Declaration: I formed a company called Keep Wythenshawe Special Ltd (KWS) which brought about a Judicial Review (2015) challenging the decision to remove General Surgery from UHSM. For further information please see http://www.keepwythspecial.co.uk

3. The Health and Social Care Act 2012 makes it clear that competition law applies to foundation Trusts and cannot be overlooked.

4. There is a poor track record of mergers providing benefits to patients that, whilst much heralded by the hospitals involved, often fail to materialise. It is clearly important than any perceived benefits are carefully scrutinised to ensure that patients will benefit from major changes to Foundation Trust structures.

5. The current proposals lack detail and do not demonstrate that these benefits can be achieved in the forseable future.

6. There is very little evidence that cost savings are likely to arise, indeed quite the opposite is likely.

7. The proposed merger would greatly diminish patient and commissioner choice and would not incentivise providers to improve quality.

8. There has been no meaningful public consultation on the proposed merger between UHSM/CMFT.

9. The proposed merger includes not only CMFT/UHSM, but also North Manchester General Hospital. North Manchester General Hospital should be included in the submission to the CMA in order to fully assess the effects on competition.

10. I firmly believe that the proposed merger between CMFT and UHSM will cause a substantial lessening of competition within Greater Manchester. Respectfully the CMA should consider the effects of the merger not only on competition the proposed merger between CMFT/UHSM/North Manchester, but also the wider effects on the other hospitals in Greater Manchester e.g. Salford, Stockport, Tameside, Bolton, Wigan, Fairfield, Bury, Royal Oldham Hospital and Rochdale Infirmary. There is a widespread view in Greater Manchester (GM) amongst clinicians and

managers in other Trusts, that the proposed merger of CMFT/UHSM will be detrimental to the entire region, reducing patient choice and disproportionately concentrating resources in one sector, leaving health care provision unbalanced across GM. For example, the South-East sector, containing Stockport and Tameside Hospitals, would become a poor relation, offering a much lower level of care than would be available to the Central area of GM. I believe that it is incumbent on the CMA to consider the effects of the merger between CMFT/UHSM on competition amongst all the Foundation Trusts in Manchester.

11. There is clinical and public concern that CMFT will asset strip UHSM and destroy the interdependent clinical services that are currently provided for South Manchester and the North West of England in the case of the portfolio of tertiary services.

12. Wythenshawe is one of the most deprived areas of the United Kingdom. Reducing services at UHSM will directly disadvantage the poor who will find it very difficult to travel over eight miles on the heavily congested road infrastructure into Central Manchester/CMFT.

13. CMFT has one of the highest PFI debts in NHS England. The PFI debt of UHSM is relatively modest. http://www.telegraph.co.uk/news/nhs/11748960/The-PFI-hospitals-costing-NHS-2bn-every-year.html

14. Merging with such a financial risk could destablilise UHSM and lead to a catastrophic financial collapse of the merged Trust. Furthermore, there is the risk that CMFT will take out the high tariff specialist work from UHSM without having to go through any tendering process, thus reducing competition e.g. cardiac services to pay off their own enormous debts.

15. The first steps towards the current merger proposals were outlined in what was known as the Partnership Agreement between UHSM and CMFT drawn up in May 2015 (Appendix 1).

16. The Partnership Agreement was reached without discussion with senior clinical staff at UHSM. Particular concern was raised by Section 7 which proposed that vascular surgery would be located on the CMFT site and CMFT would be the contractual lead provider for General Surgery. The UHSM Consultant body had first been asked on 18th May 2015 to consider the Partnership Agreement and senior clinical staff explained to the UHSM Board that moving vascular surgery to CMFT and giving CMFT contractual lead in general surgery would be highly detrimental to the sustainability of UHSM as a thriving acute Trust. Clearly this would be a major loss of competition for GM. Despite these concerns, the Board of UHSM signed the Partnership agreement and none of the concerns of the clinical staff were incorporated into the agreement.

*17.* The Chair of the Medical Staff Committee of UHSM wrote a letter on behalf of the Consultant Body to the CEO and Chair of UHSM on 17th June 2015 (Appendix 2). This letter clearly explained that the loss of Vascular Surgery and Emergency General Surgery from UHSM *"has potentially damaging consequences for the viability of secondary and tertiary services at UHSM, seriously putting at risk our ability to continue to provide high quality care to the population we serve".*

*18.* The potential sequelae of a loss of services is a loss of competition amongst providers in Greater Manchester.

19. The timing of the Partnership Agreement being signed was at a crucial moment in the Healthier Together process. On 15 June 2015 the Committee in Common (CIC) voted in favour of four single services rather than five single services. On the 8th July 2015 Healthier Together published a Decision Making Management Report for the CIC showing that the household survey revealed that, of the four hospitals, the preferred specialist hospital was Wythenshawe. The CIC met on 15 July 2015 and voted unanimously to name Stepping Hill Hospital as the fourth specialist hospital and not Wythenshawe. Should you not be familiar with Healthier Together please see: http://www.keepwythspecial.co.uk/healthier-together/.

20. Thus, the timing of the Partnership Agreement appeared to the clinical staff at UHSM to be an attempt to by-pass the Healthier Together decision making process and exclude UHSM as an option.

21. During the construction of the KWS case for the Judicial Review, emails were disclosed by the defendant that are commented in on Ground 4: Pre-determination/apparent bias (Appendix 3, paragraphs 98-114). It would be helpful if the CMA took time to consider this reference carefully to fully understand the context.

22. The documents released suggest that it was anticipated that UHSM would be the fourth Specialist Site (paragraph 103). However, a fair and reasonable reading of the emails suggests that senior officers of the Healthier Together Team and of Manchester City Council interfered with the decision making process of the CIC to prevent UHSM being chosen as the fourth specialist site.

23. This is further evidence that the Healthier Together process was by-passed in order to form a Partnership Agreement between UHSM and CMFT.

24. The Skeleton Argument (Appendix 3) is part of the court documents and therefore the contents of Ground 4 are already in the public domain. However, the original emails are not in the public domain and I have not attached them to this submission. If the CMA would like to see the original emails, I will provide them in confidence.

25. This Partnership Agreement was the basis of the proposed merger between UHSM and CMFT. This could give cause for concern that the actions of the two Boards and senior officers of Healthier Together and Manchester City Council interfered with the decision of the CIC. This might suggest that the very origins of the proposed merger of UHSM and CMFT have been most anti-competitive in nature.

26. Believing that our other grounds were sufficient to be successful in the Judicial Review, we dropped Ground 4.

27. Not only did the clinicians at UHSM have concerns over the Partnership Agreement, so did the UHSM Board. On 30 September 2015 the CEO and Chairman of UHSM wrote to their counterparts at CMFT (Appendix 4). I would urge the CMA to read this letter as the concerns that the UHSM Board expressed in this letter are particularly relevant to the proposed merger. The second to last paragraph states that "*the sections on general surgery and vascular surgery need to be amended regarding the statements about lead provider status and the receiving site for general surgery; and UHSM's status as an arterial centre*". The UHSM Board had clearly grasped the potential dangers to services at UHSM should they lose vascular surgery and give up control of general surgery.

28. The dangers of losing general surgery and vascular surgery from UHSM on the co-dependent tertiary services have been clearly articulated by the clinicians. However, these concerns were also shared by the UHSM Board. The then CEO Attila Vegh submitted a witness statement on behalf of the Board to the Judicial Review, where UHSM had registered as an Interested Party (Appendix 5). For example, in paragraph 35 Dr Vegh refers to a joint letter that he wrote with the UHSM Chairman to Ian Williamson, Senior Responsible Officer for Healthier Together stating *"Of the 18 services identified by Healthier Together as requiring support from high risk emergency surgery, UHSM provides all 18. For 5 services (cystic fibrosis, ECMO, heart & lung transplant, tertiary respiratory and burns & plastics) UHSM is on the only provider in the North West. Currently these services are all supported by an onsite, 24/7 general surgery service which is the preferred model described in the national service specifications for cystic fibrosis, cardiothoracic surgery and burns….. Moving to the "local general hospital" model would downgrade the level of general surgery support for these services, reduce their quality and risk lowering their outcomes".*

29. In paragraphs 48-55 of Appendix 5 Dr Vegh explains how general surgery is essential to cardiothoracic and heart and lung transplant surgery.

30. In paragraphs 56-65 of Appendix 5 Dr Vegh explains how general surgery is essential to the provision of an adult cystic fibrosis service.

31. In paragraphs 79-80 of Appendix 5 Dr Vegh explains how general surgery is essential to the provision of Accident & Emergency Services.

32. The UHSM Board were very clear that removing general surgery, as is proposed by the current merger, would be highly detrimental to the specialist services at UHSM. Not only that, patients presenting acutely unwell to UHSM would be disadvantaged if general surgery were to be removed. I trust that the Board of UHSM have again disclosed their concerns, so clearly previously articulated, to the CMA.

33. Putting so many specialist services under threat and in particular some that are unique to the North West must represent a potential loss of competition.

34. Furthermore, it is likely that there will be another round of commissioning looking at the national provision of cardiothoracic and heart & lung transplantation services. There is the real risk that UHSM, which currently has the best outcomes for heart and lung transplantation in NHS England, would be disadvantaged if general surgery on the UHSM site is diminished. As Dr Vegh points out in Appendix 5 paragraph 53, Papworth Hospital is moving its entire operation onto the Addenbrookes Hospital site in order to be co-located with the very services that are offered by the integrated UHSM site. Manchester is moving in the opposite direction and this means that any future tendering process by UHSM for these flag ship cardiothoracic services would be compromised, thus reducing competition for the entire population of England and Wales.

35. In the public consultation carried out by Healthier Together, the public recognised the excellent services available at UHSM and selected them as the fourth specialist site. Rather surprisingly, the Judge in the Judicial Review, ruled that the wishes of the Greater Manchester patients expressed in the public consultation could be ignored. However, patients (indeed many clinicians from surrounding hospitals, when they or their loved ones are ill) attend UHSM because of its excellent reputation and clinical outcomes. The current proposals mean that patients will not have the same opportunity to choose between providers, as UHSM will not have the same level of emergency general surgery on site. Competition will therefore be reduced.

36. This reduction in competition is particularly relevant to the residents of South Manchester following the downgrade of Trafford General Hospital Accident and Emergency Services in 2013. This downgrade was made on the basis that neighbouring hospitals, particularly UHSM, would treat patients previously treated at Trafford General Hospital. When the decision was taken to downgrade Trafford General, the Secretary of State approved the decision on the condition that £12 million would be invested in UHSM's A&E and emergency admissions wards. For further information please see letter from Councilor Newman, Chair of Manchester and Trafford Joint Health Scrutiny Committee to the South Manchester CCG (Appendix 6).

37. The current merger proposes that Elective and Emergency General Surgery will be removed be from UHSM and transferred to CMFT. Indeed this was meant to happen by April. This greatly endangers many of the co-dependent specialist services.

38. The loss of General Surgery and Vascular Surgery from UHSM will mean that the number of patients undergoing major surgery who require ITU to recover from major surgery will be reduced to zero. This will put the General ITU under threat, as it will not have elective bowel cancer surgery and vascular cases being operated on at UHSM. This means that the ITU is at risk of becoming non-viable due to a lack of patients and not sufficient for the A&E and medical patients at UHSM.

39. I am informed that the current proposals for Emergency General Surgery propose having two consultant surgeons on call during the day at CMFT and one at night. One consultant will be on call at UHSM.

40. Provisional work on rotas has suggested that 13 extra consultant emergency general surgeons will need to be recruited to provide this cover. This is a good example of the vast cost of the proposed merger.

41. Whilst there may be a consultant general surgeon on call at UHSM, a surgeon is only a small part of a much larger team required to assess and treat a critically ill patient requiring major surgery. The loss of major elective cancer surgery will mean that the experienced theatre nurses who are used to undertaking major cases, clinical nurse specialists, dietiticans, nutrition team, intensive care unit, physiotherapists, stoma nurses, interventional radiology and vascular interventional radiology will not be available to work with the surgeon to provide the multidisciplinary team to look after the patient. These resources will be concentrated at CMFT.

42. Simply having a general surgeon on call on the UHSM site without the necessary supporting structure is rather like putting a 747 pilot on a deserted airfield and saying you have a functioning airline.

43. Although a consultant general surgeon may be on call at UHSM, clearly the resources for major elective and emergency general surgery will be concentrated at CMFT. This means that the level of general surgical care, such a critical part of delivering safe and effective secondary and tertiary services, will be diminished. This reduces the quality of the services and the options and choice available to patients.

44. UHSM recently tried to recruit two emergency general surgeons. These posts are very unpopular with the majority of trainees and no suitable candidates to shortlist applied. Trying to find 13 new emergency general may prove difficult, particularly as the other areas of GM will also be trying to attract trainees to unattractive jobs.

45. The general surgeons at UHSM are experienced at looking after complex tertiary patients who have rare conditions. Putting in place a rota containing 13 new general surgeons may mean that the same level of care and expertise is not available to some of the most complex surgical conditions. Not only is this detrimental to patient care, but it reduces the ability of the specialist services to provide the same quality of service and to submit competitive tenders both locally and nationally, e.g. heart and lung transplantation.

46. In 2014 Professor Chris Moran, National Clinical Director for Trauma, NHS England conducted a review to consider options to deliver adult major trauma care in Manchester. The short list was narrowed down to Salford and UHSM. Salford was chosen, although Professor Moran noted that they lacked cardiothoracic surgery, vascular surgery, interventional radiology, plastics and burns and a helipad. All these services were available at UHSM and it was with some surprise that the Salford site was chosen. However, Professor Moran gave Salford two years to establish these services at Salford and, if this was not achievable, UHSM would become the preferred site. Bearing in mind that it has taken generations to build up these services at UHSM, this timescale did seem ambitious and frankly unachievable. As Salford still does not have these services on site, surgeons and vascular interventional radiologists have to be phoned to come and provide these life saving services to patients who have suffered major trauma. There are multiple Hospital Incident Reports in Salford documenting how this model repeatedly fails documenting adverse patient outcomes due to the inevitable delays that occur. If a patient is bleeding to death they require immediate life saving measures for such time sensitive conditions. If they are not available, the patient is obviously at great risk.

47. The current merger proposals between UHSM and CMFT and the downgrading of general surgery and removal of vascular surgery from Wythenshawe would make the UHSM site unsuitable for the provision of major trauma. The proposed merger thus removes the other potential provider of major trauma from GM, which is clearly a loss of competition to the region. Not only is this detrimental to patient care, recreating these resources and a helipad elsewhere is a vast waste of public money.

48. CMFT was specifically excluded from providing major trauma by Professor Moran's report due to their inferior results. It is therefore surprising that they are providing major trauma services for penetrating trauma (e.g. stabbings) with the apparent consent of the commissioners. This could be a breach of competition law as UHSM were identified as the alternative site for major trauma if Salford were not able to provide the necessary specialist services in a timely manner. To find CMFT, the site that was specifically excluded from providing major trauma is now doing so, rather than UHSM, speaks volumes about how services are commissioned in Manchester.

49. The pattern of UHSM tendering for services and then being thwarted is one that is familiar to the clinicians in the hospital. For example, oesophagogastric (OG) cancer services were examined in an external review carried out by Professor Alderson in 2010. Professor Alderson recommended that UHSM and Salford should provide the service and CMFT should cease. After objections were raised, the commissioners annulled the process. I am informed that two other previous reports had reached the same conclusion and were also annulled. In 2014 Urology went through an exhaustive tendering process too. Again, UHSM was selected as one of the sites to provide specialist cancer services but after objections were raised the commissioners again annulled the process.

50. The current merger proposals would allow CMFT to by-pass competitive tendering processes, as the loss of general surgery and vascular surgery from UHSM would prevent them tendering for specialist services. It is not difficult to see why CMFT are so keen to have vascular surgery removed from UHSM and have the contractual lead for general surgery. It effectively removes a competitor from the field, who, due to the current excellent quality and clinical outcomes, is consistently selected during tendering processes. This would clearly be a most substantial loss of competition in the region.

51. What is disappointing is that, although the UHSM Board have clearly articulated (please see Appendix 4 and 5) how damaging the loss of vascular and general surgery from Wythenshawe could be, they now appear complicit in the merger. The Board may seek to hide behind the cloak of Sir Jonathan Michael's report, but this did not consider general or vascular surgery, the absolute lynchpins in commissioning a great number of specialist services.

52. The Boards of UHSM and CMFT have very different levels of experience and effectiveness. UHSM is renowned for having excellent clinicians but weak senior management. Indeed there were four CEO's during my time at UHSM in as many years. In contrast, the Board at CMFT has been in place for a substantial period of time, have strong political connections locally and with the Department of Health. CMFT have coveted many of the specialist services at UHSM and there is a significant fear amongst many of the clinicians in UHSM that, should the merger takes place, services will simply be moved out of UHSM without a proper tendering process. Apart from demonstrating a loss of competition, this would be greatly to the detriment of patients, as the specialist services at UHSM are some of the best in the UK as detailed in Dr Vegh's witness statement to the court (Appendix 5).

53. Although I am sure that the CMA are being advised of the great harmony that exists between the Boards of CMFT and UHSM, things may not be all as they seem. A good example of this is the response to the UHSM letter of

30 September 2015 (Appendix 4) from CMFT. I am informed that the response from CMFT failed to address the clinical concerns raised by UHSM and launched into a scathing attack on the UHSM Board. I understand that the letter was widely circulated to Commissioners, NHS England, Manchester University and Monitor. Apparently the clinical concerns on issues of patient safety were ignored. The letter was considered ill judged by all the recipients. The Consultant Body at UHSM, who had seen the letter from our Board to CMFT, were not allowed to see the response. Monitor intervened and, I am informed, they told the CMFT Chairman and CEO, to leave matters of Board governance at USHM, to Monitor and to back off.

54. Despite three FOI requests, the Consultant Body have been denied the opportunity to see the response from CMFT or Monitor's letter to control the situation. I believe that it is crucial that the content of the response is seen by the CMA so that the nature of the proposed relationship between the Boards of the two major teaching hospitals is revealed and, in particular, how the very genuine clinical concerns of the Board of UHSM were responded to. If this demonstrates a poor relationship between the Boards, it is likely that services will be altered to suit CMFT rather than developing out of competitive forces which would be in breach of competition law, not to mention detrimental to patient care. I would suggest that it would be useful to obtain a copy of the response from CMFT to gauge for yourselves how effective the leadership structure post merger will be and the potential imbalance between the two Boards.

55. Very little information has been shared with the clinical staff at UHSM and it is hard to assess the benefits of the proposed merger. The consultant body are concerned that they have had no notice of the submission to the CMA and the short timescale. There has not been time for proper consideration by the consultant body.

56. There is a perception by the consultant body that there is no point in raising concerns with the CMA as it is felt that the merger will be rubber-stamped and that political pressure will be brought to bear on the CMA. I have reassured them that I am absolutely confident that the CMA is a totally independent body which will ensure that due process and the law are followed.

57. It should also be noted that Stepping Hill Hospital, which was chosen by the Healthier Together process as a specialist hospital, is struggling to deliver their existing surgical services. Due to £40 million deficit they have closed one of their surgical wards and are planning to reduce their workforce by 350 people. http://www.bbc.co.uk/news/uk-england-manchester-36913045. It does seem quite impossible for Stepping Hill Hospital to produce the necessary upgrades to meet the Healthier Together standards and the vast cost that this would entail. It would appear sensible to use existing resources available on the UHSM site rather than trying to recreate what is already available elsewhere. The

UHSM/CMFT merger proposals would irreparably damage the services at UHSM, so that if Stepping Hill Hospital is unable to upgrade there will be a substantial gap in NHS services in South Manchester and lessening of competition.

58. I would urge the CMA to perform a detailed phase 2 analysis to ensure that the shareholders (i.e. the patients) are not disadvantaged and that competition law is upheld. The current structure of the proposed merger will lead to a substantial lessening of local, regional and national competition by removing general and vascular surgery from UHSM. This will have a detrimental effect on the current provision of secondary and tertiary services and the ability to competitively tender for services in the future.

Andrew Macdonald
Consultant Surgeon
26-Mar-17

**Note from UHSM / CMFT / MCC meeting re sustainability of acute services.**
**On : Wednesday 3 June 2015.**
**From : Darren Banks and Stephen Gardner, CMFT, Silas Nicholls and Matthew Graham, UHSM and Geoff Little, MCC.**

**Proposal for shared services between UHSM and CMFT.**

1. **Introduction**.

Building on the discussions on 7 May, the purpose of this note is to further develop the options for partnership between UHSM and CMFT. On 7 May it was agreed that the priority was to set out further detail on options for the overarching governance structure and for partnerships for shared services, particularly cardiac, vascular and general surgery services.

2. **The opportunity**.

CMFT and UHSM are both strong organisations providing tertiary services to the populations of Manchester, Greater Manchester and in many cases regionally and nationally. The Chairs and Chief Executives of UHSM and CMFT are determined to develop a new relationship between the two Trusts. The possibility of achieving something special together is very real.

GM Devolution means now is the time to set a new vision and purpose for how the two Trusts will collaborate in order to maximise the patient benefit arising from a differentiated (where appropriate) yet unified approach.

GM needs shared services models for tertiary services if the GM Strategic Plan is to achieve financial and clinical sustainability by 2020. This is the opportunity for CMFT and UHSM to take a lead in the implementation of those models.

The opportunity exists for UHSM, CMFT and Manchester University to build a stronger academic and research platform which will directly benefit the City of Manchester as well as the wider Greater Manchester conurbation.

There has never been a better time for UHSM and CMFT to completely transform their working relationship, to empower their clinicians to innovate together and to deploy new technologies and develop new models of care.

3. **Guiding principles**

We start from a Manchester place-based perspective, which encompasses UHSM facing into the City, and having its principal partnering relationship with CMFT, as well as other partners in Manchester.

The partnership will not be a merger, but neither is it a weak collaboration.

The overarching partnership agreement will cover all aspects of the relationship between the two trusts and will apply to all services, not just those formally included in the shared service agreement.

We give equal consideration to the tertiary services provided by UHSM and CMFT and the core services in the scope of Healthier Together (A & E, acute medicine and general surgery)

We include consideration of integrated community, primary, adult social care and community mental health services.

The Trusts will aim to work collaboratively wherever possible to avoid wasteful and unproductive duplication and competition and optimise utilisation of the healthcare facilities in their ownership.

The Trusts will work together to ensure the effective delivery of the Healthier Together standards in Manchester.

## 4. Scope

The approach to collaborative working between UHSM and CMFT will be broad in scope. The intention would be to establish a long term partnering relationship. The two Trusts will look to each other as principal partners

- in the delivery of primary and secondary healthcare services for the local population in the City of Manchester
- in the provision of agreed tertiary services for the Greater Manchester conurbation and beyond
- in the development of research and innovation, and academic health sciences, in collaboration with Manchester University

In the context of this overarching approach, the specific areas of collaborative working will be developed progressively, with the two Trusts working together to identify key services where material benefits can be delivered through collaboration and integration. Some of the services of interest in the first instance are described in more detail below (see sections 6-10).

Without prejudging the arrangements for specific services (and bearing in mind the context of the Trusts' existing service portfolios) it is likely that the development of specialist tertiary services will see a primary emphasis on elective care at Wythenshawe Hospital, and an emphasis on acute care at MRI. Both sites would continue to provide a broad range of secondary care services, and both organisations would continue to develop their roles in the provision of community-based services, in collaboration with other key Manchester providers.

## 5. Governance

The options for governance will not be merger, but nor will they be weak collaboration. All governance arrangements will be based on formal agreements (eg Joint Venture, Lead Provider / Recipient Agreement, SLAs, etc) which allow each Trust to hold the other to account.

A robust overarching partnership agreement would be put in place. This will:

- Confirm the commitment of the two Trusts to work in partnership in the provision of services (see Scope above and service options (sections 6-10) below)
- Describe the intention, and create incentives, for partnership working to be a long-term, strategic arrangement between the two Trusts
- Establish governance arrangements focused around a Shared Services Board (or other entity of that sort), with equal representation from the two Trusts at Executive and Non-executive Director level. The Board could also include an independent chair and clinical director.
- The Shared Services Board would have the following elements as part of its make up –
    - Equal representation from both organisations
    - Will oversee the strategic development of the service areas under its remit, giving approval for revised clinical service models to be put into place, as well as setting clear parameters for the development of services.
    - It will have an underpinning legal agreement
    - It will have an explicit dispute resolution process, this would include setting out explicitly the consequences of early departure from the agreement.
    - Both UHSM and CMFT recognise that commissioners will have the final say on the exact contractual mechanisms that they will use to commission services, but that the shared services board will be the vehicle at provider level that would be used to co-ordinate and manage our shared response to such commissioning intentions. The shared services board will move the language away from winners and losers, and instead focus on the shared service offer that UHSM and CMFT can jointly provide.

- Establish a Clinical Standards Board to agree the appropriate service requirements to support the function of each site and each Trust, and to ensure that services are delivered to these standards. Key functions of the clinical standards board will include –
    - Ensuring the right level of clinical support in general and vascular surgery is in place for the Wythenshawe site to ensure that existing tertiary work at the site can continue in a sustainable form. (This tertiary work consists of cardiac, respiratory, breast surgery, burns and plastics). The clinical model required to deliver this would be a variant of the clinical model for general surgery as described by Healthier Together. However, the standards and outcomes required by Healthier Together will be met.
    - The Clinical Standards Board would ensure that all relevant clinical interdependencies were considered for the wider organisation of services at the UHSM and CMFT sites, not just those dependencies that relate to cardiac, vascular and general surgery.
- Sitting below the shared services board would be specific sub-groups for each of the identified specialties or workstreams, which would be made up of equal representation from both organisations. These groups will do the detailed work of developing recommendations of how services will be delivered within the explicit parameters set by the shared services board and taking note of the input and advice from the clinical standards board.

Individual agreements will be developed for specified areas of shared service provision (see section 7), with the form of these being bespoke to the requirements of each service. These arrangements will report into, and be controlled by the Shared Services Board. The lead provider for any given specific shared service within the scope of this agreement will report to the Clinical Standards Board which is accountable to the Shared Services Board.

The Shared Services Board is the decision making body for the shared services within the scope of this agreement.

The formal agreements put in place for each shared service would have sufficient contractual rights and remedies to give each Trust confidence of the commitment of the other, and the ability of the Trusts to hold each other to account. It is recognised that this is of particularly significance:

- where the two Trusts have a mutual dependency to ensure the growth and development of a service
- where one Trust might be providing a function that supported a service of key strategic interest to the other Trust.

Both Trusts will at the same time be parties to a JV or similar legal entity along with PAHT and MCC to provide integrated urgent care, community health, and adult social care. A subsequent phase should see GP providers join the JV to integrate primary care. Community mental health services should also be brought into the integrated JV.

6. **Lead Tertiary Services**.

UHSM should lead on tertiary services for:-

- Respiratory Services (including lung cancer and thoracic surgery).
- Breast Cancer (both surgery and screening).
- Burns and Plastics.

7. **Manchester Shared Services**

For a core set of services UHSM and CMFT should enter into **shared service agreements** to create new, jointly owned and managed Manchester services for:-

- Manchester Cardiac Service. Both Trusts have a strategic interest in Cardiac services and the approach would be to increase the differentiation and complementarity of the service offers at the two sites. In time this could lead to a distinct "Manchester Heart Service" jointly owned by both trusts.

- Manchester Vascular Service (including vascular surgery & interventional radiology). Both trusts have strong vascular surgery and interventional radiology services with good clinical relationships between the services including shared on-call rotas. UHSM recognises the benefits of centralising arterial surgery on one site within a Manchester shared service and that this should be at MRI. Other non-arterial vascular surgery would continue to be delivered at Wythenshawe. As a minimum the Manchester service would provide robust vascular surgery and interventional radiology support to Wythenshawe's secondary and tertiary services (in particular to maintain the quality of service in cardiac and thoracic surgery, and in other elective general surgery). The Clinical Standards Board would oversee a process for all relevant services and clinicians to be involved in the development of the detailed clinical service model.

- Manchester General Surgery Service. Manchester's response to Healthier Together should be a single shared service for emergency and complex elective general surgery delivered jointly across CMFT and UHSM, recognising the importance of general surgery in supporting the extensive range of tertiary services provided by both trusts. Within the model, UHSM would not be a receiving site for emergency general surgery. An appropriate general surgical service would be provided by the Shared Service (with CMFT as the contractual lead provider) to maximise the proportion of urgent care patients who can be appropriately managed at UHSM, and to allow tertiary services to be maintained and developed. The thinking developed in the North West and South sectors on clinical models for single shared general surgery services can inform the detailed development by our clinicians of a model for Manchester. Consideration should be given to the potential for a model which focuses elective surgery at Wythenshawe and non-elective surgery at MRI. Consistent with Healthier Together modelling, the expectation is that the vast majority of the elective surgery would continue to be provided at Wythenshawe. Within the parameters set by the Shared Services Board, senior clinicians from both organisations will be supported to work together to develop a proposal to deliver the shared service.

8. **Collaboration opportunities for other clinical and support services**

Options for **other clinical and support services** where there can be agreement between CMFT and UHSM for shared service arrangements on a case by case basis:-

- Orthopaedics. For Orthopaedics, there is potential for UHSM to become a partner in the Manchester Orthopaedic Centre on the Trafford General site.

- Use of capacity at Altrincham Hospital and Withington Community Hospital. The Altrincham and Withington Community Hospital sites have the potential to support new models of care including health and social care integration and the transfer of care away from major acute sites.

- Back office support services

- Pathology labs. For Pathology there may be productivity gains to be achieved by consolidating services between sites and in using excess capacity on the CMFT site

9. **Options for integration of community services**

- UHSM and CMFT to work with PAHT and MCC to lead the city wide integrated provision of urgent care, community health, primary care, adult social care and community mental health services.

10. **Options for alignment of research and innovation activities**

- CMFT and UHSM, within the context of MAHSC, to collaborate on their differentiated yet complementary health sciences research and innovation facilities at Citylabs and Medipark respectively.

- UHSM have outlined the potential for the use of Medipark to develop new facilities with a focus on contributing to the development of new models of supported living communities, including housing to enable self care

- UHSM, CMFT MCC and potentially PAHT to create a new vehicle to exploit the opportunities of scaling the application of technology and integrated intelligence eg tele-health and tele-care, shared care records

- A first step would be to establish a joint research office to approve and coordinate clinical trials across both sites.

## 11. **Next Steps.**

In addition to the existing work on integration of health and adult social care which is already ongoing across Manchester, the following actions are proposed:

- Healthier Together. Submit a revised, shared position statement as part of a single Manchester input to the Healthier Together decision making process. The shared input will be consistent with the arrangements described in this paper and will demonstrate the effective delivery of the Healthier Together standards in Manchester. The response from Manchester to Healthier Together will therefore say that UHSM should not be a specialist or local hospital in Healthier Together terms because it will be part of this more comprehensive shared services agreement with CMFT for secondary and tertiary services and with CMFT, Pennine Acute and MCC for community and adult social care services.
- Communications Plan. Develop a structured communications plan, with agreed key messages, specified audiences, and coordinated activities.
- Develop Strategic Partnering Agreement. Using NW Sector agreement as a starting point the two trusts, with legal support, to draft the overarching partnering agreement.
- Establish the Shared Services Board and Clinical Standards Board
- Manchester General Surgery Service. Two trusts, with legal support, to draft and agree the JV for the Manchester General Surgery Service. Due to Healthier Together timescales this JV is the priority out of the three initial shared services
- Manchester Vascular and Cardiac Services. Two trusts, with legal support, to draft and agree the JVs for the Manchester Vascular and Cardiac Services.
- Clinical Standards Board to establish appropriate arrangements to develop detailed clinical service models for the shared Manchester Cardiac, Vascular and General Surgery Services.
- Joint Research Office. CMFT and UHSM research offices, working with MAHSC/Manchester University, to collaborate to develop a recommendation for the Shared Services Board on how a joint research office would work.
- UHSM, CMFT and Manchester University to explore opportunities on how the three organisations can work more closely together in developing teaching and research opportunities across the three organisations
- Medipark / MSP. UHSM to ask CMFT and MCC to nominate a representative each to join the board of Medipark. MSP to ask UHSM to nominate a representative to join the board of MSP.
- Withington / Altrincham Hospitals. UHSM and CMFT to agree jointly with local CCGs the best mix of services to be offered from Withington and Altrincham Hospitals, making best use of the expertise in both trusts. UHSM and CMFT to work together to implement the agreed services.

University Hospital of South Manchester NHS
NHS Foundation Trust

Wythenshawe Hospital
Southmoor Road
Wythenshawe
Manchester
M23 9LT

17 June 2015

Dear Attila and Barry,

The Consultant Body at University Hospital of South Manchester (UHSM) are supportive of the principles of DevoManc and keen to develop new partnerships in Greater Manchester to improve patient care. This includes developing closer links with Central Manchester Foundation Trust (CMFT).

The UHSM Consultant Body were informed of a request to collaborate with CMFT on 18th May 2015, and subsequently raised concerns about decisions being made without detailed clinical analysis with regard to patient safety, outcomes and optimum service. We feel that none of those concerns were addressed, because less than three weeks later a "partnership agreement" was signed by executive management, without incorporating agreed clearly documented advice of senior clinical leaders.

The agreement that you have both signed with CMFT cannot be supported in its current form by the Consultant Body. The loss of Vascular Surgery and Emergency General Surgery has potentially damaging consequences for the viability of secondary and tertiary services at UHSM, seriously putting at risk our ability to continue to provide high quality care to the population we serve. Furthermore, the proposal that UHSM would not be a receiving site for acute general surgery is outwith the Healthier Together Public Consultation (see attached document).

Our primary duty as clinicians is to our patients. Any doctor concerned that a decision which would put patients, or the health of the wider community, at risk of serious harm is duty bound to raise the matter promptly and formally. Clinicians also have a duty to the wider community, our profession, our colleagues and to our organisation. All are being put at risk by decision making which is being carried out without due process, without an appropriate period of consultation, without formal assessment of risk, without adequate dissemination of detailed information and without appropriate negotiation.

The Consultant Body therefore respectfully requests that the UHSM / CMFT Partnership Agreement is suspended. A new agreement between UHSM and CMFT may then be properly constructed using due process, and in accordance with the principles of "Healthier Together".

Yours sincerely,

Mark Welch
Chair of Medical Staff Committee
On behalf of Consultant Body

**CLAIM NO: CO/4920/2015**

**IN THE HIGH COURT OF JUSTICE**
**QUEEN'S BENCH DIVISION**
**ADMINISTRATIVE COURT**
**IN MANCHESTER**

**B E T W E E N:-**

**THE QUEEN**
**-on the application of-**
**KEEP WYTHENSHAWE SPECIAL LTD**

**Claimant**

**-and-**

**NHS CENTRAL MANCHESTER CCG**
**-and eleven others-**

**Defendants**

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# CLAIMANT'S SKELETON ARGUMENT

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## Introduction

1. The claimant, a company formed by some of the consultants of the Wythenshawe Hospital, and supported by its staff, patients and the local public, challenges a decision of the defendants, the CCGs (clinical commissioning groups) of Greater Manchester (GM). The decision, taken on 15 July 2015, was to choose Stepping Hill Hospital, in Stockport, rather than Wythenshawe Hospital, as the fourth specialist hospital as part of the reconfiguration of NHS services in GM. The claimants say that the decision taken without fair consultation and irrational.

2. This skeleton has been drafted without sight of all the disclosure. The most recent material produced by NHS England also arrived too late for it to be considered. The claimant therefore reserves its position in relation to any matters arising out of that.

3. The claimant indicated in its reply that it was no longer pursuing Ground 4 – inequality – as originally pleaded. It is now no longer pursuing Ground 7, save insofar as it is

included in Ground 2 – the application of only one of the sets of criteria – Transport and access. The claimant advances a new Ground 4. It arises out of material disclosed to the claimant on 1 December 2015, albeit that it had been requested in the LBA.

4. The facts and law are set out in light of the agreed documents and have been abbreviated in order not to duplicate what is contained there. This document is also intended to be read alongside the witness statements filed on behalf of the claimant. The absence of inclusion in the skeleton of any specific matter should not be taken as an indication that any material will not be relied upon in argument if it appears in the agreed documents or witness statements.

**Summary**

5. The claimant submits that the defendants' consultation was unfair and their decision irrational and unlawful.

6. At a late stage in the decision-making process, the defendants included a small group of residents of an area outside GM in their calculations and applied the Travel and access criteria to them (also in an apparently inconsistent way in their favour) so that their interests became determinative of the decision. There was no consultation with the public about this. While the issue of the needs of that population may be said to have arisen from the consultation, it was so fundamental that it required further proper consultation.

7. The defendants consulted on the options on the basis of four sets of criteria, including Quality and safety of clinical services, but at the decision-making stage they decided to apply only one – Travel and access – in order to discriminate between them. This excluded consideration of vitally relevant factors. There was no consultation with the public about this.

8. The defendants irrationally reached their decision on the evidentially-unsupported assumption that all the options were identical in terms of Quality and safety of clinical services because they would spend money to bring whichever hospital was chosen up to

standard. There was no consultation with the public about this. Rather the public had been asked which of the criteria they considered the most important, and had responded by saying Quality and safety.

9. The decision was taken with the appearance of bias or pre-determination.

10. Although the defendants decided to take the decision applying solely the Travel and access criteria to discriminate between the options, the analysis of journey times to which criteria were applied was flawed because it did not have regard to the impact of the building of the A6 relief road which would change the relevant journey times in the future at which the decision was aimed.

11. The decision was taken on the basis of a flawed analysis of the need for the co-dependent clinical services at Wythenshawe Hospital to be co-located with emergency general surgery, which would be lost if it was not made a specialist hospital. There was no consultation with the public about this.

**Index**

12. This skeleton argument is structured as follows:

| | |
|---|---|
| Relief | 137-145 |

## Facts

13. Wythenshawe Hospital in South Manchester is a major acute teaching hospital, and is operated by the University Hospitals of South Manchester NHS Foundation Trust ("USHM"). It is recognised as a centre of clinical excellence providing district general hospital services as well as specialist tertiary services. It provides specialist expertise in the fields of cardiology and cardiothoracic surgery, heart and lung transplants, respiratory conditions, burns and plastics, cancer and breast care services, to patients within Greater Manchester and beyond.

14. The Healthier Together in-hospital model of care proposes that emergency general surgery and high risk elective general surgery will be concentrated on fewer hospital sites across Greater Manchester supported by high volume critical care.[1] The critical difference between the two types of hospitals in the Healthier Together model is that a 'local' hospital will not offer emergency general surgery which would be concentrated on the 'specialist' hospital sites.

15. During the pre-consultation phase, the CIC decided upon a shortlist of preferred options prior to public consultation. Three hospitals were identified as specialist 'fixed' points which would remain constant as specialist hospitals in all of the options going forward. Similarly, three hospitals were identified as local 'fixed' points which would remain constant as general hospitals in all of the options going forward. The Clinical Reference Group recommended that the following three hospitals should be specialist fixed points in all options going forward:[2]

    (1) Royal Manchester Children's Hospital – CMFT (Manchester Royal Infirmary)
    (2) Adult Neuroscience Service – SFRT (Salford Royal Hospital); and
    (3) Adult Burns Service – UHSM (Wythenshawe Hospital).

16. On 26 February 2014, notwithstanding the recommendations of the Clinical Reference Group, the CIC decided that both Manchester Royal Infirmary and Salford Royal Hospital would be designated 'specialist' in all subsequent options, but not Wythenshawe Hospital. On the same day, the CIC decided that Fairfield General and Tameside General would be considered as 'local' hospitals in all options.

[1] Appendix 44: Future Model of Care (Defendants' Bundle **[3/28/1286]**)
[2] Appendix 2: Healthier Together, *"Pre-consultation business case for Greater Manchester Health and Social Care Reform"* Part 2 of 2, p. 27 (Defendants' Bundle **[1/6/404]**).

17. Hurdle criteria were then introduced in order to select the third specialist hospital. It is not clear from the Pre-Consultation Business Case[3] who decided upon the hurdle criteria. The hurdle criteria for Transport and Access required that no more than 10,000 of the population of any one of the participating CCGs should have a greater than 75 minute (1hr 15min) journey by public transport to a specialist site. It should be noted that the North Derbyshire population, the needs of whom became determinative of the decision at the end of the process, did not feature at all in these calculations. Only Royal Oldham Hospital passed the hurdle criteria.

18. On 16 April 2014, the CIC decided that Royal Oldham Hospital would be the third specialist hospital in all subsequent options, and that North Manchester General Hospital would be designated as the third 'local' hospital in all options. As a result of this process, the three specialist fixed sites which went forward to public consultation were confirmed as (1) Manchester Royal Infirmary; (2) Salford Royal Hospital; and (3) Royal Oldham Hospital.

19. Between 8 July 2014 and 30 September 2014, Healthier Together conducted a public consultation, although responses were accepted until 24 October 2014. In addition to the three fixed specialist sites already identified, the consultation put forward eight options for additional specialist sites depending on whether there would be 4 or 5 single services in Greater Manchester. The Consultation Document made clear that all eight options being consulted upon met the requisite Travel and Access standards.[4] It was also made clear that the population under consideration was the population of Greater Manchester.[5]

20. The Consultation Document asked consultees to rate the four sets of criteria in terms of importance using a whole number between 0 and 10, where 10 means that the criteria is critically important and 0 means that the criteria is of no importance. The majority of responses expressed support for five rather than four single services, and therefore five rather than four specialist hospitals. In addition, of the four proposed sets of criteria, consultees consistently

[3] Appendix 2: Healthier Together, *"Pre-consultation business case for Greater Manchester Health and Social Care Reform"* Part 2 of 2 (Defendants' Bundle **[1/6/365-572]**).
[4] Appendix 4: Guide to Best Care, p. 47: *"All eight options allow everyone in Greater Manchester emergency access to their local General Hospital within 20 minutes and a Specialist Hospital within 45 minutes"* **(**Defendants' Bundle **[10/4/3385])**. See also Management Report, p. 133: *"The analysis showed that for all eight options being appraised, there was 100% compliance with Travel Standards 1 and 2 based on patients attending their 'nearest' hospital for specialist care"* (Defendants' Bundle **[1/1/133]**)
[5] Appendix 4: Guide to Best Care, p.48:*"To make sure that all Single Services can provide specialist care for the population of Greater Manchester"* **(**Defendants' Bundle **[10/4/3386])**

rated Quality and Safety as being the most important criteria with an average score of 9.7 out of 10.[6]

21. On 19 November 2014, the CIC unanimously endorsed the Decision Making approach paper which outlined six decisions that needed to be taken in relation to the in-hospital programme during the decision-making phase.

22. On 21 January 2015, the CIC voted on decisions 1-3.[7] The CIC confirmed the case for change, the proposed model of care and that only options with 4 or 5 single services would be considered.

23. On 18 February 2015, the CIC voted on the criteria to be used to select an option for implementation (decision 4).[8] The agreed criteria differed slightly from that contained within the Consultation Document and were:

(1) Quality and Safety
    (a) Clinical Effectiveness and Outcomes
    (b) Patient Experience

(2) Travel and Access
    (a) Distance and time to access services
    (b) Patient Choice

(3) Transition
    (a) Workforce
    (b) Expected time to deliver
    (c) Greater Manchester Coherence

(4) Affordability and Value for Money
    (a) Capital cost to the system
    (b) Transition costs

[6] Appendix 12: Opinion Research Services, *'Presenting the Evidence: Final Report of the Consultation Outcomes'* (July 2015) p. 87 fig 49 (Defendants' Bundle **[2/12/909]**)
[7] Appendix 31: Shared Minutes of the Healthier Together CIC meeting on 21 January 2015 (Defendants' Bundle **[3/21/1091-1110]**)
[8] Appendix 32: Shared Minutes of the Healthier Together CIC meeting on 18 February 2015 (Defendants' Bundle **[3/22/1101-1108]**)

(c) Viable Trusts and Sites

(d) Change in I&E versus 18/19 'base case' position

(e) Net Present Value

24. Further, the CIC resolved at the meeting on 18 February 2015 not to apply any weighting between the four main sets of criteria.[9] Neither during the consultation nor at this stage was there any suggestion that any of the criteria was not relevant, nor that any of them would be excluded from the considerations applied in order to make the final decision.

25. On 15 April 2015, the CIC decided to change the boundary for the hospital catchment area.[10] This was expanded to cover all addresses that are currently closest to a GM hospital but outside of Greater Manchester such as North Derbyshire, Eastern Cheshire, Chorley and South Ribble.

26. On 17 June 2015, the CIC voted in favour of four rather than five single services (decision 5).[11]

27. On 8 July 2015, Healthier Together published a Decision Making Management Report ("Management Report") for the CIC.[12] Amongst other things, the Management Report informed the decision-makers that there remained *"100% compliance with Travel Standards 1 and 2 based on the modelling assumption that patients would attend their 'nearest hospital for specialist care (in some instances, outside Greater Manchester)."*[13] However, the Management Report went on to say that *"Patients travelling from Buxton (SK17) and Castleton (S33) postcodes would not achieve the 45 minute emergency access standard in Options 4.1, 4.2 and 4.3… Patients in North Derbyshire do not have the choice of another Greater Manchester hospital that meets Travel Standard 2 other than Stepping Hill Hospital in Stockport."*[14]

28. On 15 July 2015, the CIC voted unanimously to name Stepping Hill Hospital as the fourth

[9] See also Management Report at p. 106: *"…CIC determined not to apply a weight to the criteria for decision making. This was discussed and agreed by CIC on the 18th February 2015"* (Defendants' Bundle **[1/1/105]**) and p. 109: "*Having assessed the consultation feedback and the relevant guidance, on the 18th February 2015 the CIC agreed that the existing four criteria themes are still valid and should be used in decision making (Quality and Safety, Transport and Access, Affordability and Value for Money, Transition) and that no weighting should be applied to the criteria"* (Defendants' Bundle **[1/1/109]**)

[10] Defendants' Bundle **[3/23/1109-1116]**

[11] Appendix 34: Shared Minutes of the Healthier Together CIC meeting on 17 June 2015 (Defendants' Bundle **[3/24/1117-1130]**)

[12] Defendants' Bundle **[1/1/1-242]**

[13] Management Report p. 143 (**Defendants' Bundle [1/1/143]**)

[14] Management Report p. 149 (**Defendants' Bundle [1/1/149]**)

specialist hospital (decision 6).[15] Minutes of this meeting were not disclosed to the claimant until the defendants filed their Summary Grounds of Resistance on 2 November 2015. As is clear from the minutes of the meeting, each voting representative of the 12 CCGs mentioned travel and access as the reason for choosing Stepping Hill Hospital, rather than Wythenshawe Hospital, with many of them citing this as the only set of criteria on which their decision was based.[16]

29. On 27 August 2015, members of the Medical Staff Committee of UHSM (the MSC) sent a pre-action protocol letter before claim to the defendants.[17] In its pre-action letter, the Medical Staff Committee informed the defendants that *"should it become necessary to issue proceedings, it is anticipated that an entity will be formed to constitute the Claimant in the proceedings."*[18] The claimant also requested that pending determination of this claim, the defendants should take no steps to implement the decision.[19] Notice of this potential challenge was widely publicised in the media.[20]

30. The defendants sent their response by letter dated 16 September 2015 which was received by the claimant's representative on 18 September 2015.[21] The defendants requested further information about the members of Medical Staff Committee but did not comment on the proposal that a legal entity would be formed to constitute the claimant in these proceedings. Further, the defendants confirmed that they would *"take no action to implement the decision that is being contested… before the end of September."*[22] The defendants notified the claimant that UHSM wished to be named as an interested party in proceedings.

*31.* By its claim issued on 12 October 2015, the claimant sought an undertaken from the defendants that it would not take any steps towards implementation before the resolution of these proceedings. The defendants confirmed by letter dated 15 October 2015 that *"implementation will not commence before January 2016. We will update you about implementation at that time…"*[23]

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[15] Defendants' Bundle **[1/2/243-262]**
[16] Defendants' Bundle **[1/1/243-262]**
[17] Claimant's Bundle **[C17-C31]**
[18] Claimant's Bundle **[C17-C18]**
[19] Claimant's Bundle **[C28]**
[20] See, for example, "Healthier Together: Top medics plan to apply for judicial review into Wythenshawe Hospital decision" published on 31 August 2015, http://www.manchestereveningnews.co.uk/news/greater-manchester-news/healthier-together-top-medics-plan-9958943
[21] Claimant's Bundle **[C53-C82]**
[22] Claimant's Bundle **[C63]**
[23] Supplementary Bundle

32. On 6 November 2015, permission to apply for judicial review was granted by Mr Justice Picken on the papers who observed that the claimant *"has a reasonably arguable case"*.[24]

**The Law**

*The National Health Service Act 2006 ("the NHS Act")*

33. S.3 of the NHS Act imposes duties on CCGs in relation to those persons for whom they have "responsibility". A CCG has responsibility for a person if he is provided with primary medical services (such as GP services) by the CCG. It also has responsibility for a person residing in its area and who is not provided by services by any other CCG.

34. S.14R of the NHS Act requires CCGs to exercise their functions with a view to securing continuous improvement in the quality of services provided to individuals, including the effectiveness and safety of the services.

35. S.14T of the NHS Act requires CCGs in the exercise of their functions to have regard to the need to reduce inequalities between patients with respect to their ability to access health services and with respect to the outcomes achieved for them by the provision of health services.

36. S.14U of the NHS Act states that CCGs must promote the involvement of patients, and their carers and representatives, in any decisions which relate to (a) the prevention or diagnosis of illness in the patients, or (b) their care or treatment.

37. S.14Y of the NHS Act states that CCGs must in the exercise of their functions promote research on matters relevant to the health service and the use in the health service of evidence obtained from research.

38. S.14Z1 of the NHS Act states that CCGs must exercise their functions with a view to securing that health services are provided in an integrate way where it considers that this would improve the quality of those services, reduce inequalities between persons

[24] Supplementary Bundle

with respect to their ability to access those services or reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

39. S.14Z2 of the NHS Act states that CCGs must make arrangements to secure that individuals to whom services are being provided by them or may be provided by them are involved (whether by being consulted or provided with information in other ways) in the planning of the commissioning arrangements, in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would have such an impact.

*The case law*

40. In addition to the propositions set out in the agreed list, the claimant relies upon the following.

41. In *R (Moseley) v LB Haringey* [2014] UKSC 56, the Supreme Court, when considering what fairness in consultation requires, the Court held:

> "*... its requirements in this context must be linked to the purpose of the consultation ... First, the requirement "is liable to result in better decisions, by ensuring that the decision-maker receives all relevant information and that it is properly tested" ... Second, it avoids "the sense of injustice which the person who is the subject of the decision will otherwise feel" ... Such are two valuable practical consequences of fair consultation. But underlying it is also a third purpose, reflective of the democratic principle at the heart of our society. This third purpose is particularly relevant in a case like the present, in which the question was not "Yes or no, should we close this particular care home, this particular school etc?" It was "Required, as we are, to make a*

*taxation-related scheme for application to all the inhabitants of our Borough, should we make one in the terms which we here propose?*"

42. Applying those considerations to a consultation concerning council tax where the local authority was "discharging an important function in relation to local government finance, which affects its residents generally" (para 37) and the purpose of the statutory duty to consult in that case was "to ensure public participation in the local authority's decision-making process" (para 38) it held that:

> "*In order for the consultation to achieve that objective, it must fulfil certain minimum requirements. Meaningful public participation in this particular decision-making process, in a context with which the general public cannot be expected to be familiar, requires that the consultees should be provided not only with information about the draft scheme, but also with an outline of the realistic alternatives, and an indication of the main reasons for the authority's adoption of the draft scheme. That follows, in this context, from the general obligation to let consultees know "what the proposal is and exactly why it is under positive consideration, telling them enough (which may be a good deal) to enable them to make an intelligent response*" (para 39).

43. The subject matter and statutory functions engaged in this case were at least as important, if not more vital.

44. In *Moseley* at first instance, Underhill J, refusing the application for judicial review, held that a change in the situation that was "far from conclusive" could not be sufficiently fundamental as to require being consulted upon (para 35).

45. In *Devon County Council v Secretary of State for Communities and Local Government* [2010] EWHC 1456 (Admin) the Court considered a consultation which involved the use of criteria. It held as follows:

> "*Where, as here, for the purposes of the consultation process, the decision-maker does in fact set out his crucial criteria and precisely how he will use them in his decision-making, this would, as intended, affect what topics were*

*covered by consultees, in what depth or with what focus, and would affect what is omitted ...*" (para 69)

46. In that case, the Secretary of State changed his approach to his criteria but did not consult on the change. The Court held as follows:

> "*It is significance for the approach and decision rather than relevance which matters here. Even if his criteria had excluded a relevant factor and he brought it in later so as to reach a lawful decision, the consultation would be unfair if he did not alert consultees to the need to address it – unless perhaps it was so obvious no alert was necessary*" (para 83)

It held that:

> "*... it was such a large consequence to flow from a very new and recently announced policy that the only way for consultation to be lawful would have been for the Secretary of State to alert consultees to its enormous political significance*" (para 96)

And:

> "*... I have no difficulty in seeing that consultees would have wished to contest the value of "Total Place" as a basis for a change of stances in relation to the role of the criteria, and its value as a basis for judgment (if it was the judgment) that the value for money criterion was met and met in a way which meant that failure to meet the affordability criterion was overcome ...*" (para 97)

The Court concluded thus:

> "*I am satisfied that this change in approach was also unfair and deprived the County Councils of the opportunity to make their case in the consultation process ...*" (para 98).

47. The defendants rely on *R v LB Islington ex parte East* [1996] ELR 74 and *R (Smith) v East Kent Hospital NHS Trust* [2002] EWHC 2640 (Admin) in support of the proposition that an amended proposal which (a) emerges from the consultation and (b) reflects the consultation does not require further consultation. It is submitted that these cases, one of which is very old and from a very different legal landscape and factual context, can be considered as no more than examples. Neither is sufficient to undermine the fundamental propositions articulated much more recently by the Supreme Court in *Moseley*. In particular, it is submitted that core question in every case is – what does fairness require? No sub-proposition should be allowed to undermine that.

**Ground 1 – inclusion of those residing in one area outside GM and the application of an inconsistent travel standard to them**

48. At the end of the decision-making process the CiC:

a. decided to treat the impact of the decision on residents of one area outside GM as a factor to be taken into account [DMMR p127] although that had not been its initial approach [see references below];

b. applied the 45 minute standard of the Transport set of criteria to the residents of that one area outside GM;

c. but applied the 45 minute standard to them in a different way from the way in which it had been applied to the residents of GM i.e. the residents of the area outside GM were treated as entitled to be within 45 minutes of a specialist hospital of their choosing, not of any specialist or otherwise suitable hospital [DMMR p143 and 145-150], whereas the issue of choice or even usual practice did not apply to the residents of GM when the standard was applied to them [DMMR p139 and 144];

d. made the Transport set of criteria, and in particular the 45 minute standard the decisive one [REF];

e. found that the residents of the one area outside of GM could only reach a specialist hospital (of their choosing) within 45 minutes if Option 4.4 was chosen [REF];

f. decided, in consequence of that alone since all other potential factors were treated as neutral between the options, that Option 4.4 was best and chose it.

49. Some CiC members clearly failed to understand the material fact that residents of the one area outside GM would meet the 45 minute standard if it was applied to them as it had been applied to GM residents i.e. that they were 45 minutes from any specialist hospital and not one of their choosing, if either Option 4.3 or 4.4 were chosen. They clearly believed that if Option 4.3 were chosen then some residents would not be within 45 minutes of any hospital and this was and is not true. [REF] They therefore reached their decision on a mistaken basis. It is very possible that if they had understood that the residents of the one area outside GM would be within 45 minutes of a hospital on either Option 4.3 or 4.4 they would have reached a different decision. Indeed, they might very well then have returned to the Quality and Safety set of criteria, or the preferences expressed in the consultation, in order to make the decision, and if that had been approached correctly as set out below, they would have chosen Option 4.3.

50. The consultation documents were expressly concerned with "everyone in GM" [CB/D454], "the people of GM" [CB/D456] and "everyone who lives here" [CB/D472]. They repeatedly showed maps which relied upon a boundary around GM and explicitly described what it contained geographically [CB/D463]. They explained how the travel standard was applied to "GM residents" [CB/D480] and stated "We have … agreed specific factors that will need to be considered in relation to how patients and relatives travel to hospital services. These are: Residents within GM having equitable access to specialist services …" [CB/D481].

51. By contrast, there is only one reference to "those in the surrounding localities" [CB/D479]. This phrase is relied upon by the defendants to suggest that the focus of the HT plan was always on those outside as well as inside GM but it does not bear the interpretation for which they contend. The preceding sentence makes clear that the

phrase “surrounding localities” refers to those further from the hospital but within GM. Similarly, the succeeding sentence refers to the same group of patients as being “from across a larger geography of GM”.

52. Initial decisions in the process concerning the identity of specialist hospitals were taken on this basis [REF].

53. The change on the part of the CiC from considering the impact on residents of GM as set out in the consultation documents to those of one area outside GM was so fundamental that it required further consultation. It was fundamental because the inclusion of the residents of that area and the application of the travel standard to them was determinative of the decision. We know this because the CiC stated that the Travel and access set of criteria were met by all the options before residents of areas outside GM were included. It cannot be said, and the defendants do not suggest, that if they had not included those residents of just one area outside GM then the decision would have been just the same.

54. The fundamental character of the change may be demonstrated in another way. A resident of GM who was consulted would have wished to express his view on the impact on the decision-making process of including residents outside GM where to do so was going to lead to a decision being taken that was contrary to his interest e.g. someone living close to Wythenshawe Hospital, and that it was to be taken by applying a less stringent standard to those outside GM in favour of their interests and against the interests of some within GM (whether because they lived close to Wythenshawe Hospital or because they were dependent on its services). It might also, however, be the case that a resident of the area outside GM would have said that he preferred Option 4.3 because he was a user of services at Wythenshawe Hospital and valued their quality above the shorter distance to Stepping Hill. Both putative groups, and probably others also, were not given the opportunity to express their views on what was the decisive issue for the decision-makers. This was unfair and was a failure on the part of the defendants to fulfil their statutory obligations.

55. Consultees were bound to understand from the consultation documents that only GM residents were being considered, and there was nothing to alert them to the need to express their views about the inclusion of the impact on others in the decision-making process, let alone the application to them of a more favourable travel standard.

56. Bearing in mind that the consultation concerned:

    a. the provision of life-saving and vital healthcare to which consultees are statutorily entitled;

    b. loss of or significant changes to such healthcare - certainly those residing close to Wythenshawe consider themselves to have suffered a loss of such care, as do those needing its specialist services;

    c. matters upon which the defendants were statutorily obliged to consult;

    d. complex information; and

    e. a relatively unsophisticated audience (whom the consultation report noted found it difficult to understand the consultation materials);

    it was inadequate since it failed to draw to consultees attention, or give them the opportunity to comment on, this fundamental, determinative and conclusive change in the approach of the CiC. It was wholly contrary to its express stated purpose: "… for commissioners to listen to the views of the public and stakeholders about the proposed changes to primary care, integrated care and the in scope hospital services … In particular, to listen to feedback in relation to options for the configuration of in scope hospitals services" [CB/D92] and "open dialogue" [CB/D12]

57. Given the terms of the consultation, and the nature of the obligation to consult in this case, it is submitted that the consultation document did create a legitimate expectation that only residents of GM would be included in the CiC's deliberations when choosing between options, and that the travel standard would be applied consistently.

58. Whilst it is true that the issue of the impact of the decision on those residing in this one area outside GM emerged from the consultation process, it is also true that their inclusion as set out above was determinative of the final decision. Where a change in the approach to the decision from the consultation is determinative then it is so fundamental that it must be consulted upon. It was not, and that was unfair.

59. It is not accepted that such communication as there was about the proposed changes (the defendants rely upon an opportunity given to "key stakeholders" which did not include members of the public) was sufficient to discharge the obligation. This is particularly bearing in mind the factors relevant to the evaluation of the consultation in this case set out above. There was a failure to comply with the defendants' statutory obligation to "promote the involvement" (s. 14U NHS Act) of consultees at this stage. There was no attempt comparable to the initial consultation to inform or engage with or involve ordinary consultees in any way on this issue once the change had been proposed or even after it was decided. This was even though they were potentially affected negatively by the change.

60. Crucially, to the extent that the defendants engaged with institutions about the proposed change to include residents of one area outside GM, it did not explain to them that it was to do so by applying a different travel standard to those residents from that applied to those inside GM. While the defendants note that Wythenshawe Hospital did not object to the inclusion of a wider group, it had not been informed of the inconsistent and unfair way in which they were to be treated when it made its response. So even Wythenshawe Hospital was not given an opportunity to comment upon the determinative point in its entirety; rather, it was given partial information as to what was in the CiC's mind and denied the chance of addressing the whole of what was crucial to their decision.

61. S. 3(1A) of the NHS Act provides that a CCG is "responsible" for those who are treated by its member GPs. The CiC's initial consultation and initial decision-making were entirely consistent with those statutory parameters of their functions: they referred to "our" patients. It is not accepted that the other statutory functions of CCGs cited by the defendants "necessarily", as they submit, involved the consideration of the impact of

their decision on those for whom other CCGs were responsible. Not one of the provisions cited by them bears that interpretation, although it is not disputed that they were entitled to take such interests into account albeit only in a fair and proportionate way. The claimant's case is that it was wholly disproportionate to make the interests of a group for whom the defendants were not responsible determinative of the provision they arrange for those for whom they are responsible, against their wishes, and, it is said, against at least some of their interests.

62. If the defendants are relying upon s. 14Z1 of the NHS Act which relates to integration of services to justify their position, then they have failed to explain how the inclusion of the interests of those for whom they are not responsible "improves the quality of the services" they are commissioning, or "reduces inequalities" between persons within the meaning of the provision. The evidence in relation to equalities at least was that Option 4.4 tended to increase rather than reduce them [REF], and on the defendants' case it was no better in terms of the quality of services it would elicit.

63. The decision was irrational because:

a. the application of a different travel standard to the two groups – within GM and one area outside it – was inconsistent, unjustified, and unfair;

b. it was reached on the basis of a mistaken understanding on the part of some decision-makers of the true position i.e. they believed that if Option 4.4 was not chosen then those residents of one area outside GM would not be within 45 minutes of any hospital whereas the standard was only applied upon the basis that they would not be within 45 minutes of a GM hospital that they preferred over a nearer hospital e.g. in Chesterfield, and that the standard was not applied upon the same basis to those within GM (who were treated as entitled to be within 45 minutes of any hospital); and/or

c. it failed to take into account, because they were not sought, the views of those affected by the change in the boundary and/or the application of the travel standard to them;

d. it was in breach of a legitimate expectation that the CiC would apply the boundary as they represented they would in the consultation documents, and as they had when taking earlier decisions in the process;

e. it made the interests of a very small group for whom the defendants are not responsible of disproportionate, indeed overriding, importance as against the interests of the very large group for whom they are responsible.

**Ground 2 – only Travel and Access criteria relied upon to discriminate between options and not the other three set of criteria as represented in the consultation documents**

64. The consultation document included the following:

> "*The 12 clinical commissioning groups will be making a decision on the way these hospital services are organised depending on what you tell us during this consultation.*" [CB/D454]

> "*We have provided an assessment of the strengths of each option on page 13. To do this we have looked at the effect of each option under specific headings for example, patient experience. We would like to know how important these factors are to you.*" [CB/C455]

Consultees were then asked to rate the criteria in terms of importance between 0 and 10 [REF]

> "*... criteria to assess our proposals – Quality and safety, Affordability and value for money, Transition and Travel and access*" [CB/D458]

Charts rating each open under each of those headings (which shows Option 4.3 as superior to 4.4 because of Quality and safety) [CB/D458].

65. There was no suggestion during the consultation that any of these criteria were to be treated as being of neutral effect across all the options and not discriminating between them. Rather, as set out above, they were shown in the consultation documents to

favour some options over others e.g. Option 4.3 was rated higher than 4.4 on Quality and safety and therefore overall.

66. Initial decisions in the decision-making process were taken applying all these criteria [REF].

67. On 18 February 2015 the CiC decided that "the existing four criteria themes are still valid and should be used in decision-making … and that no weighting should be applied to the criteria". [CB/D109]

68. Clinicians believed on the basis of these documents that all the criteria would be taken into account in reaching a decision, and that they would on analysis demonstrate relevant differences between the options which would affect the decision-makers' conclusions [REF]. Plainly members of the public would form the same view when considering the consultation documents and indeed process as a whole.

69. The report on the consultation found that respondents considered Quality and safety to be the most important of the sets of criteria [CB/D103 and 105].

70. Since:

    a. the consultation document stated that the decision would "depend" on what consultees stated in their consultation responses;

    b. they were asked their views on the relative importance of the different sets of criteria; and

    c. it was repeatedly represented by the CiC that the different sets of criteria would be used to discriminate between the options;

    it was unfair to make the decision on the basis that all the sets of criteria apart from Transport and access were neutral as between the options.

71. The starkness of the unfairness appears when one considers that the application of the Transport and access criteria to discriminate between options could have been achieved without any consultation at all since it was merely a mathematical exercise. All the responses of the GM consultees were in vain.

72. As under Ground 1, the unfairness in the change after consultation can be demonstrated if one imagines what a consultee might have said upon being told that the choice as between options was to be decided solely on the basis of Transport and access. He might have wished to say that he considered that Quality and safety was the most important factor (and we know this was the position of the majority of respondents [REF]) and believed (perhaps partly because of representations by the CiCs) that it discriminated well between the different options or at least should be taken into account alongside Transport and access, and indeed the other sets of criteria. Indeed, it appears from emails sent around the time of the decision that some CCGs considered that Quality and safety ought still to be taken into account, and if so, it would favour Option 4.3 over 4.4 [REF].

73. Indeed, the true choice in this case for consultees and decision-makers was between Wythenhawe Hospital, which was preferable in terms of Quality and safety (and public preference) and Stepping Hill Hospital, which was preferable in terms of Transport and access (if those in one area outside GM were included within the class persons to whom the 45 minute standard applied). However, this crucial choice was never put to consultees.

74. The claimant repeats it submissions made under Ground 1 in respect of the inadequacy of any late communication with institutions to fulfil the defendants' obligation to consult with patients and the public. The shift from applying four sets of criteria and stating that they enabled discrimination between the options, to the position that three sets were neutral and only one – Transport and access - discriminated was fundamental. That is so because the application of the Transport and access set of criteria while treating the others as neutral was determinative of the decision. Consequently, it was unfair not to consult on the decision to treat only one of the sets of criteria as discriminating between the options and therefore determinative.

75. It cannot be said, and the defendants do not suggest, that if all the criteria had been treated as discriminating as they had originally been then the decision would have been just the same. Nor would it be the case that the responses to consultation (which would have had to be conscientiously taken into account) would have been the same.

76. Given the terms of the consultation, and the nature of the obligation to consult in this case, it is submitted that consultation document did create a legitimate expectation that all the criteria would be applied and would be used to discriminate between the options. The legitimate expectation was breached in this case, without sufficient justification.

77. The decision was irrational:

    a. in that it gave disproportionate, indeed overriding, weight to Transport and access;

    b. it failed to take into account relevant considerations, namely those arising under the other sets of criteria;

    c. relied upon the unjustified assumption that the other sets of criteria, including Affordability and value for money did not discriminate between the options;

    d. it failed to take into account, because they were not sought, the views of consultees as to the impact of relying only upon Transport and access to discriminate between options;

    e. it was in breach of a legitimate expectation that the CiC would use all the criteria to discriminate between the options.

**Ground 3 – the decision to treat Quality and safety as not discriminating between the options and the failure to have due regard to clinical standards**

78. The consultation document stated that the criteria used to evaluate the options included Quality and safety, and that this comprised "Clinical effectiveness and outcomes – which outcomes will consistently provide the high standard of care patients deserve,

and meet the Greater Manchester quality and safety standards?" and "Patient experience – which options are the best, based on the NHS Friends and Family Test? This asks patients whether they would recommend services to their friends and family if they needed similar care or treatment." [REF]

79. The consultation documents presented the options to consultees on the basis that they offered different degrees of Quality and safety, and some were therefore more preferable than others on this basis [REF].

80. Respondents were asked to say which criteria were most important to them, and the majority stated that Quality and safety was the most important set of criteria [REF].

81. There was no suggestion during the consultation that any of these criteria were to be treated as being of neutral effect across all the options and not discriminating between them. Rather they were shown in the consultation documents to favour some options over others e.g. Option 4.3 was rated higher than 4.4 on Quality and safety and therefore overall.

82. Initial decisions in the decision-making process were taken applying all the criteria [REF]. On 18 February 2015 the CiC decided that "the existing four criteria themes are still valid and should be used in decision-making … and that no weighting should be applied to the criteria". [CB/D109]

83. Clinicians responded to the consultation in the belief that Quality and safety were a vitally relevant set of criteria, and that the factors arising from their application would be used to discriminate between options [REF]. Plainly, the public would have responded to the consultation on the same basis: the majority said that Quality and safety was the most important set of criteria so they were expecting the CiC to give that set of criteria weight and use it to discriminate between options. This amounted to a legitimate expectation.

84. However, by the time of the decision, the CiC were proceeding on the following basis:

> Everyone in GM is entitled to high quality healthcare. As set out in the PCBC, the required investment in the in-scope quality standards will be made under all options (costed into the affordability analysis); therefore there will be no quality distinction between the options in the options appraisal.
>
> This means that this criterion does not distinguish between 4 or 5 service options, nor does it distinguish for any specific configuration of services. [REF]

85. The CiC made its decision relying upon this assumption [REFS].

86. However, this was an assumption that could have been made at the outset of the decision-making process, as it had always been intended that all hospitals should reach the new standards that had been set [REF], and there appears to be no good reason for the CiC's change of position in relation to the discriminating function of the Quality and safety criteria.

87. The assumption was adopted by the CiC without a proper evidential basis, contrary to their statutory obligations (s.14W and s.14Y(b) of the NHS Act 2006) and their representations made during the course of the consultation [REF]. The true position is as set out in the Statements of Andrew MacDonald and David Jones [REF].

88. Indeed the DMMR at times appears to concede that steps could only be taken to "reduce" variations in the quality of care between the options but could not eradicate them completely [DMMR 118].

89. So while the CiC expressly stated that it would consider "any possible impact" of its decision on Quality and safety [DMMR 118], and anticipated at least some negative impacts (as above and [CB/D547]), in fact it took its decision on the assumption that there would be no material differences as to Quality and safety as between the options. That approach was contrary to the evidence, and its commitment to taking that evidence of difference into account.

90. In particular, there were material clinical differences between Options 4.3 and 4.4 as follows:

a. There are currently material clinical differences between the two hospitals which are the subject of the "in scope" services with which the options are concerned, even on the CiC's own evidence. But there is no evidence as to whether the current differences can be eradicated simply by the expenditure of money, or how long this might take.

b. Nationally-accepted clinical guidelines indicate, and the defendants admit that in relation to the need for colocation of co-dependent services (which is addressed further under Ground 6) the current arrangements at Wythenshawe Hospital are more clinically desirable in terms of Quality and safety than those which will be the case once the decision has been implemented (even though they do not accept that colocation of co-dependent services is necessary). It is therefore the case that there is, even on the defendants' case, a material clinical difference between the two options.

91. The CiC, by making the assumption that there were would be no material difference in Quality and safety terms between Option 4.3 and 4.4, excluded from its considerations factors that were relevant, and it did so in conflict with the legitimate expectation of consultees that Quality and safety would be taken into account.

92. There was no consultation on this change of position.

93. The decision to treat Quality and safety as not discriminating between the options was fundamental and it was unfair not to consult on it having regard to:

a. The characteristics of the consultation set out under Ground 1;

b. The respondents' view that Quality and safety was the most important criteria;

c. The critical relevance of that set of criteria to the provision of health services;

d. The fact that it is the quality of the service provided and not the speed at which it is accessed which is the main determinant of clinical outcomes [REF] and

therefore patients are rightly willing to travel further for the best quality care [CB/D479];

e. The fact that the exclusion of consideration of the Quality and safety criteria as a means of choosing between Options 4.3 and 4.4 could be said to be equally determinative (or the mirror-image of Ground 1), because then there was nothing to weigh in the balance against the Travel and access criteria which were treated as having overriding importance.

94. Once again, the unfairness of not consulting on this change may be demonstrated by considering what consultees would have said had they known that this was the way in which the CiC was to reach its decision. Certainly, clinicians would have had something to say about the taking of a decision upon this basis, and in combination with making Travel and access the determinative set of criteria [REF]. They did not accept either that (a) Quality and safety could fairly or rationally be treated as not discriminating between options (whether in relation to in-scope services or co-dependencies) or (b) that there were no material clinical differences between the options. Plainly, some other consultees would have wished to express similar views not least because respondents considered Quality and safety to be the most important factor, and were strongly of the view that Wythenshawe Hospital rated the best out of all GM hospitals on the application of the Quality and safety criteria [DMMR 207-208] (a view which is consistent with objective assessment of it [REF].) If consultees had known it was in the CiC's mind to say that Wythenshawe's long-established clinical superiority was not relevant to the decision at all, they would have had something to say. Rather they were left with the impression from the consultation documents that those clinical factors were being taken into account, and there was nothing to alert them to the need to express their views on the issue.

95. This was unfair, and contrary to the obligations of the defendants set out under Ground 1. To the extent that the assumption could have been made at the start of the consultation, it rendered all the consultees responses in vain. This was contrary to the defendants' obligations set out under Ground 1. Further, to the extent that the CiC communicated with institutions about its change of approach after the consultation

closed, it is not accepted that this amounted to discharge of its obligations of public and patient involvement as set out above.

96. The critical relevance of this factor is also exemplified by the fact that just before the decision some CCGs were attempting to resist whipping to choose Ground 4.4 on the ground that there were clinical differences which were being swept under the carpet by the CiC's approach to decision-making [REF]. This strongly suggests that if the decision had not proceeded on the unwarranted assumption adopted by the CiC late in the process, then it would have been different, and in favour of Option 4.3 which was and remains clinically superior to Option 4.4.

97. The decision, having been taken in reliance upon this assumption, was irrational because:

    a. it was based on an assumption that had no sufficient evidence-base;

    b. it excluded from consideration vitally relevant considerations – quality and safety of clinical care in a decision about hospitals;

    c. it was in breach of a legitimate expectation that the CiC would use the Quality and safety criteria as they had represented they would in the consultation documents, and as they had when taking earlier decisions in the process; and

    d. it failed to take into account, because they were not sought, the views of consultees on the decision not to rely on Quality and safety to discriminate between options.

**Ground 4: Pre-determination / apparent bias**

98. Due to very recent disclosure of relevant documentation by the defendants,[25] the claimant raises a fresh ground of challenge.

[25] The evidence upon which this challenge is brought was not disclosed by the Defendants to the Claimant's representatives until 1 December 2015 although it was requested in the LBA.

99. It is trite law that justice must not only be done, but must be seen to be done in order to maintain public confidence in decision making.[26] A decision maker must not be perceived to be biased; such perception undermines confidence in the administration of justice and administrative decision-making.[27] Further, a decision-maker must not predetermine, or appear to predetermine, a matter that falls for his or her determination. In summary, *"[b]ias is concerned with appearances whereas predetermination is concerned with what has in fact happened"*.[28] The claimant submits that both concepts of apparent bias and predetermination appear to be engaged by the evidence disclosed on the facts of this case.

100. The test for apparent bias was set out by the House of Lords in *Porter v Magill* [2001] UKHL 67. The question is whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the decision-maker was biased. In *R (Royal Brompton and Harefield NHS Foundation Trust) v Joint Committee of Primary Care Trusts* [2012] EWCA Civ 472, the Court of Appeal expressed the view that a decision-maker could receive "tainted advice" if there was apparent bias on the part of an advisory steering group.[29]

101. The documents disclosed by the defendants create an appearance of bias in senior officers of the Healthier Together programme advising the CCG decision-makers in this case. In particular, the email correspondence appears to suggest that members of the Healthier Together team, in conjunction with others, interfered with the CCGs' exercise of their independent judgment in order to secure a coordinated outcome from the CiC, and one which they, the Healthier Together officers, preferred.

102. On 27 June 2015, Ian Williamson, Senior Responsible Officer for the Healthier Together programme, wrote to Sir Howard Bernstein, Chief Executive of Manchester City Council as follows:

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[26] *R v Sussex Justices ex parte McCarthy* [1924] 1 KB 256
[27] *Gillies v Secretary of State for Work and Pensions* [2006] UKHL 2 at paragraph [23] per Lord Hope
[28] *Persimmon Homes* [2010] EWHC 535 at [116]-[117]
[29] See paragraph 123. See also *R (Compton) v Wiltshire Primary Care Trust* [2009] EWHC 1824 (Admin) at [91] per Cranston J: *"In my view the principle is clear: the bias of advisers is capable of vitiating a decision when there is a real possibility that it has adversely infected the views of the decision-maker"*.

"*Leila is I think rightly concerned that without serious efforts to get the UHSM clinicians more on board, we risk significant fall out before and after the HT decision.*

*I want to support her to make some of the right connections behind the scenes… so we need to choreograph well.*"

103. On 28 June 2015, Sir Howard Bernstein, Chief Executive of Manchester City Council, wrote to Ian Williamson, Senior Responsible Officer for Healthier Together expressing concern as follows:

"*Saw Barry Clare [Chairman of UHSM] today. He told me that a significant head of steam was building up amongst several CCG's to identify USHM as the 4th Specialist Hospital and was seeking my support. He told me that amongst the CCG's taking this line was Trafford, Tameside and Stockport. He said that Leila was due to have a conversation with him tomorrow morning.*

*The essence of the message was that UHSM would be the most cost efficient option compared with Stockport given its broader range of tertiary services.*

*I am of course not aware of any of this engagement but we need of course to get our lines straight.*"

104. Just two weeks before the decision was due to be taken, it appeared that the CCGs were inclined to vote for Wythenshawe Hospital) as the fourth specialist site for GM. However, it appears on the available material that members of the Healthier Together team and Sir Howard Bernstein took action to prevent that.

105. On 13 July 2015, Ian Williamson wrote to Sir Howard Bernstein as follows:

"*Had a long call with Barry*

- *he has been away and is embarrassed [by] how the medics are behaving. I have encouraged him to get the senior medics in to get them to see the reality and the big picture…*

*I will continue to support Barry, but most energy will be put in to trying to get all CCGs lined up for a clear and unanimous decision.*"

106. Further it is said that "the medics" (a reference to consultants at Wythenshawe Hospital) are "an embarrassment" for raising legitimate concerns about clinical standards and safety of services at their hospital.

107. It also appears that pressure was being exerted by members of the Healthier Together team to *"get all CCGs lined up for a clear and unanimous decision."* It is not understood why the CCGs were not permitted to vote freely for whichever of the four options was, in their judgment, the appropriate choice according to the criteria, even if this did not lead to a unanimous decision.

108. On 14 July 2015, Ian Williamson asked Sir Howard Bernstein whether he had spoken to Barry Clare. Sir Howard Bernstein replied on the same day as follows:

"*…It went fine and made all the right noises.*"

109. Shortly thereafter, Ian William responded:

"*…Now I've spoken to him again. Now with CCGs!*"

110. Sir Howard Bernstein responded with "Good". These exchanges to a fair-minded and informed observer would, it is suggested, lead to the conclusion that there was a real risk that the decision was tainted by apparent bias.

111. Further, alongside this email exchange about getting the CCGs lined up (in one direction of the choosing of the Healthier Together team) for voting, the Healthier Together team was preparing a press release in advance of the decision to be taken on

15 July 2015 announcing Stepping Hill as the fourth specialist site. On 13 July 2015, Geoff Little, Deputy Chief Executive of Manchester City Council, wrote as follows:

> "*Paul. The Leader has asked that we prepare some communications from the Council in anticipation of Wednesday's decision. The wording will need to be cleared with yourself and Richard and I will get something to you both tomorrow. If, as I suspect, the decision is that Stockport would be the Fourth site the message would be along the lines of…*"

112. On 14 July 2015, following a request from Geoff Little for further data, Leila Williams, Director of Service Transformation in the Healthier Together programme, wrote:

> "*I would NOT want this information including in the press release (not sure that was your intention anyway) as no doubt UHSM will challenge the numbers…*" (emphasis in the original)

113. The advanced preparation of the press release announcing Stepping Hill Hospital as the fourth specialist site (and the absence of any press release being prepare for alternative decision outcomes), coupled with the pressure being exerted on CCGs to line up for a unanimous and clear decision, suggests that the decision was pre-determined and/or tainted by apparent bias.

114. The claimant appreciates that this ground was not raised in its initial claim and that the defendants and interested parties have therefore not yet had an opportunity to respond to the claimant's concerns. The timing is explained by the recent disclosure of the material documents. The issue is raised in the public interest.

**Ground 5 – Flawed transport analysis**

115. The CiC decided that Transport and access was the only set of criteria that enabled them to discriminate between options [REF].

116. The application of the Transport and access criteria produced only a small difference between the options in terms of transport times for the residents of the one area outside GM whose times were determinative of the decision [REF].

117. For these reasons particularly, although in any event, the CiC was obliged to ensure that it analysed the information concerning Transport and access as fairly and accurately as possible: a small difference in data or its analysis would be decisive and so both should have been approached with care.

118. Of real relevance to the issue of journey times between the one area outside GM which the CiC determined to take into account and Wythenshawe Hospital and Stepping Hill Hospital is the A6 relief road. It will link the A6 at Hazel Grove to the M56 at Manchester airport and is show on a map at [REF]. Its express purpose is to reduce journey times, reduce congestion and improve access [REF]. It is expected to open in 2017.

119. Planning for the road was approved in early 2014 and so it existence, purpose and likely effect was well-known at the time of the consultation and decision.

120. The CiC decided not to take the road into account when analysing travel times under the Transport and access criteria. It did so on the basis that there no actual journey time data was yet available [REF]. However, there was information available which would have enabled the CiC or its advisors to project the likely impact of the A6 relief road [REF].

121. Even if such information were not already available, where a decision was to be taken on the future of hospitals because of a difference in journey times of a few minutes for one group of patients, it was incumbent on the CiC to make a diligent inquiry and analysis of the relevant underlying information.

122. Despite the express statement of the CiC that there was no data about the impact of the road and therefore it was not taken into account, and knowing that very precise calculations were undertaken into order to determine journey times for the purposes of deciding between the options, the defendants seek to advance an alternative case that

the A6 relief road was somehow still taken into account by the CiC in its decision. It is submitted that this is wholly inconsistent with the reasoning in the decision, and the calculations actually undertaken, and should be rejected as a defence to the claim.

123. The approach to the A6 relief road was irrational in that:

a. It was inconsistent with the approach of the CiC in relation to other issues in that in relation to them – Quality and safety and Affordability and value for money – it was prepared to make its decision on the basis of projections about the future, albeit, particularly in relation to Quality and safety, on the basis of limited evidence. Although the decision was concerned with future provision to meet future need, the CiC was only prepared to project into the future on the basis of limited evidence in relation to some of the decision-making criteria and not others. No reason has been given for this inconsistency, and it was unjustified. A rational decision-maker would have either approached its decision by considering how all factors would work in the future (to which its decision was directed) or considering how they all worked in the present. Taking different timescales for different factors without justification was bound to introduce a flaw into the decision-making.

b. It did not take into account relevant information that was available to the CiC [REF]. Perversely, the CiC arguably had available to it more evidence about the impact of the A6 relief road in the future than about the reliability of its assumption that all hospitals would be identical in terms of Quality and safety in the future, but it chose to ignore the former and adopt the latter.

c. The CiC did not adequate steps to inform itself about the impact of the A6 relief road which was highly relevant to its decision.

124. The defendants say that the claimant's case should fail on this ground because it can produce no evidence to prove that journey times would be different. First, this is not the correct test, since if journey times were relevant the CiC then it was obliged properly to inquire into them and analyse them. Second there is in fact substantial evidence available even to the claimant without access to the contacts and resources of

the CiC that journey times would be shorter, not least because it was improving journey times along that corridor which was one of the key reasons for approving the road [REF].

**Ground 6: Irrational approach to need for co-location of co-dependent services at Wythenshawe Hospital**

125. Co-dependent health services are services which either depend upon, or provide assistance to, other services. Wythenshawe Hospital provides a number of specialist services which are co-dependent with emergency general surgery. These include: cardiac surgery, thoracic surgery, heart and lung transplants, vascular surgery, specialised burns and plastic surgery, tertiary respiratory services, extra corporeal membrane oxygenation (ECMO) and cystic fibrosis. These services were not considered to be "in scope" of the defendants' decision but it is common ground that they were potentially affected by the decision. It is the claimant's case that they were not properly considered in either the consultation or the final decision.

126. The claimant submits that the defendants' decision to designate Wythenshawe Hospital as a 'local' rather than 'specialist' hospital will have a significant impact on these co-dependent specialist services. The removal of 24/7 emergency general surgery onsite at Wythenshawe Hospital will render these services less safe and lower quality at best, and clinically unviable at worst. In particular, the witness statements of Dr Attila Vegh, Chief Executive of UHSM, and David Jones, Consultant General Surgeon at UHSM, make clear that:

(4) Cardiothoracic surgery: Removing emergency general surgery from Wythenshawe Hospital would be a significant backward step for the cardiothoracic surgery services which would increase clinical risk for patients. Cardiothoracic surgery should not remain at Wythenshawe Hospital without access to 24/7 emergency general surgery.[30]

(5) Vascular surgery: Needs to be performed on the same site as emergency general

[30] Witness statement of Dr Vegh at paras 54-55, witness statement of David Jones at paragraph 20

surgery. It cannot be safely provided without onsite emergency general surgery. If emergency general surgery is removed from Wythenshawe Hospital then inevitably vascular (arterial) surgery would have to be removed.[31]

(6) Specialised burns: Removing emergency general surgery from Wythenshawe Hospital would be a significant step back for the specialised burns unit which would increase clinical risk for patients. The specialised burns unit cannot remain at Wythenshawe Hospital without access to 24/7 emergency general surgery.[32]

(7) Cystic fibrosis: Removing emergency general surgery from Wythenshawe Hospital would be a significant backward step for the cystic fibrosis service and would increase clinical risk for patients. Cystic fibrosis services cannot remain at Wythenshawe Hospital without accses to 24/7 emergency general surgery.[33]

127. The claimant contends that in respect of co-dependent services:

(1) The defendants failed to provide sufficient information about co-dependent services during the public consultation to enable intelligent consideration and response, and in breach of section 14Z2 of the NHS Act 2006;

(2) The defendants failed to take into relevant information relating to vital co-dependent services at Wythenshawe Hospital;

(3) To the extent that relevant considerations were taken into account, the information and/or conclusions upon which the defendants' decision was based, were contradictory, flawed or otherwise irrational.

*Flawed and inadequate consultation*

128. The public consultation documents made no reference to the potential impact of the proposed changes on existing co-dependent specialist services. The most that is said in the consultation documents is contained at page 40 of the Consultation Guide:

[31] Witness statement of David Jones, paragraph 22, 25-26
[32] Witness statement of Dr Vegh, paras 64-65, witness statement of David Jones at paragraph 39
[33] Witness Statement of Dr Vegh paragraphs 77-78, witness statement of David Jones at paragraph 41

"***Specialist services provided locally***

*Whilst emergency and high-risk General Surgery operations will not be provided at General Hospitals any,* ***the other parts of hospital care will still be provided locally.*** *For example, there will be rapid access clinics for patients arriving at A & E who need urgent surgical assessment. Similarly, following an emergency operation, patients can see the surgeon in an outpatient clinic at their local General Hospital. Increasingly, other specialist care will be provided in a local General Hospital – for example specific cancer or chemotherapy treatments.*"

Generally they indicated that everything would be either the same or better.

129. The consultation documents failed to provide sufficient (or any) information about the impact of the defendants' proposals on co-dependent services at Wythenshawe Hospital. In particular, it failed to make clear the risks to specialised services such as cardiothoracic surgery, vascular surgery, specialised burns and cystic fibrosis which may become clinically inferior or even unviable without emergency general surgery onsite. Without this information, members of the public could not intelligently consider the impact and risks to specialised services in order to respond meaningfully to the defendants' public consultation. It is apparent from the consultation responses that concerns about co-dependencies were only raised by those who already possessed the necessary information from other sources.[34] This falls far short of satisfying the duty of public involvement under section 14Z2 NHS Act 2006.

*Failure to take into account relevant considerations and irrational conclusions*

[34] In particular, UHSM made clear that being designated as a 'local' hospital would reduce the level of general surgical support to their specialist services and put their excellent quality and outcomes at significant risk: Defendants' Bundle **[4/45/1735]**. See, also for example, UHSM's response to the consultation: *"On-site co-location of clinical specialities is a key factor in driving better outcomes. The ability for consultants from key specialities to be available almost immediately will always be the optimum clinical model. It could be a risk (financially and operationally) to implement this structure elsewhere when it is already an established strength of Wythenshawe Hospital"* Defendants' Bundle **[2/12/143]**; and response from UHSM, Health Scrutiny Committee, Trafford Council, Healthwatch Tameside, Healthwatch Oldham, Northenden Civic Society, Graham Brady MP, Kate Green MP, and Mike Kane MP: *"I am concerned about the potential impact of the Healthier Together proposals on the many excellent specialisms at Wythenshawe which is already a leading specialist site for a whole range of conditions… The longer-term unintended consequences of not being a specialist site would inevitably mean Wythenshawe's ability to maintain and enhance its specialist services could be compromised."* Defendants' Bundle **[2/12/142-143]**

130. Moreover, the defendants' failed to take into account to relevant information in relation to co-dependent services. This was contrary to the defendants' basic duty to inform themselves of the information relevant to the decision.[35]

131. In particular, the four key documents relied upon by the defendants contain a wholly inadequate assessment of the issues:

(1) Appendix 45 – Healthier Together Assessment of feedback received during the consultation relating to dependencies with in scope services (the "Healthier Together Assessment").[36] This document is materially misinformed and its conclusions are, in parts, contradicted by the evidence. For example, in relation to cardiac and thoracic surgery, the document concludes that *"no co-location requirement was identified through the literature review"*.[37] However, the "Cardiovascular Project Co-dependencies Framework indicates that co-location is *"strongly recommended."*[38] In relation to specialised burns, the document concludes that "*24/7 radiology, pathology and transfusions services should be maintained at UHSM."* However, NHS England's commissioning specification for specialised burns states *"Burns Centres will be co-located or have onsite access to… General Surgery."*[39] The Co-dependencies Framework for Specialised Burns Services also indicates that specialised burns services should be co-located with onsite general surgery.[40] In relation to vascular surgery, the document concludes that *"Robust pathways for prompt access to vascular surgery are required."*[41] However, the South East Clinical Senate indicates that vascular surgery *must* be co-located on the same site as general surgery.[42] Further,

[35] *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014. A decision may be irrational where a decision-maker is shown to have misunderstood or been ignorant of an established and relevant fact: see further *R (Begum) v Tower Hamlets London Borough Council* [2003] 2 AC 420
[36] Defendants' Bundle **[4/29/1383-1438]**
[37] Defendants' Bundle **[4/49/1430]**
[38] Defendants' Bundle **[6/48/2195]**
[39] Defendants' Bundle **[4/29/1420]**
[40] Exhibit V13 to the witness statement of Dr Vegh at page 546
[41] Defendants' Bundle **[4/29/1416]**
[42] Exhibit V2 to the witness statement of Dr Vegh at page 76

the document wrongly cites the NHS England commissioning specification for paediatric cystic fibrosis[43] rather than for adult cystic fibrosis.[44]

(2) Appendix 50 – Clinical Co-dependencies Evidence Review (May 2015) (the "Evidence Review").[45] This document failed to address many of Wythenshawe Hospital's specialist services including: cystic fibrosis, cardiac surgery, cardiothoracic surgery, heart and lung transplants, burns, plastic surgery, ventilation and respiratory services. This is a significant oversight since the co-dependencies for these services are critical to understanding the implication of the defendants' decision.[46]

(3) Appendix 60 – Independent Clinical Review to Support Decision Making by the Committee in Common (25 June 2015) (the "Independent Clinical Review").[47] This document also failed to address many of Wythenshawe Hospital's specialist services including: cystic fibrosis, cardiac surgery, cardiothoracic surgery, heart and lung transplants, burns, plastic surgery, ventilation and respiratory services. Professor Cant, chair of the Independent Clinical Review, confirms in his witness statement that the panel did not consider any specialities other than those requested, namely paediatric services, maternity services, vascular surgery, acute medicine and upper GI surgery.[48] The review did not consider many of the specialist services offered at Wythenshawe. This is extremely surprising given the document's stated purpose was to consider *"all potential service co-dependencies arising from formal commission changes made since public consultation and those issues arising through the public consultation by respondents."*[49] The inadequacy of consideration is apparent by the glaring omissions.

[43] Exhibit V15 to the witness statement of Dr Vegh at page 616
[44] Exhibit V19 to, and paragraph 69 of, the witness statement of Dr Vegh
[45] Exhibit V18 to, and paragraph 69 of, the witness statement of Dr Vegh
[46] Witness statement of Dr Vegh at paragraph 41
[47] Defendants Bundle **[4/41/1673-1690]**
[48] Witness statement of Professor Cant at paragraph 21
[49] Defendants Bundle **[4/41/1676]**

(4) NHS England's "Headline Impact Assessment of the Healthier Together Options on the Provision of Prescribed Specialised Services in Manchester".[50] The purpose of this report is described as follows: *"...this report considers the critical interdependencies for each of the Prescribed Specialised Services delivered on hospital sites that are potentially subject to a 'downgrade' change as a result of the implementation of one of the options being considered as part of the Healthier Together programme."*[51] Despite its express intention to consider *"the impact of potentially withdrawing services from providers"*,[52] this document makes no mention of general surgery or the removal of emergency general surgery which is at the heart of the Healthier Together model. Further, the Impact Assessment highlighted a number of specific areas which required further scrutiny before the defendants took their final decision.[53] However, no further assessment has been produced. Mr Andrew Bibby states that he had a meeting with Sophie Hargreaves of the Healthier Together team on 9 July 2015 where *"we conducted a structured exploration of each of the key dependencies and the impact for specialised services provided in each potentially affected site."*[54] It is conspicuous that this meeting took place only 6 days before the decision and no record of this meeting has ever been produced.

132. Proper consideration of the issues and the evidence demonstrates that the defendants' conclusion, namely that there would be no impact on specialist services at Wythenshawe Hospital, was irrational. Specifically:

(1) Cardiothoracic surgery: The Cardiovascular Project Co-dependencies Framework indicates that cardiac surgery is *"highly dependent"* on general surgery and co-location is *"strongly recommended."*[55] In the absence of any good reason to depart from this guidance, it is irrational not to follow this recommendation

[50] *Secretary of State for Education and Science v Tameside Metropolitan Borough Council* [1977] AC 1014, 1065B per Lord Diplock: *"the question for the court is, did the [decision-maker] ask himself the right question and take reasonable steps to acquaint himself with the relevant information to enable him to answer it correctly?"*
[51] Claimant's Bundle **[C67]**
[52] Claimant's Bundle **[C67]**
[53] Claimant's Bundle **[C75-C76]**; Witness statement of Andrew Bibby at paragraph 20
[54] Witness statement of Andrew Bibby at paragraph 22
[55] Defendants' Bundle **[6/48/2195]**

which will provide a safer and higher quality service.

(2) Vascular surgery: The Clinical Co-dependencies of Acute Hospital Services indicates that vascular surgery *"should be co-located (based) in the same hospital"* as general surgery.[56] Further, the Cardiovascular Project Co-dependencies Framework indicates that vascular surgery is *"highly dependent"* on general surgery and co-location is *"strongly recommended"*.[57] In the absence of any good reason to depart from this guidance, it is irrational not to follow this recommendation which will provide a safer and higher quality service.

(3) Specialised burns: The Co-dependencies Framework for Specialised Burns Service indicates that specialised burns services need to be co-located onsite with general surgery.[58] In the absence of any good reason to depart from this guidance, it is irrational not to follow this recommendation which will provide a safer and higher quality service. Further, the NHS England commissioning specification provides that specialised burns facilities *"will be co-located with or have on-site access to general surgery."* It is also relevant that in the event of a major incident at Manchester Airport, such as an explosion, Wythenshawe Hospital is the only specialist burns centre in Manchester is best placed to receive victims of burns. The specialist burns centre was also a key factor for the Clinical Reference Group who recommended that Wythenshawe Hospital be designated as a fixed specialist site in the pre-consultation phase.[59]

(4) Cystic fibrosis: The NHS Commissioning Specification makes clear that *"where possible, surgical procedures should be undertaken at a hospital which also provides a CF service."* It is far better for cystic fibrosis patients if general surgery, including emergency general surgery, on the same hospital site.[60] In the absence of any good reason to the contrary, it is irrational not to choose a model which is clinically superior, and will provide a safer and higher quality service.

[56] Exhibit V2 to the witness statement of Dr Vegh at page 76
[57] Defendants' Bundle **[6/48/2195]**
[58] Exhibit V13 to the witness statement of Dr Attila Vegh
[59] Defendants' Bundle **[1/6/404]**
[60] Witness statement of Dr Attila Vegh at paragraph 74

133. The defendants' argument that any co-location requirement with general surgery can be met by low-risk planned general surgery, or day case surgery,[61] is deeply misguided and serves to underline the inadequacy of the defendants' understanding and approach. The high risk nature of specialised services offered at Wythenshawe Hospital means that any call for general surgery is likely to be urgent and/or require specialist attention. As explained in the witness statements of Dr Attila Vegh and David Jones, emergency general surgery cannot be safely delivered without a critical mass of personnel and expertise onsite.[62] The possibility of having an "in-reach" or "visiting" consultant general surgeon is insufficient. The consultant general surgeon performing the operation needs to have ready access to a critical mass of supporting personnel and expertise onsite. It is the very aim of the defendants' new model of care that resources for high risk and emergency general surgery are concentrated on fewer hospital sites across Greater Manchester with the support of high volume critical care.[63]

134. Further, any assurances that additional emergency general surgical support will be provided in order to maintain the specialist services at Wythenshawe Hospital are circumspect. First, it is not in line with the decision taken on 15 July 2015 to designate Stepping Hill Hospital as the fourth specialist hospital and Wythenshawe Hospital as a local hospital. Healthier Together has made clear that local hospitals will not provide emergency general surgery.[64] Second, as explained in the witness statement of Dr Vegh, commissioners are entitled to make decisions about the services they wish to contract for Trusts to provide. Whilst the defendants may agree to provide additional support in the short term, it may withdraw this additional support in future. Third, the recognition that Wythenshawe Hospital requires additional general surgical support to maintain its specialist services, over and above what can be provided for in the 'local' hospital model, demonstrates that Wythenshawe Hospital was the obvious choice for specialist status. Further, any additional emergency general surgical support provided to Wythenshawe Hospital (over and above what is provided by the 'local' hospital model) will necessarily have financial implications. It is apparent that additional support

[61] See, for example, in relation to burns: *"The specification requires access to general surgery which will be available whether or not UHSM is a 'local' or 'specialist' site as all sites will continue to operate elective, day case and outpatient care…"* Defendants' Bundle **[4/29/1420]**
[62] Witness statement of Dr Vegh at paragraph 63; witness statement of David Jones at paragraphs 5, 21 and 35.
[63] Appendix 44: Future Model of Care, Defendants' bundle **[3/28/1245-1382]**
[64] Appendix 44: Future Model of Care, Defendants' bundle **[3/28/1245-1382]**

services needed to maintain Wythenshawe specialist services was not taken into account in the financial model.

135. There was insufficient consideration was given to co-dependent services at Wythenshawe Hospital in the reports relied upon. As a consequence, the information provided to the decision-makers was materially deficient and misleading. It necessarily resulted in the CIC taking a decision on a mistaken basis and failing to have regard to relevant considerations. There has been inadequate consideration by the defendants as to whether these services would remain viable. This is an issue of quality and safety. The loss of emergency general surgery at Wythenshawe Hospital would destabilise and render unviable a number of specialist and tertiary services. The claimant therefore contends that it was irrational for the defendants to conclude that there was no material difference between the options in respect of Quality and Safety, Transition and Affordability, taking into account the specialist co-dependent services at Wythenshawe Hospital.

**Standing**

136. The claimant maintains its representations about standing made in its Reply dated 5 November 2015 and Further Reply dated 27 November 2015. The test for standing is whether the claimant has "sufficient interest" taking into account mixed questions of fact and law.[65] The claimant submits that it is plain that it has standing in this case. It is irrelevant that the claimant was not incorporated at the time of the consultation. In a case closely comparable to this, it was held that a company set up to pursue litigation challenging reconfiguration of NHS services had standing.[66] The claimant in this case represents the interests of a substantial number of persons including staff at Wythenshawe Hospital,[67] patients and members of the public.[68] It was supported by the

[65] *R v Inland Revenue Commissioners Ex p. National Federation of Self Employed and Small Businesses Ltd* [1982] AC 617

[66] *R (on the application of Save our Surgery Ltd v Joint Committee of Primary Care Trust and Newcastle upon Tyne NHS Foundation Trust* [2013] EWHC 1011 (Admin)

[67] Including five directors who are all consultants at Wythenshawe Hospital and members of the Medical Staff Committee of over 300 consultants.

[68] Second witness statement of Andrew Macdonald and third witness statement of Andrew Macdonald at paragraphs 2-3

attendance of 1,200 individuals at a recent rally.[69] It is absurd for the defendants to suggest that the claimant does not properly represent the interests of service users who the defendants are obliged to consult under s. 14Z2 of the NHS Act.

**Relief**

137. The claimant seeks an order quashing the unlawful decision of 15 July 2015 and will elaborate on the submissions below if necessary.

138. The starting point is that quashing is the normal consequence of a finding of unlawfulness. In *R (Edwards) v Environment Agency* [2008] UKHL 22 Lord Hoffmann stated at paragraph [63]:

> *"the discretion must be exercised judicially and in most cases in which a decision has been found to be flawed, it will not be a proper exercise of the discretion to refuse to quash it."*[70]

139. The defendants argue that relief should be denied because, in summary:

(8) Quashing of the 15 July 2015 decision would lead to very substantial further delay and expense and would put increase pressure upon and itself create increased pressure upon and itself create increased risk in the quality of service provided in the GM area.

(9) Neither the Joint Health Scrutiny Committee nor NHS England who at all times have been kept abreast of the developments and conclusion in relation to the consultation, and who (in the case of the Joint Health Scrutiny Committee) have power to refer the consultation to the Secretary of State, have seen fit to intervene. In short, to grant relief would be contrary to the best interests of the residents of the GM Area who require a much needed improvement to the overall quality of their care.

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[69] Third witness statement of Andrew Macdonald at paragraph 2 and exhibit AM39.

[70] See also *R (Corbett) v Restormel BC* [2001] EWCA Civ 330 at paragraph [32] per Sedley LJ: *"the judge should incline to quash what is shown to be an unlawful decision"*

140. Neither of these reasons justifies the refusal to grant relief in this case. First, any further delay and expense will have been incurred by the defendants' own unlawful actions. Further, it is denied that any further delay or expense would increase risk in the quality of services provided in the GM area or would not be in the best interests of the residents of Greater Manchester. On the contrary, the interests of local residents and the interests of protecting quality and safety in NHS services, compels the conclusion that the defective decision should be quashed and a proper decision made.

141. The fact that the Joint Health Scrutiny Committee and NHS England have not referred the matter to the Secretary of State is again no reason to deny relief. Rather, the unwillingness of other bodies to challenge the decision demonstrates the importance of the claimant having standing to bring this challenge and obtaining the relief sought.[71]

142. The decision under challenge is of huge public importance and has a wide-ranging effect. It would be wrong in principle to deny the claimant an order quashing such an important decision which was unlawfully made. As Carnwath LJ stated in *Tata Steel UK Ltd v Newport City Council* [2010] EWCA Civ 1626:

> *"…if it is found to be unlawful the normal result is that it should be quashed and the matter regularised. That is not simply a matter of concern to [the claimant and interested party]. It is a matter of public concern. That is why there are plenty of authorities which say that a normal rule is that unlawful permission should be quashed."*[72]

143. Stockport NHS Foundation Trust claims that it has committed additional funds to upgrading its services in order to prepare to be a specialist hospital. It claims that it had no choice but to do so since the decision was taken at a pivotal moment within Stockport's ongoing programme of improvement works.

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[71] See *R v Secretary of State for Foreign Affairs ex parte World Development Movement* [1995] 1 WLR 386 where the significant factors were said to be: the importance of vindicating the rule of law, the importance of the issue raised, the likely absence of any other responsible challenger, the nature of the breach of duty against which relief is sought, and the prominent role of the claimants.

[72] See also *R (Lichfield Securities Ltd) v Lichfield District Council* [2001] EWCA Civ 304 per Lord Justice Sedley at paragraph 39: *"it can rarely, if ever, be in the interests of good administration to leave an abuse of public power uncorrected."*

144. The actions of Stockport NHS Foundation Trust should not stand in the way of the court granting relief. First, Stockport's decision to undergo major improvement works was taken in June 2014, over one year before the decision under challenge.[73] Second, it was Stockport's decision to "press ahead with these works",[74] a decision which appears to have been taken in isolation from the defendants. As was made clear in the defendants' response to the claimant's pre-action protocol letter before claim, and the defendants' undertaking to the claimant when proceedings were issued, no steps would be taken towards implementation of the decision before January 2016. Third, the potential legal challenge was well publicised in the media[75] and Stockport NHS Foundation Trust acknowledge that it was aware at the time that individuals were unhappy about the decision.[76] If there were genuine concerns about implementation, Stockport NHS Foundation Trust ought to have raised these much sooner.

145. The claimant submits that the interests of Stockport NHS Foundation Trust do not override the moral and legal imperative in this case to quash an unlawful decision of huge public importance affecting all residents of Greater Manchester. The claimant therefore seeks an order quashing the decision of 15 July 2015 and remitting the decision for consideration by different representatives constituting the decision-maker.

FENELLA MORRIS QC

ANNABEL LEE

COUNSEL FOR THE CLAIMANT

39 ESSEX CHAMBERS

4 December 2015

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[73] See witness statement of Colin Wasson at paragraph 83: "In June 2014, a £17 million schedule to build a new surgical and medical centre was agreed by the Trust Board with works commencing shortly after." [REF]

[74] See witness statement of Colin Wasson at paragraph 84

[75] See, for example, "Healthier Together: Top medics plan to apply for judicial review into Wythenshawe Hospital decision" published on 31 August 2015, http://www.manchestereveningnews.co.uk/news/greater-manchester-news/healthier-together-top-medics-plan-9958943

[76] See witness statement of Colin Wasson at paragraph 84

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30 September, 2015

Mr Steve Mycio & Sir Mike Deegan
Chairman & Chief Executive
Central Manchester University Hospitals NHS Foundation Trust e-mail

Dear Steve and Mike

Thank you for meeting us at University Hospital of South Manchester (UHSM) on 17 September. It was a productive meeting and gave us a lot to think about. At our Board on 24 September we discussed the issues facing UHSM and the services we provide at length and in detail. The Board agreed that we should write to both you and Nigel Guest (as the Healthier Together CIC representative), clearly setting out our concerns about Healthier Together and the Central Manchester University Hospitals NHS Foundation Trust (CMFT) agreement and our position on how they can be addressed.

Before we do that, however, we want to affirm UHSM's support for the aims of Healthier Together and Greater Manchester Devolution and our commitment to collaboration with CMFT. We fully support Healthier Together's objective of raising clinical standards in order to save lives across GM. We are also totally committed to GM Devolution's goals of improving the health of the people of GM and achieving a financially sustainable health and social care system based on increased collaboration and partnership between all commissioners and providers. Collaboration between UHSM and CMFT, as two strong university teaching hospitals, is particularly important to achieving these goals.

As you know UHSM is a major university teaching hospital, providing a wide range of secondary and tertiary services to patients from South Manchester, across GM and the whole of the North West. UHSM's portfolio of services is one of the broadest in GM and includes a number of unique services which are only provided at Wythenshawe Hospital for the whole of Greater Manchester and in some cases the North West. Examples of these unique services include Adult Cystic Fibrosis, Heart and Lung Transplant, Burns and a variety of tertiary Respiratory services. Healthier Together, Manchester City Council, Trafford Council, the University of Manchester, our local CCGs, local politicians and CMFT have all recognised the importance to patients of UHSM remaining a strong university teaching hospital with high quality, sustainable secondary and tertiary services.

It has been widely stated by the programme and others, such as the GM Joint Overview and Scrutiny Committee, that the scope of Healthier Together is limited to general surgery, acute medicine and emergency medicine. Healthier Together has explicitly stated that other specialties will not be affected and all hospitals will retain their existing specialisms. Specifically for UHSM it was recognised at the CIC on 15 July, and reiterated subsequently by the programme, that Wythenshawe Hospital will need a higher level of general surgery support than other non-specialist hospitals due to its portfolio of services. Therefore our expectation is that the service model implemented for UHSM at Wythenshawe Hospital must:

- Maintain the quality and safety of the secondary and tertiary services currently provided at Wythenshawe Hospital; and

- Not undermine the long term sustainability and development of those secondary and tertiary services.

Despite our disappointment at the decision made by the CIC not to designate UHSM as a specialist hospital, and despite our own and our clinicians' concerns, UHSM's Board publicly supported the decision based on the assurances provided by the programme. On this basis we entered negotiations in good faith with key decision-makers in the expectation that a safe and sustainable service model which protects the interests of our patients could be found. Despite some helpful discussions we still have very significant concerns about the clinical implications and unintended consequences for patients of the CIC's decision and the service model that is being proposed.

**Clinical Concerns and Unintended Consequences**

We described at our meeting the serious clinical concerns that UHSM's clinicians and the Board have about the implications of the Healthier Together decision. The proposed service model for UHSM describes a "local hospital" general surgery service but retaining emergency general surgery for co-dependent tertiary patients. Under this service model UHSM would not receive general surgical emergencies by ambulance, would not deliver routine emergency general surgery and would not have any observation beds for general surgery patients outside A&E. Based on our understanding of this model our clinical concerns are as follows

**Immediate Concerns**

- If only patients with a tertiary co-morbidity may undergo emergency general surgery at Wythenshawe Hospital then emergency general surgery activity at the hospital will be very low. The level of emergency general surgery activity is unlikely to justify a 24/7 onsite service which would immediately create a much less responsive general surgery service, reducing the support provided to all other services on site. With only very limited emergency general surgery on site we would definitely lose general surgery trainees. Without trainees we would be unable to provide a senior registrar to provide 24/7 onsite surgical advice to other services, such as A&E, which will increase clinical risk and create delays in patient flow.
- The proposed service model would create an unacceptable and illogical two tier system in which tertiary co-dependent patients, the most complex and high risk patients, are retained and operated on locally, but less complex secondary patients are transferred to the specialist site for surgery. The service model would not provide sufficient activity to maintain the skills of ward and theatre staff who do not rotate between sites in the single service. As a result, in the proposed model, the site with the least activity, no trainees and teams which are de-skilled and lacking experience is operating on the highest risk, most complex patients.
- Without rapid access to general surgery opinion and the ability to operate, it is likely that surgeons in other specialties would take more risk averse decisions about the operations which could proceed at UHSM. In effect UHSM would be a "low risk specialised hospital". This is not in the interests of GM and North West patients. It is also inconsistent with Healthier Together's assurance that other specialties and services will not be affected by its decisions.
- UHSM currently receives over 11,000 patients with abdominal pain at A&E each year (over 10% of attendances). It is extremely difficult for ambulance crews, or even A&E, to differentiate between surgical and non-surgical abdominal pain so we are concerned that, since only a small proportion of these patients actually need surgery, this service model will lead to a large number bypassing UHSM unnecessarily. This is not in patients' interests and will affect services outside the scope of Healthier Together against the assurances provided by the programme.
- The draft service specification for Critical Care (D16) states that co-located (on the same site and immediately available 24/7) emergency general surgery is required to provide critical care on a site with unselected medical admissions. UHSM receives, and will continue to receive, unselected medical admissions therefore a robust onsite general surgery service is required. Our tertiary services and the complexity of patients managed by UHSM only increase its importance.
- We understand from Health Education England (the Deanery) that there is also a risk that other trainees, critically in anaesthetics and critical care, could also be withdrawn. This would undermine the ability to support surgery and critical care for the whole hospital.
- In combination, the issues above could lead to movement of activity away from UHSM in many specialties not considered by Healthier Together. This movement has not been planned and it is not clear that alternative capacity exists elsewhere to deliver this activity safely.

**Long-term Concerns**

- In addition to these immediate implications and unintended consequences, in the long term this service model would undermine and erode the continued provision of secondary and tertiary services at UHSM.
- It is clear from current national service specifications that, even if it is theoretically possible for services to be delivered without onsite general surgery, the preferred model for many of UHSM's services is for onsite access to general surgery (for instance cardiac surgery (A10), cystic fibrosis (A01), Burns (D06)), critical care (D16)). Through Devolution, GM intends to pursue even higher standards and better outcomes, so a site without a robust general surgery service is unlikely to meet the hurdle criteria for consideration to provide tertiary services.
- As a result, commissioners could stop investing in and developing services at UHSM. While we accept that change and consolidation is required, we believe this should be transparent and carefully planned and managed. It should not be arrived at through the unintended consequences of Healthier Together's decision which may not be in patients' best interests and contradict public statements that it will not affect other services.

**Proposed Service Model for UHSM**

For these reasons the very limited general surgery service model described so far is not in either the short term or long term interests of the patients who use UHSM's services. We believe that a much more robust and extensive service is required at UHSM as follows:

- A robust general surgical service, providing rapid access to surgical opinion and surgery, must be provided at UHSM. This must include: 24/7 onsite availability of surgical opinion (minimum ST3) to support A&E and other specialties; 24/7 onsite availability of emergency surgery.
- The service must meet national service specifications and standards for support to other services (eg Burns, cardiothoracic surgery)
- The service must meet the Healthier Together clinical quality and safety standards
- The service would operate as part of a single service with CMFT, allowing consultants and trainees to rotate between sites so they can maintain and develop the full range of skills and experience.
- To deliver this:
    - Wythenshawe Hospital would remain a receiving site for emergency general surgery patients brought by ambulance or self-presenting, including all emergency surgery patients with co-morbidities in our tertiary specialties.
    - 24/7 general surgical assessment and opinion will be available to A&E, provided by a minimum of a senior registrar (ST3) onsite 24/7, supported by a consultant on-call.
    - UHSM will retain (ie admit and manage) all patients presenting to the hospital
    - UHSM will deliver all emergency surgery procedures necessary for any patients presenting to or admitted to UHSM ie for inpatients in any specialty who deteriorate and need surgery; new patients presenting to A&E who need urgent surgery.
- This service model would:
    - Provide sufficient volume of emergency general surgery activity to:
        - Retain a 24/7 onsite service, including trainees
        - Maintain the skills of our clinical teams to manage the most complex and high risk patients (ie those with co-morbidities in tertiary specialties at the same time as a general surgery emergency)
        - Deliver a financially viable, efficient service
    - Enable a decision on how to provide complex, high risk elective surgery to be developed making best use of the resources of the whole single service.
- UHSM would commit that :
    - The service will meet the Healthier Together clinical quality and safety standards
    - UHSM will invest in the staff necessary to meet the quality and safety standards

As a Board, we are confident that this is the right model for the patients who use our services. We believe it will achieve the aims of Healthier Together to raise standards and save lives and can be delivered in collaboration with CMFT.

**UHSM/CMFT Agreement**

As we discussed at our meeting last week, UHSM is absolutely committed to collaborating with CMFT and developing a mutually beneficial partnership for the benefit of Manchester and Trafford, GM and the North West. To achieve this, the relationship must start from a position of equality which enables us to become strategically aligned and develop a trusting, transparent relationship between the trusts. In hindsight, while we recognise the importance of collaborating with CMFT on general surgery and vascular surgery, the elements of the agreement we made in June on these services were made without sufficient clinical or commissioner engagement on either side and are unsustainable. While we support the vast majority of the agreement, if we are to move forward, the sections on general surgery and vascular surgery need to be amended regarding the statements about lead provider status and the receiving site for general surgery; and UHSM's status as an arterial centre.

**GM Transformation Initiatives – Expression of Interest**

With all the issues we are managing internally in relation to Healthier Together and our agreement with CMFT, the Board considers that it would not be practical for UHSM and CMFT to embark on a consultancy exercise to develop an aligned hospital model between the two organisations. Although this should be our direction of travel, until Healthier Together is resolved it would be very hard to progress. Instead we propose that we should focus our efforts on the proposed GM Transformation Initiative expression of interest for an integrated Manchester hospital service, as discussed at recent Strategic Oversight Group meetings.

Yours sincerely

Barry Clare
Chairman

Attila Vegh
Chief Executive

CO/4920/2015

IN THE HIGH COURT OF JUSTICE

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

BETWEEN

**THE QUEEN**
**(On the application of KEEP WYTHENSHAWE SPECIAL)**

Claimant

- and -

**NHS CENTRAL MANCHESTER CLINICAL COMMISSIONING GROUP (1)**
**NHS NORTH MANCHESTER CLINICAL COMMISSIONING GROUP (2)**
**NHS SOUTH MANCHESTER CLINICAL COMMISSIONING GROUP (3)**
**NHS STOCKPORT CLINICAL COMMISSIONING GROUP (4)**
**NHS TAMESIDE AND GLOSSOP CLINICAL COMMISSIONING GROUP (5)**
**NHS BOLTON CLINICAL COMMISSIONING GROUP (6)**
**NHS BURY CCG (7)**
**NHS SALFORD CLINICAL COMMISSIONING GROUP (8)**
**NHS WIGAN CLINICAL COMMISSIONING GROUP (9)**
**NHS HEYWOOD, MIDDLETON & ROCHDALE CLINICAL COMMISSIONING GROUP (10)**
**NHS TRAFFORD CLINICAL COMMISSIONING GROUP (11)**
**NHS OLDHAM CLINICAL COMMISSIONING GROUP (12)**
**(Acting jointly through COMMITTEES IN COMMON CALLED "HEALTHIER TOGETHER")**

Defendants

- and -

**UNIVERSITY HOSPITAL OF SOUTH MANCHESTER**
**NHS FOUNDATION TRUST**

Interested Party

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**WITNESS STATEMENT OF DR. ATTILA VEGH**

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I, **DR ATTILA VEGH**, of Wythenshawe Hospital, Southmoor Road, Wythenshawe, Manchester M23 9LT SAY AS FOLLOWS:

1. I am the Chief Executive of University Hospital of South Manchester NHS Foundation Trust ("the Trust"). I am a qualified medical doctor and have a PhD in molecular cancer research and an MSc in Health Management from Imperial College, London.

2. I make this witness statement to explain the Trust's response to the claim brought by the Claimant and to comment on the decision-making process undertaken by the Defendants which has led to the decision of 15 July 2015.

3. A draft of this statement has been seen by and extensively discussed with the Trust Chair and by my fellow Board Directors. Although this is my statement and accordingly expresses my personal views, they have all confirmed to me that they fully support the position explained in this statement which is also the position of the Trust Board.

4. There are a large number of criticisms which are made by the Claimant of the decision-making process followed by the CCGs. As technical legal issues, the Trust does not propose to take a position as to whether the criticisms on grounds 1 to 5 are justified or not and, if justified, whether they would lead to the quashing of the decision. However the debate around ground 6 raises substantial issues which affect the on-going provision of services at Wythenshawe Hospital.

**The structure of the NHS**

5. Before turning to the details of the claim, it may be helpful to say something about the way that the NHS is organised. There are broadly three types of NHS organisations namely commissioners, providers and regulators. It has been the policy of successive governments to separate the organisations within the NHS that deliver care to patients from those organisations that plan how resources should be allocated and what care should be commissioned for NHS patients. This was originally known as the "purchaser-provider split" with some NHS organisations acting as purchasers and others as providers. The terminology used by the government today (and by previous governments) is that there should be a divide between "**commissioners**" and "**providers**".

6. The Defendants are clinical commissioning groups ("CCGs"). CCGs are membership organisations made up of NHS GP practices in a particular geographical area. There are 12 CCGs in Greater Manchester. CCGs were brought into existence by the government following the changes made to the NHS by the Health and Social Care Act 2012. CCGs existed in shadow form from April 2012 and took over full responsibility for commissioning NHS services on 1 April 2013.

7. The Health and Social Care Act 2012 also created the National Health Service Commissioning Board. This organisation has adopted the operational name "NHS England". NHS England commissions a wide range of specialised services from a variety of NHS providers. Specialised services are prescribed nationally in regulations and NHS England describes them as services:

> "provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills."[1]

8. There are a very wide range of types of organisations that "provide" NHS services. These range from GP practices (which are usually private sector businesses owned by GPs), care homes to a wide range of specialist providers. The majority of acute, non-mental health, services for NHS patients (i.e. those services outside of primary and community care) are provided in hospitals by NHS Trusts. These broadly fall into two categories, namely NHS Foundation Trusts and NHS Trusts which have not yet been awarded foundation trust status. The Trust is an NHS Foundation Trust and a university teaching hospital providing Accident and Emergency, secondary and tertiary services as well as medical education and research.

9. There are also NHS bodies that regulate the way in which NHS providers operate and provide care to patients. The main regulators for the Trust are the Care Quality

[1] https://www.england.nhs.uk/commissioning/spec-services/

Commission, which sets standards for health and care services, and Monitor, which is our finance and performance regulator.

**Service Change in the NHS**

10. The management of service change in the NHS is far from straightforward. However, anyone involved in the NHS has to accept that NHS services are constantly evolving and that the successful implementation of service change is an essential part of NHS management.

11. There are at least three parties who have a statutory role and hence need to be involved in a meaningful way in any proposed set of changes to NHS services, namely commissioners, providers and the public/patients. I will leave it to our lawyers to explain the legal structures which set out the roles to be played by each of commissioners, providers and the public/patients. However, NHS Guidance has repeatedly emphasised that decisions about service changes are not solely matters to be agreed between commissioners and providers.

12. The Trust Board absolutely supports the principle that patients and the public have an essential role to play in the management of service change within the NHS. Our Board recognises that members of the public are taxpayers who pay for the public services we provide through their taxes and support that payment system by electing politicians who continue to support the NHS. They are also our patients to whom we provide acute medical services. We recognise that, even though the services of the NHS are free to patients at the point of use, that does not mean that the public are not paying for the services. Our Trust Board is very conscious that we are involved in public service and we have to listen very carefully to the views of the public before making any changes to our services.

13. The Trust Board also entirely accepts that our commissioners (namely the CCGs and NHS England) have the right to define the range of services they wish to contract with the Trust to provide. In principle, subject to the CCGs following their Patient and Public Involvement arrangements, commissioners are entitled to make decisions

about the services they wish to contract for Trusts to provide. Hence, for example, the Trust has nationally recognised expertise in treating patients who are victims of serious burns. This service is provided at Wythenshawe Hospital because we are commissioned by NHS England to provide this specialised service. This service is not provided at any other hospital in the Greater Manchester area. The primary decision to commission the Trust to provide a Specialised Burns Centre thus lies with NHS England as our commissioner. It would be theoretically possible for another Trust to develop a specialised burns service but it would not be able to charge NHS England for the provision of those services unless it held a contract which required it to provide that service. At the moment there is no other Trust within Greater Manchester with such a contract therefore our Trust delivers services for the whole region.

14. However whilst NHS commissioners can be the sole decision-makers if they want to decommission a service, NHS commissioners and providers are joint decision-makers about the provision of NHS services at acute Trusts. In simple terms, the commissioners cannot commission any service that an NHS trust is unwilling or unable to provide and there is no contractual or statutory mechanism which a commissioner can use to mandate an NHS Foundation trust to provide a service model that it is unable or unwilling to provide.

15. The government has chosen to separate out commissioners and providers and to provide that the linkage between the two is the acute services contract. It therefore follows that a contract can only be concluded for the provision of a defined schedule of services, and the service models for those services, if both the commissioner and provider agree to the contract.

16. Until 2004, all NHS bodies were subject to the possibility of Directions being made by the Secretary of State. The existence of this power meant that the Secretary of State retained a reserve power to direct an NHS body to do something or to refrain from doing something. Thus if an NHS commissioner and an NHS trust could not agree about the terms of the acute services contract a decision could be made by the

Secretary of State to direct a trust to provide services that the commissioner wished to commission.

17. When NHS foundation trusts were set up, a policy decision was taken that the new foundation trusts would be accountable to their governors and would be performance managed by Monitor but would not be subject to direction by the Secretary of State. In practical terms, this means that an NHS foundation trust cannot be required to enter into a contract to provide a range of services which it is unable or unwilling to provide.

18. The Trust also has an NHS Licence issued by the regulator, Monitor, under section 97 of the Health and Social Care Act 2012. That Licence requires the Trust to deliver certain "Commissioner Requested Services" which are services to which the licence's continuity of service provisions apply. Until April 2016 Monitor has stated that all services provided by foundation trusts are designated as "commissioner requested services" but beyond April 2016 "commissioner requested services" should only be those services which must absolutely continue to be provided if a trust gets into financial difficulty. Monitor has given commissioners until April 2016 to identify and designate their local "commissioner requested services". Providers must be informed when commissioners want to designate any of the provider's services as "commissioner requested services" and Monitor will arbitrate in any disputes between commissioners and providers.

19. Since all services presently provided by the Trust have been designated by Monitor to be commissioner requested services, it follows that the Trust has a public law legal obligation to deliver those services as well as a contractual obligation.

20. The present contract that the Trust has with its commissioners ends on 30 March 2016. Accordingly, in the run up to that date, there are ongoing negotiations about the terms to be included in the contract from 1 April 2016 (as there are every year). If the point is reached where the CCGs implement the Decision they will have to change the terms of our contract and, at that point, there will have to be a negotiation as to

what services are and are not included in any new contract and the services set out in the new contract may or may not become commissioner requested services (depending on the decision of our commissioners and as agreed with us). However my understanding is that a service cannot be a Commissioner Requested Service unless the Trust has signed a contract which requires the Trust to deliver that service.

**The decision-making process adopted by the Defendants.**

21. The NHS England Guidance "Planning and delivering service changes for patients: a good practice guide for commissioners on the development of proposals for major service changes and reconfigurations" [Exhibit V1] recommends that proposals for service changes require a shared approach between organisations to build alignment on the case for change [see page 11]. The Guidance also states at page 12:

> "Chairs, Accountable Officers, Chief Executives and Medical Directors from across the organisations involved in a service reconfiguration should exercise collective and personal leadership and accountability when considering the development of proposals for major service change"

22. The Guidance also explains the "Four Tests" which a proposed service change needs to satisfy in order to comply with the terms of the 2014/15 Mandate issued by the Secretary of State to NHS England. One of these tests is that those who propose service change should be able to demonstrate evidence of:

> "Support for proposals from clinical commissioners"

23. This suggests that proposals for service change may be made by providers but that they would have to assure everyone that the proposal for final service change is supported by clinical commissioners. Therefore changes to NHS services are matters to be decided by commissioners and providers together. However this Guidance does not provide any clear explanation about what should happen where there is a difference of views between commissioners and providers about the consequences of a proposed reconfiguration. It would, of course, be possible for commissioners and providers to work together and agree to be joint decision-makers about changes to

local NHS services. If that decision making model was adopted then final decisions would be made both by commissioners and providers (after proper public involvement in the decision-making process).

24. I can fully understand that commissioners might fear that making commissioners and providers joint decision-makers may make it very difficult to take hard decisions where some providers are perceived to be "winners" and other providers are perceived to be "losers". No hospital trust likes having services decommissioned and the removal of services means disrupting established clinical teams and reducing the income for the trust from the provision of those services. There is inevitably a degree of resistance from providers to any suggestion that services should be removed from a hospital.

25. I can therefore understand why commissioners may decide they alone should become the decision-makers about the services they wish to commission. However, if that approach is taken, the commissioners need to be extremely careful to ensure that providers are prepared to sign up to the new model of service provision set out in a commissioning decision. As a Chief Executive of an NHS provider organisation, I fully accept that I cannot force a commissioner to commission a service from Wythenshawe Hospital which the CCG does not wish to commission. However, the reverse of this is that the commissioners have to recognise that they cannot force an NHS provider to provide (or continue to provide) a service that the NHS provider is unable or unwilling to continue to provide.

26. If agreement on a new service model is not reached between commissioners and providers, there is a real danger that the CCGs will make proposals for changes to services A, B and C and, as a consequence of those changes, the provider will reluctantly say that it cannot continue to provide services D, E and F. If this happens, a decision by commissioners to implement service change which affects services A, B and C will actually lead to a much wider set of changes to NHS acute services. In these circumstances, members of the public will not have been consulted about the real

effects of the proposed service change because they will have been assured that the only changes would be to services A, B and C.

27. The "knock on" consequences of changes to other services as a result of service reconfigurations is a well-recognised problem within the NHS. It is referred to in a paper prepared by Dr Peter Barrett, the retiring Chair of the Government's Independent Reconfiguration Panel (see paragraph 93 of the witness statement of Dr Andrew McDonald where the Panel is referred to incorrectly as the Independent Review Panel and Exhibit AM29). Dr Barrett says [see page 320]:

> "Clinical developments are inevitably, therefore, a considerable driver for reconfiguring services. But as I have hinted, while centralisation must be a serious consideration for a number of clinical services it does not come without downsides - notably to the range of services that can then be provided from the local DGH [*District General Hospital*]. Nor is it the solution for every service, care of the elderly being an obvious example. In general, I think it is true to say that the public has yet to be convinced by the benefits in healthcare that can be gained from greater centralisation of certain services"

28. Dr Barrett has enormous experience of these matters and his words need to be treated with considerable respect. The report "Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review" dated December 2014 (Exhibit V2) produced by the South East Coast Clinical Senate makes a similar point stating in its Foreword:

> "The case for centralisation has been made for certain specific conditions and pathways, but for the majority of acute inpatient services, there is uncertainty as to the evidence and need for centralisation, and the impact on hospitals that might lose services." [page 2]

29. Where decisions by NHS commissioners lead to far more substantial changes to NHS acute hospital services, a substantial problem of public trust can arise. I suspect the public by and large do not understand the complex decision-making processes operating within the NHS or appreciate the difference between commissioners and providers. In my experience, patients identify with their local general hospital and are

concerned about changes at their hospital. Our local population around Wythenshawe has complained very loudly about the changes proposed by the CCGs. However, they have not been consulted about any changes to their hospital services beyond those changes set out in the public consultation document.

30. Members of the public will complain even more when they realise that they have only had their views canvassed under a proposal about service changes in areas A, B and C but, without any public consultation, those who run their local NHS services are making much more substantial changes.

31. Ahead of the Healthier Together public consultation in July 2014, all NHS Trust Chief Executives were asked to sign the Foreword to the Consultation Document issued by the CCGs [pD461]. This was carefully worded to ensure that the public were not given the impression that the Trusts were all of one mind or were signing up in advance to whatever plans the CCGs decided after consultation. The Trust Board acknowledges that NHS services needed to change in Manchester, as indeed they need to change throughout the NHS. The NHS is in a period of constant flux and change and we accept that the services this Trust provides are not immune from the forces which drive change. However, we have a duty of care to both our patients and our staff and will only sign up to changes that the Trust considers it can deliver in a way that is consistent with that duty.

32. The detail of the model for changes to hospital services was described at page 40 of the Consultation Document [pD478]. The only services which were subject to consultation were Accident & Emergency, Acute Medicine and General Surgery. The document contained specific assurances that the model would not lead to changes to other services. It said [pD478]:

> **"Specialist services provided locally**
>
> While emergency and high-risk General Surgery operations will not be provided at General Hospitals any more, **the other parts of hospital care will still be provided locally.** For example, there will be rapid access clinics for patients arriving

at A & E who need an urgent surgical assessment. Similarly, following an emergency operation, patients can see the surgeon in an outpatient clinic at their local General Hospital. Increasingly, other specialist care will be provided in a local General Hospital - for example specific cancer or chemotherapy treatments, and diagnostic tests"

33. The Trust Board took a measure of comfort from these assurances. It appeared to us that the CCGs were making it clear that whatever commissioning model they resolved to adopt at the end of this consultation process, the specialist services provided at hospitals like Wythenshawe would not be affected.

34. In October 2014 the Trust submitted a comprehensive response to the public consultation (EXHIBIT V3). The response made the case for Wythenshawe Hospital to be designated as a specialist hospital. It highlighted the issues of interdependencies between services and the potential consequences for our specialist services of not being designated a specialist hospital:

> "Wythenshawe Hospital has an existing portfolio of high quality specialist services. Whilst some of the services are not directly within the scope of the Healthier Together consultation, they remain of critical importance to the overall service for the people of Greater Manchester and the Southern Sector in particular. Due to the interdependencies of these specialist services it is important that these services are maintained." [p3]
>
> "On-site co-location of clinical specialties is a key factor in driving better outcomes. The ability for consultants from key specialties to be available almost immediately rather than via an on-call for example will always be the optimum clinical model." [p5]
>
> "While the consultation is not about our highly specialist services we feel the longer term unintended consequences of not being recognised as a specialist site would inevitably mean our ability to maintain and enhance our specialist services could be compromised." [p5]

35. Following the consultation we continued to raise our concerns, focused on the loss of onsite emergency general surgery, about the implications for our services of not being designated a specialist hospital with the Healthier Together programme team and our commissioners. On 30 June, I wrote a joint letter (EXHIBIT V4) with our Chairman to

Ian Williamson, Senior Responsible Officer for Healthier Together, again making the case for Wythenshawe Hospital to be designated a specialist hospital in which we stated:

> "Of the 18 services identified by Healthier Together as requiring support from high risk emergency surgery, UHSM provides all 18 (table 3 below). For 5 services (cystic fibrosis, ECMO[2], heart & lung transplant, tertiary respiratory and burns & plastics) UHSM is the only provider in Greater Manchester and the only provider in the North West. Currently these services are all supported by an onsite, 24/7 general surgery service which is the preferred model described in the national service specifications for cystic fibrosis, cardiothoracic surgery and burns. In a 2 week period, there were 47 emergency inpatient referrals from other specialties to general surgery at UHSM, of which 10 required surgery within 24 hours (table 4 below). Moving to the "local general hospital" model would downgrade the level of general surgery support to these services, reduce their quality and risk lowering their outcomes."

This case was repeated in our sector update to the Healthier Together Programme Board on 3 July 2015 (EXHIBIT V5).

36. But on 15 July 2015, the CCGs took the decision to designate Stepping Hill Hospital, run by Stockport NHS Foundation Trust, as the fourth and final Healthier Together specialist hospital in Greater Manchester. UHSM's Wythenshawe Hospital was designated as a Local General Hospital in a single service with Manchester Royal Infirmary, run by Central Manchester University Hospitals NHS Foundation Trust.

37. The local general hospital model of care is defined in Appendix 44 to the Decision Making Management Report, The Hospital Model of Care [pD928-1065]. For general surgery it describes a "single service" consisting of a "specialist hospital" and at least one "local general hospital". Staff in the single service, particularly consultant surgeons but potentially other staff too, would rotate between sites to work in both the specialist and local general hospitals. The specialist hospital would undertake all emergency general surgery and high risk elective general surgery while the local

[2] ECMO stands for "Extra Corporeal Membrane Oxygenation"

general hospital would only provide low or intermediate risk elective and day case general surgery. The critical difference is that no emergency general surgery would be performed at the local general hospital. Any patient presenting to the local general hospital A&E needing emergency surgery or any inpatient in another specialty who deteriorates and needs emergency surgery would be transferred by ambulance to the specialist hospital to have the surgery performed.

38. As described above, Healthier Together has consistently argued that no services outside the scope of the programme (with the in scope services being A&E, Acute Medicine and General Surgery) will be affected by its decisions. We absolutely agree with them that this should be the case.

39. Unfortunately we have some concerns about the analysis that the programme has completed and the conclusions it has arrived at in support of the assurance that no other services will be affected. Healthier Together published three key documents as part of the Decision Making Management Report (which was the key document to support the CCGs in making their decision on 15 July 2015). These were:

    a. Appendix 45, Healthier Together: Assessment of feedback received during the consultation relating to dependencies on other services (pD1066-1120);

    b. Appendix 50, Clinical Co-dependencies Evidence Review dated May 2015 (pD1121-1142); and

    c. Appendix 60: Independent Clinical Review to Support Decision Making by the Committee in Common for the Greater Manchester Healthier Together Programme dated 25 June 2015 (pD1143-1160)

40. Appendix 45 states its purpose as to provide an assessment of the feedback received on service co-dependencies during the public consultation and identify any implications for either selecting an option for implementation during the programme's decision making, or for the safe implementation of the programme [pD1073]. It refers

to Appendices 50 and 60, as well as a wide range of other references. The specific service examples below will highlight some of the concerns we have about the conclusions this document draws.

41. Appendix 50 states its scope as *"accident and emergency, acute medicine, major trauma units, general surgery, vascular surgery, cancer surgery, interventional GI radiology, women's and paediatrics"* [pD1123]. This scope excludes Wythenshawe Hospital's key services such as cardiothoracic surgery (including heart and lung transplant), cardiology (including complex interventional cardiology), respiratory medicine (including cystic fibrosis and other specialised respiratory services) or burns. Since the co-dependencies for these services would be critical to understand the implications of any decision not to designate Wythenshawe Hospital as a specialist hospital this was very surprising and concerning.

42. Appendix 60 was a review by the North of England Clinical Senates, represented by a panel of the most highly respected consultants in the region outside Greater Manchester. Its purpose was to review whether *"Healthier Together properly addressed the potential co-dependency issues raised in consultation feedback comments"* [pD1146] and its scope was described as *"all potential service co-dependencies arising from formal commissioning changes made since public consultation and those issues arising through the public consultation by respondents"* [pD1146]. In practice, however, its scope was then narrowed to *"particularly, but not necessarily exclusively, paediatric surgery, maternity services, vascular surgery, acute medicine and upper GI surgery"* [pD1146]. Again I was surprised and concerned that none of UHSM's key services such as cardiothoracic surgery (including heart and lung transplant), cardiology (including complex interventional cardiology), respiratory medicine (including cystic fibrosis and other specialised respiratory services) or burns were reviewed. Even for the services it does review, my assessment is that it concentrates on the co-dependencies of the in scope services (A&E, acute medicine and general surgery) on the services being reviewed, not vice versa. For instance in its conclusions the report states that *"the Healthier Together programme has gone to great lengths to ensure that at this stage in their work the clinical co-dependencies of*

*the in-scope services have been considered and understood*"[pD1160]. The scope and approach of this review was particularly disappointing given that this independent external clinical review should have provided a robust and comprehensive clinical assessment of the co-dependency issues for all potentially affected services without any organisational bias.

**Services at Wythenshawe Hospital**

43. UHSM, and Wythenshawe Hospital, is one of only three university teaching hospitals in Greater Manchester and is a provider of numerous specialised services. Our clinicians, other staff and patients are very proud of the services, research and education provided at the hospital.

44. We believe it is in the interests of patients, and the interests of the health system in Greater Manchester, that Wythenshawe Hospital remains a vibrant, thriving university teaching hospital with its wide portfolio of specialised services. We have developed high levels of expertise in these services and we have invested significantly, over £45m in the last ten years, in our facilities and estates to support them. The quality of our services and our patient outcomes are high and we have an excellent reputation with clinicians, patients and the public. We are recognised nationally as a centre of excellence in many services.

45. Our strategy is to invest in and develop our specialised services, particularly in our key areas of heart and lung (also known as cardiothoracic and respiratory) services, plastic surgery and burns and breast cancer.

46. We strongly believe that the quality of these services is fundamentally underpinned by the wide range of other services we have on site, which create a complex, inter-dependent system of services. As I will explain below, in particular we believe, and a wide range of guidance makes clear, that the availability of emergency general surgery, including the ability to operate, onsite at all times of the day and night is by far the optimum model.

47. I will now provide a number of examples of the implications of removing emergency general surgery, as proposed in the Healthier Together Local General Hospital model, on the high quality services provided at Wythenshawe Hospital.

**Cardiothoracic Surgery**

48. Wythenshawe Hospital provides specialist cardiothoracic (heart and lung) surgery including heart and lung transplant surgery. Wythenshawe is the only hospital in the Greater Manchester area which provides a full range of these extremely specialised services. It is one of only five hospitals providing heart and lung transplant surgery in England and one of only five hospitals providing an Extra Corporeal Membrane Oxygenation service (ECMO). ECMO cares for patients with severe respiratory failure by re-oxygenating their blood outside their body rather than in their lungs. It is a highly specialised form of critical care.

49. Based on the most recently published outcomes data, our cardiothoracic services have a mortality rate well below the national average and well below the rate expected. For the year to 31 March 2015, based on the national audit methodology, our services mortality was 1.4% compared to a national average of 2.2% and an expected mortality rate for our service of 2.1% [Exhibit V6]. A recent draft report by NHS Blood and Transplant on Cardiothoracic Transplantation (Exhibit V7) demonstrates that Wythenshawe Hospital also has good outcomes for post-transplant survival for both heart and lung transplant. For heart transplants, post-transplant survival is consistently in the top two heart transplant providers in England and Scotland.

50. When the Healthier Together assessment of service co-dependencies (pD1066-1120) was finally published on 8 July 2015, only a week before the final decision was taken, I was surprised to see that no co-location requirement was identified through the literature review for cardiothoracic surgery, including heart and lung transplant surgery, [pD1113] and that this was supported by examples of NHS hospitals such as Papworth and Harefield which do not have on-site general surgery. I was also surprised that neither the "Clinical Co-dependencies Evidence Review" completed by Midlands and Lancashire Commissioning Support Unit for Healthier Together [pD1121-

1142] nor the "Independent Clinical Review to Support Decision Making by the Committee in Common for the Greater Manchester Healthier Together Programme" [pD1143-1160] completed by the North of England Clinical Senates even examined the question of the co-dependency of cardiothoracic surgery on emergency general surgery.

51. Our own review of the evidence and guidance, however, comes to a different conclusion. The London Cardiovascular project co-dependency framework [Exhibit V8] states that *"collocation is strongly recommended"* (internal p5) for both cardiac and thoracic surgery with general surgery while the South East Coast Clinical Senate (SECCS) framework [Exhibit V2] states that cardiac surgery should be *"ideally on the same site"* (internal p30) as general surgery. The SECCS report also states, however, that cardiac surgery must be co-located with vascular surgery and that vascular surgery must be co-located with general surgery, so in practice implementing the SECCS co-dependency framework would ensure that cardiac surgery is always co-located with general surgery. The London Cardiovascular project also states that *"there is evidence to suggest that the collocation of services can improve outcomes for patients undergoing acute and complex cardiovascular procedures"* (internal p3) reinforcing the conclusion that the optimum model is for collocation of cardiac and thoracic surgery with general surgery.

52. The recently updated NHS England Specialised Service Specification for adult cardiac surgery [Exhibit V9] states that *"All cardiac surgical units must have detailed and robust working relationships with all other major branches of acute medicine and surgery, in particular: ... general and plastic surgical..."*. The previous service specification [Exhibit V10] went further stating a requirement for *"access to many additional specialists who will be available to attend at short notice. This should be available without a transfer of hospital"*.

53. The example of Papworth Hospital in Cambridgeshire is often cited in support of the view that cardiothoracic surgery, including heart and lung transplant, can be delivered without access to onsite emergency general surgery. However, Papworth Hospital is

moving its entire operation onto the Cambridge University Hospitals Addenbrookes Hospital site. In their report for Monitor on the options for the future location of Papworth Hospital [Exhibit V11], Professors Terence Lewis FRCS and Tony Davison FRCP observed that:

> "For Papworth to stay as an isolated speciality hospital on its present site without huge expenditure is unsustainable. The buildings, clinical safety and governance arrangements are now inadequate. Clinical support from such specialities as neurology, neurosurgery, vascular surgery, upper GI medicine and surgery and general surgery, and also in other sub-specialities is inadequate for an organisation performing such complex work on a patient age group which is getting older with more concomitant co-morbidity. The clinicians at Addenbrooke's work hard to provide this service but the role of an isolated dual speciality hospital for complex, dangerous work is now inappropriate. Unstable very sick patients with complications occurring during complex surgery or other interventions need rapid support from a wide range of specialities like those mentioned above. At present, with these being covered from Addenbrooke's, the delay for specialist help can be unacceptably long." (Internal p11)

One theme of the clinical vision described in the Business Case produced by Papworth Hospital [Exhibit V12] for the move was to "Provide improved access to the full spectrum of specialist clinical services." While the business case does not explicitly mention emergency general surgery, the argument is the same: increased co-location of services improves the quality of care and improves outcomes.

54. Therefore I am convinced, and my consultant cardiothoracic surgeons strongly advise me, that removing emergency general surgery from the Wythenshawe site as envisaged in the Healthier Together local general hospital model would be a significant backward step for our cardiothoracic surgery services which would increase clinical risk for our patients in these important specialised services.

55. Since the Trust and our clinicians, and only the Trust and our clinicians, have duties of care to patients, we cannot agree with commissioners that our cardiothoracic surgery services should remain at Wythenshawe Hospital without access to 24/7 emergency general surgery. Since the decision to designate Wythenshawe Hospital as a local

general hospital was taken on 15 July, the Trust has been negotiating with commissioners to secure binding and detailed assurances that a robust general surgery service, including access to 24/7 emergency surgery, will be retained on the site. Without this level of service, the commissioners' assurances to the public that no services outside the scope of the Healthier Together services (A&E, acute medicine and general surgery) would be affected by their decision will turn out to be incorrect.

**Specialised Burns Care**

56. Wythenshawe Hospital provides the regional Specialised Burns Centre for patients with the most severe and complex burns. It is one of only a small number of Specialised Burns Centres for adult patients in England. Its facilities are excellent and include a dedicated burns intensive care unit. Our consultants are highly regarded in this field and our specialty lead, Mr Ken Dunn, holds a number of national positions and was chair of the clinical expert panel on the London burns reconfiguration in 2011.

57. At present the consultants who run the Specialised Burns Centre at Wythenshawe Hospital have access to 24-hour emergency general surgery. They regard this as essential because serious burns are often associated with other serious injuries which require emergency surgery. The proposals by Healthier Together suggest that the Specialised Burns Centre can continue to operate at Wythenshawe Hospital without the support of 24-hour emergency surgery. This is not the position taken by our Trust Board or our consultants who run the service and our case is supported by the best professional guidance.

58. A report from the Burns Clinical Expert Panel dated October 2011 is Exhibit V13. The purpose of this report was to develop a *"clear, clinically agreed and robust statement of the dependencies for specialised burn services"*: see page 7 of the report.

59. The report looked at the services needed to support the delivery of a specialised burns service and divided them into three categories namely:

a. Those services that the authors of the report considered needed to be delivered on site;

b. Those services that the authors of the report considered should ideally be co-located on a single site; and

c. Those services that the authors of the report considered would provide an optimal level of care if co-located on a single site.

60. Page 17 of Exhibit V13 shows that general surgery falls into the first category, namely services which are needed to deliver a burns service and must be provided on-site. The problems of attempting to run a Specialised Burns Centre at a hospital without general surgery on-site are illustrated by the London Health programme "case for change" dated October 2011 [Exhibit V14]. The Queen Victoria Hospital, East Grinstead was developed during the war to treat airmen who frequently had serious burns as a result of combat injuries. It developed very considerable expertise but does not have on-site general surgery. The report concluded that the Queen Victoria Hospital did not meet the criteria for a burns centre.

61. The NHS England Service Specification for specialised burn care (Exhibit V15) defines requirements for supporting services for a Specialised Burns Centre (internal p6-7). Under the title "On Site Support Services" it clearly lists general surgery as needing to be co-located with burns services.

62. Given the nature of the patients treated by a specialised burns centre, described in the NHS England Service Specification as those with the most severe and complex injuries, including those needing the highest levels of critical care, I was surprised to discover that Healthier Together had concluded that the requirement for general surgery to be co-located with a specialised burns centre did not mean that 24/7 onsite emergency general surgery was required. Healthier Together's interpretation of the NHS England Service Specification and of the Burns Clinical Expert Panel from October 2011, as stated in Appendix 45: Healthier Together Assessment of Feedback received during

the consultation relating to dependencies with in scope services, is that *"no requirement for 24/7 access is identified"* [pD1103]. In what appears a slightly circular argument it also references that Healthier Together's own co-dependency framework identifies a "minimally dependent" relationship for burns services on general surgery.

63. In its conclusion, Healthier Together's assessment states that access to on-site general surgery will be provided for our burns patients, described as those with the most severe and complex burns injuries, because Wythenshawe Hospital would retain elective, day case and outpatient general surgery care under a local general hospital model. I cannot understand and completely disagree with this conclusion; I believe it is a significant misinterpretation of the guidance. These are emergency patients, arriving at Wythenshawe Hospital at any time of the day or night, with the most severe and complex injuries so logically any services which are required on site to deliver a specialised burns centre service must also be available to deal with an emergency at any time of the day or night.

64. The Trust Board considers, based on strong advice from our consultant burns surgeons, that a close examination of the Healthier Together documents demonstrates that they have proposed a far from optimum clinical arrangement for the Specialised Burns Centre at Wythenshawe Hospital. We are convinced that removing emergency general surgery from the Wythenshawe site as envisaged in the Healthier Together local general hospital model would be a significant backward step for our Specialised Burns Centre which would increase clinical risk for our patients in this important specialised service.

65. Since the Trust and our clinicians, and only the Trust and our clinicians, have duties of care to patients, we cannot agree with commissioners that the Specialised Burns Centre can remain at Wythenshawe Hospital without access to 24/7 emergency general surgery. Since the Decision to designate Wythenshawe Hospital as a local general hospital was taken on 15 July 2015, the Trust has been negotiating with commissioners to secure binding and detailed assurances that a robust general surgery service, including access to 24/7 emergency surgery, will be retained on the

site. Without this level of service, the commissioners' assurances to the public that no services outside the scope of the Healthier Together services (A&E, acute medicine and general surgery) would be affected by their decision will turn out to be incorrect.

**Adult Cystic Fibrosis Services**

66. Cystic fibrosis is a genetic disorder that affects mostly the lungs but also the pancreas, liver, kidneys, and intestine. Long-term issues include difficulty breathing and coughing up mucus as a result of frequent lung infections. Other signs and symptoms include sinus infections, poor growth, fatty stool, clubbing of the finger and toes, and infertility in males among others. The condition is inherited in an autosomal recessive manner. It is caused by the presence of mutations in both copies of the gene for the cystic fibrosis transmembrane conductance regulator protein.

67. Treatment of cystic fibrosis is a highly specialist area of medical practice. These patients have multiple medical problems and need to be managed extremely carefully in the acute environment. Treatment pathways are complex because of risks to these patients, particularly the risk of hospital acquired infections. Doctors who specialise in the treatment of cystic fibrosis patients need to work extremely closely with other specialists in order to tailor the way that other specialist services are provided to meet the needs of this particular patient group. The work of cystic fibrosis specialists therefore involves planning and coordination with a wide range of other specialist areas of medicine.

68. Exhibit V16 is a list of specialist centres which provide services to paediatric patients suffering from cystic fibrosis. The specialist centre for treating paediatric cystic fibrosis patients in Manchester is the Royal Manchester Children's Hospital. Exhibit V17 is a list of the adult specialist cystic fibrosis centres in the United Kingdom. Wythenshawe Hospital is the adult specialist cystic fibrosis centre for Greater Manchester, Lancashire and South Cumbria.

69. Services for cystic fibrosis patients are sufficiently specialised that they are commissioned by NHS England as opposed to being commissioned by local CCGs.

There are two separate commissioning service specifications for cystic fibrosis patients, namely A01/S/a which describes the commissioning requirements for adult cystic fibrosis patients [Exhibit V18] and A01/S/b which describes the commissioning requirements for paediatric cystic fibrosis patients [Exhibit V19].

70. The section of the Healthier Together final report concerning cystic fibrosis is at pD1110. It states that UHSM is the only Trust in Greater Manchester which currently provides this service. That is incorrect. Services to paediatric cystic fibrosis patients are provided at Royal Manchester Children's Hospital and services to adult cystic fibrosis patients are provided at the Trust. It then makes reference to the NHS England Commissioning Specification A01/S/b [Exhibit V19]. However this is a reference to the commissioning specification for paediatric services for cystic fibrosis patients (which this Trust does not provide). There is no reference in the Healthier Together documentation to the NHS England commissioning specification for adult services for cystic fibrosis patients (which are the services that this Trust is currently commissioned to provide). It therefore appears that the commissioners were working from the wrong NHS England commissioning specification.

71. The Evidence Summary provided by Healthier Together at pD1110 states:

> "There is no requirement for co-location with other services"

72. This single sentence fails to acknowledge the full position set out in the commissioning specification. The NHS England specification sets out the "Specialist Centre Responsibilities" in Exhibit V18:

> "The service must be able to provide for urgent care needs and advice 24 hours a day, seven days a week. This will include management of emergencies such as haemoptysis, pneumothorax and bowel obstruction (including Distal Intestinal Obstruction Syndrome (DIOS))"

73. The section of the NHS England commissioning specification [Exhibit V18] on Surgery reads as follows:

**"Surgery**

... Where possible, surgical procedures should be undertaken at a hospital which also provides a CF service. If this is not possible, full access to CF specialists should be available to ensure that the patient's CF needs are fully taken into account, including during any post-operative period of inpatient care. A clear care plan should be developed, with regular contact and review between the relevant parties"

74. It is thus perfectly clear from the commissioning specification that it is far better for cystic fibrosis patients if general surgery, including emergency surgery, is available on the same hospital site. At present the consultant team at Wythenshawe which delivers the service for cystic fibrosis patients has access to general surgery on site. Removing emergency surgery would therefore be a retrograde step for this service and would introduce substantial risks for the patients.

75. The CCGs reached their conclusion about the co-dependencies for our cystic fibrosis service without securing our agreement to them. If the CCGs had asked the Trust whether it was prepared to continue to provide the specialist cystic fibrosis service without emergency surgery on site then we would have explained the complexities to them.

76. As with cardiothoracic surgery, discussed earlier, the example of Papworth Hospital is often given to support the proposal that the cystic fibrosis service can continue to be provided without onsite access to emergency general surgery. But, as I explained earlier in my statement, Papworth Hospital is now in the process of moving to the Addenbrookes Hospital campus precisely to address the issue of lack of access to other acute specialties (see paragraph 46 of this statement).

77. The Trust Board considers, and our cystic fibrosis consultants strongly advise us, that Healthier Together's assessment of the co-dependencies for the service is at best incomplete and will create a suboptimal service for cystic fibrosis patients at Wythenshawe Hospital. We are convinced that removing emergency general surgery

from the Wythenshawe site as envisaged in the Healthier Together local general hospital model would be a significant backward step for our cystic fibrosis service which would increase clinical risk for our patients who come to Wythenshawe from across the North West.

78. Since the Trust and our clinicians, and only the Trust and our clinicians, have duties of care to patients, we cannot agree with commissioners that the cystic fibrosis service can remain at Wythenshawe Hospital without access to 24/7 emergency general surgery. Since the decision to designate Wythenshawe Hospital as a local general hospital was taken on 15 July, the Trust has been negotiating with commissioners to secure binding and detailed assurances that a robust general surgery service, including access to 24/7 emergency surgery, will be retained on the site. Without this level of service, the commissioners' assurances to the public that no services outside the scope of the Healthier Together services (A&E, acute medicine and general surgery) would be affected by their decision will turn out to be incorrect.

**Accident & Emergency Services**

79. The Consultation document proposed making changes to Accident & Emergency (A&E) services broadly following the scheme set out in the report by the NHS England Medical Director, Sir Bruce Keogh dated November 2013 [Exhibit V20]. This proposed two levels of hospital-based emergency department which Healthier Together has replicated in this scheme. In effect Specialist Hospitals under Healthier Together will provide a "Major Emergency Centre" as described in Sir Bruce Keogh's report, while Local general hospitals will provide an "Emergency Centre".

80. The College of Emergency Medicine's report from 2008 "The Way Ahead" [Exhibit V21] describes the supporting services required by an A&E:

> "The supporting specialties required on site to support an ED have been extensively reviewed in previous documents. It remains our view that the required support for the ED is provided by "seven key specialties" – Critical Care, Acute Medicine, diagnostic imaging, laboratory services, Paediatrics, Orthopaedics and General Surgery."

81. Later in the report it qualifies the seven key specialties as the "optimum support" and states that:

> "The absolute minimum is 24-hour on site Acute Medicine, Intensive Care / Anaesthesia, diagnostic imaging (including 24-hour CT) and laboratory services, including blood bank"

82. If the Healthier Together decision is implemented, Wythenshawe Hospital will become a local general hospital and with the removal of emergency general surgery will lose the optimum set of supporting specialties recommended by the College of Emergency Medicine.

83. To the public, and as repeatedly emphasised in Healthier Together's publicity, all local general hospitals will retain a full A&E department. The only difference is that the most seriously ill patients with abdominal pain will be taken direct to the nearest specialist hospital if they are transported by ambulance. In Wythenshawe Hospital's case, even this is not entirely true, as patients needing the specialist services only provided at Wythenshawe, eg patients awaiting a heart or lung transplant, burns patients or cystic fibrosis patients, will still be brought to Wythenshawe Hospital in an emergency rather than one of the specialist hospitals. This means that all local general hospitals, and particularly Wythenshawe Hospital even if it remains designated as a local general hospital, will continue to receive all types and severities of emergency patients in their A&E departments because even the sickest patients sometimes bring themselves to the A&E instead of being brought by ambulance.

84. This is important because a recent 2015 report by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) into gastrointestinal haemorrhage (or "GI Bleeding"), "Time to Get Control" [Exhibit V22] made the following recommendation:

> "Patients with any acute GI bleed should only be admitted to hospitals with 24/7 access to on-site endoscopy, interventional radiology (on-site or covered by a formal network), on-site GI bleed surgery, on-site critical care and anaesthesia."

Under the Healthier Together model, however, all hospitals in Greater Manchester will still admit patients with an acute GI Bleed, but only specialist hospitals will have on-site GI bleed surgery, otherwise known as emergency general surgery.

85. I also feel that I have to highlight that Wythenshawe Hospital currently fulfils all the requirements in the NCEPOD recommendation described above. We already provide a 24/7 GI Bleed endoscopy service and we are one of only three hospitals in Greater Manchester with on-site interventional radiology. Not all the hospitals chosen to be specialist hospitals on 15 July 2015 are currently able to fulfil that recommendation.

86. While the Trust does not consider that we could not provide an A&E as a local general hospital, it is also quite clear that the removal of emergency general surgery will again be a backwards step, in contradiction to the latest guidance and recommendations, in the support provided to our A&E.

**The negotiations following the decision of 15 July 2015**

87. Nothing I say in this witness statement ought to come as any surprise to our commissioners because we have been expressing serious reservations throughout this very lengthy process about the implications on many of our services of removing emergency general surgery from the Wythenshawe Hospital site as envisaged in the Healthier Together local general hospital model.

88. We absolutely agree with commissioners that we do not want any of our other services at Wythenshawe Hospital to be affected by any decisions taken by the commissioners about A&E, acute medicine and general surgery. Unfortunately, we do not agree that this can be the case if the local general hospital model (as described by Healthier Together in the public consultation and used as the basis of its decision making on 15 July 2015) is implemented at Wythenshawe Hospital. The examples I

have provided above clearly demonstrate the negative consequences for our services of implementing this service model.

89. As we have stated numerous times to commissioners and in public, the Trust Board and the whole organisation were extremely disappointed not to have been chosen as the fourth specialist hospital for Greater Manchester. We believe our comprehensive range of services (including all the supporting services required to meet the Healthier Together clinical quality and safety standards), and our status as a university teaching hospital and specialised services provider made a strong case for choosing us. Our preference would still be to be designated as a specialist hospital and to continue to work in partnership with other providers to develop shared services to the benefit of patients and the NHS in Greater Manchester.

90. We do, however, understand that health services in Greater Manchester need to change, as they do throughout the country, and that this will entail difficult decisions. Therefore since the decision was taken we have been seeking to negotiate with commissioners to agree a service model for general surgery at Wythenshawe Hospital that meets the Healthier Together quality and safety standards and retains a robust general surgery service at the hospital, including 24/7 onsite emergency surgery. This would maintain an appropriate level of general surgery support to our other services and enable us to fulfil the commissioners' assurances to the public that no other services would be affected by their decisions about A&E, acute medicine and general surgery.

91. Following a number of promising discussions with commissioners, we were disappointed when we received a letter from Healthier Together [Exhibit V23] which effectively told us that they envisaged Wythenshawe Hospital implementing the local general hospital model with the exception of emergency general surgery being retained for a very small number of cases related to our specialised services. Following agreement at our Board on 24 September that we needed to make our concerns and desired outcome completely clear to commissioners, on 30 September we wrote back to them setting out in detail our concerns about their proposed model

and describing an outline service model for general surgery which we believe would meet the needs of Wythenshawe Hospital [Exhibit V24]. The concerns we raised in the letter included:

a. That the model proposed by commissioners would retain too little emergency general surgery at Wythenshawe Hospital to maintain a 24/7 onsite service which would immediately create a much less responsive service and reduce the level of support to all other services on site. With very little emergency general surgery onsite we would lose general surgery trainees which would prevent us providing a resident senior registrar to provide 24/7 onsite surgical advice to other services, such as A&E. This would increase clinical risk and create delays in patient flow.

b. The proposed model would create a two tier system in which patients needing care from our specialised services (described as patients with "tertiary co-morbidities"), and therefore the most complex and high risk patients, could be operated on at Wythenshawe Hospital but less complex patients in our non-specialised services (described as "secondary patients") would be transferred to the specialist hospital. So two patients in adjacent wards, needing the same general surgery procedure, would be handled differently. We were concerned that the small amount of emergency general surgery which would be retained at Wythenshawe Hospital would not be sufficient to maintain the skills and experience of ward and theatre staff who do not rotate between sites in the single service. So the most high risk patients would be operated on on the site with the least activity and cared for by teams with less experience.

c. Without rapid access to general surgery opinion and the ability to operate in an emergency, our consultants advised us that they would have to take more risk averse decisions in other specialties, for instance gynaecology, about the operations which could still proceed at Wythenshawe Hospital. In effect Wythenshawe Hospital would become a "low risk specialised hospital" which we do not believe is in the interests of patients or tenable in the long term. It is also

not consistent with Healthier Together's assurance that other services and specialties would not be affected by its decisions.

d. In addition to the immediate implications and unintended consequences, in the long term we were concerned that the proposed model would undermine and erode the continued provision of secondary and tertiary services at UHSM. Since it is clear, as I have shown in my examples above, that onsite general surgery is the preferred model for many services it seems unlikely that commissioners would continue to invest in and develop services at Wythenshawe Hospital without it. While we accept that change is required, we believe this should be transparent and planned, not the unintended consequence of Healthier Together's decisions and in contradiction to its assurances about the effect on other services.

92. In response and following some further negotiations we received a letter from Healthier Together on 8 October [Exhibit V25]. This letter re-affirmed Healthier Together's support for Wythenshawe Hospital as a "*vibrant and thriving*" university teaching hospital and stated that there "*is no intention of undermining its specialised services*". It also recognised that there are "*significant and understandable concerns*" raised by clinicians at UHSM. It proposed establishing a "Clinical Leadership Group" consisting of commissioners, a representative of the University of Manchester and clinicians from both UHSM and Central Manchester University Hospitals NHS Foundation Trust. This group would "*work through and seek to resolve the concerns raised in your detailed letter of 30.9.15*".

93. Although there was no recognition of the service model we proposed in our letter, the Trust responded in support of the Clinical Leadership Group on 20 October 2015 [Exhibit V26]. The first meeting has not yet happened, but, on 19 November, commissioners proposed a meeting on 26 November. Since this is the day of our monthly Board meeting and our medical director is at a conference in London it is not the day we would have chosen, but we will endeavour to ensure that we have appropriate senior clinicians attending to represent the Trust.

94. The Trust Board is totally committed to attempting to negotiate a solution which meets the legitimate clinical concerns raised by our staff and also is acceptable to the commissioners. It is important to us to retain a good working relationship with our commissioners but equally we can only deliver services to NHS patients in cooperation with our clinical staff, and thus have to retain the confidence of our consultants and their clinical leaders. The Trust has therefore been seeking to find an arrangement of services at Wythenshawe Hospital which delivers the Healthier Together outcomes whilst, at the same time, providing sufficient assurance for our clinical staff that it is safe and appropriate to continue to provide the hugely difficult and complex medical services they provide at the moment. It seems unlikely, however, that negotiations can be accelerated so that matters are resolved before the Judicial Review hearing in December. Given the many other issues and projects which depend on clarity about the model for general surgery at Wythenshawe Hospital a decision is required quickly.

95. I hope I have made it extremely clear that we are sympathetic to the essential concern raised by the Claimant at Ground 6 that the issue of co-dependent services has not been properly addressed by the Defendants. This is the fundamental reason we have been pursuing negotiations with commissioners to modify the local general hospital service model proposed for Wythenshawe Hospital in the Decision on 15 July 2015. So far, as I have set out above, these negotiations have not resolved our concerns.

96. Our perspective is not that commissioners reached conclusions that were inherently unreasonable or irrational but that they assumed that if they satisfied themselves that a particular specialist NHS service could continue to be provided in a Local general hospital, then the commissioners and only the commissioners were the decision-makers as to whether that service would continue to be provided at the hospital. In practice, as I have explained above, service change can only be delivered if there is agreement between the commissioner, the provider Trust and the key clinical teams who are being called on to provide the services. At present this is not the position in this case.

97. As I have explained throughout this statement, the Trust, and our clinicians, have reached an equally reasonable view (based on a full reading of the relevant professional guidance) that the commissioners' decision, if implemented without any modifications, will have significant, negative implications for many of our services. We believe that the solution which is in the best interests of our patients and everyone who may need to use our services, is to agree modifications to the local general hospital model set out in the Decision of 15 July 2015 which will enable us to provide robust general surgery support to our services, including onsite 24/7 emergency general surgery.

98. Ultimately, however, if we cannot agree changes to the model proposed in the Decision of 15 July 2015 and thus are required to implement the current local general hospital model which would remove emergency general surgery from Wythenshawe Hospital, we would, very reluctantly, accept that decision in the interests of the NHS and patients overall. However a direct, but unforeseen, consequence of this decision will be, as I have explained, that we could not continue to deliver many of our services without a significant increase in clinical risk which would not be in the best interests of our patients and was not what was consulted upon.

99. The interconnected nature of our services (which as I have said I believe is a strength of our hospital) means that we would have to conduct a wide ranging strategic review of all of our services. This review would have to identify the best future configuration and location for our existing services in order to preserve the current high quality of these services. Further public consultation on any new proposals which emerged from this review would be required.

100. In either scenario, it seems to the Trust Board that modifications to the decision of 15 July 2015 are required. Either we will be successful in negotiating modifications to the decision to change the local general hospital service model consulted on by Healthier Together to enable our existing services to be properly supported (and this is absolutely our preferred solution); or unforeseen modifications to the other services provided at Wythenshawe Hospital will be required which is the opposite of what the

public was assured in the consultation. The latter outcome is absolutely not what the Trust Board wants, nor do we believe it is what commissioners want. Most importantly we do not believe it is in the interests of our patients or the interests of the health system in Greater Manchester and beyond.

**Financial Modelling**

101. Finally, I must make observations about ground 7. Unless the negotiations I have referred to above proves successful, the financial modelling which has led to the decisions made by the CCGs assumes a far smaller set of service changes than will be caused by the Decision. It seems inevitable that this will result in a need for additional capital expenditure because transferring potential services from one NHS hospital to another is never straightforward or cheap. As I have stated above, the Trust has invested over £45m in the last ten years in facilities for specialised services which would have to be replicated elsewhere if they have to be moved.

102. It therefore seems to the Trust that the whole financial modelling exercise for the NHS in Greater Manchester which led to the Decision of 15 July 2015 may need to be reconsidered (depending on the outcome of the present negotiations) because the true consequences of the Decision are far greater than those which are presently acknowledged.

103. However, once again, the Trust Board is hopeful that negotiations to change the terms of the Decision in order to produce a more clinically sustainable model will avoid the need to make radical changes to the capital expenditure consequent to the service changes.

104. I believe that the facts stated in this statement are true.

Signed .....

Dated 23/11/2015

**From:** cllr.e.newman@manchester.gov.uk [mailto:cllr.e.newman@manchester.gov.uk]
**Sent:** 07 July 2015 17:39
**To:** Burns Philip (NHS SOUTH MANCHESTER CCG)
**Cc:** Kurzeja caroline (NHS SOUTH MANCHESTER CCG)
**Subject:** Healthier Together Committee in Common Meeting - 15 July
**Importance:** High

To Dr Phillip Burns, the Representative of South Manchester CCG on the Healthier Together Committee in Common (cc. Deputy Representative, Caroline Kurzeja) (cc. the Members of the Manchester and Trafford Joint Health Scrutiny Committee)

Dear Dr Burns

I am writing to you in my capacity as Chair of the Manchester and Trafford Joint Health Scrutiny Committee. This Committee is made up of ten elected councillors from Manchester and Trafford who at our recent meeting unanimously agreed to ask me to write to you. Our main role is to monitor the effects of the New Health Deal for Trafford on the residents of both Trafford and Manchester. As I am sure you are aware, under the New Health Deal for Trafford, the Accident and Emergency Department at Trafford General Hospital was downgraded to an Urgent Care Centre and is expected to be further downgraded in the medium term future to a Minor Injuries Unit.

Wythenshawe Hospital was already the main General Hospital and A & E Unit for the residents of South Manchester and South Trafford. There has been a significant increase in attendances at and admissions to University Hospital of South Manchester (Wythenshawe Hospital) due to the changes at Trafford General. These increases mean that services for residents of both Manchester and Trafford are under greater pressure.

The Councils of both the City of Manchester and the Borough of Trafford, our respective Health Scrutiny Committees and our Joint Scrutiny Committee have all consistently supported the case for UHSM to be designated under Healthier Together as a “specialist” or “single site services” hospital. We accept the basic tenet of Healthier Together that concentration of much emergency surgery and procedures in a few Greater Manchester hospitals should save lives. My Committee strongly support the original proposal for CMFT to have this status, and have no objection to this also being the case for Salford Royal and Oldham Hospitals. As the Healthier Together Committee in Common have decided last month that there will only be one additional hospital joining these three, I strongly urge you to select UHSM at your meeting on 15 July.

In this letter to you, I am not going to repeat the many reasons which have been put forward why UHSM should be selected to retain the life saving emergency surgery and treatment which will be concentrated in four Greater Manchester hospitals. You are familiar with these reasons. I will just ask you to also consider three additional points.

Firstly, all NHS Greater Manchester hospitals – whether or not foundation trusts, university hospitals, or whatever their specialisms – need to increase co-operation in the interests of their patients and potential patients. So I hope that the recently announced agreement between UHSM and CMFT is in the interests of patients, but this is not a substitute for UHSM also being designated as the fourth principal Hospital under Healthier Together. I understand that, if UHSM is designated as the fourth Specialist Hospital, they would develop a single service for general surgery with one or more of the Southern Sector Trusts. This would not prevent UHSM collaborating with CMFT in other areas, including on education, research and tertiary services.

Secondly, the downgrading of services at Trafford General Hospital were justified by Greater Manchester NHS, CMFT (which runs Trafford General) and Trafford CCG in large part because they said that the neighbouring hospitals – in particular UHSM’s Wythenshawe Hospital – would be able to take the strain of the patients who would previously have been treated at Trafford General. In fact, the Secretary of State only finally approved the changes to Trafford General on condition that the necessary £12 million capital investment into Wythenshawe Hospital’s A & E Department and emergency admission wards would go ahead. This investment is currently taking place. At no time in the decision making process over the New Health Deal for Trafford was it suggested that Wythenshawe Hospital would lose some emergency services or surgery.

Thirdly, in my view, the people of Manchester and Trafford would not understand if the representatives of their Clinical Commissioning Groups were to vote at the Committee in Common meeting against the designation of UHSM’s Wythenshawe Hospital as the fourth principal hospital, and instead to support a different hospital for this role. We are not calling for this only because Wythenshawe Hospital is local for us. If it was not already an excellent hospital providing the full range of emergency surgery and procedures, being local would not be enough. However, it is not just local, and the Healthier Together ethos of saving unnecessary loss of life can be achieved with the designation of UHSM as the fourth principal hospital.

Please vote on Wednesday, 15 July for UHSM!

Yours sincerely

Councillor Eddy Newman Chair, Manchester and Trafford Joint Health Scrutiny Committee