

IRP

Independent Reconfiguration Panel

*ADVICE ON PROPOSALS FOR CHANGES TO
HEALTHCARE SERVICES FOR CHILDREN, YOUNG
PEOPLE, PARENTS AND BABIES IN GREATER
MANCHESTER, EAST CHESHIRE, HIGH PEAK AND
ROSSENDALE*

Submitted to the Secretary of State for Health

26 June 2007

IRP

Independent Reconfiguration Panel

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RECOMMENDATIONS

- **The Panel believes that changes to maternity, neonatal and paediatric services are overdue given the need to provide safe, sustainable and accessible clinical services, changes to workforce regulations and other factors impacting on local health services.**
- **The Panel supports the proposal to provide consultant-led maternity services on eight sites in Greater Manchester.**
- **Having considered the proposals for eight locations of consultant-led maternity services from a wide range of perspectives, the Panel supports the proposed locations for the future provision of these services as described in option A of the consultation document *Making it Better: Making it Real*.**
- **Taking into account the guidance provided in Report of the Neonatal Intensive Care Services Review Group (Department of Health 2003), the Panel supports the development of a clinical network of three level 3 neonatal intensive care units located at St Mary's, the Royal Bolton and the Royal Oldham Hospitals.**
- **The Panel agrees that paediatric services should be co-located with consultant-led maternity and neonatal services on the eight selected sites as described in option A of the consultation document *Making it Better: Making it Real*.**

RECOMMENDATIONS

- **Developments in community and primary care must be successfully introduced before changes to inpatient services are implemented. Such developments must ensure that antenatal and postnatal care and child health services are accessible locally wherever possible and fully integrated with other relevant services including social care.**
- **The issue of choice for maternity service users must be formally addressed by the Children, Young People and Families' Network. The demand for and feasibility of midwifery-led care in the eight units together with *standalone* units at Bury, Salford and Trafford should be fully explored.**
- **The new location of services in Greater Manchester will mean that patients, their families and friends, and staff are more dependent on good public transport and good physical access to hospital sites. Local authorities and the local NHS should work closely with the transport authorities to put in place much improved public and community transport access to hospital sites from local communities.**

RECOMMENDATIONS

- **The scale of change to maternity, paediatric and neonatal services is so significant that implementation of the changes must be approached in a methodical and well thought out manner. The NHS bodies concerned must work together in a cohesive, constructive and co-ordinated way to develop their human resources functions, to build on existing internal and external communications strategies, and to ensure successful implementation of the proposals.**
- **The Panel's recommendations on the *Healthy Futures* consultation should be read in conjunction with these recommendations and implementation of both sets of recommendations throughout the north east sector of Greater Manchester should be co-ordinated as a single exercise by the NHS bodies concerned.**
- **NHS North West (SHA) should oversee and monitor the implementation of the two sets of proposals for Greater Manchester as well as the reconfiguration of clinical services in East Lancashire. The SHA should assume lead responsibility for ensuring the continuity of safe, sustainable and accessible services for those people affected by all of the changes.**

OUR REMIT

What was asked of us

- 1.1 The Independent Reconfiguration Panel's (IRP) general terms of reference are included in Appendix One.
- 1.2 On 26 January 2007, Councillor Joe Kean, Chair, Community, Health and Social Care Scrutiny Committee of Salford City Council, wrote to the Secretary of State for Health Patricia Hewitt, exercising powers of referral under the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. The referral concerned proposals for changes to healthcare services for children, young people, parents and babies in Greater Manchester, East Cheshire, High Peak and Rossendale. The proposals were developed by the Children, Young People and Families' Network and were consulted on under the title *Making it Better: Making it Real* by the Joint Committee of Primary Care Trusts commissioning services for Greater Manchester and surrounding areas¹.
- 1.3 Mr Roger Ellis, Chief Executive of Rochdale Metropolitan Borough Council wrote to the Secretary of State on 9 February 2007 on behalf of the Council's Health Overview and Scrutiny Committee to refer proposed changes to the provision of hospital services currently provided at Rochdale Infirmary. These related to both the *Making it Better* proposals for children, young people, parents and babies and proposals developed as part of another consultation, *Healthy Futures* (see para 1.8 below), concerning the future of health services in the north east of Greater Manchester.
- 1.4 On 13 February 2007, Councillor John Smith, Chair, Healthier Communities Scrutiny Commission, Bury Metropolitan Borough Council also wrote to the Secretary of State referring the *Making it Better* proposals.

¹ Following the reorganisation of the NHS in 2006: Ashton Leigh and Wigan PCT, Bolton PCT, Bury PCT, East Cheshire PCT, Derbyshire High Peak and Dales PCT, East Lancashire PCT, Manchester PCT, Oldham PCT, Rochdale Heywood and Middleton PCT, Salford PCT, Stockport PCT, Tameside and Glossop PCT, Trafford PCT. See para 1.7 for explanation of subsequent actions regarding East Cheshire PCT.

- 1.5 The Secretary of State responded to each of them advising that she had asked the IRP to undertake a review of the proposals. Terms of reference were set out in the Secretary of State's letter of 8 March 2007 to the IRP Chair, Dr Peter Barrett and were accepted in his reply of 15 March 2007. Copies of all correspondence are included in Appendices Two to Nine.
- 1.6 The Panel was asked to advise by 26 June 2007
- a) whether it is of the opinion that the proposals for changes to inpatient services for women, babies, children and young people set out in the decision of the Joint Committee of Primary Care Trusts of 8 December 2006 will ensure the provision of safe, sustainable and accessible services for Greater Manchester, East Cheshire and High Peak. And if not, why not:*
 - b) on any other observations the Panel may wish to make in relation to the proposals for changes to inpatient services for women, babies, children and young people and implications for any other clinical services; and*
 - c) in the light of a) and b) above, on the Panel's advice on how to proceed in the best interests of local people.*
- It is understood that in formulating its advice the Panel will pay due regard to the principles set out in the Independent Reconfiguration Panel's general terms of reference.*
- 1.7 Services provided from Macclesfield District General Hospital (DGH) were not included in the Panel's consideration of the *Making it Better* proposals. Although the Hospital was included within the consultation, the meeting of Joint Committee of Primary Care Trusts on 8 December 2006 agreed that the Central and East Cheshire PCTs would undertake their own review for the provision of paediatric and maternity services at Macclesfield DGH. The Panel has, however, taken account of the fact that residents of east Cheshire may make use of the services considered as part of this review.
- 1.8 The Secretary of State for Health has asked the IRP to examine two sets of proposals for health services across Greater Manchester, *Making it Better: Making it Real* and *Healthy Futures* which concerns the provision of acute services in the north east sector of Greater

Manchester. The Panel has carried out these reviews separately but has throughout sought to ensure that the views and recommendations expressed in both reports are compatible.

OUR PROCESS

How we approached the task

- 2.1 NHS North West (the Strategic Health Authority) was asked to provide the Panel with relevant documentation and to arrange site visits, meetings and interviews with interested parties. The Children, Young People and Families' Network for Greater Manchester, East Cheshire and High Peak (the Network), together with the SHA and relevant PCTs and NHS Trusts, completed the Panel's standard information template. This can be accessed through the IRP website (www.irpanel.org.uk).
- 2.2 The Making it Better Joint Health Scrutiny Committee, Bury MBC Healthier Communities Scrutiny Commission, Rochdale MBC Health Overview and Scrutiny Committee and the Community, Health and Social Care Scrutiny Committee of Salford City Council were also invited to submit documentation and to suggest other parties to be included in meetings and interviews.
- 2.3 The Panel Chair, Dr Peter Barrett, wrote an open letter to editors of local newspapers on 12 March 2007 informing them of our involvement (see Appendix Ten). The letter invited people who felt that they had new evidence to offer or who felt that their views had not been heard adequately during the formal consultation process to contact the Panel.
- 2.4 The Panel issued press releases on 12 and 27 March, 30 April and 14 June. These can be accessed from the IRP website at www.irpanel.org.uk.
- 2.5 In all, IRP members visited Greater Manchester on 20 occasions and were accompanied by the Panel Secretariat. Details of visits, meetings and conversations held are included in Appendix Eleven.
- 2.6 The Secretary of State for Health asked the Panel to review the proposals contained in the *Making it Better* and *Healthy Futures* consultations as separate but interlinked exercises – and to the same timetable. On its visits to Greater Manchester, the Panel received evidence relating to both referrals. Appendix Eleven records *all* Panel visits, meetings and conversations held relating to both *Making it Better* and *Healthy Futures*.

- 2.7 A list of all the written evidence received – from the SHA, PCTs, NHS Trusts, Joint Health Scrutiny Committee, individual scrutiny committees, MPs and all other interested parties is contained in Appendix Twelve. The Panel considers that the documentation received, together with the information obtained in meetings, provides a fair representation of the views from all perspectives.
- 2.8 Throughout our consideration of these proposals, our aim has been to consider the needs of patients, public and staff taking into account the issues of safety, sustainability and accessibility as set out in our terms of reference.
- 2.9 The Panel wishes to record its thanks to all those who contributed to this process. We also wish to thank all those who gave up their valuable time to present evidence to the Panel and to everyone who contacted us offering views.
- 2.10 The advice contained in this report represents the unanimous views of the Chair and members of the IRP².

² New Panel Members appointed on 1 June 2007 were not involved in the preparation of this report.

THE CONTEXT

A brief overview

- 3.1 The history of redesigning children's services in Greater Manchester has been a long and challenging one. Since the mid 1960s, many discussions and debates have been undertaken in Greater Manchester about how to improve and modernise children's services. Each has proved controversial and met with opposition from clinicians, politicians and the local public. As a consequence, Greater Manchester's children's services have remained largely unchanged over the last forty years.
- 3.2 The main debate has concerned the number and location of the specialist children's hospitals - currently Royal Manchester Children's Hospital (RMCH or Pendlebury) in Salford and Booth Hall Hospital in North Manchester. There has, however, always been a clear recognition that no debate could take place about specialist children's services without also considering local children's services, and this has added further complexity to the process. Most recently, it has been recognised that neonatal and maternity services should be considered together with secondary paediatric services.
- 3.3 In 1996, Manchester Health Authority and Salford & Trafford Health Authority issued two separate public consultations³ on secondary and tertiary children's services. The outcome of these consultations was a decision to build a new specialist children's hospital in central Manchester and to relocate local secondary children's services to North Manchester General Hospital (from Booth Hall) and to Hope Hospital (from Pendlebury).
- 3.4 In 1998, Salford and Trafford Health Authority undertook a public consultation on closing the inpatient children's ward at Trafford General Hospital. The proposal met with significant local opposition and the consultation was subsequently withdrawn on the instruction of the then Secretary of State for Health, Frank Dobson, in July 1998.
- 3.5 By the end of the 1990s, there was a growing feeling amongst paediatricians in Greater Manchester that the configuration of secondary local children's services was clinically unsustainable and of poorer quality than should be available in such a large conurbation.

³ Improving Children's Services in Manchester, Manchester Health Authority
A Review of Specialist Hospital Services for Children, Salford & Trafford Health Authority

There were also concerns about the *magnetic* effect that a new “state of the art” children’s hospital in central Manchester would have on the viability of local services if they were not robust and well developed before the new facility opened⁴.

- 3.6 The Greater Manchester Secondary Care Children’s Project commenced in early 2000. The project had a high level of clinical involvement from paediatrics, maternity and neonatal services and in summer 2001 a discussion document *Shaping the Future* was published with a proposed new, modern clinical model for children’s services. It suggested a reduction in the number of hospitals providing overnight paediatric care but did not make specific recommendations about sites.
- 3.7 Following the reorganisation of the NHS in 2002, the new Greater Manchester SHA formed the Children, Young Peoples and Families’ Network to take forward the work begun in *Shaping the Future*. The Network was overseen by a Network Supervisory Board (NSB)
- 3.8 In July 2004, a new model for children’s services was presented to the Greater Manchester SHA Board, together with a recommendation from the NSB to reduce the number of overnight paediatric sites in Greater Manchester. The SHA Board decided to hold a formal public consultation and, recognising the close relationship between maternity, neonatal and paediatric care, decided also to include these services within the consultation. A Joint Committee of the Primary Care Trusts commissioning services for Greater Manchester held a formal consultation between January and May 2006. The consultation document, *Making It Better: Making It Real*, listed five options for the future location of inpatient paediatric and consultant-led maternity services and for neonatal intensive care. A Joint Health Scrutiny Committee (Joint HSC) was formed by the local authorities affected by the proposals and responded to the consultation in April 2006.
- 3.9 The consultation generated a large response and as a result seven further options on the location of services were developed for consideration by the Joint Committee of PCTs. On 8 December 2006, the Joint Committee of PCTs met to make decisions on the future provision of care for women, babies and children in Greater Manchester. The Joint Committee agreed to:

⁴ The new specialist children’s hospital is being built on the Central Manchester Hospital site and will open in summer 2009.

- introduce a new, modern model of care for women, babies and children
- enhance and develop as many services at home or close to home, where clinically appropriate, with all hospitals continuing to provide most services
- concentrate inpatient women's and children's services on eight hospital sites in line with Option A as described in *Making it Better: Making it Real*
- to develop three centres of excellence for neonatal intensive care in line with Option A as described in *Making it Better: Making it Real*

- 3.10 Option A would lead to inpatient paediatric services and consultant-led maternity care being provided at eight locations – the Royal Albert Edward Hospital, Wigan; the Royal Bolton Hospital; the Royal Oldham Hospital; St Mary's Hospital, Manchester; Stepping Hill Hospital, Stockport; Wythenshawe Hospital, South Manchester; North Manchester General Hospital and Tameside General Hospital.
- 3.11 Level three neonatal intensive care would be centred at St Mary's Hospital, the Royal Bolton Hospital and the Royal Oldham Hospital.
- 3.12 The Joint HSC met on 9 January 2007 and agreed by a majority vote to endorse the decisions made by the Joint Committee of PCTs.
- 3.13 Councillor Joe Kean, Chair, Community, Health and Social Care Scrutiny Committee, Salford City Council, wrote to the Secretary of State for Health, Patricia Hewitt, on 26 January 2007 to refer the decision to approve Option A under the *Making it Better* consultation.
- 3.14 On 9 February 2007, Roger Ellis, Chief Executive, Rochdale Metropolitan Borough Council, wrote on behalf of the Council's Health Overview and Scrutiny Committee to refer proposals under the *Making it Better* and *Healthy Futures* consultations that would affect Rochdale Infirmary.
- 3.15 A further referral concerning the *Making it Better* proposals was submitted on 13 February 2007 by Councillor John Smith, Chair, Healthier Communities Scrutiny Commission, Bury, Metropolitan Borough Council.

- 3.16 The Secretary of State for Health wrote to the IRP Chair, Dr Peter Barrett, on 8 March 2007 asking the Panel to undertake a review of the proposals for both the *Making it Better* and *Health Futures* consultations.

INFORMATION

What we found

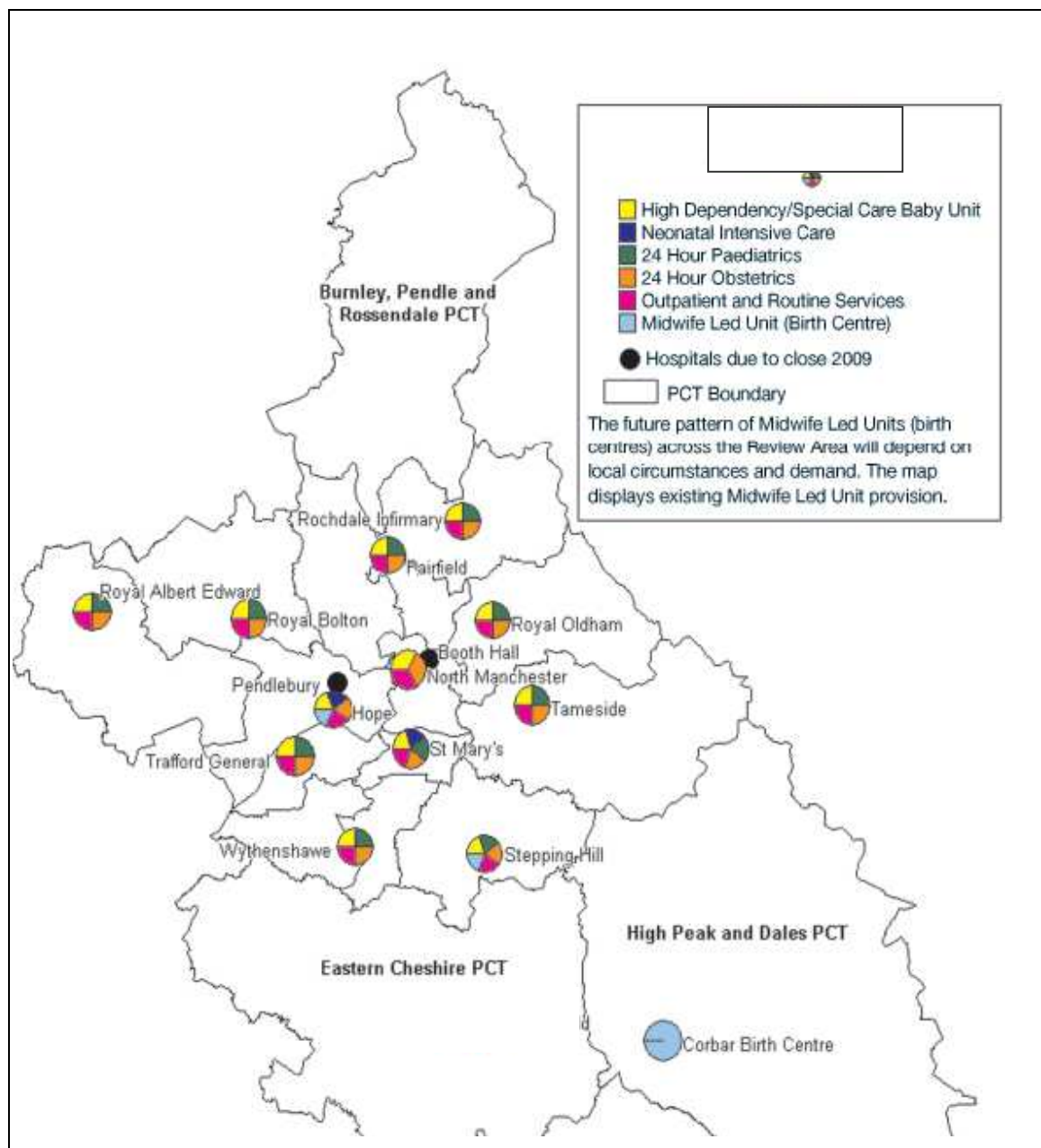
- 4.1.1 A vast amount of written and oral evidence was submitted to the Panel. We are grateful to all those who took the time to offer their views and information. The evidence put to us⁵ is summarised below – firstly general background information followed by an outline of the proposals, the reasons for referral by the three health overview and scrutiny committees and issues raised by others. The tables, maps and general information contained in this section have been reproduced from information supplied by the Children, Young People and Families’ Network.
- 4.1.2 *Making It Better* has been the largest and most complex exercise in patient and public involvement in England to date. The review area covers a wide and diverse geographic area with a population in excess of three million (including 580,000 children) and a broad range of socio-economic and minority ethnic groups (from 0.9% of the population in High Peak and Dales to over 30% in central Manchester).
- 4.2 **Services provided and activity**
- 4.2.1 The review covers maternity, neonatal and paediatric care provided at 14 hospitals run by nine different trusts:

HOSPITAL	TRUST
Booth Hall Hospital*	Central Manchester and Manchester Children’s University Hospitals NHS Trust
Fairfield General Hospital, Bury	Pennine Acute Hospitals NHS Trust
Hope Hospital, Salford	Salford Royal Hospital NHS Foundation Trust
North Manchester General Hospital	Pennine Acute Hospitals NHS Trust
Rochdale Infirmary	Pennine Acute Hospitals NHS Trust
Royal Albert Edward Infirmary, Wigan	Wrightington, Wigan and Leigh NHS trust
Royal Bolton Hospital	Bolton Hospital NHS Trust
Royal Manchester Children’s Hospital, Pendlebury*	Central Manchester and Manchester Children’s University Hospitals NHS Trust
Royal Oldham Hospital	Pennine Acute Hospitals NHS Trust
Stepping Hill, Hospital Stockport	Stockport NHS Foundation Trust
St Mary’s Hospital	Central Manchester and Manchester Children’s University Hospitals NHS Trust
Tameside General Hospital	Tameside and Glossop Acute Services NHS Trust

⁵ Some of the evidence submitted to the Panel from organisations, patients and residents in the north east sector of Greater Manchester related also to the proposals contained in *Healthy Futures*. In accepting this evidence, the Panel recognised that for many people in this part of the conurbation the prime concern was the overall provision of services at their local hospital.

Trafford General Hospital	Trafford Healthcare NHS Trust
Wythenshawe Hospital	University of South Manchester NHS Foundation Trust
*Note: Booth Hall Hospital and the Royal Manchester Children’s Hospital, Pendlebury will close by the end of 2009 on completion of the new Children’s Hospital in Central Manchester.	

4.2.2 The current services provided at each site are shown in the map below:



Map based on OS mapping with the permission of the Controller of HMSO. Crown copyright. Unauthorised reproduction infringes Crown Copyright and may lead to prosecution or civil proceedings. Licence Number 100019568. Manchester Joint Health Unit (December 2005).

4.2.3 Twelve hospital sites currently provide consultant-led maternity (obstetric) care. Two of those hospital sites – Hope Hospital in Salford and Stepping Hill Hospital in Stockport - also provide midwifery-led maternity care. A standalone midwife-led unit is established

at the Corbar Unit in Buxton. In total, around 34,000 births per year take place across the review area.

- 4.2.4 Inpatient paediatric services are provided at twelve hospital sites. Two of these, the sites at Booth Hall and Royal Manchester Children's Hospital, Pendlebury, will close in 2009 on completion of a new Children's Hospital currently being built at the Central Manchester and Manchester Children's University Hospitals NHS Trust in central Manchester. Some 60,000 inpatient stays take place across the review area each year.
- 4.2.5 Level 3⁶ neonatal intensive care is provided from two recognised specialist neonatal units – at Hope Hospital, Salford and St Mary's Hospital in central Manchester. Each of the other sites providing consultant-led maternity care also provides special care or high dependency care for babies, or both. Around 3,000 babies a year require some form of additional neonatal care across the review area.

4.3 **Geography, demography, access and transport**

- 4.3.1 Greater Manchester, with a population of around 2.8 million, encompasses the cities of Manchester and Salford as well as a number of other distinct communities, including Stockport, Wythenshawe, Trafford, Wigan, Bolton, Bury, Rochdale, Heywood and Middleton, Oldham and Tameside. The review area also takes in parts of Cheshire in the south and the Rossendale Valley to the north taking the total population covered by the review to more than three million.
- 4.3.2 Deprivation across the review area varies widely. As can be seen from the table on the following page, which shows child poverty scores for Greater Manchester PCTs⁷, the main pockets of deprivation are in north, central and south Manchester.

⁶ Units providing care for new-born babies fall into three categories from level 1 providing routine and special care to level 3 providing the most specialised intensive neonatal care. Report of the Neonatal Intensive Care Services Review Group, Department of Health April 2003.

⁷ Prior to reorganisation in 2006.

PCT	Poverty Population	Population Under-16 (2001)	Child Poverty Score 2004	Child Poverty Rank 2004
Ashton Leigh and Wigan	12766	61801	20.7	11
Bolton	13811	56748	24.3	9
Bury	7372	38954	18.9	12
Central Manchester	13255	28431	46.6	2
Heywood and Middleton	4658	16548	28.1	5
North Manchester	14148	26426	53.5	1
Oldham	13489	49992	27.0	7
Rochdale	8536	30333	28.1	6
Salford	14465	44171	32.7	4
South Manchester	10980	27931	39.3	3
Stockport	9271	57799	16.0	13
Tameside and Glossop	12162	52569	23.1	10
Trafford North	4850	18975	25.6	8
Trafford South	2817	23515	12.0	14

Income Deprivation Affecting Children Index 2004 in Greater Manchester Primary Care Trusts aggregated from Super Output Areas (Index of Multiple Deprivation 2004)

- 4.3.3 The highest percentages of minority ethnic groups are in central Manchester (31.2%), Rochdale (16.4%), north Manchester (14.1%) and Oldham (13.8%).
- 4.3.4 Greater Manchester is well supported by a motorway network including the M60 orbital motorway, and other motorways providing access to the north, south, east and west. An extensive bus, rail and tram network runs throughout the conurbation but in common with many other large urban areas traffic congestion is considered by many residents to be a significant problem.
- 4.3.5 In recognition of public concern about transport issues, the Network has undertaken extensive work on travel times to hospitals under each of the reconfiguration options considered. This information is available on the Network website at www.bestforhealth.nhs.uk.
- 4.4. **Estate**
- 4.4.1 IRP members undertook visits to each site included in the proposals for *Making it Better*.

4.5 Healthcare Commission annual assessment

4.5.1 Healthcare Commission ratings for each acute in 2005/06 are shown in the table below:

Acute NHS Trust	Health Care Commission Ratings 2005/2006	
	Quality of Service	Use of Resources
Bolton Hospital NHS Trust	FAIR	FAIR
Central Manchester and Manchester Children's University Hospitals NHS Trust	GOOD	FAIR
Pennine Acute Hospitals NHS Trust	FAIR	FAIR
Salford Royal Hospital NHS Trust	EXCELLENT	GOOD
South Manchester University Hospital NHS Trust	GOOD	GOOD
Stockport NHS Foundation Trust	GOOD	EXCELLENT
Tameside and Glossop Acute Services NHS Trust	GOOD	GOOD
Trafford Healthcare NHS Trust	FAIR	WEAK
Wrightington, Wigan and Leigh NHS Trust	GOOD	FAIR

4.6 The Making it Better proposals

4.6.1 The Children, Young People and Families' Network describe the proposals as:

<p><i>“a fundamental redesign of the way healthcare for babies, women and children are provided for Greater Manchester. The new clinical model of care involves:</i></p> <ul style="list-style-type: none"> <i>• a major increase in the provision of services in the community, for example the significant expansion of children's community teams</i> <i>• the development of centres of excellence for overnight (inpatient) services</i> <i>• expansion of centres of excellence for neonatal intensive care</i>
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The proposals involve:

- *significant additional Capacity expenditure (approx £60m) and recurring annual revenue expenditure (approx £10m per annum)*
- *an improvement in key safety and quality areas for example provision of 60 hours per week consultant labour ward cover*
- *anticipated improved survival rates for premature babies*

Daytime services will continue to be delivered at all hospital sites but overnight services will be concentrated on eight sites. Neonatal intensive care will continue to be initiated on all eight sites but longer term care will be provided on three sites (currently two) which are geographically sited to maximise access for patients.

It is anticipated that implementing the new model will take 3-5 years.”

4.6.2 The options for the location of services under the five options included in the consultation are included below:

Option A	Option B	Option C	Option D	Option E
Preferred Option 8 inpatient paediatric sites 8 inpatient obstetric sites	7 inpatient paediatric sites 7 inpatient obstetric sites	7 inpatient paediatric sites 8 inpatient obstetric sites	8 inpatient paediatric sites 8 inpatient obstetric sites	No change
RAE, Wigan	RAE, Wigan	RAE, Wigan	RAE, Wigan	RAE, Wigan
Royal Bolton	Royal Bolton	Royal Bolton	Royal Bolton	Royal Bolton
Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham
St Mary's	St Mary's	St Mary's	St Mary's	St Mary's
Stepping Hill	Stepping Hill	Stepping Hill	Stepping Hill	Stepping Hill
Wythenshawe	Wythenshawe	Wythenshawe	Wythenshawe	Wythenshawe
North Manchester	North Manchester	North Manchester	North Manchester	North Manchester
Tameside		Hope (obstetrics only)	Macclesfield*	Tameside
Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Hope Rochdale Infirmary Fairfield Bury Trafford Macclesfield*
3 Neonatal Intensive care Units	3 Neonatal Intensive care Units	3 Neonatal Intensive care Units	3 Neonatal Intensive care Units	2 Neonatal Intensive care Units
St Mary's	St Mary's	St Mary's	St Mary's	St Mary's
Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham	Hope
Royal Bolton	Royal Bolton	Hope	Royal Bolton	

* Services provided from Macclesfield District General Hospital are now part of a separate review.

4.6.3 Following the consultation, seven further options were developed for consideration.

Option F (a)	Option F (b)	Option G	Option H (a)	Option H (b)	Option I
8 inpatient paediatric sites 8 inpatient obstetric sites	8 inpatient paediatric sites 8 inpatient obstetric sites	7 inpatient paediatric sites 8 inpatient obstetric sites	8 inpatient paediatric sites 8 inpatient obstetric sites	8 inpatient paediatric sites 8 inpatient obstetric sites	8 inpatient paediatric sites 8 inpatient obstetric sites
RAE, Wigan	RAE, Wigan	RAE, Wigan	RAE, Wigan	RAE, Wigan	RAE, Wigan
Royal Bolton	Royal Bolton	Royal Bolton	Royal Bolton	Royal Bolton	Royal Bolton
Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham
St Mary's	St Mary's	St Mary's	St Mary's	St Mary's	St Mary's
Stepping Hill	Stepping Hill	Stepping Hill	Stepping Hill	Stepping Hill	Rochdale
Wythenshawe	Wythenshawe	Wythenshawe	Wythenshawe	Wythenshawe	Wythenshawe
Bury	Rochdale	Bury	North Manchester	North Manchester	North Manchester
Tameside	Tameside	Hope (obstetrics only)	Bury	Rochdale	Macclesfield
Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies	Every inpatient obstetric site will have High Dependency cots and Special Care Cots for babies
3 Neonatal Intensive care Units	3 Neonatal Intensive care Units	3 Neonatal Intensive care Units	3 Neonatal Intensive care Units	3 Neonatal Intensive care Units	3 Neonatal Intensive care Units
St Mary's	St Mary's	St Mary's	St Mary's	St Mary's	St Mary's
Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham	Royal Oldham
Royal Bolton	Royal Bolton	Hope	Royal Bolton	Royal Bolton	Royal Bolton

Option J: substitute Wythenshawe Hospital for Oldham for the provision of neonatal intensive care services

4.7 **Issues raised by scrutiny committees**

4.7.1 The Making it Better Joint Health Scrutiny Committee formed the view at an early stage of its consideration that change was needed to ensure the future provision of “*safe, effective high quality healthcare services for children, young people parents and babies in the review area...*”. However, it also recognised that some doubts existed among local communities about the need for change.

4.7.2 In its response to the formal consultation, the Committee accepts that “*there is evidence to suggest that eight inpatient obstetric and paediatric units is a manageable number*”

though recognising that the distribution of these services across the review area “*will have a detrimental impact on access to healthcare services for residents*”.

4.7.3 Following the decision by the Joint Committee of PCTs on 8 December 2006, the Joint HSC decided by a majority vote to support option A and not to refer the decision to the Secretary of State for Health.

4.7.4 **Community, Health and Social Care Scrutiny Committee, Salford City Council**

The Committee was represented on the Making it Better Joint HSC and was one of the bodies that voted to oppose the decision of the Joint Committee of PCTs. The Committee’s opposition to the decision is set out in its letter to the Secretary of State of 26 January 2007. In addition to expressing concerns about the decision-making process, the Committee commented:

“Throughout the process, members of the Committee have always indicated their support for and understanding of the need for change. The Committee produced a report in response to the consultation to inform the response of the MIB Joint Health Scrutiny Committee. That report recommended that Option C should be supported on the following grounds:

- *All 4 options for change in the consultation document were considered safe, equitable, and feasible. No evidence was presented which suggested the “preferred” option A was any more so than the others.*
- *Why close the MLU at Hope Hospital when it is one of only 3 in the review area? Why not build on the current excellent provision and established expertise of a leading midwife led birth centre at Hope Hospital? Option C would build on existing services at Hope in respect of the MLU and neonatal Intensive Care Unit meaning these would not need to be developed from scratch.*
- *Removing the MLU would take away choice for the people of Salford and Greater Manchester conurbation. The only “choice” would be a home birth in Salford or hospital birth elsewhere in the conurbation. This seems perverse because the MLU is a successful unit which has doubled its intake of low risk women over the last couple of years.*
- *Members saw no evidence to support the relocation of the NICU to Bolton. The current model of care at hope, with maternity, MLU and NICU provides safe and effective services.”*

4.7.5 **Rochdale Health Overview and Scrutiny Committee**

The HOSC was represented on both the *Making it Better* and *Healthy Futures* joint health overview and scrutiny committees and in both instances voted to oppose the decisions

made. Roger Ellis' referral letter of 9 February to the Secretary of State relates to both *Making it Better* and *Healthy Futures*.

4.7.6 That letter indicates that:

"This Council's HOSC has considered the details of both proposals and do not consider the proposals contained in either reconfiguration to be in the interests of the local community, nor in the interests of local Health Services in the Borough on the grounds that:

- *It does not believe that the proposals are consistent with the ethos of the White Paper "Keeping the NHS local"*
- *There is a lack of detailed financial information about the capital costs of the proposals, in particular, concern at the figures quoted for the cost of providing maternity and paediatric services at Rochdale Infirmary compared to the cost of initiating the same services at North Manchester.*
- *There is insufficient weight given to the health inequalities and relative deprivation of Rochdale compared to other parts of the conurbation.*
- *The communities of Rochdale, Whitworth and Rossendale are substantial communities and have a legitimate expectation that health services will be provided at a District General Hospital in their areas.*
- *In recognising the need for change, there is, nevertheless, concern that the Joint Committee failed to look at alternative models for the provision of local services."*

4.7.7 **Healthier Communities Scrutiny Commission, Bury**

The Commission was represented on the Making it Better Joint HSC and voted to oppose the decision of the Joint Committee of PCTs. Members of the Commission agreed that this matter be referred to the Secretary of State for the following reasons:

- *"The proposal is not in the interests of the local health service in the north of Bury, Rochdale and Rossendale areas and therefore would have a detrimental effect on the health and experience of these patients.*

Members were concerned with the fact that there would be no provision in areas of the borough to the north of the M60 motorway and this factor would also affect residents of the neighbouring authorities who currently utilised the facilities at the Fairfield site.

- *That they had concerns that the consultation process was not carried out reasonably due to the omission of information relating to the preferred number of births per unit from the consultation documents.*

The Commission understands that the Joint Committee of PCTs has advised that there was no material difference between the options.

- *The Commission was told that the two options debated most intensely were the Bury option (Option Fa) which would include the Fairfield site and the preferred option (Option A).*

The main issue that the committee looked at was where 32,000 births could be accommodated across Greater Manchester and it was stated it was crucial to St Mary's that their figures were no more than 6,000 per year.

In the opinion of the Commission this information was not included within the consultation document. As it was considered an important factor, it should have been and it could possibly have changed the initial decision of which model to adopt.

The Joint Committee of PCTs accepted that in relation to the issue of accessibility, the favoured option was Fa and indeed this was backed up with evidence from the Ambulance Trust. Evidence considered by the Commission showed that residents from Bury and other authorities north of the M60 motorway would be disadvantaged. Evidently then, the information not mentioned in the consultation, that is, the optimum size of units (between 3,000 and 6,000) was a critical part of the Joint Committee's decision making process and it seems to the Commission that the best interests of the local health service was set aside on the basis of this criteria.

It is considered that this issue was a crucial part of the decision not to select Option Fa.

Members were concerned that had the information relating to optimum numbers of deliveries been available within the consultation documents, they may have considered the need for change more thoroughly and reached an alternative decision.

- *There were concerns regarding the capital funds for the new development at north Manchester General Hospital and the lack of confirmation that those funds are in place. If the Fairfield maternity and paediatric inpatient beds were to be closed and the business case for the North Manchester development was financially unsustainable, this would be especially detrimental to the residents of Bury.*

The Commission was not happy with the response given by the..... Pennine Acute Trust when questioned about the availability of finances for the capital build.

[A representative of the Trust] explained that Pennine Acute had given reassurance about the funding required for the capital project as it was no more of a risk than other capital developments that they were undertaking.

Members felt that detailed financial information and/or a business case should have been submitted as part of the consultation process setting out available costings and funds available.

- *The newly upgraded facilities currently in place at Fairfield General Hospital would not be put to their optimum use and therefore would be a waste of a well resourced and functioning unit.*

Members of the Commission referred to the upgrade of facilities of the Maternity unit at Fairfield hospital which had been a massive investment by the NHS. Concern was raised that this would be a waste of public funds if the Unit were to close (£2.5m invested in 2001)."

4.8 **Issues raised by others**

4.8.1 In the course of our consideration of this referral, a large number of views and issues were presented to us from many sources. These are summarised below and are discussed more fully in the next section together with our recommendations.

4.8.2 *Clinical views – the current situation for maternity, paediatrics and neonatal care and need for change*

- Significant concerns about the safety and sustainability of current service provision
- Inability to meet statutory and other requirements for provision of care
- The desire to improve the quality of care provided both in hospitals and in developing care in primary and community settings

4.8.3 *Clinical views – the Making it Better proposals*

- Widespread agreement amongst medical staff that reducing the number of inpatient sites will enable compliance with statutory and other standards
- Widespread agreement amongst paediatric medical staff that reducing the number of inpatient sites will facilitate the development of high quality community paediatric

services - but that improvements to primary and community services should be implemented before any reduction in inpatient care is initiated

- Widespread agreement on the number of sites that should in future provide inpatient services - though some differing views on their location
- Concerns that within a model of a reduced number of inpatient sites, the future location of consultant-led maternity, paediatric and neonatal intensive care should provide the best possible coverage of services throughout the review area
- Concerns about the relocation of well-established neonatal intensive care services
- Conflicting views about the necessity of co-locating consultant-led maternity and paediatric care though general agreement on the desirability of co-locating consultant-led, maternity, neonatal intensive care and paediatric care
- Concerns about the effect on staff of relocating services and the need for co-ordinated HR and communication strategies
- Concerns amongst midwifery staff that a reduction in the future location of consultant-led maternity services will limit choice about place of birth for a significant proportion of women in the review area
- Concerns amongst midwifery staff about future training opportunities under the proposals

4.8.4 *Public and patient views*

- Strongly held views were expressed by representatives of many of the communities involved, notably those in Bury, Rochdale, Salford and the Rossendale Valley
- Access to services is a major issue due to poor transport links and a lack of mobility amongst many residents
- Concern about gaps in service provision arising from the proposals, notably north of the M60 motorway
- The desire to retain well-established existing services within local communities and the right of substantial communities to have local access to hospital services
- There are many pockets of high social and health deprivation and areas with significant ethnic populations, throughout the Greater Manchester area, that justify the maintenance of inpatient services in those locations
- The right for children to be born within their own distinct localities and communities
- Lack of consistency with government initiatives on choice and providing care closer to home

- Concern about the high cost of relocating existing services to new locations

4.8.5 *Managerial issues*

- Capacity issues around maternity services at several sites and St Mary's Hospital in particular: physical constraints on the development of services at certain sites
- Predicted flow of maternity deliveries under each option
- Initiatives to bring about improvements in transport and access to services
- The desire to modernise and improve the quality of service provision: and to meet the choice agenda and provide more care closer to home
- Significant capital and revenue costs attached to the proposals
- Workforce implications and affordability
- Desire to cause the least amount of disruption to patient services across the review area and to balance the needs of deprived, ethnic minority and special needs groups with appropriate geographical access and best overall fit of services

4.8.6 *Process issues*

- The joint health overview and scrutiny committee opted not to refer the proposals though three individual HOSCs subsequently chose to refer the matter to the Secretary of State for Health
- A widespread public engagement and consultation programme produced an extensive response, the decisions made were taken in the interests of the review area as a whole but were contested by individual communities causing delay and uncertainty for the wider population
- Absence from the consultation document of information about desired minima and maxima birth numbers per consultant-led maternity unit and of alternative options for site selection
- Concerns about the decision-making process for the selection of the eight sites for consultant-led maternity and paediatric services and lack of continuity of membership of the Joint Committee of PCTs
- Concerns about the lack of weighting given to the extent of public opinion in particular locations

OUR ADVICE

Adding value

5.1 **Introduction**

- 5.1.1 The Secretary of State for Health asked the Panel to undertake two reviews relating to the provision of health services in Greater Manchester – *Making it Better: Making it Real* covering inpatient services for children, young people, parents and babies in Greater Manchester, East Cheshire and High Peak and *Healthy Futures* covering acute services in the north east sector of Greater Manchester. This report concerns the proposals contained in *Making it Better* and should be read in conjunction with the Panel’s separate report on *Healthy Futures*.
- 5.1.2 *Making it Better* covers a large area, numerous diverse communities and a total population in excess of three million people. It also covers fourteen hospital sites (including the two current specialist children’s hospitals). The scale of this exercise is not be underestimated and the Children, Young People and Families’ Network is to be commended for its hard work and dedication in tackling such complex and contentious issues, especially as their work overlapped with a period of NHS organisational change.
- 5.1.3 The job of scrutinising such a large project was also no easy task and the Joint Health Scrutiny Committee deserve praise for examining the issue in such a balanced and measured manner. While the Joint HSC opted not to refer the matter to the Secretary of State for Health, it is understandable that three of the participating scrutiny committees most directly affected by the proposals should choose to refer the matter individually.
- 5.1.4 Views differ about the merits or otherwise of the option selected but the one aspect on which there is clear clinical agreement throughout Greater Manchester is that no change is not an option. It is also worth stating that these proposals are not about saving money, indeed all the options for change put forward involved significant capital and revenue consequences. These proposals are about improving services for people by strengthening primary and community services as well as the strategic location of inpatient services. The modernisation of these services for Greater Manchester is long overdue.

5.1.5 Recommendation One

The Panel believes that changes to maternity, neonatal and paediatric services are overdue given the need to provide safe, sustainable and accessible clinical services, changes to workforce regulations and other factors impacting on local health services.

5.1.6 The IRP was asked to advise on whether the proposals for changes to inpatient services for women, babies, children and young people would ensure the provision of safe, sustainable and accessible services for Greater Manchester, East Cheshire and High Peak. The issues of safety, sustainability and accessibility have been at the forefront of our considerations throughout this review.

5.2 Issues relating to consultant-led maternity services**5.2.1 Safety issues**

The safe provision of health services is of paramount importance. What constitutes safe practice is a constantly evolving concept – what was considered to be safe twenty years ago may no longer be considered safe by modern standards. NHS organisations have a statutory responsibility in relation to the standard of clinical care they provide. Standards for good practice in maternity services include:

5.2.2 Standards for good practice in maternity services

- The maternity standard of the National Service Framework for Children, Young People and Maternity Services
- The Royal College of Obstetrics and Gynaecology's (RCOG) standard for labour wards requires that dedicated consultant cover should be available for a minimum of 40 hours during the working week
- This standard specifies a minimum of 60 hours consultant cover per week by the end of 2008

5.2.2 *Standards for good practice in maternity services (continued)*

- The Postgraduate Medical Education and Training Board (PMETB) approves junior doctors' posts subject to compliance with appropriate training and supervisory standards
- The European Working Time Directive limits junior doctors' hours to 58 hours per week
- This reduces further to 48 hours per week in 2009
- Guidelines for Obstetric Anaesthesia Services, published in May 2005 by the Obstetric Anaesthetists Association (OAA)/Anaesthetic Association of Great Britain and Ireland (AAGBI), require that dedicated obstetric anaesthetic services are available in all consultant-led maternity units
- Revised guidance on minimum standards for the organisation and delivery of care in labour is expected to be published in 2007 by a joint working party of the RCOG, Royal College of Midwives (RCM), Royal College of Anaesthetists (RCA) and Royal College of Paediatrics and Child Health (RCPCH)

Such national standards and guidelines are developed for good reason – they enhance the safety of services

Reproduced from IRP report on maternity and paediatric services in North Tees and Hartlepool, December 2006

5.2.3 The Department of Health has this year published two further documents on maternity services:

- *Making it Better: For Mother and Baby – Clinical case for change*
- *Maternity Matters: Choice, access and continuity of care in a safe service*

These documents demonstrate the ever-evolving nature of standards for the provision of healthcare.

5.2.4 There is a broad consensus of clinical opinion in Greater Manchester that it is not possible to meet these standards within the current configuration of services and that a reduction in the number of consultant-led maternity units is inevitable. Meeting such standards is not simply a question of recruiting more staff to meet cover and rota requirements, even if finance would allow. Units require a sufficient throughput and case mix to enable staff to develop and maintain skills.

5.2.5 The reorganisation of maternity care must also result in a service that is fit and sustainable for the years to come. Forecasts derived from population and birth data⁸ suggest that there will be in the region of 35,000-37,000 births per annum in Greater Manchester by 2015.

5.2.6 The Panel heard evidence that, for the anticipated figure of 35,000–37,000 births by 2015, a total of no more than eight consultant-led maternity units across the review area would be appropriate. Clinical views expressed to the Panel supported this number which would ensure that each unit was of an appropriate size of between 2,700 and 6,600 deliveries per year. The Network has confirmed that concentration on eight sites would enable the immediate implementation of 60 hour dedicated consultant cover on labour wards and would also be compliant with all aspects of the European Working Time Directive (EWTD).

5.2.7 **Recommendation Two**

The Panel supports the proposal to provide consultant-led maternity services on eight sites in Greater Manchester.

5.2.8 While the Panel heard broad agreement on the number of future sites, it soon became clear from our evidence gathering sessions that the location of the eight units was a far more contentious issue. The Consultation document, *Making it Better: Making it Real*, lists five options (including a no change option) for the location of consultant-led maternity services. These options had been developed by the Network after extensive modelling work to examine maternity delivery patterns (that is, where women would choose to give birth). Following the consultation, in response to comments received, seven further options were developed by the Network for consideration by the Joint Committee of PCTs.

5.2.9 The Panel heard strong and heartfelt arguments in favour of a number of the options. The Network's analysis of the options considered by the Joint Committee of PCTs deemed there to be no discernable difference between any of the options for change (excluding the no change option) in terms of the safe provision of services. The Panel has seen no evidence to disagree with this analysis.

⁸ *Making it Better: Making it Real* Financial Assessment – Final Report

5.2.10 *Sustainability issues*

Sustainability requires that services should be stable for the foreseeable future taking into account the emergence of new and improved quality standards. It requires that patients receive care in buildings of an acceptable standard and life expectancy. It requires that care is provided for an appropriate critical mass of population and in compliance with relevant training requirements for all staff.

5.2.11 In considering the sustainability of services, the Panel was presented with a large amount of evidence about the pressure on maternity services capacity at St Mary's Hospital in central Manchester. This is due to the increasing numbers of people opting to live in the inner city and also the significant predicted rise in new communities living in that part of the city. The Panel also heard about the "pulling power" of the central site and the natural inward flow of births that could be anticipated under particular options.

5.2.12 St Mary's Hospital is part of a major new building programme currently taking place on the Central Manchester Hospital site that will result in new facilities for maternity, paediatrics and neonatal care becoming available in 2009. In discussions with representatives of the Central Manchester and Manchester Children's University Hospitals NHS Trust, the Panel was advised that, because of physical capacity constraints, the new maternity facilities would cater for a maximum of 6,600 births per year. In addition to physical capacity issues, there were also doubts about the desirability of creating a maternity centre with any greater capacity (see para 5.2.17 below).

5.2.13 Any option that takes the number of births anticipated at St Mary's Hospital beyond 6,600 must be open to question on sustainability grounds.

5.2.14 Work was commissioned by the Network to consider where births were expected to occur in 2015 under each of the options under consideration. This work was undertaken by Teamwork Management Services Ltd⁹. Using post code data of births in Greater Manchester for a three year period the anticipated hospital site to be chosen by women if their "local" site would no longer provide a consultant-led service was made using three different methods: distance to next nearest consultant-led site; peak time travelling time

⁹ Delivery spells using latest 2004-based ONS birth projections and 2005/6 activity baseline, *Making it Better: Making it Real* Financial Assessment – Final Report

by car to next nearest consultant-led site; and off peak travelling time by car to next nearest consultant-led site. Further evaluation was then undertaken to assess whether the results were considered “reasonable”.

5.2.15 The data indicates that several of the options would result in the number of births taking place at St Mary’s Hospital exceeding 6,600. Of the options most strongly supported by those who made representations to the Panel - options F(a), and G¹⁰ - the number of births per year predicted to take place at St Mary’s Hospital by 2015 would rise to 8,318 and 7,358 respectively.

5.2.16 These increases arise primarily as a result of the anticipated effect if the maternity services at North Manchester General Hospital were closed under option F(a), and services at North Manchester and Tameside General Hospital closed under option G. In both cases, the inward flow towards central Manchester as a place to give birth would result in unsustainable pressure on St Mary’s and for this reason the Panel considers that options F(a) and G are not viable.

5.2.17 The Panel heard some criticism¹¹ of the consultation process that optimum minima and maxima birth numbers per consultant-led maternity unit were not detailed in the consultation document yet this consideration formed a crucial part of the decision-making process. While there may be some validity in this criticism of the process, the physical capacity constraints at St Mary’s Hospital remain. Even if this constraint could be overcome, clinicians throughout the review area have consistently maintained that Greater Manchester does not need a “super-maternity centre” and the Panel agrees that such a centre at St Mary’s is neither necessary nor desirable.

5.2.18 *Accessibility issues*

In the context of this section, accessibility refers to the location of consultant-led maternity services. Access to antenatal and postnatal care is considered in section 5.6.

¹⁰ See table para. 4.6.3

¹¹ See para 4.7.7 Referral to Secretary of State for Health by Bury Healthier Communities Scrutiny Commission. Also evidence submitted by Salford Royal Hospital NHS Foundation Trust.

- 5.2.19 As discussed above, data on the predicted location of maternity deliveries suggests that any option that does not include a consultant-led service at North Manchester General Hospital would overload services at St Mary's Hospital. Equally important, while recognising that significant pockets of deprivation exist in many other parts of the review area, north Manchester is the most deprived area in Greater Manchester as well as having a significant minority ethnic population. In view of these factors, the Panel considers that consultant-led maternity services should continue to be provided at North Manchester General Hospital.
- 5.2.20 The other option strongly supported in evidence put to the Panel was option C which would retain consultant-led services at Hope Hospital, Salford and close the service currently provided at Tameside Hospital. There was a clear body of support amongst staff, residents of Salford and the local scrutiny committee to retain services at Hope Hospital. Much of the argument was based on the desire to retain level 3 neonatal intensive care at the Hospital. This issue is considered in the next section.
- 5.2.21 The main disadvantage of option C would be to retain three consultant-led maternity units relatively close to the centre of Greater Manchester whilst leaving a large area to the east of the review area without a consultant-led service.
- 5.2.22 All options considered by the Joint Committee of PCTs would retain consultant-led maternity services at the Royal Bolton, Royal Oldham, Stepping Hill, South Manchester, and the Royal Albert Edward Hospital, Wigan. The Panel considers that these locations provide an equitable distribution of services throughout the review area.
- 5.2.23 The Panel accepts that a reduction in the number of consultant-led maternity units across the review area will inevitably cause disquiet in the locations where services are discontinued. Nevertheless, a reduction in the number of sites is necessary. Having considered the arguments carefully, the Panel concurs with the view of the Joint Committee of PCTs that the locations identified under option A provide an appropriate distribution of services throughout the review area.

5.2.24 Recommendation Three

Having considered the proposals for eight locations for the provision of consultant-led maternity services from a wide range of perspectives, the Panel supports the proposed locations for the future provision of these services as described in option A of the consultation document *Making it Better: Making it Real*.

5.3 Issues relating to neonatal services**5.3.1 Safety and accessibility issues**

All of the hospitals covered by the review currently provide some form of neonatal care and under the proposals each of the designated hospitals providing consultant-led maternity and paediatric care would continue to provide level 1 special care baby cots or level 2 high dependency cots.

5.3.2 The most specialised neonatal intensive care (level 3) is currently provided at St Mary's Hospital and Hope Hospital in Salford. The retention and development of neonatal intensive care at St Mary's Hospital was an accepted fact within the consultation and the service will move into new facilities on completion of the new building in 2009. Under option A, level three neonatal intensive care would additionally be provided at two new units at the Royal Bolton and the Royal Oldham Hospitals.

5.3.3 The Panel heard strong representations in support of the continuation of level three care at Hope Hospital: in view of the existing links to other related specialist services (renal services, neurology, radiology); its close proximity to areas of high deprivation in Salford; and the well-established and highly regarded centre that already exists.

5.3.4 The Panel accepts that access to associated clinical services for babies and children are an important factor in the provision of neonatal intensive care. Access to these services must be available wherever neonatal intensive care is located.

5.3.5 While Salford does indeed suffer from high levels of deprivation in several of its wards, there are other areas in Greater Manchester where deprivation is of a similar or higher level. The nature of neonatal intensive care means that patients can potentially be transferred to a unit from many miles away. The Network contends that neonatal

intensive care services should be provided alongside maternity units with the largest number of births. Accessibility maps produced by the Network indicate that the best coverage for the overall population of Greater Manchester would be achieved by placing neonatal intensive care at St Mary's, the Royal Bolton and the Royal Oldham Hospitals.

5.3.6 Relocating a service is not a proposal to be suggested lightly but the Panel agrees with the decision of the Joint Committee of PCTs that neonatal intensive care would best be provided from centres with the largest number of births. The Panel appreciates that transferring the service from Hope Hospital will take time and significant effort before it is firmly re-established in the new location. The neonatal intensive care unit at Hope Hospital is a highly rated service founded on the quality of its staff. It is vital that the quality of this service is preserved. The move is not a closure but a transfer to new locations that will allow the service to develop and improve even further.

5.3.7 *Sustainability issues*

South Manchester Hospital in Wythenshawe presented evidence to the Panel for that hospital to be one of the sites providing level 3 neonatal intensive care. The unit currently provides level 2 neonatal care and in some instances provides care equivalent to level 3.

5.3.8 The Network's analysis of the neonatal care provision required indicates that for a population the size of Greater Manchester, three neonatal intensive care units would be an appropriate level of coverage and would be in line with national guidance¹². The Panel considers that three neonatal intensive care units is an appropriate number for the Greater Manchester area and is satisfied that the service provided by St Mary's Hospital is sufficient for the population of south Manchester.

5.3.9 **Recommendation Four**

Taking into account the guidance provided in the Report of the Neonatal Intensive Care Services Review Group (Department of Health 2003), the Panel supports the development of a clinical network of three level 3 neonatal intensive care units located at St Mary's, the Royal Bolton and the Royal Oldham Hospitals.

¹² Report of the Neonatal Intensive Care Services Review Group, Department of Health, April 2003

5.4 Issues relating to inpatient paediatric services

5.4.1 Safety issues

The nature of paediatric services has changed markedly in recent years. Today's paediatric care places a strong accent on community-based care, outpatient assessment and very short lengths of hospital admission. Evidence on the mode of travel for children attending A&E indicates that most arrive by private car and, after assessment and treatment, are able to return home without admission to a ward. For those that are admitted, inpatient length of stay is on average just one day which means that the majority of children return home very quickly.

5.4.2 Maternity care, neonatology and paediatrics have a number of linkages that make their co-location desirable, for example neonatal and paediatric support for newborn babies. The Panel heard criticism of the decision-making process adopted by the Joint Committee of PCTs that eliminated Hope Hospital from the selection of sites to provide consultant-led maternity care because of the current absence of a co-located paediatric service at the hospital¹³.

5.4.3 Representatives of the Trust and of the Salford Health and Social Care Scrutiny Committee cited a report on neonatal care¹⁴ produced by Teamwork Management Services Ltd quoting the Department of Health's 2003 Neonatal Intensive Care Services Review Group that "*there is no requirement for the very largest neonatal centres to be adjacent to paediatric units*". The Panel accepts that for a level three, tertiary neonatal service this may be practicable though it considers that in a large conurbation like Greater Manchester it is desirable wherever possible for inpatient paediatrics to be co-located with level 1 and 2 neonatal services. That argument notwithstanding, the Panel's support for the future location of consultant-led maternity, neonatal and paediatric services as described in option A is based on the desire to see the most appropriate location of services rather than the current absence of paediatric services at Hope Hospital.

¹³ Paediatrics is not currently located at Hope Hospital largely for historical reasons related to the hospital's close proximity to the Royal Manchester Children's Hospital, Pendlebury.

¹⁴ Neonatal Medicine Report, Review of Intensive and High Dependency Care for Greater Manchester, East Cheshire and High Peak Children and Young People's Network, February 2005

5.4.4 Sustainability and accessibility issues

The other unit currently not providing inpatient paediatric services is North Manchester General Hospital. This is because of the close proximity of Booth Hall Children's Hospital. Under the proposals, prior to the closure of Booth Hall Hospital in 2009 (when the new unit at St Mary's Hospital opens), a new inpatient paediatric unit would be built on the North Manchester site.

5.4.5 It was put to the Panel that, given developments in the provision of paediatric services, building a new unit on the North Manchester site may not be justified. On the other hand, the area surrounding North Manchester General Hospital is accepted to be the most deprived in the review area. Residents would clearly benefit greatly from a new modern unit with appropriately sized inpatient provision.

5.4.6 **Recommendation Five**

The Panel agrees that paediatric services should be co-located with consultant-led maternity and neonatal services on the eight selected sites as described in option A of the consultation document *Making it Better: Making it Real*.

5.5 **Bringing the discussion so far together**

5.5.1 A large number of options for the location of consultant-led maternity and paediatric services were explored by the Network and the Panel has examined each of them. The Panel accepts that in seeking to concentrate services onto eight sites there will inevitably be a perceived gap in service provision somewhere. This is most keenly felt in areas to the north of the M60 – Bury, Rochdale and the Rossendale Valley.

5.5.2 In taking evidence, the Panel tested the argument about whether nine consultant-led units could be maintained across the review area. We were advised that this would create significant workforce issues – to meet EWTD and other standards would require significant additional hospital-based staff across all staff groups and at all grades. This would, in turn, compromise the ability to move more services into community settings. Indeed, the Panel heard some evidence that a reduction in the number of consultant-led units to seven would be clinically justifiable but believes that the Joint Committee of PCTs was correct not to pursue this option. The Panel considers that consolidation onto eight sites is an appropriate step to take.

- 5.5.3 Similarly, the relocation of level 3 neonatal intensive care services to three sites in Bolton, Oldham and St Mary's will result in safe, sustainable and accessible care.
- 5.5.4 Overall, the Panel is satisfied that the sites selected for the provision of consultant-led maternity, paediatric and neonatal services – as described in option A in *Making it Better: Making it Real* - are appropriate.
- 5.5.5 The Panel appreciates that moving services and relocating staff is not a matter to be taken lightly. The transfer of skilled staff will require careful management and appropriate human resources policies to be put in place. However, the staff we have met on our many visits to units throughout Greater Manchester are both highly dedicated and highly adaptable and with appropriate policies in place their special skills can be retained for the benefit of the wider community.
- 5.5.6 Similarly, the Panel appreciates that some residents will have concerns about the loss of local services and potential difficulties with transport. It is important to remember that most antenatal and postnatal care, and paediatric outpatient appointments will continue to be provided locally. Level 1 and 2 neonatal care will be provided from eight locations. More is needed though - the development of primary and community care locally, more choice in maternity care and improvements in public and community transport links are all essential elements to providing a better service in the future. These issues are addressed in more detail in the following sections. They are as important to the overall provision of healthcare for women, children and young people across Greater Manchester as the implementation of the changes to inpatient maternity, neonatal and paediatric services. Implementation of the overall package is essential to proceeding in the best interests of local people.
- 5.6 **Primary and community developments**
- 5.6.1 *Making it Better: Making it Real* consulted only on the proposals for the number and location of inpatient maternity, neonatal and paediatric services. These are, of course, only a small part of the overall range of healthcare services provided for women, babies and children. The proposals provide an opportunity for a significant increase in the provision of services in the local community.

- 5.6.2 This is in line with government policy on providing care closer to where people live¹⁵. The maternity standard of the Children's National Service Framework (NSF) for children, young people and maternity services requires that a range of antenatal care and postnatal care services be available locally. Other guidance, such as the NSF for Children and Every Child Matters¹⁶ set standards for the integrated delivery of children's services across health, social services and education.
- 5.6.3 Some good progress has already been made. The Panel heard about the development of primary care resource centres in Bolton. Panel members also visited a LIFT centre in Wythenshawe to see the range of health and related services that can be provided in the heart of a community. The co-location of NHS services with other agencies was particularly striking.
- 5.6.4 The Panel heard evidence of the intention to greatly expand children's community nursing teams and of plans to build up to 35 LIFT (local improvement finance trust) centres from which primary and community services could be provided. These sites will require either new capital build or refurbishment of existing capital stock. It is anticipated that there will be a 3-5 year lead-in phase before the new clinical model can be fully implemented.
- 5.6.5 It is essential that these developments are in place and fully operational before changes to inpatient services commence.

5.6.6

Recommendation Six

Developments in community and primary care must be successfully introduced before changes to inpatient services are implemented. Such developments must ensure that antenatal and postnatal care and child health services are accessible locally wherever possible and fully integrated with other relevant services including social care.

¹⁵ Our health, our care, our say: a new direction for community services. Health and social care working together in partnership. Department of Health

¹⁶ Every Child Matters: Change for Children, HM Government

5.7 **Increasing choice in maternity care**

- 5.7.1 Maternity Matters: Choice, access and continuity of care in a safe service (Department of Health, April 2007) highlights the Government's "*commitment to developing a high quality, accessible maternity service through the introduction of a new national choice guarantee for women. This will ensure that by the end of 2009, all women will have choice around the care that they receive, together with improved access to services and continuity of midwife and support*".
- 5.7.2 The Panel acknowledges that the reduction in the number of consultant-led maternity units from twelve to eight will involve greater travel for some women at the time of birth. For the majority of women, however, pregnancy and childbirth is a normal physiological process in which clinical intervention should only be used where indicated. In many instances, women can be most appropriately cared for by a midwife.
- 5.7.3 *Making it Better: Making it Real* stated that the future pattern of MLUs across the review area will depend on local circumstances and demand. The Panel heard about plans to introduce a midwife-led unit (MLU) at the Royal Bolton Hospital. The Panel considers that each of the other sites identified under option A should similarly consider the demand for a midwife-led service co-located with the consultant-led service.
- 5.7.4 Concern was expressed to the Panel about the lack of choice in place to give birth north of the M60 motorway should the proposals (as described in option A) proceed. The Panel considers that a *standalone* midwifery-led unit would be a suitable means of providing further choice to residents in this part of the conurbation. We understand that plans to establish MLUs in the Rossendale Valley are already in development and believe that consideration should be given to establishing a unit at Fairfield Hospital in Bury.
- 5.7.5 We also understand that the Trafford Healthcare NHS Trust has held discussions with the Central Manchester and Manchester Children's University Hospitals NHS Trust about the possibility of establishing a *standalone* MLU at Trafford Hospital. A successful MLU is already operating at the Hope Hospital, Salford. The Panel considers that its continuation as a standalone unit would also be worthwhile.

5.7.6 It is important that all options for the development of MLUs at appropriate locations are now explored in detail and that work proceeds as quickly as possible in confirming their locations.

5.7.7 **Recommendation Seven**

The issue of choice for maternity service users must be formally addressed by the Children, Young People and Families' Network. The demand for and feasibility of midwifery-led care in the eight units together with *standalone* units at Bury, Salford and Trafford should be fully explored.

5.8 **Transport issues**

5.8.1 The difficulty of travelling around Greater Manchester was emphasised by many of those who submitted evidence to Panel. We do not underestimate these concerns – particularly those dependent on public transport - but found on our visits that transport links were generally good with an extensive motorway network and tram, train and bus links. We also understand that the Greater Manchester Passenger Transport Executive has major plans for the future development of the public transport system.

5.8.2 The great majority of maternity and paediatric care will be provided locally. Nevertheless, improvements to the public and community transport network will be vital to ensure suitable access for those requiring care from any of the inpatient sites.

5.8.3 The co-operation of the local ambulance service will be equally important. In discussions with the Panel, representatives of the North West Ambulance Service NHS Trust expressed concern about the current configuration of maternity services across Greater Manchester – in particular, instances when maternity units have temporarily been forced to close to new arrivals having reached their capacity. Ambulance Trust representatives were satisfied that the concentration of consultant-led services onto eight sites would ensure that each location is appropriately staffed and equipped to deal with demand.

5.8.4 The Ambulance Trust confirmed that the proposals for both *Making it Better* and *Healthy Futures* would have implications for resources and staff training and would require the development of new protocols. Nevertheless the Ambulance Trust considered that, overall, both sets of proposals were manageable and would lead to better healthcare.

5.8.5 Recommendation Eight

The new location of services in Greater Manchester will mean that patients, their families and friends, and staff are more dependent on good public transport and good physical access to hospital sites. Local authorities and the local NHS should work closely with the transport authorities to put in place much improved public and community transport access to hospital sites from local communities.

5.9 Implementation of proposals

5.9.1 The services under consideration within these proposals cover a population of more than three million people. They are currently provided from 14 inpatient sites administered by nine acute trusts plus the ambulance trust and commissioned by more than a dozen primary care trusts.

5.9.2 The transfer of services amongst inpatient sites together with the shift of more services into community settings will require careful and methodical management. It will require close co-ordination between all the NHS bodies concerned to ensure comprehensive and sympathetic support for the staff concerned. It will require efficient and complementary communications to ensure that everyone – public, patients, families and staff – are kept abreast of changes as the work progresses.

5.9.3 Recommendation Nine

The scale of change to maternity, paediatric and neonatal services is so significant that implementation of the changes must be approached in a methodical and well thought out manner. The NHS bodies concerned must work together in a cohesive, constructive and co-ordinated way to develop their human resources functions, to build on existing internal and external communications strategies, and to ensure successful implementation of the proposals.

5.10 Link to *Healthy Futures*

5.10.1 Within the north east sector of Greater Manchester, the situation is even more complex with consideration of the proposals in the *Healthy Futures* consultation to be taken into account.

5.10.2 The Secretary of State for Health asked the Panel to undertake separate but interlinked reviews of the two sets of proposals. The Panel has, throughout its considerations, sought to ensure that the views and recommendations expressed in both reports are compatible with each other. In implementing the proposals, the NHS in the north east sector needs to take this a stage further co-ordinating activity as a single exercise.

5.10.3 **Recommendation Ten**

The Panel's recommendations on Healthy Futures consultation should be read in conjunction with these recommendations and implementation of both sets of recommendations throughout the north east sector of Greater Manchester should be co-ordinated as a single exercise by the NHS bodies concerned.

5.11 **Overall co-ordination**

5.11.1 To add even further to the complexity, *Making it Better* and *Healthy Futures* are not the only proposals under consideration that will affect some residents to the north of Greater Manchester. *Meeting Patients' Needs*, which outlines proposals for changes in East Lancashire including services at the Royal Blackburn Hospital and Burnley General Hospital, has a further bearing on healthcare provision for people living in the Rossendale Valley.

5.11.2 The SHA should assume responsibility for ensuring the appropriate continuity of health services for residents of the Rossendale Valley.

5.11.3 **Recommendation Eleven**

NHS North West (SHA) should oversee and monitor the implementation of the two sets of proposals for Greater Manchester as well as the reconfiguration of clinical services in East Lancashire. The SHA should assume lead responsibility for ensuring the continuity of safe, sustainable and accessible services for those people affected by all of the changes.

5.12 **A final comment**

5.12.1 *Making it Better: Making it Real* was the result of many years hard work by the Children, Young People and Families Network. The consultation was the largest exercise relating to

the reconfiguration of local health services undertaken in England to date and elicited a quarter of a million responses.

5.12.2 It was always going to be the case that not everyone would agree with the outcome of a strategic review to identify the appropriate location of future services. Some of the work associated with the consultation has been criticised as has the decision-making process.

5.12.3 Overall, whilst acknowledging that there are a number of learning points for the future, the Panel considered the Network's handling of this large and complex issue to have been of a high standard.

SOME PERSONAL OBSERVATIONS

Dr Peter Barrett, Chair IRP

I am very grateful to all those who gave their valuable time to meet and inform us about their perspectives on *Making it Better: Making it Real*.

The proposed changes to maternity, paediatric and neonatal services for over three million people living in the Greater Manchester area have been the most complex yet considered by the IRP. Given this complexity, it was of the greatest importance that the Panel maintained its focus on the three key areas of our Terms of Reference; those of safety, sustainability and accessibility. It was inevitable that given the scope of the proposals some localities were bound to feel a sense of profound loss and fear that the proposed services would not be as safe as those that currently exist in their area. We took their concerns very seriously as evidenced by the quantity of written information reviewed and the recording of evidence presented by the large number people we met in various locations throughout Greater Manchester. We had to balance their heartfelt anxieties about the outcome of the consultation and the consultation process against the wider health needs of the region and the pressing drivers for change.

The preceding report outlines the long and tortuous history of previous attempts to change the delivery of paediatric, neonatal and maternity services. It records the stagnation resulting from previous strong opposition to change. It was clear that the vast majority of those we met agreed that change was necessary and that further delay was not acceptable. It was noteworthy that the Joint Health Scrutiny Committee decided not to refer the changes to the Secretary of State for Health. A majority of localities in the Greater Manchester area agreed that the proposed changes should go ahead. Could the opposing minority of local health overview and scrutiny committees argue their cases sufficiently well to persuade us that the proposals were not in the best interests of all the residents of Greater Manchester? They certainly put forward their individual cases with passion and made many valid points including building on successful teams, maintaining levels of care in very deprived areas, accessibility, reduction in choice and fears of a breakdown in services if a precipitate rush to ill-defined and developed community care took place.

Just as passionate were those in other, often equally deprived, areas who feared that further stagnation and an eventual breakdown in services would occur if the proposed changes did not go ahead. This was supported by the vast majority of clinical opinion. It was evident that no one set

of proposals was going to find favour with all concerned. We, as an independent panel, had to consider what would happen to other areas in Greater Manchester if we accepted an opposing HOSC view. It was evident that the population of just over three million will generate about 35,000-37,000 births a year and it would be difficult to sustain more than eight consultant-led maternity units on these numbers. This seemed to be accepted by the majority of those we met. If we agreed that a particular maternity unit not currently in the proposed list should remain open, then which other unit would have to close and what would be the impact of that on surrounding services?

The Network Team leading on the consultation have spent years gathering information and assessing the implications of various proposals. In my view they have tried to be as inclusive as possible in gathering opinion. They achieved the remarkable distinction of receiving almost a quarter of a million responses to their options for change and took the step of having the results of consultation externally assessed.

However, given the scale of the changes it is not surprising that there have been certain criticisms about the process. If we accepted the criticism as valid the IRP still had to consider whether a different approach would have led to a safer or more sustainable future for the relevant health services. After long and very careful discussion it was the unanimous view of the Panel members that the proposals under Option A selected by the Joint Committee of PCTs and supported by the majority of the Joint HSC were on balance the most effective way forward. It seemed important, however, to make sure that patient choice was advanced by the provision of midwife-led units in Bury, Salford and Trafford and the co-location of MLUs alongside consultant-led maternity units.

Having spent some time travelling around the area I certainly appreciated the comments of Manchester residents when talking about access to services. Greater Manchester is a congested conurbation with high levels of deprivation. I think it important for joint working to take place to find innovative solutions to health service access. This should in part involve a greater emphasis on outreach services in the community bringing care closer to home but also the establishment of dedicated transport links to and from hospitals, linking with park and ride sites and transport termini for staff, patients and visitors.

I was reminded during the course of this work that care is provided by dedicated teams of people, not by bricks and mortar. I fully understand the fear of losing a service from a particular and

familiar building but the people of Manchester deserve the best care delivered in the most appropriate location to ensure a safe and sustainable future. I believe that our recommendations to the Secretary of State for Health, if accepted, will help the people of Greater Manchester benefit from the undoubted skills available to them.

List of abbreviations used

AAGBI	Anaesthetic Association of Great Britain and Ireland
DHG	District general hospital
EWTD	European Working Time Directive
HDU	High dependency unit
HSC / HOSC	Health (Overview and) Scrutiny Committee of local authority
<i>Healthy Futures</i>	Healthy Futures. Public consultation on the future of health care in the north east of Greater Manchester
IRP	Independent Reconfiguration Panel
LIFT	Local Improvement Finance Trust
<i>Making it Better</i>	Making it Better: Making it Real. Public consultation on changes to healthcare services for children, young people, parents and babies in Greater Manchester, East Cheshire, High Peak and Rossendale
MBC	Metropolitan Borough Council
MLU	Midwife-led unit
NHS	National Health Service
NICU	Neonatal intensive care unit
OAA	Obstetric Anaesthetists Association
PCT	Primary care trust
PMETB	Postgraduate Medical Education and Training Board
RCOG	Royal College of Obstetricians and Gynaecologists
RCM	Royal College of Midwives
RCPCH	Royal College of Paediatrics and Child Health
SCBU	Special care baby unit
SHA	Strategic health authority
The Network	Children, Young People and Families' Network for Greater Manchester, East Cheshire and High Peak