Office for Public Management

Evaluation of Making it Better

Evaluating the programme to reconfigure maternity, neonatal and children's services in Greater Manchester

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OPM
252B Gray's Inn Road,
London WC1X 8XG

tel: 0845 055 3900
fax: 0845 055 1700
email: office@opm.co.uk
web: www.opm.co.uk

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Author	Lauren Roberts
Quality assurance by	Cath Broderick (We Consult); Leila Williams (Healthier Together); Carol Ewing (CMFT); Dr Heather Heathfield (OPM)
Contact details	
Main point of contact	Lauren Roberts
Telephone	07920 492222
Email	lroberts@opm.co.uk

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Disclaimer:

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Executive summary

In 2013, the former North-West Strategy Health Authority commissioned an evaluation of the 'Making it Better' reconfiguration programme that took place in Greater Manchester between 2000 and 2012. The purpose of this evaluation was to review good practice and lessons learnt from the management and delivery of the change programme, that could be of interest to other health economies planning service changes in future. It was not intended to evaluate the specific quality, outcomes and productivity benefits of the service changes themselves.

This report presents the many and varied lessons emerging from the Making it Better reconfiguration, which will be of interest to stakeholders across the health and care sector. The evaluation has involved a retrospective review of the processes involved in Making it Better, with the aim of generating transferable learning for others considering or currently undertaking major service change.

Although the policy and financial landscape has changed significantly since Making it Better was originally conceived and implemented, the programme generated considerable learning on how to manage programmes of service change that are likely to be relevant to today's system and context.

Thematic analysis of the emerging findings led to the identification of eight core themes underpinning Making it Better. The key learning emerging under each theme can be summarised as:

- **Clinical and managerial leadership**: Strong clinical and managerial leadership of a healthcare service reconfiguration was vital; clinicians should instigate the process, supported by managerial leadership. Leadership should remain strong and consistent throughout what can be a lengthy process; effective governance and reporting structures must work in tandem with informal relationships in order to drive forward the process. Leaders should define the parameters of the reconfiguration and generate buy-in to the shared vision, prior to developing specific options for change. Clinical leaders can play a vital role in this process by helping to ensure credibility and clinical viability of the proposals for change; make sure that clinicians are directly involved in the communications and engagement. Making it Better suggests that certain groups of clinicians and senior executives may initially be resistant to changes to their local services. However, they are more able to give their support if they are engaged early, and if it is presented effectively in the context of the benefits of system wide change, based on a solid clinical rationale.
- **Engagement and consultation**: Extensive engagement with all potential stakeholders should be planned and undertaken at the earliest opportunity. In the case of Making it Better, it was important to generate buy-in to the principles of the reconfiguration and case for change, before consulting on specific options. Effort should be put into engaging with seldom heard stakeholders, and empowering community representatives to undertake engagement and consultation activities. Making it Better shows that it helps to have a single succinct and clear message about the purpose of the proposed reconfiguration. Throughout the process, engagement was recorded, including numbers of individuals and groups involved, the nature of the engagement and the feedback received.

- **Politics**: Local and national politicians are important stakeholders to engage when planning any service reconfiguration. Making it Better found that whilst politicians may support the vision for future service provision, specific options involving local unit changes or relocations may well prove contentious. Maternity, neonatal and children's services are particularly high profile. In the context of the new commissioning system, it is particularly important for commissioners to begin dialogue and build relationships with politicians around the need for service change, before detailed plans for major reconfigurations are formulated, and to sustain that engagement as plans begin to be conceived and implemented. Having a dedicated PR and engagement lead, as well as engagement specialists who can meet face-to-face with politicians at their convenience throughout the reconfiguration process, was vital for Making it Better.
- **Design**: Extensive workforce and financial modelling were undertaken to ensure the reconfigured services under Making it Better met national standards and guidelines. Stakeholders from service areas within Greater Manchester and other local and national organisations were engaged at the earliest opportunity in order to inform the design. This was vital in order to ensure the knock-on implications of the reconfiguration were considered during the design stage of the process. Careful decisions also had to be taken regarding the level of detail to share with different stakeholder groups, to avoid providing too much complex information whilst simultaneously ensuring transparency in the decision making process. To be credible, the rationale for change focussed on service improvement, sustainability and safety, and not solely on economic drivers. This was supported by multiple robust data sources and detailed analysis. It was vital that clear, agreed governance arrangements were established at the outset, to provide clarity and transparency regarding the decision making process. Inconsistencies in pathways can cause issues for patients who use services across Trusts, and therefore it was important to explain and give exemplars of patient pathways prior to implementation. Putting in place on-going outcome measurement helped to reassure stakeholders that the key objectives continue to be met.
- **Programme management**: The dedicated, consistent and highly skilled programme management team for Making it Better proved critical to its success. Recruiting programme managers with the right skills and experience to implement the reconfiguration process was vital; reconfigurations can take many years to realise, and require extensive management and coordination throughout. The experience of Making it Better suggests that reconfigurations cannot simply be 'added on' to people's existing roles; sufficient capacity has to be made available. Resourcing decisions should be informed by the scale of the reconfiguration: number and range of units under review; the level of potential controversy; the level of preparatory work already undertaken; the feasibility of secondments; and the proposed reconfiguration timescales. Establishing a core programme team for the different phases of the reconfiguration, strengthened by bringing in expert consultants at key points in the process, can help to ensure the programme benefits from the necessary expertise and capacity at critical points.
- **Collaborative working:** Making it Better benefitted from the informal networks which were in place across Greater Manchester. Senior clinicians and leaders took the time and effort to generate buy in across staff and stakeholders at all levels, building a sense of 'moral purpose' to successfully realise the reconfiguration. This sense of 'all being in it together' proved vital in overcoming some of the challenges and resistance encountered. Although some groups were resistant to the changes, engaging wider stakeholders

during early stages of discussions enabled difficulties to be explored and mitigation plans to be developed, and this helped to provide a whole system perspective. This included partners participating in programme meetings at operational and strategic levels where appropriate, and also engaging them on a more direct one-to-one basis.

- **Workforce planning and development:** Extensive engagement took place with national organisations including trade unions and Royal Colleges, in order to inform the workforce modelling of Making it Better. Clinical Advisory Groups played a vital role in ensuring the workforce plans were feasible, equitable and would improve patient safety. Extensive staff engagement took place, with aspiration interviews and team building in the new units forming important parts of the process. The Making it Better Network Team benefited from the expertise of a specialist HR consultant, with a good understanding of the TUPE process and experience of workforce planning, augmented by external expert workforce advisers. The Making it Better programme considered training and skills requirements, and these were carefully factored into the process and resourced accordingly.
- **Financial planning:** Financial planning was undertaken to ensure Trusts understood the financial implications of the reconfiguration, and to ensure sufficient resources were available to finance the transfer process and capital builds. This forward planning was vital; and important to consider potential financial implications for other services. National standards and statistics including staffing rates, birth rate predictions and the European Working Time Directive (EWTD, later termed EWT Regulation) were considered as part of the financial modelling. Ensuring transparency in the financial planning and assumptions taken; can help engage the public, politicians and clinicians.

How to use this report

This evaluation report has been generated through interviews and analysis with participants involved in the planning and delivery of the Making it Better programme between 2000 and 2012. It has been developed as a supportive, shared learning resource that may be of value to organisations planning major service changes in future. As this is a retrospective review, and pre-dates the establishment of the new clinical commissioning system that went live on 1 April 2013, it is not intended to provide a definitive legal or policy position on how major service changes or reconfigurations should be planned and delivered. **It is not intended to be regarded as formal guidance and it is not officially endorsed either by NHS England nor any other national health system bodies.** Commissioners, providers, local authorities and other groups involved in major service changes are welcome to adapt and apply any learning and findings in this report as they find relevant, and as would be appropriate to their specific circumstances**.**

In December 2013, NHS England published 'Planning and delivering service changes for patients'[1] which provides advice and good practice for commissioners on the planning and delivery of service changes. This built on the former reconfiguration framework that operated prior to 2013, under which Making it Better was undertaken, and brought this up to date for the new clinical commissioning system, also reflecting new relationships between the NHS and local authorities through health and wellbeing boards, and the new regulatory regimes.

[1] http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

Commissioners and other health and care organisations considering major service changes are recommended to consult ‘Planning and delivering service changes for patients’ for current guidance.

Introduction

'Making it Better' involved the reconfiguration of maternity, neonatal and children's services across Greater Manchester and was completed in 2012. In January 2013, the Strategic Health Authority (SHA) for the North West contracted the Office for Public Management (OPM) to undertake an evaluation of Making it Better. NHS England took oversight of the project from April 2013, following the creation of the new clinical commissioning system and closure of strategic health authorities.

The evaluation was commissioned to capture valuable learning from Making it Better to help inform future major service change and reconfiguration in the NHS. The objectives were to:

- Increase the evidence base on the effective planning and delivery of major service change programmes in the NHS.
- Capture specific and generic lessons and best practice that may be beneficial to future service change programmes.
- Provide a clear understanding of the process of implementing major change, to support such change being managed effectively, with greater consistency and to save others 're-inventing the wheel'.
- Enable commissioners and providers of NHS services to identify which approaches should be considered when developing and implementing proposals for major service change to support the delivery of improvements in health outcomes.

The evaluation has focused on the implementation of Making it Better, whilst also considering the pre-consultation and consultation phases of the process. Consequently, the evaluation has engaged a wide range of stakeholders who have been involved in or affected by the reconfiguration. These include senior leaders and managers, programme staff, clinicians, commissioners, media representatives and politicians.

Introduction to this report

This report presents the key findings emerging from the evaluation. The findings from the various strands of evaluation activities have been thematically analysed and presented in this report, enabling stakeholders to gain an understanding of the whole process of the reconfiguration and key learning arising. Alternatively, stakeholders can focus in their specific area of interest, with the findings and key learning points being presented by theme and by learning for specific stakeholder groups.

The report presents an overview of Making it Better, providing a descriptive narrative of the processes undertaken and exploring the successes and challenges encountered, as well as the key learning points arising.

This report will be of use or interest to commissioners, clinicians and managers working across the NHS, including those within children's, neonatal and maternity services, as well as those from other disciplines. It provides both specific and generally applicable learning emerging from the Making it Better reconfiguration.

This evaluation report will be published as part of a suite of wider good practice for clinical commissioning groups. As a retrospective review of a reconfiguration scheme, it should be read as a supportive resource, rather than a definitive statement of national policy.

Methodology

The evaluation of Making it Better took place between January and September 2013, culminating in this report. We selected the methodology based on the following principles:

- Capturing data from a wide range of stakeholders who were involved in (and in many cases, impacted by) Making it Better.
- Avoiding 'reinventing the wheel', drawing on existing reports where possible to inform our findings.
- Regular engagement with a Steering Group comprised of key stakeholders who were involved in Making it Better. This group helped to agree the parameters of the evaluation, refine our approach, inform research tool design and validate emerging findings.
- Minimising the burden on research participants.

The methodology that we adopted is outlined below.

Project initiation – We met with members of the Steering Group at the evaluation inception to agree the parameters and scope of the study, and to capture existing data, reports and documents for review. Following this meeting, the data collection tools were developed.

Scoping interviews – During the early stages of the evaluation, we carried out scoping interviews with all Steering Group members. This enabled us to capture valuable insights regarding the processes followed as part of Making it Better, and to identify key areas of focus. Scoping interviewees also identified the stakeholders for us to engage as part of the evaluation, signposting and providing contact details where appropriate.

Document review – We carried out an in-depth review of the documentation provided, capturing evidence of the monitoring arrangements and drawing on previous reviews and evaluations conducted into Making it Better, including the external evaluation of the consultation process. The full list of documents reviewed is appended in Appendix B.

Reference to an underlying logic model – Drawing on the scoping interview data and document review, we developed a 'pathways to outcomes' logic model. This clearly articulates the relationships between the inputs and activities, and the intended outputs and outcomes (early and longer term) of the reconfiguration. This model demonstrated the complexity of the Making it Better processes, and helped us to ensure that we considered in detail the full range of elements involved in the programme, including the role, importance and impacts of each element.

Stakeholder interviews – We produced a briefing note for all stakeholders that we sought to engage in the evaluation (appended in Appendix A). This was emailed to all stakeholders identified by the Steering Group, with chaser emails sent to encourage participation by non-responders. Interviews took place with over 70 different stakeholders, including Members of Parliament, senior clinicians, Trust managers, commissioners and members of the programme team. The full list of interviewees is appended in Appendix C. Interviews were semi-structured, informed by the participants' engagement in Making it Better and issues that they felt were particularly pertinent to reflect upon.

Analysis of emerging findings – Data captured via the in-depth interviews and document review were mapped and analysed to identify key themes. We used traditional approaches to

qualitative analysis, and organised the data by constructing a thematic framework, identifying a number of themes under which data were sorted and then analysed. This framework consisted of hypotheses developed during the fieldwork, alongside the original overarching evaluation questions. In addition to thematic analysis, we also undertook investigative analysis, developing and testing hypotheses, bringing added depth to findings.

Validation of emerging findings – Once we had identified key themes emerging from the evaluation findings, we held interactive workshops with Steering Group members and representatives from national organisations, in order to validate the findings and identify areas for further exploration in the final stages of fieldwork (see Appendix C for details of the participants). The findings relating to individual themes were subject to further review and validation by Steering Group members.

Stakeholder workshops – In addition to the workshop with representatives from national stakeholder organisations, further workshops took place with clinicians and commissioners. These explored the critical issues that clinicians, commissioners and providers are grappling with when considering or undertaking major service change in the current climate, as well as how best to ensure utility of the outputs produced from this evaluation.

The findings from the above processes have informed this report. It is anticipated that the evaluation report will be supplemented by a range of additional outputs produced during 2014, to meet the specific needs of different audiences.

How to read this report

This report presents an overview of all of the evaluation findings. The findings are presented thematically. With this in mind, some readers may wish to focus on specific sections, whilst others will want to review the entire document.

When reviewing the findings, it is important to note the following caveats:

1. Timescale of Making it Better – Making it Better was fully implemented by Autumn/Winter 2012, having spanned a twelve year period from inception to completion. The clinical discussions had begun at least 20 years before. During this time, personnel changed across Greater Manchester, leading to some people being only involved in partial aspects of the process. Others who were involved during the early or middle stages of the process have since left the NHS, or were otherwise not available for interview. This means that some interviewees did not have a full perspective of the entire process from start to finish, and could only offer partial reflections. Additionally, as might be expected, stakeholders were not involved in all aspects of the reconfiguration; some were able to offer insights regarding transfers, for example, but could not provide detail regarding financial planning or politics.
2. Time elapsed since Making it Better – Related to the point above, recollections of the earlier stages of Making it Better may have shifted over time, and some interviewees found it impossible to remember specific details when probed. Others expressed concern that the process may now be viewed through '*rose tinted glasses'*, with stakeholders preferring to reflect on more successful aspects of the process and forgetting about some of the challenges or aspects that worked less well.
3. Voluntary participation in the evaluation – Stakeholders were approached by the evaluation team, receiving up to three invitations to take part in an interview. There was no financial incentive for participation, and despite our best efforts not everyone

that we approached was willing to engage in the evaluation. This means that some of those who experienced the most challenging aspects of Making it Better may have been unwilling to participate in an interview.

Making it Better: Timeline of key activities and milestones

Table 1, below, presents a summary of the key activities and milestones that formed part of Making it Better, presenting the situation from immediately prior to its inception through to completion.

Table 1: Making it Better Timeline

Timeline of Major Events in the 'Making it Better' Reconfiguration Process	
	Pre-Consultation (2000 – 2005)
2000 **2001**	**Recognition of key drivers** – Clinical leaders raised concerns regarding training exposure, locum usage for rota gaps and an inability for the status quo to meet the required standards, in particular the European Working Time Directive. Radical reductions in hospitalisations of children and statutory controls on the working hours of junior doctors were making it impossible to sustain 12 inpatient paediatric units in Greater Manchester. **Greater Manchester Secondary Care Children's Project was initiated (later to become known as the 'Making it Better' Project).** The project team were responsible for leading the early engagement activities and later the consultation and implementation. **Discussion paper 'Shaping the Future'** produced.
2002	**Formation of a working group** comprising of lead consultants and lead midwives from all 12 maternity units existing at the time concluded that maternity services needing to be included in the reconfiguration. Development of the Greater Manchester Maternity Network Board.
2002-2004	**Professional consensus** emerged across Greater Manchester that in order to create sustainable 'critical mass' for inpatient services the number of inpatient paediatric and maternity units should be reduced from 12 to between 6 and 8. **Clinical Networks** established with multidisciplinary membership – exploring clinical models and evidence for change. East Cheshire PCT and Macclesfield Hospitals join the process.
2003 **Aug 2003 – July**	**Establishment of Greater Manchester Children's Network Team** with an initial and specific remit to support the Maternity, Paediatric and Neonatal Clinical Networks in delivering the clinicians' vision for these services. **Establishment of Network Supervisory Board** to provide multi stakeholder oversight of the implementation of Making it Better. **Involvement** process to identify priorities and issues for children, young

2005	people and families across Greater Manchester and develop engagement methods.
2005	**Publication of a discussion document** putting forward the case for change, but no specific proposals on how to achieve this. March – May: **Series of criteria setting events** and a **Joint Council** held to evaluate options. July – December: **Professional and managerial engagement** in the development of the options for reconfiguration. July – August: 63 lead **clinicians agreed preferred site options** for 8 inpatient maternity and paediatric units and 3 intensive care neonatal units. September: **Major stakeholder event involving clinicians and senior managers** was held to debate and add to the clinician's options. October 31st: **Establishment of legally constituted Joint Committee** of the 10 Greater Manchester PCTs (plus East Cheshire). December: **Joint Committee of PCTs debated and agreed 4 options** (plus a 'do nothing' option) for formal consultation with a preferred option (option A) recommended in a public meeting.
	Formal Consultation (January - May 2006)
2006	12th January – **Publication of formal consultation document**. 31st May – **Closure of consultation period.** **Formation of a Joint Overview and Scrutiny Committee** comprising of representatives from all affected local authority areas to provide a Greater Manchester wide response to the proposals. December- **Joint Committee of PCTs decision to support preferred option (Option A)** at a meeting that considered the response of the Joint OSC and external analysis of all the public and professional responses to the consultation document. East Cheshire PCT withdraw from the process.
2007	**Joint OSC agreed to support Joint Committee of PCTs decision**; three dissenting authorities making a formal referral to the Secretary of State. March: Secretary of State requests review by **Independent Reconfiguration Panel.** 26th June: **Independent Reconfiguration Panel produced report supporting the decision of the Joint PCT.** August: **Secretary of State** accepts the recommendation of the Independent Reconfiguration Panel and **gives formal authority to proceed with the implementation of Option A.** The Chief Executive of NHS North West is made personally responsible for ensuring safe implementation.
	Start of Implementation Process (September 2007)

2007 - 2008	**Establishment of a revised Children Young People and Families Network Team supporting:** • **Making it Better Programme Board** to provide commissioner and SHA management of the project. • **Locality implementation groups** constituted on a geographical basis and led by a linked commissioner. • **High level project plan** managed by the Network Team. • **Provider Partnership Board** supporting further Trust involvement in implementation.
2009	**Realignment of the implementation process and creation of task based Delivery Groups** with core remit to decommission a specific unit and ensure availability of an alternative. **Creation of four Clinical Advisory Groups** aligned to ~~the four~~ Delivery Groups. **Greater Manchester CYP&F Network Team** focuses on planning and programme managing the work of the Delivery Groups. Programme managers were in place to coordinate activities regarding maternity, paediatrics, neonatology, workforce, HR and communications lead, helping to devise the project plan and facilitating its implementation. **New Children's Hospital** opened on the Central Manchester site, with the closure of Booth Hall and Royal Manchester Children's Hospital.
2010	**Creation of 4 Sector Project Boards** to oversee the work of each Delivery Group and facilitate agreement of contentious decisions. **Start of reconfiguration activity**, including the expansion of the children's community nursing team, and the relocation of inpatient maternity and paediatric unit away from Trafford. **NCAT review** of clinical evidence for change in response to introduction of the four reconfiguration tests, and confirmed that the future model of care met the required standards.
2011	**Continuation of reconfiguration activity**, including the relocation of inpatient maternity and paediatric units from Rochdale and Salford, as well as relocation of the neonatal intensive care services at Salford; the expansion of maternity and paediatric capacity at Saint Mary's, Bolton and North Manchester Hospitals; opening of a standalone Midwife Led Unit in Salford and level 3 neonatal unit in Bolton. All sites where inpatient services were relocated from continued to have day case and outpatient activity.
2012	**Completion of reconfiguration activity**, including closure of inpatient maternity and paediatric services at Fairfield, expansion of maternity and paediatric capacity at University Hospital of South Manchester and Royal Oldham Hospital (Pennine Acute) and opening of level 3 neonatal unit at the Royal Oldham Hospital.

	Reconfiguration Formally Closes

Context

Local History

Greater Manchester is one of the largest metropolitan areas in the UK, covering almost 500 square miles and hosting around three million residents. There is a mix of high-density urban areas, suburbs, semi-rural and rural locations. The population is diverse with a significant ethnic minority and high levels of inequality between the poorest and most affluent areas.

There is a long history of debate and controversy with regard to the configuration of children's services in Greater Manchester. Originally this focussed on the two specialist children's hospitals, one of which was located in Salford and the other in North Manchester. The key question at the time was whether there should continue to be two hospital sites or one, and if there was to be only one site, where should this be located.

In the 1980s an options appraisal led by the Regional Health Authority reviewed potential sites to host a new specialist children's hospital. The appraisal recommended a single centre be built on an existing teaching hospital site in Greater Manchester, although this went against general opinion that Central Manchester was the preferred option.

The first formal public consultation on children's services in Greater Manchester took place in 1994. However, 'Caring for our Children' was viewed as flawed as it addressed mainly tertiary services, and Manchester City Council called for a judicial review. As a consequence, the Regional Office subsequently instructed that the consultation be withdrawn.

Acknowledging the links between secondary and tertiary services, Manchester Health Authority and Salford and Trafford Health Authority issued two separate public consultations: 'Improving Children's Services in Manchester' and 'A Review of Specialist Hospital Services for Children (Salford)' in 1996. The outcome of these was a decision to build a new specialist children's hospital in Central Manchester and to relocate district or local (secondary) children's services to North Manchester General Hospital from the two sites in Salford (Booth Hall and Hope Hospital).

This relocation prompted a second consultation in 1998 on closing the inpatient ward at Trafford General Hospital. However, children's services, especially in Greater Manchester, were under huge public and political scrutiny at this time. Public opposition groups formed and lobbied to save their local services from closure and local MPs became involved in parliamentary debate. As a result the Secretary of State at the time (Frank Dobson) instructed the consultation to be withdrawn in 1998.

By the late 1990s there was a general consensus amongst clinicians that there were too many children's hospitals in Greater Manchester, coupled with a feeling of frustration at the lack of change. A number of leading paediatricians met with the Chief Executive from the Greater Manchester SHA and approached the six Greater Manchester Health Authorities, stating that the configuration of the secondary/local children's services was, in their view, clinically unsustainable and of poorer quality than should be available in a large conurbation such as Manchester. They also voiced concerns over the effect the planned new 'state of the art' children's hospital in Central Manchester would have on the viability of local services if

they were not sufficiently robust and well developed by the time it opened (expected in 2006).

Changing policy and system context

Making it Better took place over twelve years, and during this time there were a number of policy and system changes that impacted on the reconfiguration plans and processes:

- The introduction of the Health and Social Care Act 2001, and in particular the requirements set out in Section 11, were key drivers for proactive and widespread engagement with the full range of stakeholders, including those that are traditionally harder to reach.
- The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 introduced the requirement on NHS bodies to consult local authority overview and scrutiny committees on substantial service changes.
- In 2002, the existing NHS Health Authorities, which had been in existence since 1996, were renamed and merged to form the 28 new Strategic Health Authorities. The Greater Manchester SHA was created.
- The introduction of Foundation Trusts was announced in January 2002.
- Notice of the introduction of the European Working Time Directive (EWTD) for junior doctors in 2004 became a key driver for change (having been highlighted by lead clinicians at the start of the reconfiguration discussions). The EWTD stipulates that doctors in training should not work more than an average 48-hour week, and became known as the European Working Time Regulation in 2009.
- In 2005 the government announced that the number of SHAs and Primary Care Trusts (PCTs) in England would be reduced, the latter by about half (152 reduced from 303) on 1 October 2006. This had a significant effect on the number and nature of PCTs involved in the process, and resulted in a need to develop new relationships and processes at a crucial time in the consultation process.
- In April 2008 the government required that all new reconfiguration proposals going to public consultation should be assessed to determine whether an Office of Government Commerce (OGC) Gateway review was needed. The Health Gateway team managed this process for the NHS and provided scrutiny of Making it Better. The National Clinical Advisory Team (NCAT) provided the clinical assurance.
- In 2010 the Coalition Government came into power. In July 2010 the Government set out four tests against which reconfiguration processes need to be assessed. The NHS Chief Executive also issued guidance for local GP commissioners (supported by PCTs) to lead reconfiguration processes locally and to assure themselves, and their SHA, that any proposals pass the four tests.

Evaluation findings

This section of the report presents the findings from the evaluation. The following eight key themes were identified as part of the analytical process, and a descriptive overview of the process, the challenges and successes encountered, and key learning has been presented under each theme:

- Clinical and managerial leadership.
- Engagement and consultation.
- Politics.
- Design of Making it Better.
- Collaborative working.
- Programme management.
- Workforce planning and development.
- Financial planning.

Service specific findings are presented in boxes, whilst general learning points, challenges or success factors are outlined in the main body of the text. The 'lessons learnt' sections are intended to distil the findings of the evaluation into helpful tips and pointers for those considering future service changes, but are not intended to be mandated or to replace any official guidance from NHS England, the Department of Health or other national health service bodies.

Clinical and managerial leadership

Presented below are the findings relating to the clinical and managerial leadership overseeing Making it Better.

There was strong and genuine leadership, participation and commitment to Making it Better from senior clinicians, executives and managers from start to finish.

Members of the North Western Deanery first recognised the need for reorganisation of the paediatric inpatient units in Greater Manchester as far back as 1999. The six Greater Manchester Health Authorities initiated the Greater Manchester Secondary Care Children's Project early in 2000. The project engaged widely with healthcare professionals and consequently it became apparent that the debate should be extended to include maternity services. A report titled 'Shaping the Future' was published in 2001 and a working group of consultant obstetricians and midwives from the 12 Greater Manchester maternity units was formed in 2001.

In 2003 the Greater Manchester SHA formed the Greater Manchester, East Cheshire and High Peak Children, Young People and Families' Network (CYP&F Network). The Network's remit was to support the implementation of the vision set out in Shaping the Future.

There was genuine and committed leadership by senior clinicians from paediatrics, obstetrics and neonatology for the extensive engagement with the clinical community that took place between 2002 and 2004. During this period, clinical consensus emerged that in order to create sustainable high quality children's inpatient services, the number of inpatient

paediatric and maternity units should be reduced to between six and eight. The Making it Better Programme Team also undertook extensive modeling to define the optimum number of doctors and grades to deliver the best and most effective service, according to nationally acknowledged standards. The model was reviewed and endorsed by a wide range of stakeholders.

In July and August 2005 a group of 63 clinicians from all the affected units agreed a set of options for eight inpatient maternity and paediatric units and three intensive care neonatal units. In September 2005 a major stakeholder event was held for senior managers and clinicians, including Trust Chief Executives, to debate and refine the options

Clinicians took leading roles in all the aspects of Making it Better throughout its lifetime, including the initial engagement and debate around options, formal consultation and implementation. The Clinical Networks provided broad input into Making it Better for the full twelve-year span of the project. The Networks become a forum for gathering evidence, developing principles of collaborative working to reduce unwarranted variation, for ongoing debate and to provide a consensus approach. Clinicians also played specific roles through their membership of the Network Supervisory Board, four Delivery Groups and associated Clinical Advisory and Strategic Workforce Groups.

Senior executives and managers played an important role in Making it Better. Managers participated in the Network Supervisory Board and chaired each Delivery Group. Chief Executives from affected Acute Trusts sat on the Programme Board and four Sector Project Boards. They attended monthly meetings with PCT Chief Executives to facilitate information sharing and collective decision-making. A recently retired Acute Trust Chief Executive who was well known and respected by other Chief Executives in Greater Manchester chaired the Provider Partnership Board. After the dissolution of the Provider Partnership Board, the Chair was commissioned to undertake engagement and problem solving with local Trust Chief Executives.

Successes

Clinical credibility of the need for reconfiguration – There was genuine clinical ownership of the need for change across the whole of Greater Manchester and credible, impartial clinical and managerial leadership for paediatrics, obstetrics and neonatology. This promoted a strong recognition amongst the majority of stakeholders that the need for change was underpinned by a robust clinical argument rather than one of efficiency, and would lead to improved care and safety for mothers and babies across Greater Manchester.

> *'It needed clinical leadership- it couldn't just be seen as led by SHA or PCT. People trust clinicians and they will be the ones working in the new arrangements, so it has to be driven by them, and work for them. This project had SHA support in principle from the outset, but was initially conceived by a clinician working in one of the departments to be shut. That was key to getting others interested and taking it further… that had a lot of power to it because he wasn't being protectionist over his own service.'*

> *'It had leadership from clinical leads and lead midwives in each Trust. If it had just been PCT or SHA led, it wouldn't have worked – people would have viewed it as a cost saving exercise.'*

Development of clinically robust options - Strong clinical participation and a high level of discussion and genuine debate in the development of the options promoted a strong feeling that the process had been fair and open, and the conclusions were supported by robust data

analysis. The Network Team also undertook extensive modelling to define the optimum number of doctors and grades to deliver the best and most effective service according to a number of standards and regulations such as the EWTD, Consultant Obstetric labour ward presence, Birth Rate Plus midwifery staffing ratios, Royal College of Nursing staffing ratios, BAPM standards for neonatal nurses and Royal College of Paediatrics and Child Health (RCPCH) recommendations. The model was reviewed and endorsed by a wide range of stakeholders including the RCPCH.

Coherent and cohesive clinical and managerial leadership across the whole of Greater Manchester – The project structures and processes ensured that clinicians, executive directors and managers across the whole of Greater Manchester presented a united front and worked together to implement Making it Better. For example, the Network Supervisory Board and Programme Board considered the wider implementation of Making it Better, whilst the Clinical Networks each focussed upon a specific clinical speciality across Greater Manchester. The networked approach proved vital to the success of Making it Better; the Networks acted as clinical reference groups, and helped to build consensus amongst local stakeholders.

Widespread acknowledgment and support for the greater good - There was a strong clinical ethos of aspiring to the greater good:

> *'While naturally having loyalty to their own particular units, the clinicians realised that in some cases their own unit may no longer be able to remain as a consultant led unit in the interest of providing high quality labour and delivery of care for all women across Greater Manchester.*[2]*'*

This impartiality and the collective vision that services must be designed around the needs of patients not staff or organisations was seen as a key factor in reaching a successful conclusion.

> *'In the early discussions we were clear that the broader case was compelling, it would save lives in Greater Manchester and improve service quality.'*

Proactive and ongoing involvement from senior executives – Monthly meetings were held for Trust and PCT Chief Executives, with the aim of promoting ownership of the problem of short-term closures of maternity units, agreeing bespoke employment contacts to enable seamless transition of staff, and revised implementation arrangements. These meetings provided a forum for Chief Executives to raise issues and agree solutions, as well as a constant reminder of the importance of senior managerial leadership to ensure patient safety in the context of a complex and large-scale reconfiguration.

Personal development and satisfaction – Making it Better offered many clinicians, senior executives and managers the opportunity to develop new skills and experiences. Being responsible for the safe implementation of a large scale and complex reconfiguration led to personal satisfaction and a strong ethos of commitment to change. As a consequence, stakeholders who were involved report feeling better equipped to deal with reconfiguration projects in the future. Several have gone on to share their experience and learning from Making it Better with others across the UK via reports, presentations and meeting with others considering reconfiguration.

2 'Making it Better' 2002 – 2012: Final Report to the Programme Board

Challenges and lessons learnt

Dealing with vested interests – Making it Better inevitably involved the relocation of inpatient care from some Trusts. Where this occurred clinicians had to balance their personal views with the need for safe and sustainable services across all of Greater Manchester. However, the project structures focussed upon the system wide implementation, and therefore legitimised a more holistic viewpoint for clinicians and executive leaders.

Ensuring clinical accountability for delivery in the implementation phase – Initially the delivery of Making it Better was through four Locality Implementation Groups each led by a commissioner. However, these arrangements lacked direct and clear accountability for delivering Trust specific changes, as some Trusts were affected by changes in more than one locality. As a consequence, Delivery Groups were formed to undertake specific tasks, and their membership composed of clinicians and managers affected by the specific closure or service change.

Maintaining continuity of leadership – Making it Better spanned twelve years from inception to completion and took place within a context of great change across the NHS. As a consequence, there was considerable turnover of managers (although Making it Better did benefit from consistency in terms of Network leadership). This was a particular issue for the Joint Committee of PCTs. Sporadic attendance by some members impacted negatively on the decision making process. Changing membership raised the risk of previous Board decisions being questioned.

Contextual barriers to implementation – The Delivery Groups were intended to focus on detailed operational issues and risk management. However, pressures from the reduced NHS budget, political opposition and the internal agendas of local Trusts led to difficulties in agreeing decisions regarding contentious issues. The formation of the four Sector Project Boards to oversee the work of each Delivery Group enabled contentious issues to be addressed at a more strategic level.

Acknowledging the contribution of teams – Some staff involved in the wider service changes reported that they did not receive any formal thanks or recognition from leaders for their commitment.

Stakeholders suggested that celebrating success would have been helpful. This was viewed as a missed opportunity to recognise the contributions made by staff within the Trusts to the process, and to generate learning.

Engagement and Consultation

Prior to the formal start of Making it Better there were four formal consultations on children's services in Greater Manchester. The first consultation took place in 1994. However, 'Caring for our Children' was viewed as flawed as it addressed mainly tertiary services and Manchester City Council called for a judicial review. As a consequence, the Regional Office subsequently instructed the consultation to be withdrawn.

Acknowledging the links between secondary and tertiary services, Manchester Health Authority and Salford and Trafford Health Authority issued two separate public consultations 'Improving Children's Services in Manchester' and 'A Review of Specialist Hospital Services for Children (Salford)' in 1996. The outcome of these was a decision to build a new specialist children's hospital in Central Manchester and to relocate district or local (secondary)

children's services to North Manchester General Hospital from the two sites in Salford (Booth Hall and Hope Hospital).

This relocation prompted a second consultation in 1998 on closing the inpatient ward at Trafford General Hospital. However, children's services were under huge public and political scrutiny at this time. Public opposition groups formed and lobbied to save their local services from closure and local MPs became involved in parliamentary debate. As a result the Secretary of State at the time (Frank Dobson) instructed the consultation to be withdrawn in 1998.

Early Engagement

Against this troubled backdrop, the Making it Better Network Team sought to actively engage with local stakeholders prior to the start of the formal consultation. Soon after its formation in 2003, the Network commissioned MORI North to conduct a telephone survey of around 800 people to gather data about how children and young people used emergency services. They collaborated with partners in Central Manchester University Hospital NHS Trust and Manchester University Children's NHS Hospital Trust to capture people's experiences of using these services. Two Citizens' Councils met to consider changes to services for children and young people and maternity services. Art, play and interviews were used to facilitate capture of the views of more than 500 children, young people, parents, carers and staff on the use of A&E services and day case surgery. A group of local Patient and Public Involvement (PPI) leads worked with members of the public, the voluntary sector and local authority staff to undertake wider engagement with local people.

Overall, between 2003 and 2004 more than 22000 children, young people, parents, carers, staff and contributors from the voluntary sector and local authorities were involved in 300 separate engagement projects. This scale of engagement was made possible by using engagement experts to train and support local stakeholders to undertake activities.

This initial period of involvement and discussion led to the publication of a discussion document in July 2005. This document put forward the case for radical change and also a series of specific recommendations about what the changes should be, and became the focal point for an intense period of engagement. The contents of the discussion document were highly influenced by the feedback from local stakeholders, in particular the Citizens' Councils, which highlighted the need to consider the wider impact on maternity services.

Engagement and Debate

Between July and September 2005 further public engagement took place with more than 9000 members of the public, a third of which were children and young people. Channels and methods for engagement developed during the early phase of involvement were used where possible to facilitate communication and debate about the proposals put forward in the discussion document. Between March and May 2005 a series of criteria-setting events with a wide range of stakeholders, including citizens, managers, clinicians, GPs, and a Joint Council were held to develop criteria to evaluate the options.

During this period significant clinical and managerial engagement also took place. In July and August 2005 a group of 63 clinicians from all the affected units agreed a set of options for eight inpatient maternity and paediatric units and three intensive care neonatal units. In September 2005 a major stakeholder event was held for senior managers and clinicians, including Trust Chief Executives, to debate and refine the options. External consultants were

commissioned to score the options generated at this meeting. A key outcome of this event was the recognition that decisions would be driven by objective criteria rather than local politics or power.

At the end of October 2005, a legally constituted Joint Committee of the ten Greater Manchester PCTs was established. The Joint Committee of PCTs agreed the formal criteria that would be used to assess the various options as safety, feasibility and equity.

A public meeting was held in December 2005 at which the joint Committee of PCTs debated and agreed four options (plus a 'do nothing' option), with Option A as the preferred option. These options were put forward for formal public consultation.

The Formal Consultation (January - May 2006)

The 'Making it Better, Making it Real' Consultation Document issued by the Joint Committee of PCTs contained 131 pages. It set out why change was needed and the vision for new services, using three themes: safety (including workforce), equity and feasibility. The document also set out the preparations for change being made, the options for change and the way in which they had been formulated and ways of responding.

The Network Team devolved overall responsibility for the delivery of the consultation process to the participating PCTs and Acute Trusts, building upon the expertise, relationships and channels of engagement developed in the pre-consultation phase. The process also drew on the priorities and the concerns expressed by stakeholders during the early involvement and engagement activities.

The Network Team distributed a wide range of communication materials. This reflected the preferences and perspectives of different stakeholder groups. These included 30000 consultation documents, 320 summary leaflets, 5000 standalone response forms, 4000 posters, 50000 'Dr Tilly's Big Idea' booklets aimed at children and young people (which was used in schools), 320 DVDs and a regularly updated website which had around 14000 hits during the formal consultation period.

A huge amount of effort was made to ensure that the full range of stakeholders were engaged with, especially those who do not respond to traditional engagement methods such as paper-based surveys. The key philosophy was to proactively consult with people in places where they lived and worked. Meetings and activities were undertaken in places of work, local venues (e.g. supermarkets, playgroups, leisure centres) and community group settings. In total more than 750 meetings were held and attended by 16000 people. An online engagement exercise also took place aimed at young people.

Priorities Identified by Local Stakeholders

More than 30,000 people gave their views during the early involvement and engagement stages of the 'Making it Better' Project. Some of the key issues that emerged were[1]:

- The majority of people were happy about the need for change.
- The Citizen's Council stated that 'change to the structure of children's health services in Greater Manchester is necessary to ensure the highest standards of care are available to all children in the area'.
- Respondents wanted better quality of services.
- Respondents supported the principle of care delivered closer to home and they especially valued local community and hospital teams.
- Respondents identified the need to review staffing and workforce training and development.
- Respondents valued being asked to give feedback, comments and views.

However, respondents were concerned about:

- Distance to travel to specialist services.
- Travelling times and difficulty of travelling on public transport from all parts of the review area.
- How changes would happen and whether services would deteriorate during the transition.

These issues were carefully considered and used to inform the scoping of options leading up the formal consultation.

Responses to the Consultation

The responses to the consultation were analysed by an external consultancy company. They reported more than 50,000 responses in different formats, representing the views of nearly a quarter of a million people, which at the time was the highest response ever to an NHS consultation. This included more than 40000 responses on locally produced lobby forms, 7000 on the standard questionnaire, 121 organisational responses including 14 from MPs, reports on around 750 group activities, 782 responses for children and young people, 653 letters, 39 petitions with 176,388 signatures and transcripts of 54 telephone calls.

The analysis concluded that the majority of the respondents agreed with the need for change although over 40% did not express a preference for an option. It was noted that many respondents considered they were taking part in a vote and had not understood the difference between a vote and a consultation. Concerns were expressed about reduced choice of services, insufficient staff to support implementation, access to services (with regard to distance and transport) and the transition and operation of reconfigured services.

A Joint Overview and Scrutiny Committee (JOSC) was formed to coordinate a response across Greater Manchester. The committee included representatives from all the affected

local authority areas. It supported the case for change in principle but declined to express any preferences with regard to the options put forward.

In December 2006, the Joint Committee of PCTs met to consider the responses to the public consultation and the response from the JOSC. A number of expert witnesses were called to give a summary from their perspective of the case for change, and answer questions. The committee reviewed the original options; including a further seven options on the location of services developed as a direct result of the responses to the consultation, and identified Option A as their preferred option.

Early in 2007 the JOSC gave their support for the decision of the Joint Committee of PCTs by majority vote. However, three local authorities did not support the decision.

Successes

Pre-consultation engagement and scoping - The extensive and intensive level of research, discussion and debate undertaken prior to the formal consultation ensured that the proposed model of service delivery and options for change took full account of the detailed requirements and views of the population. It also informed the engagement channels and approaches used in the consultation. Such proactive and inclusive stakeholder engagement was seen a key factor in ensuring the proposals were practical and fit for purpose.

Clinical leads undertaking engagement and consultation activities – Lead clinicians played a key role in the engagement and consultation process. This included presenting to Citizen's Councils, to individual Overview and Scrutiny Committees and the JOSC. Clinician used clinical scenarios and pathways to explain the changes proposed as part of the reconfiguration.

Reflective learning and flexibility – The Network Team actively sought out stakeholder feedback and commissioned several external evaluations during the lifespan of the project, including an evaluation of the engagement and consultation. They were very willing to review and change their strategy, for example, after early feedback they recognised the need to extend the redesign to cover maternity services and adjusted their scope accordingly. They were also reactive to changing context, which given the long timescales involved, enabled the reconfiguration to remain relevant.

Networking and capacity building – In the early stages of engagement, a significant amount of work was put into building relationships with PPI leads, voluntary and community organisations and experts in working with children, and also supporting the development of skills within individuals. This work was seen as one of the building blocks for the subsequent successful delivery of the consultation by participating PCTs and Acute Trusts.

Extensive and inclusive engagement - The Network Team were highly praised for their commitment to meaningful and inclusive engagement. This was reflected in the wide variety of approaches they used, for example to engage with children and young people. Much of the engagement was undertaken in community settings using existing contacts with communities, and was important in ensuring participation by the full range of stakeholders, including harder to reach groups. The large number of responses to the formal consultation reflected the effectiveness of the engagement.

An external evaluation of the consultation concluded:

> *'All evidence collected throughout the consultation exercise was fairly and openly put to the Joint Committee of PCTs to help them make their decision on 6th December 2006.*

Expert witnesses were called to answer detailed clinical and technical questions. We are confident in confirming that the approach to the consultation exercise was as robust as could have been reasonably expected.[3]*'*

Use of external expertise - The Network Team worked with a variety of external consultants and small companies handpicked for their specific skills and expertise. A consultant who worked with the team commented upon the flexible and constructive nature of the relationship with the team. By liaising directly with individual consultants with a good track record for this sort of work, the Network Team could command a quick turnaround of tasks and reduce the overheads associated with dealing with a brokering agency.

Media engagement - Extensive engagement took place in order to work collaboratively with local media, including Manchester Evening News, TV and radio broadcasters, and local newspapers. The time that the Network Team put into engaging local media, building informal relationships with them and providing them with evidence to support the case for change, all proved critical in building collective buy in to the proposed changes. Media representatives report that they were informed of the proposals prior to the launch of the formal consultation, enabling them to feel well briefed and that they understood the issues, and subsequently were able to present the information to the public.

Network Team members and Clinical Leads took the time to get to know reporters as individuals, were well prepared for media appearances, and kept the media informed about developments with the reconfiguration. This collaboration proved critical in presenting balanced arguments to the public.

Compliance with Cabinet Code of Practice - The Network Team proactively sought to ensure their approach to reconfiguration met the requirements of Section 11 of the Health and Social Care Act 2001 and the standards set out in the Cabinet Office Code of Practice on Consultation. From the start the priorities for the process were that the genuine voice of communities was heard, that their cultural and ethnic diversity was reflected and that the voices of children and young people from the well child to the chronically disabled were represented. The consultation was originally intended to run from 12 January 2006 until the 13 April 2006, the minimum period set out in the Cabinet Code of Practice for Consultations. However, the Network Team decided to extend the deadline, demonstrating their commitment to engage meaningfully with the full range of stakeholders.

Challenges and lessons learnt

Historical and local context – There is a long history of debate and controversy with regard to the configuration of children's services in Greater Manchester and a number of consultations have taken place causing a great deal of public and political opposition. Communities in Greater Manchester (in common with elsewhere) have a strong pride in local services and a tendency to equate provision of care with hospital buildings. Furthermore, there is a perception that travelling more than a few miles to hospital is unacceptable and poses potential safety issues. This backdrop meant that the Network Team had to work hard to put across the case for change and convince the public that it was clinically safe.

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[3] *Making it Better, An evaluation of a large-scale public consultation and engagement in the reconfiguration of in-patient services for women, babies, children and young people in Greater Manchester, East Cheshire and High Peak.* Dr Ann Shacklady-Smith, January 2008, Manchester Business School, University of Manchester.

Accessible communications – Professional groups considered the layout and language of the consultation document favourably but voluntary and community groups criticised its length, organisation and use of clinical language:

> *'They [the consultation documents] were very, very good. Really helpful, really put you in the picture of numbers and figures and hospitals and difficulties facing with transport and everything else, and it really showed you that you know, it just wasn't a one line topic, it really needed sorting out.*[4]*'*

> *'The document was bad enough as it was, no person that I know of from any outlying estates or anything like that would pick that up and read that no chance, too off putting to start with.'*

Whilst some stakeholders reported that the summary document was short and accessible, the evidence indicates that not all potential audiences were aware of its existence or had access to it, although it was circulated to all NHS premises across Greater Manchester.

Dealing with scepticism – Many stakeholders remained convinced that the reconfiguration was being driven by the need to cut costs rather than improve services. This view became increasingly difficult to counter as the recession worsened. There was also suspicion about the criteria used to generate options and many members of the public believed these were based on clinicians' requirements, such as work experience, rather than patients' needs. The Network Team did not anticipate the high level of public scrutiny that ensued and held to their decision not to publish the supporting documentation (including more than 50 spreadsheets) given its complexity and volume. However, in hindsight this decision is seen as more of a hindrance than help.

Misconceptions about the role of consultation - A consultation seeks to capture the full range of views and suggestions made by respondents. However, many respondents mistakenly assumed a consultation simply involves voting for their preferred option and that the option with the most votes will be the winner. The Network Team worked hard to ensure that respondents fully appreciated the purpose of a consultation and that feedback about the responses clearly showed that all views had been listened to, but for some respondents there was a strong perception that it was a 'done deal.'

Staff consultation – Some staff groups working in the units to be affected by the proposed changes report lacking confidence in the consultation process. For example, some clinicians (including midwives) report not feeling confident when putting dissenting views across as part of the consultation process, whilst also finding it difficult to attend meetings or receiving late notification of when meetings were taking place. Others felt that they would not be listened to, feeling it was a 'done deal' and that Making it Better did not involve a genuine consultation exercise. Some clinicians expressed concerns that pre-existing power relationships were unduly influencing the process, leading them to feel that they lacked a credible voice or influence in the process. Whilst these appear to be the views of a minority of clinicians, it is important to note these concerns with the process and the challenges some staff experienced in putting their opinions across.

Team capacity - The Network Team was relatively small given the geographical coverage and population of the reconfiguration footprint. The team did not anticipate the sheer volume and variety of responses to the consultation (more than 50000 responses representing nearly

[4] Ibid

one quarter of a million views). They reported feeling overwhelmed by the work needed to deal with these responses and the associated requests for information and meetings. The additional responses resulted in two extra staff members being brought in to count responses and review all comments made.

However, Network Team members reported that if the core team had been larger it would have been more difficult to form the close relationships and trust between members which proved to be critical enablers of the project.

Politics

There is a long history of debate and controversy with regard to the configuration of children's services in Greater Manchester. Once Making it Better was underway, it became highly visible in the media and attracted a great deal of political attention, particularly around the time of the formal public consultation in May 2006. Presented below are the findings relating to politics, political engagement and influence as part of the Making it Better process.

Successes

Designated lead for political engagement – There was early recognition of the complex political backdrop surrounding children's services in Greater Manchester and the need to proactively manage the media communications and political engagement around Making it Better. Therefore, a Programme Partnership and Engagement Manager was appointed to lead on SHA political engagement from the beginning of the project, with the explicit remit of liaising with senior politicians, whilst the CYP&F Network Team dealt with the day-to-day communications. A Parliamentary Monitoring System was used to manage media messages and track political debates.

> *'We engaged all the local MPs; a clinician and member of the Network Team went out to visit all MPs in the area to discuss it with them. They knew where we were coming from and that it wasn't all for cost savings. We would talk to them for an hour about what it was about. We started by discussing the principles rather than the absolutes.'*

London based management of Public Affairs - Making it Better contracted a London based Public Affairs Agency for a limited time period to manage the media and liaise with politicians. Being located in London was advantageous in that the agency was viewed as credible in the capital and agency staff could meet with politicians based during the week in Westminster at short notice. However, whilst some politicians said this approach was helpful, others who became engaged during the later stages of Making it Better report being unaware of its existence.

Engagement with local politicians and decision makers - The Network Team put significant effort and resource into developing relationships firstly with the Association of Greater Manchester Authorities, and then with the developing JOSC. There were regular discussions and involvement by the Network Team to ensure that local politicians from all the communities involved were kept up to date with developments, had a deep understanding of the case for change and contributed to the way that engagement and consultation was planned and delivered. This relationship is vital if the consultation and change is to succeed.

Engagement with local media – A proactive approach was taken to dealing with the local media. Considerable time and effort was put into explaining that Making it Better represented a change that would bring about many more positives than perceived negatives across

Greater Manchester. This approach helped to prevent the media from putting out exclusively negative messages about isolated closures and ensured coverage of opposition was set within the context of the strategic aims of the project.

> *'We used the Manchester Evening News, local TV and radio and local papers. It helped because the Manchester Evening News covered the whole locality and there were some real positives for some areas and negatives for others, so it couldn't take an unbalanced or overly negative view. They put the message out in the papers about the proposals, did lots of articles and we put in messages, they would provide stories. When there was a challenge from a politician or a public group we could put forward a counter view to balance it in the press.'*

Challenges and lessons learnt

Clarity of messages – Some politicians considered that early communications about Making it Better lacked clarity. Lengthy documents using clinical jargon were criticised as being difficult to read and understand. In particular, there was a perception by some politicians that the rationale for change took a long time to crystallise.

Scepticism about the rationale – Some politicians did not agree with the clinical rationale for change. Others accepted the need for centralised services but did not agree with the detailed plans for relocation of inpatient services, arguing they were designed to support individual Trust agendas rather than the public needs across Greater Manchester. In particular, there was criticism of the plans to move inpatient services away from units that were perceived to be established and successful. The impartiality of clinicians' views was also questioned by some stakeholders, given that they led on requirements for training and gaining experience, which may predicate a particular service configuration.

Misunderstanding about the role of the consultation – Making it Better was a high profile and contentious project, and the formal consultation received more than 50000 responses. Many of the responses opposed local closures, and some politicians assumed the weight of the opposition would lead to a reconsideration of the preferred option. The Network Team worked hard to ensure that respondents fully appreciated the purpose of the consultation and that feedback about the responses clearly showed that all their views had been listened to. However, for some there remains a perception that the decision was a 'done deal.'

Local politics – Changes to the NHS, and especially children's services, always attract a huge amount of public attention. Whilst politicians and the public generally recognised the need for system wide change to achieve improved care and safety for mothers and babies across Greater Manchester, they opposed any perceived reductions in local services. Local opposition from three Overview and Scrutiny Committees led to the referral of Making it Better to the Secretary of State; this in turn led to the referral to the Independent Reconfiguration Panel in 2007, and delayed implementation by several months.

National policies – The change of government in May 2010 and the introduction of the 'four tests' whilst Making It Better was already in its implementation phase presented a challenge, as whilst it brought further rigor to the process, it reopened earlier opposition which required additional time to readdress. In addition, the twelve year timescale of Making it Better saw significant changes to the NHS in England, including the disbandment of PCTs and introduction of CCGs, the move to separate community services (Transforming Community Services), and tightening of budgets available across the health and care sector. This changing context impacted on Making it Better by reducing organisational memory,

introducing funding restrictions not previously anticipated, and creating competing pressures for participating organisations.

Design of Making it Better

Presented below are the key findings regarding the decision making processes which led to the design of Making it Better. It is important to recognise that this is a summary overview; further detail is found in other sections of this report regarding the scope and scale of engagement and clinical involvement in co-producing the reconfigured model.

From the outset it is important to note that the reconfiguration was large and complex, and took place over a lengthy timescale. The decision making arrangements were carefully planned to ensure different viewpoints could be considered.

Whilst the original driver for the project came from leading paediatricians in Greater Manchester, particularly those involved in education and training, the CYP&F Network gathered a substantial amount of intelligence to inform the design of Making it Better:

- A report in 2002 from a working group of senior consultants and midwives from the 12 Greater Manchester maternity units.
- Between August 2003 and July 2005, more than 22000 children, young people, parents, carers, staff and contributors from the voluntary sector and local authorities were involved in 300 separate engagement projects.
- Several Citizens' Councils were held between March and November 2004 to explore and develop the model of care.
- A joint stakeholders Council of clinicians, senior managers, citizens, public health professionals, midwives and GPs was held in March 2005 to develop priorities and models for change.
- Extensive engagement with the clinical community took place between 2002 and 2005.
- In-depth workforce modelling[5]using a number of published standards / legislation (including the EWTD, Consultant Obstetric ward presence, Royal College of Nursing and BAPM neonatal nursing patient/staffing ratios, Birth Rate Plus midwifery/patient staffing ratios, RCPCH standards and best practice advice for community nursing teams) was undertaken to define the optimum number of doctors and grades to deliver the safest and most effective service for each option.
- Review of the workforce model by a large number of clinicians and external stakeholders, including the RCPCH.
- In July and August 2005 a group of 63 clinicians from all the affected units agreed a set of options for eight inpatient maternity and paediatric units and three intensive care neonatal units.
- In September 2005 a major stakeholder event was held for senior managers and clinicians, to debate and refine the options. External consultants were commissioned to score the options generated at this meeting.
- Between July and September 2005, further public engagement took place with more than

5 Joint Committee of PCTs (2006)

9000 members of the public, a third of which were children and young people.

- A public meeting was held in December 2005 at which the joint Committee of PCTs debated and agreed four options, with Option A as the preferred option.
- More than 50000 responses in a variety of formats, representing 242,000 individual views on the formal public consultation were received by May 2006.

The Network Team proactively sought to ensure their approach to the reconfiguration met the requirements of Section 11 of the Health and Social Care Act 2001 (later Section 242 NHS Act 2006) and the standards set out in the Cabinet Office Code of Practice on Consultation. From the start the priorities for the process were that the genuine voice of communities was heard, that their cultural and ethnic diversity was reflected, and that the voices of children and young people from the well child to the chronically disabled were represented.

Successes

Early consideration of priorities for local people – Making it Better engaged widely with local people at the very start of the design process (see the Consultation and Engagement section of this report for further details). This early engagement made it clear there was an acceptance of the need for change and a strong requirement for safer services. It also identified key concerns for local people, which were explicitly built into the design and decision making processes from the start.

There were demonstrable changes to priorities and the model as a result of Citizens' Council feedback; for example, the inclusion of child and adolescent mental health within the scope of the consultation and model for care.

Robust and credible clinical case for change – A key success factor cited for Making it Better was the strength of the case for change. This was rooted in clinical concerns about the viability and safety of services rather than economic considerations. As a consequence, the case for change was seen as credible and compelling, making it difficult to ignore. Some stakeholders (including clinicians and media representatives) have suggested that the patient safety arguments could have been presented even more strongly as part of the case for change.

System wide change – System wide change offered the opportunity to deliver significant improvements to care and safety, whilst making new investment in staff and facilities: in particular, the expansion of care closer to home, in the form of children's community nursing teams. The sheer scale of these benefits was a strong antidote to opposition over the closure of four relatively small units across Greater Manchester, and was a key success factor in gaining momentum for the project.

Overall positive effect of the proposed model – Despite the reduction in units, the overall model put forward for Making it Better offered improved services and safety for the public across Greater Manchester. This focus on the greater good was an important second step in the design process, building upon the acceptance of the clinical case for change and further legitimising the reconfiguration.

Detailed workforce modelling using national standards – The CYP&F Network Team employed an independent consultant to support the workforce modelling. The models developed were grounded in an in-depth understanding of the local workforce context and engagement with Clinical Directors from the affected units. They also upheld the nationally

accepted workforce standards (further details can be found in the Workforce Planning and Development section).

Consideration of a wide range of factors – Early engagement with local people meant that factors such as travel times, parking and public transport were considered as part of the development of options. However, the conclusions of the Independent Review Panel in 2007 included a recommendation to further address transport issues, including the need to work closely with the North West Ambulance Service (NWAS).

Extensive and inclusive formal consultation – The formal consultation on Making it Better is highly regarded by the majority of stakeholders.

> *'Decision making wasn't just made by a small group of people – it was a genuinely collaborative process with different viewpoints taken into account. This was a critical success factor.'*

As noted by the JOSC:

> *'The consultation organised locally by PCTs has been rigorous and inclusive….Members generally agree that efforts to engage widely and specifically with hard to reach groups have been considerable.'*

In order to develop inclusive and extensive engagement across communities it is necessary to build on existing contacts and activity rather than impose events and methods on local people. The use of local resources, coordinated and supported by a central team is vital. An external evaluation of the consultation also supported this viewpoint[6].

Another important issue was the co-production of not only the clinical model but the style, scope and methods for engagement. The methods and networks developed through the consultation process of Making it Better were utilised as part of later engagement, particularly with the media, clinicians and politicians, during implementation.

Challenges and lessons learnt

Unanticipated effects of change – Despite the intensive modelling work undertaken and high level of attention to detail there were many unanticipated side effects of the planned change. Examples include insufficient staff car parking spaces where units had been expanded, the emergence of new staff roles with attendant training needs, additional paper work associated with new care pathways and information governance issues.

Change across different systems – Making it Better spanned many different Trusts using different service models and patient pathways. Where units served mothers from the catchment areas of multiple Trusts, inconsistent pathways sometimes meant that important health checks or procedures were missed. For example, where Trust policy is to conduct baby hearing tests in hospital but the mother attends hospital in a Trust which conducts them in the community, the baby may slip through the net and not receive a hearing test.

Changing context – Twelve years elapsed from the initial idea to the completion of Making it Better. During this time there were many changes both locally and in the wider policy context.

6 *External Evaluation of Process*, paper by University of Manchester and Peninsular Medical School included in the Report to the Joint Committee of Primary Care Trusts, 8th December 2006.

Whilst every attempt was made to factor predicted changes into the model, some changes were totally unforeseen, for example the recent increase in birth rates and changes in immigration rules which reduced the pool of available junior doctors.

Flexibility – At the point where implementation began, there had been many changes in the NHS context. Some respondents said they would have liked more flexibility at the implementation stage to suggest changes to the model, but felt this was not an option given the weight of opinion behind the model.

Measuring outcomes – Whilst the implementation of Making it Better has been quality assured, there has been no on-going collection of outcomes data across Greater Manchester. Many stakeholders have highlighted the need for reassurance that standards continue to be achieved now the project is complete and considered 'business as usual'.

Programme management

Presented below are the key findings regarding the programme management arrangements for Making it Better.

Structures established: pre-consultation phase

A CYP&F Network Programme Director was appointed and made responsible for the successful delivery of the reconfiguration project. A Network Team was appointed to deliver the vision and included experts in public engagement, HR, clinical workforce design, finances and information analysis.

The Minister for Health at the time instructed the creation of a Network Supervisory Board (NSB) to oversee the development of primary, secondary and tertiary paediatric services across Greater Manchester, and awarded the Board the power to veto decisions that could undermine the integrity of children's services.

The NSB supervised the four Managed Clinical Networks (paediatrics, obstetrics, neonatology, and child and adolescent mental health services). Each of these clinical networks had membership comprising the lead clinicians from each organisation providing acute services, and was supported by a manager from the Network Team. The NSB also had representation from the public and managers of the PCTs and Trusts involved, and was chaired by a PCT manager.

The NSB provided multi-stakeholder oversight of the implementation of Making it Better. It was supported by the Programme Board, which provide a forum through which commissioners and the SHA could oversee the implementation of Making it Better. It had the authority to approve or reject proposals to change the project. Board members included the Chief Executives of affected Trusts, SHA representatives and senior commissioners. The Network Director reported to the Programme Board.

Consultation phase

The Network Team undertook extensive modelling using national standards and legislation to define the optimum number of doctors and grades to deliver the best and most effective service. The model was reviewed and endorsed by a wide range of stakeholders.

At the end of October 2005, a legally constituted Joint Committee of the ten Greater Manchester PCTs (plus East Cheshire, East Lancashire and Glossop and High Peak) was

established. The Joint Committee of the PCTs agreed the three formal criteria that would be used to assess the various options as safety, feasibility and equity.

Progressing from the early recognition in some circles that the existing configuration of children's services in Greater Manchester was unsustainable, to the widespread acknowledgment of the need for change and the development of options based on local stakeholders' preferences and needs, took five years. This timescale reflected the complexity of the process and unprecedented scale of the reconfiguration.

Implementation

Initially, the implementation process was organised on a geographical basis and led by a commissioner working across Locality Implementation Groups. Trusts were involved in implementation through a Provider Partnership Board chaired by a recently retired Acute Trust Chief Executive, who was locally known and well respected.

The Locality Implementation Groups were in place from July 2007 to the end of 2008. However, some Trusts were affected by changes being implemented by more than one of these groups, leading to a lack of direct accountability for delivering overall changes in a single Trust.

At the beginning of 2009, the implementation process was realigned to task based Delivery Groups, which had a remit to decommission a specific unit and ensure synchronised availability of alternative capacity. Membership of these groups was drawn from all affected Trusts and comprised mainly of people with senior clinical and managerial roles who could focus on practical implementation issues. At this time, the Partnership Provider Board was decommissioned, although the chair was retained in an advisory and troubleshooting role at Trust Chief Executive level.

Each Delivery Group was assigned a Clinical Advisory Group, comprising lead clinicians representing the affected Trusts, whose remit was to assure all decisions made by the Delivery Groups that impacted on clinical practice and patient safety.

Sector Project Boards were established to provide a higher level of authority when decisions being made in the Delivery Groups were contentious. They became important in a climate of recession and political scrutiny that put pressure on Trusts to focus inwards. Members included the Chief Executive or an Executive Director from each constituent Trust. The Network Director or the Chair of the Provider Partnership Board chaired each Board.

Some of the Network Team who had successfully delivered the pre-consultation involvement and engagement work and the formal consultation moved into a supporting role for the implementation process. They provided specialist input, ensured a full and auditable record of the process was captured, and worked across the four Delivery Groups to support communication and coordination of actions.

The four Clinical Networks played an important role in securing broader clinical input to the implementation process and maintaining clinical support for the on-going changes. Extensive preparation and project management was required to ensure safe transfers of patients, and this required time and planning. Coordinated by the Network Team, Trust managers liaised with their respective Clinical Network to plan for and oversee safe implementation of the changes. This included changing staff rotas to ensure there were additional staff on duty to carry out the transfers and monitor progress whilst others carried out their usual clinical roles; undertaking phased moves based on patient care requirements; liaison with external

partners to ensure alignment across the system, for example, NWAS and the Trust pharmacy; and making sure patients and their relatives were aware of the arrangements. Many of the transfers were timed to take place at weekends, to avoid competing priorities within the Trust and traffic congestion. This was all coordinated and led by the Network Team.

Staff were assigned 'gold, silver or bronze' command roles during the transfers. 'Bronze' staff carried out their usual functions within the ward to ensure continuity of patient care; 'silver' command staff had responsibility for carrying out the transfer of patients and ensuring their safety during this time; 'gold' control staff were the overarching group comprising the Network Team, senior managers, divisional managers and NWAS, with responsibility for ensuring overall success of the transfers. The arrangements were jointly resourced by the Making it Better programme funds and Trust funding.

Following the transfer of services, the Clinical Networks played a strong quality assurance role. They commissioned independent clinicians to review care pathways, operational processes and staffing levels and to work with lay representatives to undertake site visits.

Formative Learning

The Network Team commissioned an external evaluation of the project in 2005, which delivered a final report in January 2008[7][8]. This covered the early involvement and engagement, consultation, decision making and initial planning phases. Early findings from the evaluation were included as a paper in the 2006 Report to the Joint Committee of PCTs. The report highlights retrospective learning by the Network Team, which questioned the value of publishing the first report of a new model of children's services to the SHA in July 2004. The specific nature of the recommendations in this report led to public concerns and the team felt it would have better to confine the debate to making the case for change at this early stage. However, the team did not simply '*battle on and say it will look like this*', but instead undertook a complete rethink of their strategy[7].

With each unit where services were relocated from or overnight inpatient services closed, the Network Team and Trust(s) involved adopted rigorously controlled approaches, and by the last transfer the processes were tried and tested, and had proved effective.

The Network Team carried out a short review at the end of each phase and transfer, to produce a 'lessons learnt' document. The learning following each transfer was shared at Programme Board level, at Clinical Network level, as well as via more informal conversations amongst those involved within the Trusts.

Trusts developed their own processes for reviewing transfers that they were involved in, reviewing each aspect in detail (including the 'dummy run' practice transfers that took place in advance of the patient transfers). The Clinical Networks also took part in formative learning.

[7] *External Evaluation of Process*, paper by University of Manchester and Peninsula Medical School included in the Report to the Joint Committee of Primary Care Trusts, 8th December 2006.

Successes

Continuity of the Network Team and Leads - The resilience and commitment from Network Team members, the Network Director and the background support and advice from the Clinical Networks, meant there was considerable continuity within the team throughout the different phases. The same Network Director led the programme from 2000 through to 2012 (with a replacement Director during a period of maternity leave which coincided with the formal consultation), and many team members were involved for the majority of this period. This helped maintain organisational memory, whilst also facilitating effective relationships with clinicians and external stakeholders. Having a consistent named individual for support, information, advice, training and coordination of activity was seen as particularly useful during the difficult consultation stage.

Expert programme managers recruited - The formation of the highly skilled and expert Network Team early in the pre-consultation phase provided a vital resource to support the stakeholder engagement and the development of options, and later the successful implementation of the reconfiguration.

The Programme Director was widely regarded as a highly competent project manager, being '*driven'* and '*determined*' in approach, with excellent engagement skills. She was supported by the Network Team and Clinical Network Leads, who all brought different experience and qualities to the process. This variety of complementary skills helped to ensure all aspects of the reconfiguration could be well planned and implemented with credibility and confidence.

Use of external consultants to complement the competencies of the core team - The programme team brought in external consultants to provide additional expertise and capacity when required. A former Trust Chief Executive well known to stakeholders across Greater Manchester was brought in to provide additional strategic leadership. His experience helped ensure his credibility and enabled him to build on pre-existing relationships.

> *'[He] was an-ex Chief Executive and he chaired a Chief Executive group of providers, which fed into the Programme Board. [He] banged heads together, he could discuss any issues openly with the Chief Executives… because he understood their situation. He wasn't afraid to challenge them if they weren't playing ball.'*

Others provided specialist support regarding HR and workforce planning, PR and communications, and option modelling. This ensured plans benefitted from expert input at the right time in the process.

Strong but flexible project management structure – Stakeholders praised the effective governance and project management arrangements in place to support Making it Better. The structures were sufficiently flexible to meet emerging needs and respond to changing circumstances, but remained consistent enough for stakeholders to understand the accountability, management and delivery arrangements in place.

There was no blue-print to follow for Making it Better; and by definition, the Network Team and stakeholders learnt as they went along. Consequently, not everything went smoothly at first. However, the flexibility and adaptability of the Network Team meant that issues that arose were addressed quickly and did not pose barriers to progress with the reconfiguration.

Engagement at the right levels at the right time - Sub-groups were formed for limited periods in order to meet specific needs of the programme. The groups reported to the Clinical Networks, and their 'task and finish' nature ensured they remained focused on delivering specific outputs within set timescales. The Network Team recognised from the

outset the importance of engaging Trust leaders as well as operational managers who played a key role in implementing the changes. The Making it Better programme structure facilitated engagement at these different levels.

Effective communications – The communication with leaders, staff in all affected Trusts, and patients receiving or due to receive care around the time of implementation, was reported to be highly effective and carefully planned.

A dedicated postholder within the Network Team coordinated all communications activities, whilst the specialist London-based PR agency supported engagement with MPs. Informal communications based on existing relationships reinforced the formal communication channels.

Managing the transfer process - The extensive preparation undertaken in advance of unit closures ensured that each transfer took place safely, with all parties being informed of the arrangements and their role in the process. The careful timing of transfers, detailed briefings, standardised documentation, and resourcing of the transfers were all critical success factors.

> *'Units that weren't affected had to know key dates and what was happening when and where. We [Bolton midwifery] knew about the Rochdale move – so we made sure we were fully staffed on that weekend. We put the 'Greater Manchester' message out to the staff.'*

The visibility of ward managers before, during and after the transfer of services enabled transferring staff to become familiar with their new managers, and to ask any questions or raise concerns, whilst also ensuring tight management of the process.

Trust preparation and ensuring safe patient transfers

> *'In the paediatric unit the medical staff made sure that the ward rounds were timed to avoid the move, for example. We were still receiving referrals even whilst children were being moved. We made sure families knew at least 48 hours before when their child would be moved and when we'd be moving. So [they knew] when the transfer would take place, or when they had to arrange transport for discharge. We worked with the [Trust] pharmacy to make sure all discharge medicines were ready for the discharge time, to avoid delays. We risk assessed which children left first, and we moved the least sick first. We had to rent equipment where needed, because we had to have the equipment on both sites.'*

Some staff referred to running 'dummy run' transfers, using dolls in incubators to simulate the transfer of a neonatal patient from one unit to another. This enabled unit managers to identify where additional support was required and critical points on the journey – for example, where there were draughty corridors or ramps to navigate.

Rotas were changed and staff leave cancelled to enable units to be double-staffed whilst transfers were taking place. The 'command' transfer management system helped ensure effective and safe transfers, providing clarity of responsibilities:

> *'Everyone knew what their responsibility was – personally and the team. We put it in place locally, it worked like clockwork. We still have copies of all the pre-transfer handbooks, details of what was happening when and who was involved.'*

There was flexibility in the timing of transfers; for example, one neonatal unit transfer took place on a Monday morning, because this was coincided with incubator resources and

capacity within the Greater Manchester Neonatal Transport Service.

All staff involved in patient transfers received a transfer document, which outlined the type and level of care required for that patient during the move, and the type of escort required. Databases of patients were established, showing which mothers-to-be were expected to give birth around the time of the transfer and which unit they had been assigned to (known as 'VIP women'), as well as details of all babies in neonatal units.

> *'We had a project plan, which was to be communicated to our staff… It outlined the processes and who to contact regarding safeguarding, social services etc, who to refer a child with a cleft lip and pallet to. You have to think through every single pathway you follow, and explain it to staff.'*

Project plans and documentation such as those referred to above were useful both during the transfers and in the weeks and months afterwards, as staff became familiar with their new Trust and the partner agencies and pathways.

The detailed forward planning at Trust level also proved critical. There were strong project management skills and visible leadership within the units, along with effective communication to ensure everyone knew what was happening and when. Trust and Network managers ensured effective resourcing to support the transfers:

> *'I made sure we put staff where it was appropriate – we're lucky that the team are flexible. I was there on the day to support the move. Neonatal staff here are ok about working flexibly across sites, which helped us resource it.'*

The preparation and follow up monitoring were viewed by some clinicians as being overly burdensome at the time, but these processes were vital to ensure successful transfers.

Adopting a whole system approach – The tight programme management and regular communications ensured that the reconfiguration did not clash with other activities taking place within the Trusts. For example, engagement with leaders from Pennine Acute Trust ensured no conflicts arose as a result of their simultaneous Healthy Futures reconfiguration. The Network Team also managed to convince one Trust to delay their refurbishment until the transfer of patients across other units was completed, to maximise capacity in the system.

Reflections following each transfer – The delay between the Trafford closure and the implementation other Making it Better changes enabled lessons to be learnt and implemented throughout the remainder of the process. Working Groups fed back into the Programme Board, enabling formative learning to be captured regarding different aspects of the transfers.

> *'We had a flexible enough programme to make changes, and time the moves so it worked effectively. We could address critical issues and consider feedback that was being raised, or at least explain why we couldn't.'*

Formal and informal networks - Staff welcomed the formal and informal opportunities to reflect, and messages were shared openly with a view to informing subsequent transfers. The frequency of forums enabled staff to come together to discuss specific aspects of the reconfiguration. This generated a sense of common purpose amongst those involved in Making it Better. Equally critical were the informal relationships amongst staff. Many staff knew each other prior to the reconfiguration, and were able to draw upon these personal relationships as part of the formative learning process.

Monitoring and assurance processes - The RAG-rated quality assurance processes introduced by the Network Team for each service change seemed overly burdensome and 'tedious' to some at the time. However, it ensured the required processes were followed. Before and following the transfers, assurance visits took place to all reconfigured units. These enabled a variety of stakeholders to assess the impact of the changes and complete a checklist of monitoring requirements. However, further ongoing assurance visits were invited by some stakeholders.

Challenges and lessons learnt

Parity in reporting – The four Clinical Network Programme Leads all produced project plans in different formats, requiring additional work by the Network Team to synthesise the plans. This variation and additional work could have been avoided if standardised project planning systems had been introduced across the Networks from the outset.

Competing pressures – All clinicians involved in Making it Better also had clinical duties to perform, with many having to participate on top of their daily workload. Some struggled to commit the time to attend meetings or read documents; others worked in their spare time to ensure the process ran smoothly. Members of the Network Team also worked additional hours at key points, for example when preparing the consultation document, in order to meet the timescale requirements. This relied on personal dedication and passion.

> *'Clinicians have a day job to do. There were competing pressures, but it does need [their] input. It was hard to manage. You had to have clinical sign up to it, making sure clinicians were involved in decision making, including plans for building alterations etc. So that pulls them away from their clinical area.'*

Delays with opening the third neonatal unit – Delays in government sign-off of the expenditure required to create the neonatal unit in Pennine Acute led to timescales being pushed back, and required collaboration across the existing neonatal units in Greater Manchester. Additional resources were brought in to cover the shortfall, with staff having to transfer between the units as required to ensure the quality of care was not compromised.

> *'The delay was due to central government changes, we couldn't do anything about it. The impact of the delay was that we had a neonatal unit at Rochdale and Oldham, we had to look at the services we already had, to see how we could enhance them to take on the activity that was transferring. We had to do temporary work to increase the number of neonatal and children's beds and develop an observation and assessment unit.'*

Transfer of records – Despite managing a smooth transition process overall, challenges emerged when patient records were transferred later than expected, whilst others were concerned that women might 'slip through the net'. This led to additional workload in reviewing data, as well as anxiety for those managing the transfer within the Trust.

> *'The transfer of records wasn't straight forward, we didn't get the women's records from Salford that we expected. There's usually a summary sheet in hospital notes for pregnant women – we thought we'd get that, which would outline the plan for their care. We got the information fairly late, and we thought some [records] were missing. So we wrote to all women to tell them that they should make contact if they didn't hear from us. No one slipped through the net, but it generated some phone calls.'*

Lack of confidence during transfers – Despite the extensive planning and preparation, some staff managing transfers in Trusts did not feel confident in the processes they were putting in place or following, with many not having previous experience of managing similar processes or feeling confident in the assurance arrangements in place. This led some to feel they had to *'just do what felt right'.* This created additional anxiety for staff managing the transfer process. However, some reported benefitting from the personal development that managing the process entailed, whilst others welcomed the sense of 'ownership' and personal responsibility taken on my ward managers and heads of units.

Lack of formal de-brief - Despite informal reflection taking place, the lack of formal programme level de-brief at the end of Making it Better left some stakeholders wondering what lessons had been drawn from the process overall. Despite reviews taking place after each transfer, several stakeholders expressed a desire to reflect on and share their experiences across the programme. The high workload and tight timescales associated with implementation made it difficult for managers to formally reflect on the learning emerging whilst the process was taking place.

> *'We logged learning events, but we were so busy at the time, it was hard to stand back and reflect on it. You just get wrapped up in the process.'*

Collaborative working

Presented below are the key findings regarding collaborative ways of working. This builds on the 'Engagement and Consultation' and 'Managerial and Clinical Leadership' sections of this report.

Collaborative working was a key strength of the Making it Better reconfiguration, and a critical enabler to its success. Trusts worked in partnership with one another and the Network Team to ensure the transfers went smoothly. Collaborative working also took place across the local authorities of Greater Manchester. The joint working was supported by the formal structures of the Joint Committee of PCTs, the JOSC, Clinical Networks, the Network Supervisory Board, Programme Board, as well as informal relationships.

The Network Supervisory Board brought senior leaders together from across Greater Manchester, and provided strategic steer and oversight of the process. The Board was supported by the four Clinical Networks, which met regularly throughout the duration of Making it Better. The Clinical Networks provided a forum for senior clinicians within each specialism to come together to advise how best, and on what available evidence, to take forward the reconfiguration, and its impacts on their service area. Representatives from all Trusts came together in the Networks, providing a forum for considering how to achieve the best possible clinical outcomes across the Greater Manchester area.

The JOSC established on a Greater Manchester level brought together the ten (originally thirteen) participating local authorities into a collective overview and scrutiny function. The Joint Committee of PCTs operated under a similar structure. During the implementation of Making it Better, national policies outlined plans to abolish PCTs and introduce CCGs. Implementation of the changes was finalised shortly after Making it Better was completed.

The partners involved in Making it Better also benefitted from informal relationships that pre-existed the reconfiguration. Many of the clinicians in the area knew one another, having attended joint training opportunities or worked together previously. This facilitated collaborative working and proved to be a critical enabler during the implementation phase of

Making it Better. The medical workforce subgroup, for example, was there to advise on the strategic direction throughout the consultation and implementation phases, bringing together SHA, North West Deanery and Network leads with members of the Network Team

Trusts agreed to a centralised recruitment process led and coordinated by the Network Team to fill identified gaps in capacity in reconfigured units. Trusts and Clinical Leads agreed to standardisation where possible (for example, in the assurance processes) and agreed to collaborate to resolve issues emerging during the transfer process. This included delaying refurbishments whilst transfers took place across other units, and providing additional capacity when buildings were delayed.

Successes

Clinical Network structures covering Greater Manchester - The Clinical Networks enabled clinicians to take a Greater Manchester perspective, develop pathways of care, and provide consensus based on evidence wherever possible. This facilitated collaborative working, enabling clinicians to avoid 'parochial' mind-sets, and proved critical in generating consensus on the development of options. The Networks also provided formal and information opportunities for sharing formative learning.

The Joint Overview and Scrutiny Committee - This group is credited with facilitating collaborative working, by enabling senior officers from the local authorities to represent their authority's interests, whilst decision making took place at Greater Manchester level. Whilst all representatives lobbied on behalf of their local Trust, the remit of the group to reach decisions on a Greater Manchester basis facilitated collaborative working.

> *'I had to manage some of the local politics. It was a really hard tension for me wearing two hats. The Joint [Overview and Scrutiny] Committee gave us power, the air cover to advocate for a local position and remain onside with local politicians, whilst also being able to work towards the greater goal. Once the decision was taken by the Joint Committee I was bound to delivering the solution.'*

This group's purpose and remit was formalised, ensuring the governance arrangements could not be challenged. This proved helpful when controversial decisions were taken.

Informal relationships - Existing informal relationships between stakeholders working in Trusts across Greater Manchester helped to facilitate collaborative working. These pre-existing relationships meant that trust was already established in many places, and time did not have to be spent on building relationships from scratch.

> *'Relationships helped. Most clinicians at senior level knew each other, so that trust was built up. The clinical leaders knew everyone and could build on relationships with colleagues.'*

Leadership encouraging collaborative working - Leaders and senior clinicians recognised from the outset that the reconfiguration would not be an easy process, and would require careful negotiation and controversial decision making. They encouraged their staff to engage in the process and to work together to resolve difficulties which emerged.

> *'At times there were tensions, people didn't agree with the model or process necessarily. But that will always happen. It was overcome by strong clinical leadership, strong collaboration between the PCTs involved, and good understanding and leadership at Chief Executive level, even from units that would lose their services. Manager and*

commissioner involvement was key. But people did recognise that it wasn't sustainable to continue in the same way, they needed that leadership and to not let it falter.'

Recognised need to collaborate – Collaboration was facilitated by a shared recognition amongst senior clinicians from across Greater Manchester that the status quo was not sustainable longer term. By developing collective agreement regarding these principles before exploring the finer details of the options, a sense of collaboration was built.

'I was concerned about service sustainability. I came together with other clinicians to try to make it more sustainable. We recognised the need for change and re-organisation. We were part of the concerned group and wanted to improve the situation strategically.'

Supporting this was the understanding that Greater Manchester covers a large population and workforce, and that no one individual had the whole perspective. The inter-dependencies inherent in adopting a whole system viewpoint facilitated collaborative working amongst clinicians and leaders.

Large scale public consultation – As outlined in the 'Engagement and Consultation' section of this report, the Making it Better consultation generated the highest number of responses ever received at that time for a NHS consultation. In addition to generating a high volume of responses, the Network Team and Leads worked with local community leaders to train and empower them to carry out consultations with their local communities. This devolved responsibility from the Network, and proved effective in generating a wide range of different responses, including from 'seldom heard' communities. The consultation processes enabled local communities to work collaboratively with the Network Team to consider the options for future service provision.

Consultation teams were developed which were supported, trained and developed centrally by the Engagement Lead. The teams included Chief Executives, senior managers, clinicians, patient and public engagement leads, midwives and communications professionals. Resources and materials were made available which enabled effective and consistent approaches to engagement and communication.

Sense of momentum and shared endeavour – Once the need for change was agreed, there was a strong sense of momentum driving the programme forward, with recognition that it required input and commitment from all parties. The sense of 'all being in it together' encouraged ongoing dialogue and engagement, with one clinician stating that *'you don't want to be the weak link in the transfer process.'*

'The whole project had a strong sense of momentum. Partly [that was] to do with the scale and investment, and profile it had. Also the sense that this really had to be done – the hospital reconfiguration was going to happen, so people had to make sure it would work. Also, there was a sense of a 'moral purpose', people referred to it as important and worthwhile.'

Partner engagement – NWAS and Manchester University were engaged via both the formal and informal Making it Better channels. For example, NWAS was represented on the Clinical Networks. This collaborative working enabled wider considerations to be factored into decision making, ensuring clarity about the expectations of, and impacts on, other services: '*So we could have conversations and develop protocols based on that.'*

Ongoing collaboration to develop policies and protocols – Following implementation of Making it Better, work has continued to develop appropriate protocols, guidelines and procedures for staff working in the units. This has involved ongoing staff collaboration and

engagement; this includes those working alongside one another in newly formed or merged units, as well as cross-unit working to ensure alignment and standardisation where possible.

Challenges and lessons learnt

Sense of competition - Provider Trusts receive funding for services that they provide and cases dealt with (for example, inpatient admissions and length of stay). This created a sense of competition amongst some, with fear of 'losing out' on key services and the funding associated with delivering those.

Tensions also arose as a result of an underlying perception amongst some that one Trust was seen as the 'dominant' Trust. Some stakeholders perceived that they did not face the same scrutiny as other Trusts participating in Making it Better when decisions were being taken regarding where to place units. This led to tensions amongst some clinical staff working in other units across Greater Manchester.

Deviation from agreed arrangements - Some Trusts did not adhere to the collaborative recruitment agreement established as part of Making it Better, working outside of the arrangement to recruit their own staff in reconfigured units. Those that did participate were not always satisfied with the outcome, preferring to select their own staff and feel a greater sense of control over the process. This coincided with the development of Foundation Trusts, who were keen to pursue their own developments and recruitment and in some cases bypass the collective agreements.

Changes to PCTs – The disbandment of PCTs and introduction of CCGs led to a lack of continuity on commissioning boards at a critical time in the reconfiguration. This has led to a loss of some organisational memory at this level, and the need to foster and develop new relationships in areas where there was a change of staff and decision makers. A key learning point is that it is vital to maintain central continuity in the face of organisational or structural change, in order to drive through with agreed changes.

Challenge of engaging the right partners at the right time - GP engagement varied, with the Network Team struggling to consistently engage GPs in the planning and implementation phases. This was as a result of competing demands on GP time and limited budgets to provide backfill cover.

GP engagement – GPs were invited to participate in forums, attend Network meetings and decision making meetings, and formed a critical part in the patient pathway. They reported good information flows and communications; feeling informed about what changes were proposed, and the implementation plans. There was significant success in engaging GP commissioning consortia during the four tests review, being asked to confirm their support for the changes and whether they had any dissenting views. This was to ensure alternative proposals could be considered for clinical viability and affordability. All GP commissioning consortia agreed to continued support.

> *'As a GP, we did receive a fair amount of info about what Making it Better would do, changes to be made etc. But we were told [rather than engaged with].'*

Collaborative working in the newly established units - Whilst senior clinicians often had pre-existing relationships facilitating collaborative working, this was often not the case for more junior clinicians and support staff. Staff transferring from one Trust to another had to establish relationships with their new colleagues. The ease with which this occurred varied

significantly; whilst some colleagues coming together worked collaboratively as a single team within a few weeks, others report tensions still existing today.

> *'For our staff who were here throughout, people underestimated the impact on them, their service will change. Everyone wanted to change procedures. We had to work through the team dynamic – people aren't a team from the first minute, they have to develop as one.'*

Workforce planning and development

Presented below are the key findings regarding the planning and development of the neonatal, maternity and children's services workforce across Greater Manchester which took place as part of Making it Better.

The key strategic aim of the Workforce Strategy was to improve the quality and safety of care, enabling national standards to be met. This included standards and guidelines regarding consultant obstetric ward presence, Birth Rate Plus standards for midwifery, and Royal College of Nursing staffing standards, whilst also ensuring the requirements of the EWTD could be met.

The Network Team negotiated a £65 million five-year budget to deliver 'Making it Better'. This was used to recruit project staff, pay for double running costs when major services transitioned from one location to another and support the costs of decommissioning services.

Implementation of the reconfigured model commenced in 2007 and was completed in 2012. Since the original decision in 2007, over £120 million has been invested in new buildings and equipment.

Extensive workforce modelling was undertaken to define the optimum number of clinicians to deliver the safest and most effective service across the eight units. This drew upon the national standards outlined above, and the resulting model was reviewed by a large number of clinicians and national bodies including the Royal Medical Colleges. A 'best practice' model for the staffing requirements for community nursing teams was also used. During the implementation phase, there was a dedicated Programme Lead for Workforce Implementation, supported by a HR Adviser and a Medical Strategic Workforce Lead, as well as the Clinical Leads. A Workforce Strategy was produced bringing together medical education/training and staffing requirements for the units. This Greater Manchester strategic approach, coupled with tight project management, enabled the Network to take a holistic view of the staffing requirements across Greater Manchester, and to undertake centralised recruitment in a staged way as required**.**

Extensive staff engagement and communications took place throughout Making it Better. This included formal communications delivered via letters, newsletters and 'cascade approach' briefings, as well as informal engagement within teams. Aspiration interviews took place, with each staff member in decommissioned units having two rounds of interviews with a member of the Network Team and the HR Lead. During these interviews, staff were given the opportunity to state their preferred transfer destination. Staff had the opportunity to change their minds, and steps were taken to accommodate staff wishes where possible. A formal appeals process was introduced as part of Making it Better.

Prior to transfers taking place, managers from the 'new' units visited staff in units that were being decommissioned, to meet with them prior to the transfer. These informal visits were accompanied by a formal induction programme and steps to accommodate the shift and annual leave preferences of transferring staff wherever possible.

Staff in the units taking on new joiners also introduced informal buddying arrangements, and welcomed new joiners into the organisation by organising and self-funding buffets during lunchtimes on the first week, as a way of getting to know their new colleagues.

Successes

Workforce modelling based on agreed standards - The detail, transparency and robustness of the workforce modelling, combined with endorsement from the RCPCH, and the objective of achieving national standards, were key factors in gaining clinical buy-in to the model. Both the modelling and engagement with clinicians were substantial pieces of work carried out in a great deal of detail and sustained over the duration of Making it Better. For example, clinical scenarios were used to inform the competencies needed, and a complex matrix was developed to plan the workforce requirements. Also the '11 cell model' was developed and agreed across the Clinical Networks, as a way of ensuring that junior doctors had adequate exposure to training opportunities, by employing eleven doctors at middle grade level. This was further refined to include consultants carrying out resident shifts, as a way of meeting the EWTD requirements and supporting doctors in training, and was quoted as an example of good practice in the Temple report[8].

> *'We could show that we were investing to achieve workforce standards, and that helped get buy in.'*

Planning and organisation of the process – The time spent communicating with staff and exploring the competencies needed in each unit was a particularly effective element of Making it Better. The allocation of staff to different units involved responding to changes as they occurred; for example, when staff left the organisation or changed their transfer choice. This required a high level of organisation and commitment by the Network Team's HR lead, as well as input from staff and managers within each Trust. A strategic report produced by the Network Team also helped to guide the HR process across Greater Manchester.

Aspiration interviews - The two-wave aspiration interviews were particularly effective in engaging affected staff on a one-to-one basis, providing them with a confidential opportunity to express preferences regarding their transfer. These interviews also provided the opportunity for staff to ask questions and put their views across to those managing the process, helping staff to feel listened to and valued within the process.

This deviation away from the traditional TUPE model gave staff a choice in the process and tried to match their skills and aspirations with service demands.

> *'The aspiration interviews were well designed, it was clear what we were trying to achieve. Don't underestimate how valued they were by staff, it was one of their chances to feed in to the process.'*

The formal appeals process enabled staff to challenge decisions that they were not satisfied with, and the whole process was underpinned by clear policies and guidelines. The aspiration interviews and transfer planning process mitigated the risk of some staff leaving the workforce or grievance proceedings being issued.

Whilst the aspiration interviews proved effective in ensuring staff transferred to their preferred

[8] Professor Sir John Temple: Time for Training (May 2010)
http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf

option wherever possible, the process was extremely time consuming and required a huge amount of organisation and resource. Staff often changed their minds mid-way through the process, and a lot of man-hours went into preparing for, attending and then following up after the aspiration interviews. Not all staff could be placed in their first choice Trust, leading to some dissatisfaction, whilst staff changing their minds led to a constantly evolving picture.

> *'Staff choice was critical in the decision making. But in cases of a large move across two sites, as in Trafford, it could be hard to manage the transfer aspirations if they didn't match the staffing needs across the units.'*

Specialist HR input – The Network Workforce Lead provided specialist HR expertise into the Making it Better process, and forged effective linkages with Manchester University and employers across Greater Manchester. This ensured alignment and also integration with the training and placement programme for junior doctors. There was a strategic overview of the training requirements both during Making it Better and over the longer term.

Visible management – The visible leadership provided by ward managers helped staff transferring into their units to feel welcomed and familiar with their new manager. Likewise, it provided a valuable opportunity for ward managers to get to know their new recruits. Managers remained highly visible during the weeks following the transfer.

Proactive union engagement – Unions including the Royal College of Nursing and Unison were actively engaged as part of Making it Better, enabling them to champion the interests of their members and remain involved and informed about changes proposed and being implemented. Trade union stewards helped to support staff in the affected units whilst the changes were taking place.

Peer support for transferring staff – The self-directed steps initiated by staff to help their new colleagues to feel welcomed were valued. Whilst not universally successful or adopted in all units, these proved successful in fostering a sense of team relatively quickly in some of the units. Staff referred to a feeling of '*togetherness in adversity'*, with examples of new and old colleagues pulling together in solidarity.

Challenges and lessons learnt

Developing the workforce strategy and plan – The Network Team developed a workforce strategy and several iterations of the workforce plan. The plan was dependent on baseline information being obtained from, and agreed by, all provider organisations. However, obtaining this was time consuming. The workforce planning proved challenging and time consuming.

Later inclusion of maternity services – Maternity services were not considered in the service reviews or reconfiguration proposals considered prior to Making it Better. This led to some midwifery staff feeling that plans for their service area were developed too quickly. This led to some staff feeling disenfranchised from the process.

The Network Team had to make significant efforts to redress the balance, and stakeholders report a sense of disenfranchisement following initial inclusion. This was addressed by ensuring that specific engagement projects built on the contacts, expertise and knowledge of midwives and lead managers in the Trusts.

Central recruitment – The centralised recruitment process was designed to ensure that sufficient staff were in post to match the workforce plans agreed. However, challenges emerged regarding the lack of input that unit managers had in the selection process. Some managers experienced problems with cultural fit and were wary about taking on staff that they had not recruited.

> *'In the early days of the workforce plan in 2009-10, the recruitment to neonatal nursing was undertaken by the central [Making it Better] team. The principles were ok, but it became challenging because providers felt it wasn't an efficient way to recruit staff to teams. For example, they did central recruitment of Band 5 nurses, who would be allocated to a unit. So the units got an allocation of nurses that they hadn't interviewed for their team. Neonatal unit managers felt they would prefer to appoint their own staff. It was probably done so recruitment could be tracked and controlled.'*

Securing temporary staff cover - The Network recruited clinical staff to provide cover across different units whilst the transfers were taking place, to plug gaps in capacity but avoid longer term over-staffing. These staff were intended to rotate around different units, but post-holders left their posts shortly after recruitment.

Importance of organisational culture and supporting staff during the transition - Organisational culture and 'fit' are critical success factors for any service reconfiguration; it is vital that staff feel comfortable and productive within their new unit and when working with new colleagues. Staff transferring to other units as part of Making it Better had varied experiences of the process, as outlined above; whilst some managed a smooth transition, for others it was a more challenging move which caused great upheaval. Steps were taken to try to alleviate the anxieties of staff; however, these were not always successful, with high levels of concern reported amongst staff in some of the units being decommissioned. Concerns ranged from fear about not having a role in the reconfigured service, to concerns about organisational culture, having to adapt to new ways of working, or more logistical issues regarding car parking or annual leave arrangements at their new workplace.

> *'The biggest opposition to reconfiguration is that people don't want to move from their unit. They worry about shift patterns, new ways of working etc. Some clinicians just decide to retire.'*

These challenges have not been quickly resolved in all units, with some staff still reporting difficulties in building a cohesive culture within reconfigured units.

> *'The radical change was hard for staff at Hope [Hospital], which was completely de-commissioned... It's more about team working, shared experience, it doesn't emerge overnight and you can't just focus on the physical moves.'*

Some units lost staff following the reconfiguration, with those unhappy following the changes deciding to look for alternative employment elsewhere. There is anecdotal evidence that this was a particular challenge when staff from smaller, more specialist units transferred to merged units, and had to adapt to new ways of working.

Stakeholders referred to a 'family' culture in some of the units, which takes time to establish elsewhere and was difficult for staff to leave behind. Some suggested that there was insufficient support to help transferring staff to adapt to ways of working in their new workplaces, with a pressure to '*just get on with it'* being reported in some units.

Wider factors impacting on staff willingness to transfer - Many of the nursing staff were not the main earner within their household, with many staff being part time or managing their hours around caring responsibilities. This led to reluctance amongst some to transfer to a new workplace; part-time hours and lower wages meant that additional travelling time and costs incurred as a result of the reconfiguration made employment less viable.

Some perceived that the implications of the additional travelling costs and journey times on individual staff were underestimated, leading to some staff seeking alternative employment elsewhere.

Consultant influence - Consultants historically have a strong influence over decision making within Trusts; Making it Better was no exception to this. Challenges emerged when consultants were unwilling to work in ways recommended by the Clinical Network or Network Team. For example, some paediatric consultants refused to change the resident consultant shift patterns, despite evidence of the case for this work pattern in order to have senior clinical decision making at critical times, and with endorsement by the Paediatric Network Board. However, several units did reshape their working patterns for the team so that consultants were providing resident shifts at peak times of activity.

Another example of consultant influence was the reluctance of surgeons on one site to provide a surgical opinion for children, despite this being an agreed component of the Making it Better model.

Lack of equipment standardisation - Consultant influence dominated decision making regarding equipment purchases. This led to a lack of standardisation across Greater Manchester, as consultants expressed strong preferences for particular providers or specifications. This creates challenges when transferring staff across units. Staff in the units are trained and familiar in using a particular item of equipment; when they move to work in another unit using equipment with a different specification, they require additional training and induction time.

Complex cultural demands – Greater Manchester has a very diverse population, with different units facing different demands and challenges. This impacts on staff capacity and skill requirements, as one GP observed:

> *'You need to consider demography of women giving birth, the women of Manchester are multicultural and come with different expectations. There can be problems associated with vitamin D deficiency or the need for translators. These challenges all need to be managed.'*

Staff burn out – Following the transfers, some staff experienced 'burn out' or fatigue, due to the additional hours worked and the challenges associated with ensuring safe transfer. The lack of formal recognition for staff playing pivotal roles or making sacrifices in order to facilitate successful transfers compounded this for some.

Challenge of placing senior staff – The reduction from twelve units down to eight resulted in reduced demand for ward sisters. This led to difficult decisions being taken by the workforce planning leads and unit managers regarding where to place those with senior roles. In addition, staff transferring from decommissioned units often brought specialist skills and experience, which were also challenging to place under Making it Better workforce plans. This was mitigated by extensive discussions with staff and attempts to place them in roles and units which met their interests. The majority but not all preferences could be accommodated as part of the process.

Previous HR issues not considered – Challenges emerged when placing staff with previous HR complaints or concerns regarding competencies, and the extent to which previous concerns could be considered as part of the workforce planning process.

Variations in community nurse remits - The introduction of children's community nursing teams across Greater Manchester created some challenges with regards to staff development. The nursing staff within the Making it Better clinical model were expected to rotate between the community, emergency and if possible, inpatient settings. The skills required to provide care to sick children in community settings are different to those required for providing care in acute settings, and the introduction of new community-based posts led to some challenges with recruiting staff with the necessary competencies.

Variations in competencies - Ward managers raised concerns that some of the staff they transferred into their units did not have the full complement of competencies that they would typically expect new recruits to have. For example, Band 6 and 7 clinical staff transferring to an intensive care unit did not have the expertise normally expected of that grade working in an intensive care unit. Additional training had to be provided by Trusts in order to fill the skill gaps identified.

> *'It wasn't such an issue for the junior bands. Band 5s were offered to support regarding intensive care clinical competencies. We had to also offer it to Band 6s and 7s, normally you'd expect them to come with that clinical expertise. That's a baseline normally for shortlisting for interview, but we had to work with them around it.'*

Separation of gynaecology and obstetrics services - Following Making it Better, these services were separated in Salford Royal, whilst both functions continued to be carried out at Bolton Royal. Because the services are commonly jointly provided, clinicians are usually trained and retain competencies in both services. Consequently, some staff were unwilling or reluctant to move to hospitals where both services are not provided. This separation impacted on medical training opportunities. This has impacted on gynaecology departments, despite that function falling outside of the Making it Better remit.

Delay in developing new guidelines and protocols – In order to generate consensus and buy in regarding ways of working, some newly merged departments waited until all transferring staff were in post before reviewing procedures and protocols. Whilst this was anticipated to lead to greater buy in longer term, it caused some initial challenges as staff in that unit did not have up to date guidelines to follow from the outset.

Challenge of sustaining sufficient capacity – Clinicians and managers in some units report a lack of capacity to meet the demands placed on the service. This was as a result of the need to predict future birth rate numbers, challenges associated with responding to diverse cultural needs, variations in the roles undertaken by community nurses, and recruitment freezes in some units.

Financial planning

Presented below are the key findings regarding the financial planning that took place as part of Making it Better.

Making it Better commenced at a time of different financial circumstances across the public sector as a whole. There was shared understanding that the Making it Better process would require significant investment of £65m over a five year period in order to achieve sustainable high quality children's and maternity services across Greater Manchester. The capital programme of new hospital facilities and buildings was financed with £120 million.

Several key policy drivers informed Making it Better. These included immigration law changes, which placed restrictions on junior doctors coming into the UK to provide care.[9] The European Working Time Directive (now EWTR) also acted as a key driver for change, limiting junior doctor working hours to 48 per week.

The reconfiguration itself had a ring-fenced budget to cover the costs associated with all aspects of the process, from pre-consultation through to the final stages of implementation and assurance. Assurance processes were put in place to ensure that the programme funding was spent effectively and as originally intended. The Programme Board held this accountability, and the SHA and commissioners were represented in regular meetings to review key issues, next steps and ensure the process remained on track.

Specific budgets were allocated for all aspects of the reconfiguration, including option development, consultation, communications, capital investment, HR and recruitment, project management and assurance.

Trusts provided additional resources both before and during transfers, and managers secured funding from the Making it Better budget to provide agency staff coverage. This flexible approach enabled Trusts to meet on-going service demands whilst the reconfiguration took place.

The on-going costs associated with delivering inpatient and community based services were factored into the financial planning process. Staff recruited on a temporary and permanent basis had to be costed into the model, whilst the model of paediatric community nurses that was developed also had to be resourced. This was based on good practice identified in operation at Tameside Hospital, and rolled out across Greater Manchester as part of Making it Better.

Successes

Efficiency savings as the secondary focus - The focus on the clinical case for change enabled the Network Supervisory Board and all supporting groups to focus on patient care. From the outset, it was recognised that the reconfiguration would require short term investment in the system, with the expectation that in the long term it would lead to improved

9 The change to immigration rules in March 2009 means that those applying for the tier one category (covering junior doctors who have completed the foundation stage of their training and want to move on to specialist training), require a master's degree. But a medical degree is only classed as a bachelor degree. http://news.bbc.co.uk/1/hi/health/8048744.stm

patient outcomes. This enabled focus to be placed on developing the most clinically viable models, with new capital infrastructures being commissioned to support the new units. .

> *'It was planned to invest in the service, more nurses and community paediatric staff – so as well as reducing units and making savings, there was the development of the service – both capital builds and staffing costs.'*

Longer term benefits for both patients and from a financial perspective can be assessed by the systems and processes in place, for example assessing locum usage and medical negligence claims.

Ring-fenced budget for the reconfiguration – The ring-fenced investment into Making it Better was essential to its success; stakeholders argued that the reconfiguration could not have succeeded to the same extent had the programme not been so well resourced:

> *'The amount of money invested in the reconfiguration was essential – it did have a sufficient budget supporting it, and without that, it wouldn't have been so easy to provide a project team, or to really plan services to be effective. It might have been a more piecemeal effort without the funding.'*

In addition, there was financial support for the engagement process and clinical modelling. The aim of this funding was to utilise the learning from this large scale exercise and new methods in engagement and clinical involvement.

Consideration of Trust finances - Partners in all Trusts were kept well informed about the finances supporting the reconfiguration, and could consider how the changes would affect their future financial planning. At an operational level, Trusts reported that transitional costs were factored in from both their own budgets and the central programme budget, to enable the transfers to be sufficiently resourced.

> *'It worked well for us – our team knew what the budget changes were and how that would work for PCTs. The Network [Team] were flexible enough in that we could access more money when needed for education changes.'*

Flexible and responsive resourcing - Making it Better generated innovation and creative thinking to resolve challenges in providing high quality care across Greater Manchester. For example, when delays in government decision making meant that the third neonatal unit was not able to open on time, another unit took on additional cots on a temporary basis to ensure service provision was not compromised. Without sufficient resourcing, this would not have been possible. Staged finances were provided at key points, for example ensuring Trusts had sufficient money in advance for recruitment. Targeted financing was viewed as an enabler to change, with the Network Team monitoring expenditure to ensure accountability in how funds were utilised.

The use of national standards – National standards were considered when planning service provision across Greater Manchester, and attempts were made to adhere to these wherever possible. Stakeholders agreed on the aspiration to achieve the Royal College of Midwife's Gold Standards using Birth Rate Plus, the BAPM staffing rates for births, RCOG standards for consultant labour ward presence, and best practice advice for community

nurses and paediatricians, as well as guidance from the Academy of Medical Royal Colleges[10].

Achieving these standards meant investing in staffing levels in the specialist units, whilst also increasing the levels and competencies of community nurses. The costs associated with adhering to national standards were factored into the financial modelling work undertaken by the Network Team.

Adaptation of tariffs - National tariffs were adapted where they were not perceived as meeting local needs. For example, a Greater Manchester top-up tariff for maternity care was developed, to ensure dedicate funding was available to fund local provision. This innovative thinking was credited as a success factor of Making it Better, as one stakeholder reported: *'This shows that you should think creatively about the financial model.'*

Challenges and lessons learnt

Financial disincentives - Stakeholders report that financial disincentives within the NHS discouraged efficient use of resources in some cases. Trusts were seen as operating in competition, receiving funding for all patients admitted.

> *'There was a problem that there were financial disincentives in the system. So if you arranged a child's care so they weren't admitted, the Trust would lose some money – so it wasn't in the financial interests of a Trust to not admit a child. These were difficult problems for people to work with.'*

This conflicted with the desire to provide community-based care to children and expectant mothers. This was resolved as part of Making it Better by the strong desire to work collaboratively to achieve the vision of improved clinical care across Greater Manchester. This highlights the importance of developing a strong vision that stakeholders buy in to.

> *'The need to balance the books – those drivers weren't necessarily in sync with the desire to look after children at home. Perverse incentives confused the issue. It made it hard for people running services to have to make sure that they were meeting financial targets. How was this resolved? [It was] because people had a sense of common purpose, and tried to work around the issues to make sure it didn't stop the development of services happening. It wasn't seen as a barrier, it was a hard hurdle to get over.'*

Other referred to 'horse-trading', with Trusts competing for new buildings and resources as part of the reconfiguration.

Challenge of full financial modelling – It was challenging for the Network Team to obtain a full picture of the service costs across the whole system.

> *'The financial analysis was ok, but it could have been stronger.'*

Stakeholders reported that the financial modelling could have been improved, with greater attention paid to the longer term financial implications of the reconfiguration plans.

Perceived lack of transparency – Directors of Finance from the Trusts involved in Making it Better met and worked collaboratively, and financial models and detailed analysis were shared with those who needed to have an oversight of that level of detail. This negated the

[10] The Benefits of Consultant Delivered Care. Academy of Medical Royal Colleges, January 2012

need to engage in extensive discussions with others who were not involved in the financial aspects of the reconfiguration, but was perceived to be a barrier to transparency in the decision making process. During Programme and JOSC meetings stakeholders raised their concerns regarding the balance of information provision, and there was ongoing debate about the need for strong financial information, especially regarding the benefits of the changes. The Independent Review Panel subsequently identified this as a theme in all reconfigurations, with planners frequently failing to provide sufficient detail regarding financial modelling and information.

Changing financial climate - Despite the financial climate changing whilst Making it Better was still being implemented, some stakeholders report that they felt powerless to revert decisions that had been taken following the consultation process. They report a lack of clarity about which decisions were 'set in stone' and had to be followed through, and which elements of the plans could be reconsidered in light of the changing financial climate.

Some argued that the Making it Better reconfiguration focused too greatly on the clinical case for change.

Impacts on other services – North West Ambulance Service (NWAS)

Whilst consideration was given to the knock-on impacts and consequences for other services, this was identified as an area for improvement. Making it Better led to changes in demand for other services, including for example, NWAS. This has implications for their service planning and financial modelling, and Making it Better operated alongside other reconfigurations.

As a direct result of variable community midwifery services across Greater Manchester, NWAS commenced added training for their senior staff to deal with obstetric emergencies. In addition, the medical priority dispatch system grades some pregnancy-related conditions as a lower priority than other emergencies, which can lead to a perceived delay in ambulance attendance.

> *'Under Making it Better there are fewer, [more] expert units that are often busy. Community midwife availability is more variable now, in some part of Greater Manchester there are reduced numbers. It's an issue for us – knowing what we can expect in the patient's home…'*

NWAS report that slightly longer journey times have arisen for patients in some areas partly as a result of the reconfiguration. Patients were made aware of this during the consultation phase, and were advised to call for an ambulance earlier than they would have previously.

Sustainability challenge – Whilst Making it Better took place, finances within the public sector as a whole, including the NHS, became increasingly under pressure. There was a perception amongst some that there should have been greater future proofing of the models developed, with greater consideration given to potential funding restrictions within the NHS.

Concluding comment

This report presents the many and varied lessons emerging from the Making it Better reconfiguration. A number of the characteristics of Making it Better were unique to the programme, given the scope and scale of the changes, and the era in which they were undertaken. This report does not argue that all the learning will necessarily be relevant to the current health and care context, but that organisations considering future service changes may find there are useful pointers to help shape their own plans.

The majority of stakeholders involved in the evaluation were, on the whole, confident that Making it Better achieved what it set out to do, and was a success. This report has explored process learning emerging from the reconfiguration programme itself. Some stakeholders have suggested that valuable learning could be captured to supplement the findings by undertaking a summative evaluation of the impacts emerging as a result of Making it Better. These might usefully include the financial, care quality, workforce and patient experience impacts. Whilst interim monitoring reviews have been undertaken following each unit change, and overall monitoring reports were compiled at the end of the reconfiguration and reviewed by the Network Supervisory Board, we suggest that undertaking a programme level review of the outcomes emerging may help to strengthen the findings presented here.

Appendix A: Stakeholder briefing note

Evaluation of 'Making it Better': Evaluating the reconfiguration of Children's, Neonatal & Women's Services in Greater Manchester

The Strategic Health Authority (SHA) for the North West contracted the Office for Public Management (OPM) to undertake an evaluation of the 'Making it Better' reconfiguration of Children's, Neonatal & Women's Services in Greater Manchester. NHS England will, as the successor body to SHAs, oversee the project from April 2013.

The evaluation will capture valuable learning from 'Making it Better' to inform future major service change and reconfiguration in the NHS. Specific objectives of the project are to:

- Increase the evidence base for major service change and reconfiguration in the NHS.
- Capture specific and generic lessons and best practice, with commentary on how these can be applied within the current NHS context of structural reforms and financial constraints.
- Provide a clear understanding of the process of implementing major change, to support such change being managed effectively, with greater consistency and to save others 're-inventing the wheel'.
- Enable commissioners and providers of NHS services to identify which approaches should be considered when developing and implementing proposals for major service change to support the delivery of improvements in health outcomes.

Stakeholder involvement

The evaluation focuses upon the implementation of 'Making it Better' and involves a wide range of stakeholders who have been involved in or affected by the reconfiguration. These include senior leaders and managers, programme staff, clinicians, commissioners, women and children and young people using services, community groups, media and politicians.

OPM are inviting stakeholders to participate in a one to one or small group interviews or attend a focus group. Interviews will last around 45 minutes and focus groups 1-2 hours.

We would welcome your involvement in the evaluation by taking part in an interview. Participation is voluntary; your feedback will be treated as confidential, data will be handled in accordance with the Data Protection Act, and all findings will be reported anonymously.

The project is running until September 2013. The outputs will take various forms and be made publicly available by the SHA.

Contact details and next steps

For further details, please contact Lauren Roberts (email: lroberts@opm.co.uk, mobile: 07920 492222)

One of the evaluation team will contact you shortly to try to arrange a convenient interview time. If you do not wish to participate, please do let us know.

Many thanks in anticipation of your help.

Appendix B – Documents reviewed

- AoMRC. (2012) The Benefits of Consultant-Delivered Care. *Academy of Medical Royal Colleges*
- Shacklady-Smith, A. (2008) Making It Better; An evaluation of large-scale public consultation and engagement in the reconfiguration of in-patient services for women, babies, children and young people in Greater Manchester, East Cheshire and High Peak. *University of Manchester*
- Burns, F. (2013) Reorganisation of maternity, paediatric and neonatal services in greater Manchester, "Making it better" 2002 – 2012: final report to the programme board
- Broderick, C. From Vision to Reality; Influencing change and improvement in health services for children and young people through patient and public involvement
- Bishop D., Bidwell, H (2004) Greater Manchester, East Cheshire & High Peak Children & Young People's Network; a report of the maternity services citizens' council. *Vision 21*
- Independent Reconfiguration Panel. (2010) Learning from Reviews; an Overview. Third Edition. *IRP*
- Making it Better Consultation – review (No author)
- Making it Better (2010) Satisfying the 4 Reconfiguration Tests; Volume 2: Supporting Information, Test 2: Patient and public engagement and Test 4: Patient Choice
- Rogers, Y (2010) Making it Better for children, young people, babies and families. South West Sector - Project Closure Report
- Platt, J. (2012) Making it Better for children, young people, babies and families. Project closure Report: Re-commissioning Salford
- Platt, J (2012) Making it Better for children, young people, babies and families. Project closure Report: Re-commissioning Bury
- Platt, J. (2012) Making it Better for children, young people, babies and families. NICP Project Closure Report: Establishment of a Neonatal Intensive Care Unit and Tertiary Maternity Service at Royal Oldham Hospital
- Heritage, A., Clarke, J. (2011) Making it Better for children, young people, babies and families. Rochdale Next Steps: Lessons Learnt Report
- McNally, D., Bell, M. (2012) NHS North West; Making It Better (MiB) Monitoring Assurance update
- Dowler, C. (2012) Great Manchester Changing Primary Care. *HSJ Local Briefing*
- Royal College of Paediatrics and Child Health (2012) Mission, Vision and Values
- Whittle, M. (et al) (2007) Safer Childbirth. Joint publication of the Royal College of Anaesthetists, the Royal College of Midwives, the Royal College of Obstetricians and Gynaecologists and the Royal College of Paediatrics and Child Health
- The Scrutiny Committee (2006) Making it Better for Children, Young People, Parents and Babies in Greater Manchester, East Cheshire, High Peak and Rossendale: Consultation Document, Response of the Making it Better Joint Health Scrutiny Committee
- Temple, J. (2010) Time for Training. Medical Education England

Appendix C - Stakeholder involvement in this evaluation

The tables below show the stakeholders who have informed this evaluation. This includes those who have taken part in an interview, as well as those who have attended one of the three events that we have organised as part of the evaluation process.

Stakeholder Interviews

Name	Organisation and role
Alan Russell	Obstetrics & Gynaecology Consultant and link to BMA, Pennine Acute Hospitals NHS Trust
Alex Heritage	Service Transformation & formally CYP&F Network team
Andrew Bingham MP	Member of Parliament for the High Peak
Andrew Lansley MP	Member of Parliament, Secretary of State for Health until September 2012
Rt Hon Andy Burnham MP	Member of Parliament for Leigh
Anjal Ahluwalia	Consultant Obstetrician & Gynaecologist, University Hospital South Manchester NHS Foundation Trust
Dr Ann Hoskins	North West Strategic Health Authority, Director of Children, Young People & Maternity
Anthony Emmerson	Greater Manchester Neonatal Network
Avril Danczak	Primary Care Medical Educator / Trainer
Barbara Barlow	Bury Links
Dr Bose Haider	Pennine Acute Hospitals NHS Trust, Paediatric Consultant
Dr Bunmi Lawson	Tameside Hospital, Lead Consultant Paediatrician
Carol Ewing	RCPCH / Central Manchester Foundation Trust Hospital
Cath Broderick	Royal College Obstetricians and Gynaecologists - Chair of RCOG Consumers Forum
Dr Chris Clough	National Clinical Advisory Team, Chair
Chris Jefferies	NHS Northwest, Interim Director of Workforce and

	Education
Christine Ashworth	Neonatal Network Manager in Greater Manchester
Christine Morgan	Chair of Paediatric Network Board/Chair of the Development Board for CSS
Claire Swithenbank	NHS North West / NHS England, Regional Lead
Claire Woodford	Stockport NHS Foundation Trust, Children's Services Manager / Lead Nurse
David McNally	NHS North West / NHS England, Deputy Director for Patient Experience
David Nuttall MP	Member of Parliament for Bury North
David Ratcliffe	North West Ambulance Service, Deputy Medical Director
Denise McTaggart Richardson	Neonatal Nurse Manager, Stockport NHS Foundation Trust
Graham Brady MP	Member of Parliament for Altrincham and Sale West
Hazel Blears MP	Member of Parliament for Salford and Eccles
Heather Birds	Associate Director of Operations Family Division, Bolton NHS Foundation Trust
Hugh Mullen	Pennine Acute Hospitals, Director of Operations
Dr Ian Dady	Consultant Neonatologist, Clinical Lead, Greater Manchester Neonatal Transport Service, Central Manchester University Hospitals NHS Foundation Trust
Dr Ian Yates	Neonatal Lead Nurse, Pennine Acute Trust, Royal Oldham Hospital
Dr Jacqueline Birch	Consultant Paediatrician, Tameside Acute NHS Foundation Trust
Jeanette McGrogan	Central Manchester University Hospital NHS Foundation Trust, Head of Service
Jill Colbert	Head of Service, Commissioning; Integrated Commissioning Unit, Trafford
Jim Bruce	Clinical Head of Division, Tertiary Centre Provider, Central Manchester University Hospitals NHS Foundation Trust

Joanne Ellis	Associate Director Women's & Children's Services, Stockport NHS Foundation Trust
Jonathan Moise	Greater Manchester Paediatric Network, Clinical Lead
Jonathan Martin	Service Transformation Team & formerly CYPFN team
John Saxby	Chief Executive, Pennine Acute Hospitals NHS Trust
Julie Flaherty	Children's Consultant Nurse, Salford Royal Hospitals
Karen Bancroft	Consultant in Obstetrics & Gynaecology (Maternity Network Board), Royal Bolton Hospital
Karen Connolly	Acting Divisional Director, Central Manchester University Hospitals NHS Foundation Trust
Karen Kenton	Lead Commissioner - Children & Maternity, NHS Heywood, Middleton and Rochdale
Karen Mainwaring	University Hospitals South Manchester
Kate Green MP	Member of Parliament for Stretford and Urmston
Kirstie Haines	Programme Director, Greater Manchester Public Health Network
Leila Williams	Director of Service Transformation, former Making it Better Programme Director
Lesley Gaskell	Royal College of Midwives
Lesley Mort	Deputy Managing Director, NHS Heywood Middleton & Rochdale
Dr Lisa Kauffman	Consultant Paediatrician; Clinical Director Children's Community Services Central Manchester University Hospitals NHS Foundation Trust
Mark Robinson	Greater Manchester Paediatric Network - Clinical Lead & Consultant Paediatrician at Wrightington, Wigan & Leigh NHS Foundation Trust
Mary Rooney	Retired from Royal College of Midwives
Dr Massarano	Tameside General Hospital, Paediatrics
Matthew Bluck	NHS Northwest, Workforce modeller
Maxine Pamphlett	Lead Nurse - Clinical Support Services & Tertiary Medicine,

	Salford Royal Hospitals
Dr Olubusola Amu	Clinical Director of Obstetrics and Gynaecology – Pennine Acute Hospitals NHS Trust (Fairfield General Hospital)
Michael Maresh	Previous Lead Obstetrician, Greater Manchester Children, Young People & Families' NHS Network
Mike Burrows	Director, Greater Manchester Area Team, NHS England, formerly Chief Executive, NHS Greater Manchester
Dr Ngozi Edi-Ogasie	Clinical Director for Newborn Intensive Care Services, Saint Mary's Hospital Central Manchester University Hospitals NHS Foundation Trust
Nick Fayers	Commissioning Manager, Children's Commissioning, Cumbria CCG
Nick Hall	NHS England, Head of Service Reconfiguration, Strategy Team
Pat McKelvey	NHS Tameside and Glossop, Children's Services Manager
Paul Healy	Academy of the Royal Medical Colleges
Professor Peter Callery	University of Manchester, Chair in Children's Nursing
Peter Powell	NHS Northwest, Previous Paediatric Clinical Lead
Ruth Clay	Clinical Lead, Panda Unit, Salford Royal NHS Foundation Trust
Salman Desai	North West Ambulance Service
Sam Bradbury	Deputy Director, Commissioning & Quality team NHS Manchester CCG North, formerly Head of Children's Commissioning NHS Manchester
Dr Sarah Vause	Clinical Lead for Obstetrics, Central Manchester University Hospitals NHS Foundation Trust
Sheila Shribman	Now retired, previously Department of Health National Clinical Director for Children, Young People and Maternity Services
Stephen McLaughlin	Children Services Manager, Tameside Hospital
Sue Anderton	Acting Head of Midwifery, Royal Bolton Hospital NHS Foundation Trust
Sue Coates	Royal College of Midwives, Retired

Susan Elliott	Commissioner for Children's Services, NHS Ashton Leigh & Wigan
Wendy Pickard	Associate Director of Operations Family Division, Bolton NHS Foundation Trust
Yvonne Tunstall	Pennine Acute Hospitals NHS Trust, Divisional Lead Nurse

Clinicians Workshop – 23 September 2013

Name	Organisation / Role
Alison Whitman	East Midlands NHS
Dr Alyson O'Donnell	Consultant Neonatologist, Divisional Clinical Director
Bernadette Hurst	Strategic Clinical Networks Manager (Cheshire & Merseyside)
Bob Winter	NHS England, National Clinical Director for Critical Care and Emergency Preparedness
Catherine Calderwood	National Clinical Directors for Maternity
Charlotte Joll	South West London, Programme Director, Better Services Better Value
Chris Clough	Chair, National Clinical Advisory Team
Christina McKenzie	South West & Surrey Downs, Newborn and Maternity Development Lead
David McNally	NHS England, Deputy Director for Patient Experience
Dot Parry	Independent Midwife, Birth Care Manchester
Fiona Smith	Chief Operating Officer and Deputy CEO, Barnet and Chase Farm Hospital Trust
Geoff Lawson	Consultant Paediatrician, Sunderland Royal NHS Foundation Trust
Hannah Knight	Research Fellow, Clinical quality and patient standards
Kate Anderson	Clinical Network Facilitator
Kathy Murphy	Head of Nursing and Midwifery, Saint Mary's Hospital Manchester

Lesley Gaskell	Regional Officer, Royal College of Midwives
Liz Gatrell	Obstetric Directorate Manager
Lynn Deacon	North West Local Specialist Child and Maternal Health Intelligence Network
Martyn Boyd	Neonatal Network Manager
Marwan Habiba	East Midlands NHS, Consultant, Leicester Royal Infirmary
Micheala Firth	Quality Improvement Lead (Children & Maternity Services), Strategic Clinical Network
Rosalind Given-Wilson	Medical Director, St George's Healthcare NHS Trust
Ruth Ashmore	East of England, Associate Director Strategic Clinical Network – Senate, NHS England
Dr Ryan Watkins	Joint Clinical Director, Consultant Neonatologist, Brighton and Sussex University Hospitals NHS Trust
Sharon Verne	East Midlands NHS
Sundeep Harigopal	Consultant in Neonatal Medicine, Neonatal ICU; Royal Victoria Infirmary
Susan Dryden	Child Health Strategy Lead, East Midlands NHS
Suzanne Sweeney	Senior Project Manager, Strategic Clinical Networks
Suzanne Tyler	Director for Services to Members, Royal College of Midwives
Teresa Manders	Director of Midwifery, St George's Healthcare NHS Trust
Toni Hunt	Network Delivery Team Facilitator, NHS England
Vanessa Preece	General Practitioner

Commissioners Workshop – 19 September 2013

Name	Organisation
Andrew Donald	Stafford & Surrounds and Cannock Chase CCGs
Ashley Moore	NHS England
David McNally	NHS England
David Mallett	London Region
Elaine Kirton	NHS England
Nicola King	NHS England
Marie Clayton	Salford CCG
Nigel Littlewood	London Region
Paul Tulley	Shropshire CCG
Rachel Pearce	Arden CSU
Samantha Kelley	NHS England
Dr Simon Stockill	West Leeds CCG

Stakeholder Event – 5 July 2013

Name	Organisation and role
Anita Dougall	RCOG - Representative for clinical quality and patient standards
Belinda Phipps	NCT, CEO
Candy Perry	NCT, Director of Professional Services
Carol Ewing	CMFT, Consultant Paediatrician
Claire Swithenbank	NCAT, Head of Patient and Public Voice – North
David McNally	NHS England, Deputy Director Patient Experience

Lesley Gaskell	RCM, Regional Officer RCM
Paul Healy	NHS Confederation, Senior Policy & Research Officer
Rona McCandlish	CQC, National Clinical Advisor
Suzanne Tyler	RCM, Director for Services to Members