



Health Scrutiny Committee

Meeting to be held on Tuesday, 24 September 2019

Our Health Our Care Programme – Update on the future of acute services in Central Lancashire.

1.0 NHS England Assurance Gateways:

The Our Health Our Care programme cleared the Stage 1 “strategic sense check” gateway of the NHS England process for assuring proposals which could constitute major service change in July 2018.

This process triggered “Stage 2” which involves the production of four key assurance documents – developed in turn:

- An updated Case for Change,
- An updated Model of Care,
- A defined list of service options, including shortlisted options,
- A Pre-Consultation Business Case.

In short, the documents developed in Stage 2 should take account of the outcomes from clinical, service user and broader stakeholder engagement activities which have previously taken place; the requirement to meet the assurance conditions set by the regulator; and the duties to respond to the programme objectives and the delivery of safe, effective and affordable healthcare.

Upon the completion of the above four key assurance documents and the direction provided by the Health Scrutiny Committee, the regulator determines if the documentation is of the required quality, depth, and alignment with the necessary standards so as to enable clearance to be provided for a consultation activity to take place. Prior to approaching the regulator, the programme should consider options (if available) which may not trigger the need to consult, as part of an open-minded approach to option generation, modelling and appraisal.

More detail about the NHS England guidance is included in Annex 1. A full electronic version of the guidance can be found by following this link:

<https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf>

For clarity, Clinical Commissioning Groups (CCGs) are under a statutory duty to have regard to this guidance.

With respect to the Our Health Our Care programme, the above documents are presented to a Joint Committee of the Clinical Commissioning Groups for Chorley and South Ribble and Greater Preston, known as the OHOC Joint Committee. The OHOC Joint Committee comprises the membership of the two clinical commissioning group governing bodies, including Executive Directors, GP Directors, Lay Members and Professional Leads.

2.0 Headline Progress:

The programme is currently developing the third of these four assurance documents – a defined list of options, including shortlisted options. These matters were presented to a the Our Health Our Care Joint Committee in a meeting in public on Wednesday, 28th August. A copy of the report can be found by following this link.

<https://www.chorleysouthribbleccg.nhs.uk/download.cfm?doc=docm93ijjm4n7363.pdf&ver=13593>

This report considered the process by which these options were developed, the assumptions, the viability criteria, the options themselves, and those which will now be developed for further detailed modelling (the shortlist). All options are “on the table” and the opportunities to seek further capital investment in Central Lancashire are to be explored expeditiously.

Only when the detailed modelling and shortlisting has taken place, and the approval from regulators achieved, will a public consultation on the options considered to be viable will then take place. This will also incorporate any opinions and recommendations received relating to the options from the North West Clinical Senate, who visited both Royal Preston and Chorley and South Ribble hospitals on Monday 16th and Tuesday 17th September respectively.

Any public consultation will be open, honest, and fair - providing sufficient and transparent information to the public so as to enable them to form a reasoned response to the proposals. The length of a consultation process is likely to be at least twelve weeks and may be extended such the period of consultation overlap with a planned holiday season.

The programme has undertaken extensive public engagement to date but will further take the advice of the Consultation Institute relating to the form and manner of a consultation. The programme continues to benefit from the expertise of its Stakeholder Reference Panel and partners such as Healthwatch to ensure that the materials it is developing, and the communication approaches proposed will enable the programme to communicate effectively with the public. The programme, relating to its Stakeholder Reference Panel, and existing patient liaison forums including the Patient Voice Committee and the Patient Advisory Group have also supported the implementation of a proactive media/engagement strategy so as to build public awareness around the options. This work has already commenced with an engagement strategy covering print, social and website-based media approaches. A political briefing has also been offered to all local members of parliament.

Consultation processes will also include all statutory consultees, local stakeholders and neighbouring commissioning and provider organisations. The programme also wishes to maintain effective communication and co-working with the Health Scrutiny Committee throughout all remaining stages of Our Health Our Care.

2.1 Programme Background:

The mandate to develop the report containing programme options arose from the approval of the Case for Change (13th December 2018) and Model of Care (13th March 2019) respectively. More information about the Case for Change and Model of Care can be found in Appendices 2 and 3 of this paper respectively.

As discussed above, the report containing programme options was presented to a meeting in public of the Our Health Our Care Joint Committee on 28th August 2019. The outcome from the Joint Committee on the 28th August enabled the programme to continue detailed modelling activities relating to all of the options, as part of its work in proceeding with the development of the Pre-Consultation Business Case. This included a proposal to revisit the opportunity for a new build site in at an unspecified Greenfield site in Central Lancashire.

2.1.1 Supporting the options development process:

To support its work in the development of the report containing the programme options, the programme also engaged additional assurance during this process, details as follows:

1. The **Royal College of Emergency Medicine** conducted an Invited Service Review on Wednesday, 3rd April and Thursday, 4th April. The terms of reference for this review can be found in Annex 4. The report received from the Royal College is intended for future publication as part of the Pre-Consultation Business Case in the programme, citations were also provided in the report containing the programme options. The review team from the Royal College included expert clinicians from across the country, also including Lay representation and the Registrar.
 2. The **Care Professionals Board** is an independent, multi-disciplinary panel covering Lancashire and South Cumbria. The membership of this group, including external representatives and a separate reviewer team drawn from clinicians beyond the Lancashire and South Cumbria geography, will review the options for Our Health Our Care on the 19th July and will provide a report shortly afterwards. The report received from the Care Professionals Board is also intended for future publication as part of the Pre-Consultation Business Case in the programme.
 3. At a formal level, the Health Scrutiny Committee has received representations from the North West Clinical Senate manager, Caroline Baines, relating to the function, role, and objectivity of clinical review provided by the Clinical Senate. The Stage 2 external review from the **North West Clinical Senate** took place on 16th and 17th September. The Senate process required the programme to develop detailed information relating to all options and the supporting Model of Care. This group also received details of the opinions from the other assurance functions; the previous report commissioned by NHS England in 2016; and the correspondences and action plans arising from the Committee's consideration of these matters in 2017. The final report from the North West Clinical Senate will not be received until 25th November. The report received from the North West Clinical Senate is also recommended (by them) to be made public. The report will be published as part of the Pre-Consultation Business Case in the programme.
-

2.1.2 The Options Development Process:

Within the report, the options development process and described followed has reflected a three-stage approach, indicated below. All stages were clinically led. The options process itself has been split in to three consecutive stages, known as Stages A to C. The work continuing with the options represents an extension of Stage C.

2.1.3 Stage A: Agreeing the approach and methodology

This stage included defining the approach by which options will be generated in the programme, making sure that the approach is objective and clinically led. The approach taken with the Our Health Our Care programme has included developing relevant assumptions, constraining the options to those which could reasonably respond to the issues cited in the Case for Change and Model of Care, but also, at the same time, including possibilities which appear unlikely, or outside the frame of current thinking.

Options, as developed, must outline the full breadth of changes which are required to deliver improved population health and clinical outcomes, but equally must be clear in terms of the points where they differentiate. In short, this also mean that the options under consideration in the process must not avoid describing choices which are not easy, potentially controversial, or unlikely to attract universal levels of support.

2.1.4 The assumptions within the programme include:

- The need to maintain access to emergency care in Central Lancashire as a core requirement for population health.
- To maintain access to two acute hospitals serving the Chorley and South Ribble and Greater Preston CCG populations in Central Lancashire.
- Restricting the scope to the clinical activities directly commissioned by the two clinical commissioning groups in Central Lancashire.
- Not assuming that enabling capital will be made available to develop any of the options.
- With the exception of a “do nothing” option, the programme assumes that the requirements for effective prevention activities and an out of hospital strategy must stand part of any of the options.
- With the exception of a “do nothing” option, the programme assumes that the engagement responses – to deliver more care closer to home where safe and clinically effective, must stand part of any of the options.

2.1.5 The three main outcomes from the approach followed in Stage A were as follows:

1. An agreed methodology for generating and assessing options.
2. A benefits and outcomes framework against which options can be identified.
3. A theoretical long list of options being developed.

2.1.6 Outcomes of the Stage A process:

In total, thirteen options were generated as a result of this process, including a “do nothing” option, and a further possibility (option 2) of focussing exclusively on transforming services across primary and secondary care, without delivering reconfiguration of acute services. This option considers retaining services in their existing set up but focussing on schemes employed by the trust to improve flow and patient experience. This includes schemes focussing on improving length of stay for admitted patients, improving the utilisation rates for theatres, improving urgent care access, and improved working with partner agencies such

as social care, mental health, and the North West Ambulance Service. This option also considers the benefits which can be delivered by the clinical commissioning group in terms of developing primary care networks, delivering more care closer to home, and avoiding unnecessary referrals to the acute system for outpatient services.

All further options (11) include the benefits available from the above. This is based on the principle tested in Stage B namely, can this option deliver the necessary benefits for patients and the broader health economy or is a form of structural change, which is likely to require consultation (subject to the view taken by the Health Scrutiny Committee), also required? Of the remaining 11 options, it was considered likely that at least 10 of the variants would be likely to trigger the need to consult and with the decision to proceed with consideration of all options, this is more likely. Please refer to Annex 1 or the service change guide (see previous hyperlink) for details.

The exception to the above, around the need to consult, is Option 3 – the creation of a Type 1 Accident and Emergency facility at Chorley and South Ribble District General Hospital. Based on guidance received from the Royal College of Emergency Medicine and the content of the national service specification developed by NHS England, such an option would require levels of service access at that site to be in excess of those provided prior to the closure in 2016. Such an option is unlikely to be considered to require consultation because, extraneous to any clinical or financial viability assessment, the requisite impact on local access to healthcare would be positive and more care would be delivered closer to home overall than in the current service model. The likely level of sensitivity of the option would be low. Therefore, such an option would be unlikely to require consultation. However, such a decision, in the event that such an option was proceeded with by the OHOC Joint Committee, would also rest with the Health Scrutiny Committee. However, it should be pointed out that if Option 3 were to stand part of a shortlist comprising one or more other alternative options then consultation would still be required.

The remaining options (4a-e and 5a-e) differentiate based on how the site at Chorley and South Ribble District General Hospital can be best utilised to deliver safe and effective clinical care to patients. The assessment of safe and effective clinical care relates to the clinical standards relating to the Model of Care and the co-dependency framework (which services need to be co-located), contained also within that document.

The service models, access standards, and workforce delivery approaches reflect those prescribed by NHS England. A short guide to Urgent Treatment Centres (reference options 5a-e), based on the direction set nationally (and required for services of this type), was published in July 2017 and can be found on the hyperlink below. The Urgent Treatment Centre guidance applies to all urgent and emergency care services which do not meet the service access standards described in the Type 1 specification (and are not site-specific or specialist Type 2 A&E departments).

<https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf>

Remaining variants of options (4a-e) describe service models significantly enhanced beyond the Urgent Treatment Centre specification but incorporating all elements; and options which create varying access thresholds to elective surgery and critical care, depending on the type and case mix of patients using the facility.

2.1.7 Developing Options Without Enabling Capital:

The Scrutiny Committee are advised that the options have been developed without the assumption of enabling capital. The reason for taking this approach is that the programme was declined access to enabling capital from Wave 4 of the NHS England bidding process in December 2018 and neither an alternative source of capital funding has yet been agreed, or another wave of funding announced. Whilst this development was and remains disappointing, it remains an objective of all partners in the Our Health Our Care programme to maximise access to capital investment for the benefit of patients in Central Lancashire, and those who would also benefit more broadly across the Integrated Care System, should a realistic opportunity materialise within the development timescales for the programme.

In this context, the options have also been developed with the perspective of the urgent need to act, as defined in the Case for Change in mind. In short, this means that the issues identified in the Case for Change require a solution, and an option, which is capable of being developed towards implementation in the short to medium term, as part of a longer-term transformation of services.

For clarity, it is a requirement of the regulator to have confirmed support for capital to be in place before any option which is contingent on capital funding can be consulted upon. This means that the approach being developed by the programme is the only one permissible within the rules set by NHS England. The concept of enabling capital to support any future option, but not a particular one option, was declined as part of the Wave 4 outcome. As the awarding body, NHS England have also indicated that no further capital funding routes of this scale are forecast to be open. However, as part of the Joint Committee outcome, the Committee resolved to continue pursuing this route.

This means that the options for the programme have been developed from the perspective of what can be improved without enabling capital in the short term, and further represent a framework which could be developed to accelerate benefits and improved outcomes for patients, should enabling capital become available at a later stage, from whatever source.

2.1.8 Stage B: Alternatives to major service change

This stage involved the Governing Body considering, from the long list of options, whether or not an option which would be unlikely to require consultation could be developed successfully – see references to Options 1, 2 and 3 discussed above.

To make this assessment, there were two forms of high-level review:

- A **clinical assessment** – led by the Clinical Oversight Group. This comprises clinical representatives from each partner in the Our Health Our Care programme and is chaired by the Director of Transformation from the CCG. The clinical assessment comprises a review of the given option against the clinical standards and the co-dependency framework, also taking in to account the external assurance information available.
 - A **financial assessment** – led by the Finance, Investment and Activity Group. This comprises representatives from across the Integrated Care Programme and comprises a view of the option from modelled outcomes looking at how far clinical activity would be able to fit, relating to inpatient/admitted and theatre-based activity. Each of the options reviews how far it may be specifically possible to improve resource utilisation via that option and so identify if the option is more likely, or not, for the system to operate within the financial resources available. The Finance, Investment and Activity Group is chaired by the Chief Finance Officer from the CCG.
-

The outcomes and recommendations from the Clinical and Finance groups respectively are reviewed by the Programme Oversight Group, before being presented to the Governing Body. The recommendations arising are subject to the external and independent scrutiny of the assurance processes listed above, including the Care Professionals Board and the North West Clinical Senate.

2.1.9 Stage C: Consideration of Remaining Options

Beyond those matters already referred to in the programme's report around options, the outcomes of the additional modelling and the external assurance opinions received will influence whether or not the options remain on the short list.

If they do not remain on the short list, then they will not stand part of a future Pre-Consultation Business Case and the spectrum of options upon which the programme would intend to commence a consultation activity with the public. The public will be able to express comments around the whole programme and indeed to suggest possibilities which they may feel have not been fully considered.

2.2 Determination of the OHOC Joint Committee – 28th August

The determination of the OHOC Joint Committee, by unanimous approval, varied from the initial recommendation presented in the report. The decision, providing clarity and direction to the programme, can also, as referred to above, be summarised as an extension of Stage C:

- 1. All options on the table:** All 13 options would be considered further, and this position will be outlined to the Health Scrutiny Committee on the 24th September. No final decisions on any of the options was made and an open-minded approach was maintained.
- 2. New Build option:** The feasibility study previously undertaken for a new build acute site in central Lancashire and referred to in the background section of the options paper, would be subject to a request for funding from the Chief Officer of the CCGs and Senior Responsible Owner of the OHOC programme to the Department of Health and Social Care.
- 3. Preferred approach – significant capital investment to transform care outcomes:** With respect to this preferred approach for significant capital investment in a new build site in central Lancashire, the Committee reflected on the position outlined in the background section of the report, namely:

“Local commissioners will continue earnestly, and in an open-minded way, to work with others to build the case for significant capital investment across both primary, community and acute care. Local commissioners believe that such an approach will improve patient experience, quality, and care outcomes and for the benefit of people in Central Lancashire. Such an approach will support the delivery of a long-term sustainable solution to the planning and delivery of healthcare services of a growing population with changing needs.

Local commissioners will continue to work in partnership across Healthier Lancashire and South Cumbria to identify how capital funding may be acquired and the

conditions upon which a future application for investment is more likely to be successful.

Local commissioners stand ready to review and revisit all options should significant capital investment routes become open.

Local commissioners agree that, in the circumstances of the present Case for Change and the Model of Care developed by the programme, it must consider options at this stage which are based around the resources currently available to the health economy, seeking to deliver the best outcomes for patients.”

In taking the decision to outline and pursue further the case for significant capital investment in central Lancashire, it should be emphasised that the Committee agreed that, at this stage, there appeared to be neither a funding route for enabling capital, nor a confirmed funding stream for capital of this scale.

However, the purpose of exploring this option further was to improve confidence in the process overall and to evidence that this preferred approach would be given primary consideration alongside all other options for change. The Committee continues to recognise that consultation can only occur if it can be demonstrated that an option is viable. In addition to clinical criteria, this assessment also considers other factors, including funding streams and affordability, as specified by the regulator, NHS England.

4. **Enhanced clinical scrutiny** would take place relating to all of the options, further ensuring that no alternative route has been omitted in Stages A and B. This would take place via a number of routes, namely:

- **Clinical Summit:**

A Clinical Summit, drawing together primary care network leads, partners, and secondary care clinicians and others, such that the options for acute change could be fully discussed, scrutiny be applied, and the links/dependencies with the out of hospital workstream of the programme be adduced. This has been arranged for the evening of the 3rd October.

This forum will present the opportunity for an ongoing dialogue and process of scrutiny to ensure that the appropriate options are generated and that best clinical outcomes for the people of central Lancashire result. This will involve significant close working with the Wellbeing and Health in Integrated Neighbourhood (WHiN) platform and a discussion around how the system economic and financial reform strategies may act as enablers to successfully and sustainably redesign care across the whole central Lancashire system.

- **Clinical Oversight Group – scrutiny role:**

An enhanced and extended role for the Clinical Oversight Group for the programme, additionally comprising of greater primary care network clinician engagement; secondary care clinicians and the role of other non-medical professional groups, such as nursing and allied health professionals.

- **Independent Clinical Director:**

The planned appointment of an independent clinical director for OHOC who will oversee the clinical scrutiny and support the programme through the remaining stages.

- **Primary Care network – engagement and scrutiny:**

Further engagement with each primary care network leadership team and the Peer Groups in Chorley and South Ribble and Greater Preston respectively. In the case of the former group, this will take account of the recent formal establishment of primary care network leadership teams and in the latter reflect the ongoing partnership working with the Peer Groups which has taken place over the past 18 months to 2 years.

- **Independent Clinical Senate:**

The independent clinical senate will visit both LTH sites on 16th and 17th September to provide a report on the options and the scope of work undertaken with respect to developing a sustainable Model of Care. The independent clinical senate is satisfied that it has received sufficient information from the programme relating to the Model of Care, such that it can provide assurance at this stage and usefully add to the information which will be relied upon by the OHOC Joint Committee in determining which of the options are viable.

The formal report from the clinical senate will be received by the end of November. Part of the role of the independent clinical senate will be to test the rigidity of proposals which could see more care delivered outside of the acute sector. They will also receive the opinions outlined in the reports published by the Royal College of Emergency Medicine and the Healthier Lancashire and South Cumbria Care Professionals Board forum.

- **Activity and Impact Modelling:**

Detailed activity modelling will take place relating to the options. This work is currently being developed and will be shared in the public domain when complete and accepted as part of the Pre-Consultation Business Case for the programme.

This modelling will project planned patient movements across each outpatient, elective and emergency care categories, across specialties and the existing operational sites used by patients in central Lancashire. This work will also include a detailed Equality Impact and Patient Impact Analysis, also incorporating an analysis of travel and access considerations relating to the options.

3.0 Next Steps:

The programme remains keen to maintain its constructive and open relationship with the Health Scrutiny Committee, and its membership. The programme team will endeavour to respond to the concerns of the Committee to ensure that the process is correctly followed. Assuming that the steps indicated in section 2.2 hold as planned and the Clinical Senate's report is received as indicated, the programme team would propose to update the Scrutiny Committee again in December, whilst the programme remains at this formative stage,

Jason Pawluk

OHOC Programme Director

16th September 2019

Annex 1: The Major Service Change Guide

The NHS England guidance “*Planning, assuring and delivering service change for patients (March 2018)*” is designed to be used by those considering and involved in service change to navigate a clear path from inception to implementation of decision made. It supports commissioners and their partners to consider how to take forward their proposals, including effective public involvement, enabling them to reach robust decisions on change in the best interests of their patients. Clinical Commissioning Groups (CCGs) are under a statutory duty to have regard to this guidance.

There is no legal definition of service change but broadly it encompasses any change to the provision of NHS services which involves a shift in the way front line health services are delivered, usually involving a change to the range of services available and/or the geographical location from which services are delivered.

There is also no legal definition of ‘substantial development or variation’ and for any particular proposed service change commissioners and providers should seek to reach agreement with the local authority on whether the duty is triggered. Regular local authority engagement should continue through the lifecycle of service change. Service reconfiguration and service decommissioning are types of service change. Change of site from which services are delivered, even with no changes to the services provided, would normally be a substantial change and would therefore require consultation with the local authority and public consultation.

Effective service change involves full and consistent engagement with stakeholders including (but not limited to) the public, patients, clinicians, staff, neighbouring ICSs and Local Authorities.

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

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

Prior to public consultation NHS England will assure proposals for substantial service change in accordance with the process set out within the guidance. For any service change requiring public consultation which also requires capital funding, NHS England and NHS Improvement will assess any proposals to provide assurance that they do not require an unsustainable level of capital expenditure and that they will be affordable in revenue terms. Not all substantial service changes require capital expenditure.

There are a number of other key points made in the guidance:

- Service changes should align to local Integrated Care System plans and the service, sustainability and investment priorities established within them.
 - NHS commissioners and providers have duties in relation to public involvement and consultation, and local authority consultation. They should comply with these duties when planning and delivering service change.
 - The public involvement and consultation duties of commissioners are set out in s.13Q NHS Act 2006 (as amended by the Health and Social Care Act 2012) for NHS England and s.14Z2 NHS Act 2006 for CCGs.
-

- NHS trusts and foundation trusts are also under a duty to make arrangements for the involvement of the users of health services when engaged with the planning or provision of health services (s.242 NHS Act 2006).
- The range of duties for commissioners and providers covers engagement with the public through to a full public consultation. Public involvement is also often referred to as public engagement.
- Where substantial development or variation changes are proposed to NHS services, there is a separate requirement to consult the local authority under the Local Authority (Public Health, Health & Wellbeing Boards and Health Scrutiny) Regulations 2013 (“the 2013 Regulations”) made under s.244 NHS Act 2006. This is in addition to the duties on commissioners and providers for involvement and consultation set out above and it is a local authority which can trigger a referral to the Secretary of State and the Independent Reconfiguration Panel.
- Where a proposal for substantial service change is made by the provider rather than the commissioner, the 2013 Regulations require the commissioner to undertake the consultation with the local authority on behalf of the provider.
- Both commissioners and providers need to ensure that they have satisfied their statutory duties to involve and consult. In general, where there is commissioner led consultation with the local authority on a substantial service change, full public consultation will also be required.

The Our Health Our Care programme has been developing proposals in receipt and knowledge of this guidance and has substantive relationships developed with the regulator for information sharing purposes.

Annex 2: The Case for Change

The updated Case for Change for the programme was presented and approved by the OHOC Joint Committee on 13th December 2018.

The document identified five main reasons why change to health services is required, based on a system approach:

1. Workforce:

We do not have the workforce we need in critical staffing areas. Our urgent and emergency care system workforce is stretched — a symptom of the issues with recruitment and retention being experienced right across our health system and more widely in the NHS.

2. Flow:

We are not delivering effective patient flow in our hospitals. In short, this means that too many patients are waiting too long for their care, whether their care is either planned or unplanned. Too many patients are experiencing delays to be discharged. Our hospitals are struggling to balance the needs of patients with urgent and emergency care issues (including critical care) with those receiving planned care, including day cases and outpatients. They are not running as efficiently as they could do.

3. Lack of alternatives:

We do not have a comprehensive range of alternative options available to using the urgent and emergency care system at all times. This means that too many patients are using urgent and emergency care services because they either do not know the best alternative to use, or because that alternative is not available to them at a time and place to best meet their needs. This is a problem right across our health system – we recognise that the problem does not start at the front door of our hospitals' Emergency Departments.

4. Demographics:

We are serving a growing and ageing population which continues to experience inequalities in health status, reflected in different clinical outcomes. This means some local people have worse life expectancy than others; some people are more likely to have chronic and complex long-term conditions than others; and some people are making additional use of urgent and emergency care services because they do not know the best alternative to use. This includes community-based and self-care alternatives.

5. Effective use of Resources:

To build a sustainable healthcare model, we must use the resources as an integrated health and social care system. We are not currently doing this well enough. This is because we have yet to fully develop an asset-based approach to healthcare, particularly where this impacts on the best use of our urgent and emergency care system. We can also do more in terms of delivering a neighbourhood care model, and we will need to deliver more care closer to home where this is safe and practical.

The full Case for Change can be reviewed by following this link:

<https://www.greaterprestonccg.nhs.uk/download.cfm?doc=docm93jjjm4n6397.pdf&ver=12217>

Annex 3: The Model of Care

The Model of Care sets out a clear, clinically led vision to protect and improve the NHS services which our patients rightly care about in Central Lancashire. It is based around the principle of delivering better, joined up (or integrated) care which will provide the best opportunity for the services provided by our local hospitals to improve for the benefit of the people who use them.

The Model of Care has been developed in relation to the acute sustainability ('in hospital care') element of the Our Health Our Care (OHOC) programme. It is based on the rich learning and engagement that the programme has undertaken with the public, clinicians and wider stakeholders and creates an exciting and compelling agenda for action, which seeks to resolve the issues identified in the Case for Change.

Our aim for the population of Chorley, South Ribble and Greater Preston is for them to be supported to stay healthy, but where care is needed, for them to receive this joined up care. By this we mean where a person's care needs are co-ordinated, their support and interventions are connected, and their pathways of care are seamless. For the professionals delivering this care, their contributions are co-ordinated, regulated for quality, and measured against performance and quality standards. The aim of providing joined up or Integrated Care is to put patients at the heart of what we do and in doing so, avoid duplication and unwarranted clinical variation.

Our Vision and OHOC Ethos:

The OHOC programme has a central delivery ethos – our number one priority always remains simple and crystal-clear – taking the right actions now which will transform patient experience and clinical outcomes. All of the lead partners in the Our Health Our Care programme are united in delivering this common purpose for the future. The lead partners are Chorley and South Ribble and Greater Preston Clinical Commissioning Groups, Lancashire Teaching Hospitals NHS Foundation Trust; Lancashire Care NHS Foundation Trust. This Model of Care focusses on how we can deliver sustainable hospital services in the future and what enabling changes will be required across the whole care pathway in Central Lancashire to deliver this. They are based around the principle of delivering joined up or integrated care with partners coming together to deliver better care for the benefit of patients.

This Model of Care will be used to develop open-minded options for change which are clinically led, patient-centred and focus on dealing with the issues addressed in the Case for Change.

The full Model of Care, including the clinical standards and co-dependency framework can be accessed by following this hyperlink.

<https://www.greaterprestonccg.nhs.uk/download.cfm?doc=docm93ijjm4n6620>

Annex 4: Terms of Reference for the Royal College of Emergency Medicine review

The Royal College of Emergency Medicine were engaged by the Our Health Our Care programme to deliver an Invited Service Review. The Invited Service Review provided an opportunity for the urgent and emergency care service at both sites to be reviewed in the light of the previous report commissioned by NHS England and the actions taken arising. The Terms of Reference for the review were agreed by the Programme Oversight Group and the decision to engage the review was agreed by the Governing Body. The terms of reference for the review are shown below.

To conduct a service review of the departments provided at Chorley and South Ribble Hospital and Royal Preston Hospital, linked to the objectives specified on the next page. The service review has been requested with a view to providing recommendations which can be used by the trust to support existing transformation schemes and to the clinical commissioning groups (Chorley and South Ribble CCG and Greater Preston CCG) who are considering future service models as part of the Our Health Our Care programme.

The Our Health Our Care programme is currently developing a Model of Care for future service provision at Stage 2 of the NHSE assurance cycle. The request to engage the Royal College also emanates from a recommendation made to the programme by the Stage 1 strategic sense-check service review in Summer 2018 and equivalent discussions with the North West Clinical Senate.

1. Our current transformation plans: *The NHSI ECIST transformation activities and out-of-hospital strategies seek to improve the usage of emergency care services in Central Lancashire, complementing plans to expand the use of urgent care. To what extent do you feel that these plans are robust and complete, in terms of them helping us to transform outcomes on a “whole pathway” basis? In particular, what is the RCEMs opinion on the emerging model of care for the urgent and emergency services under the remit of the acute hospital services – are we taking sufficient account of best practice, new service models and emerging thinking from the NHS 10 Year Plan?*

2. Sustainability and Quality: *The previous NHSE service review of emergency care in Central Lancashire resulted in the Accident and Emergency department re-opening at Chorley and South Ribble Hospital on a 14/7 basis. Based on your present assessment of safety/sustainability, service quality, and the available workforce, do you feel that the circumstances which led to that recommendation are still valid?*

3. Emergency Department service adjacencies: *In terms of enhancing service quality and sustainability, what is the RCEMs opinion on service integration and structures in the critical adjacencies to the emergency departments, in particular relating to acute medicine?*

4. Focus: *In terms of reducing unnecessary demand for urgent and emergency care services, what is the RCEM's opinion on the clinical pathways which should be prioritised for transformation activity based on an “end to end / whole pathway” approach.*

5. Future Proofed: *The NHS Ten Year Plan describes the NHS Clinical Standards Review due out in the spring, developing new ways to look after patients with the most serious illnesses. To what extent would the proposed model support any new standards that are likely to result.*

For clarity, the review team did not examine issues around the specifics of quality of care or governance structures in place within the Emergency Department at the Trust, nor did they specifically examine issues around training and education.