Lancashire County Council

Health Scrutiny Committee

Tuesday, 4th February, 2020 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any Pecuniary and Non-Pecuniary Interests they may have to disclose to the meeting in relation to matters under consideration on the Agenda.	
3.	**Minutes of the Meeting Held on 5 November 2019**	(Pages 1 - 4)
4.	**Healthier Lancashire and South Cumbria Integrated Care System - five year local strategy**	(Pages 5 - 44)
5.	**Commissioning Reform in Lancashire and South Cumbria**	(Pages 45 - 88)
6.	**Our Health Our Care Programme**	(Pages 89 - 264)
7.	**Report of the Health Scrutiny Steering Group**	(Pages 265 - 274)
8.	**Health Scrutiny Committee Work Programme 2019/20**	(Pages 275 - 288)
9.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the Minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	

Lancashire County Council

10. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 31 March 2020 at 10.30am at County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 5th November, 2019 at 10.30 am in Cabinet Room 'C' - The Duke of Lancaster Room, County Hall, Preston

Present:

County Councillor Peter Britcliffe (Chair)

County Councillors

J Burrows	M Iqbal
Mrs S Charles	A Schofield
B Dawson	K Snape
C Edwards	D Whipp
J Fillis	

Co-opted members

Councillor David Borrow, (Preston City Council)
Councillor Tim Dant, (Lancaster City Council)
Councillor Margaret France, (Chorley Council)
Councillor Bridget Hilton, (Ribble Valley Borough Council)
Councillor Gordon Lishman, (Burnley Borough Council)
Councillor Julie Robinson, (Wyre Borough Council)
Councillor Viv Willder, (Fylde Borough Council)
Councillor Tom Whipp, (Pendle Borough Council)

County Councillors C Edwards, A Schofield and B Dawson replaced County Councillors J Shedwick, E Pope and N Hennessey respectively.

1. Apologies

Apologies were received from County Councillor S Morris and Councillor D Howarth.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

No interests were declared.

3. Minutes of the Meeting Held on 24 September 2019

Resolved: That the minutes of the meeting held on 24 September 2019 be confirmed as an accurate record and signed by the Chair.

5. Terms of Reference for the proposed Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)

The Committee received the Terms of Reference for the proposed Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System.

During discussion, Committee members made the following comments:

Concern was raised that as Lancashire was the largest geographical area covered by the proposed joint committee, Lancashire residents would not be proportionately represented if Lancashire only had three seats. It was suggested that three additional seats with voting rights be allocated to Lancashire's district council members.

Concern was raised that appointing strictly on the basis of two members of the administration and one member from the largest opposition group would not adequately represent the wider political makeup of the Lancashire and South Cumbria area.

It was suggested that the wording on page one of the Terms of Reference under the membership heading be amended to read "Each local authority to appoint on the basis of two members from the administration and one opposition member." Upon being put to the vote it was;

Resolved: That;

1. The Health Scrutiny Steering Group in collaboration with the other relevant authorities give consideration to:

    i. Amend the terms of reference under membership to read "Each local authority to appoint on the basis of two members from the administration and one opposition member."

    ii. Allocate three additional seats with voting rights for Lancashire's district councils.

2. The Health Scrutiny Committee receive the minutes of the meetings of the Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System.

4. Impact of recruitment of additional Occupational Therapists

The Chair welcomed Sue Lott, Head of Social Care Service, Adult Social Care and Val Knight, County Occupational Therapy Manager, who presented a report detailing the development of the Occupational Therapy Service within Adult Social Care at Lancashire County Council.

It was noted that significant improvements had been made in timeliness of assessments and the increase in Disabled Facilities Grants recommendations since 2014, and that all Occupational Therapy posts had been recruited to.

Members requested clarification on a number of issues as detailed below:

- The report stated that eight districts were now using discretionary grants, and concern was raised regarding the other four and the potential for inequity of provision across Lancashire. It was explained that this was due to historical carry forward of funding, which was higher in some districts than in others.

  It was requested that a further report on the differing allocations of Disabled Facilities Grants to each district council and the challenges and opportunities this offered in terms of discretionary grants and potential inequity for the people of Lancashire be presented to a future meeting.

- It was clarified that the target date to achieve 100% of people referred for an Occupational Therapy assessment within 28 days was April 2020.

- It was commented that Occupational Therapists were trusted intermediaries in people's homes and therefore could have a wider responsibility for service users' welfare; for example, around gas and fire safety. In response to a question around training it was clarified that the Occupational Therapists were trained to have a preventative mindset and would refer issues to other organisations such as home improvement agencies or the Fire Service where appropriate. Also, Telecare technicians would be receiving training to be able to identify and action low level issues.

- Responding to a question about hospital discharge arrangements, it was clarified that the acute social work team identified patients who would likely need major or urgent adaptations to allow them to return home, and worked with the Occupational Therapists to facilitate the adaptations, although it was not always possible to complete this before the patient returned home. However, hospital Occupational Therapists were now equipped to take some people home and would undertake any immediate small adaptations to ensure the patient was safe, for example, by moving furniture.

- In response to a question around the return and recycling of equipment, it was clarified that any equipment loaned by MedEquip would be collected by that company once the user no longer needed it, and this could range from a few days to a few weeks. It was commented that decontaminating and recycling equipment was expensive, and could cost more than double the price of new equipment. There was no specific service in place to collect and recycle equipment, but letters were sent to service users advising them that many charity shops would accept second hand equipment.

Resolved: That:

i. The report be noted.

ii. The improvements seen in the performance of the Lancashire County Council Occupational Therapy Service be welcomed.

iii. A further report on the differing allocations of Disabled Facilities Grants to district councils in Lancashire with a focus on discretionary grants be presented to a future meeting.

6. Report of the Health Scrutiny Committee Steering Group

The report presented provided an overview of matters considered by the Health Scrutiny Steering Group at its meeting held on 16 October 2019.

Resolved: That the report of the Steering Group be received

7. Health Scrutiny Committee Work Programme 2019/20

The Work Programmes for both the Health Scrutiny Committee and its steering group were presented to the Committee.

Resolved: That the report be noted.

8. Urgent Business

There were no items of urgent business.

9. Date of Next Meeting

It was noted that the meeting scheduled for 3 December 2019 had been cancelled.

The next meeting of the Health Scrutiny Committee will be held on Tuesday 4 February 2020 at 10.30am in Cabinet Room C – the Duke of Lancaster Room, County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on Tuesday, 5 November 2019

Electoral Division affected:
(All Divisions);

Healthier Lancashire and South Cumbria Integrated Care System - five year local strategy
(Appendix 'A' refers)

Contact for further information:
Dr Amanda Doyle, GP and ICS Lead for Lancashire and South Cumbria
Andrew Bennett, Executive Director for Commissioning in Lancashire and South Cumbria
Gary Raphael, Executive Director for Finance and Investment in Lancashire and South Cumbria

Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny), Lancashire County Council, gary.halsall@lancashire.gov.uk

Executive Summary

This report presents the draft five year local strategy for the Lancashire and South Cumbria Integrated Care System (ICS). The draft strategy is set out at appendix A. The ICS was required to submit the strategy to NHS England in response to the NHS Long Term Plan (LTP) and the local needs of our population over the next five years.

Recommendation

The Health Scrutiny Committee is asked to consider and provide feedback on the draft Lancashire and South Cumbria Integrated Care System Strategy.

Background and Advice

The NHS Long Term Plan (LTP) was published in January 2019 and set out a range of ambitions for the NHS for the next 5 – 10 years. All 'Local health systems' were asked to produce local plans for implementing the commitments set out within the LTP. For South Cumbria, this means Lancashire and South Cumbria Integrated Care System.

The Lancashire and South Cumbria Integrated Care System (ICS) was required to submit an ICS Strategy to NHS England in response to the NHS Long Term Plan and the local needs of our population over the next five years. A copy of the draft strategy is set out at appendix A. This follows a request from the committee at its meeting held on 24 September 2019, to review the strategy.

Lancashire County Council

This document has been developed with the involvement of each of the partners of the Integrated Care System and describes how partners will work together to deliver the crucial improvements to the health and wellbeing of the Lancashire and South Cumbria (L&SC) population, the quality of care that they receive and the most effective use of taxpayers' money in doing so.

There has been extensive direct engagement with staff, patients, public and partners over the past three years in the development of local and system plans, individual programmes of work and on initiatives which have contributed to the development of more integrated care. The majority of engagement and involvement activity has taken place within each of the five local health and care partnerships. In these areas local people have been involved in the design of local partnerships and their priorities.

The Health Scrutiny Committee is asked to consider and provide feedback on the draft Lancashire and South Cumbria Integrated Care System Strategy.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

The report at appendix A represents the views of the partnership known as the Lancashire and South Cumbria Integrated Care System and are not those of Lancashire County Council.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Appendix A

Healthier Lancashire & South Cumbria

DRAFT

Our Integrated Care System Strategy

Published January 2020

Working together to improve services and help people in Lancashire and South Cumbria live longer, healthier lives

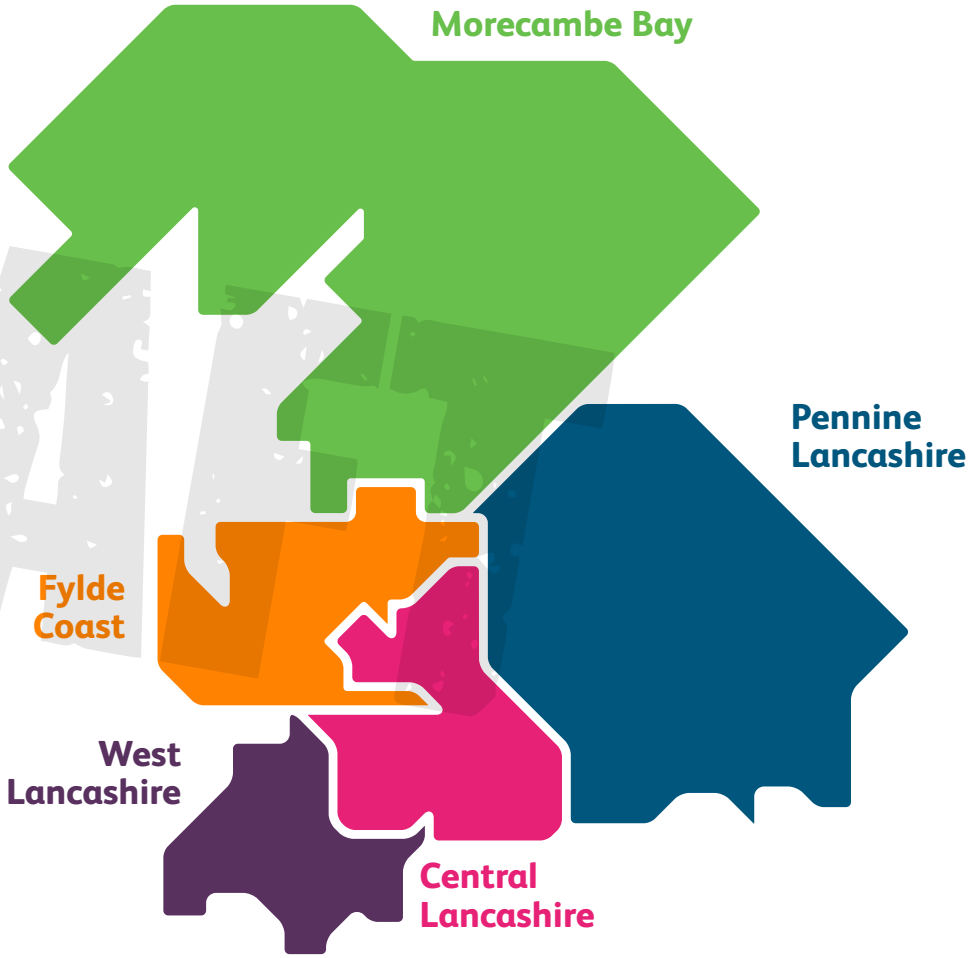
Welcome

We have an ambitious vision to empower and support healthy local communities, so that local people have the best start in life and can live and age well.

We are Lancashire and South Cumbria Integrated Care System (ICS), a partnership of NHS, local authority, public sector, voluntary, faith and social enterprise and academic organisations. We work together to join up health and care services, listen to the priorities of our communities, local people and patients and tackle some of the biggest challenges we are all facing.

Healthier Lancashire and South Cumbria is the name of our shared vision and five-year strategy for improving health and care services and helping the 1.8million[1] people in Lancashire and South Cumbria live longer, healthier lives. To achieve this we will need to make difficult decisions about how and where our services are delivered and how we organise ourselves to achieve our aims as a partnership.

We have listened to local people and worked together to set out how we will deliver the aims of the NHS Long Term Plan and address the most urgent needs of our population.



References

1. Source: NHS Digital. (December 2019). Patients registered at a GP practice.

Contents

This document is written for local people interested in developments in our health and care system, our staff and partners. It describes our plans for the future.

Our purpose – together we can make things better

The partnership of organisations working across the Integrated Care System have agreed a clear purpose for our work together.

This will happen in neighbourhoods, local places and across the whole of Lancashire and South Cumbria.

Our vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

Healthier Lancashire & South Cumbria

At the heart of this vision are the following ambitions:

We will have healthy communities

We will have high quality and efficient services

We will have a health and care service that works for everyone, including our staff

In your neighbourhood and community

- Health and social care will work together to support your social needs, physical and mental health and wellbeing
- You will be supported to care for yourself where you can, including using digital technology
- Community groups and local teams, including your GP, will work with you
- You will be encouraged to take an active role in managing your own health and wellbeing and to support others in your community

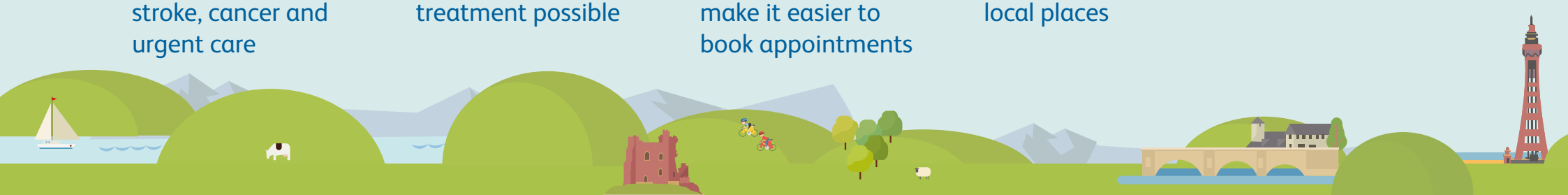
Our vision for Lancashire and South Cumbria

In your local area

- Most care will be locally delivered, managed and planned
- We will make the best use of all the expertise and staff skills available to us
- We will talk to you and your community about how best to provide care
- You know best what you and your community needs

Across Lancashire and South Cumbria

- We will work together on issues like mental health, stroke, cancer and urgent care
- Our hospitals will work together so you have the best treatment possible
- We will use technology to share health records and make it easier to book appointments
- As much of our finances as possible will be spent in local places
- We will manage our spending better



Tackling our biggest challenges together

Our partners across Lancashire and South Cumbria are committed to taking coordinated action to improve health and wellbeing, provide clinically sustainable services and to do this within available resources.

We need to accelerate changing the way we provide services across Lancashire and South Cumbria over the next four years.

We will take action as a partnership to:

- Reduce health inequalities
- Improve our performance on national targets, particularly for waiting times for urgent treatment, cancer services and routine surgery
- Provide more consistent, high quality care for everyone
- Deliver more care in our local communities
- Ensure good care at the end of life
- Make better use of our collective resources and stop overspending on our budgets.

To tackle these challenges, the partners across Lancashire and South Cumbria recognise that we need to change how services are provided to offer more joined-up, proactive care that is organised in neighbourhoods.

This change needs to be led by clinicians – including doctors, nurses and health professionals, who know that tailored and personalised care will support local people, carers and families to live healthier lives within their communities. We will fully involve local people and patients in changes to services.

This cannot be done without significantly changing the way organisations invest in, provide and manage the whole health and care system including GPs, A&Es, specialist centres, hospitals and care services.

A change in the way we use our resources is required to enable us to increase our focus on promoting good health and preventing illness as we work with local residents, as well as ensuring we can provide safe and effective treatment when people do become unwell. There are already dynamic examples of this starting to happen in Lancashire and South Cumbria.

There are currently a number of fragile services, which are unsustainable in their current form. The required workforce for the service structures simply does not exist. Despite a number of national and local workforce initiatives, the likelihood is that for the medium term the prospects for filling staffing vacancies remains poor. If the partnership does not change the way in which these services are organised, they will fail.

The evidence for financial unsustainability in some services is also clear. NHS trusts in Lancashire and South Cumbria are spending more than the income they receive, meaning that they are increasing their level of debt and spending money that should go to other parts of England.

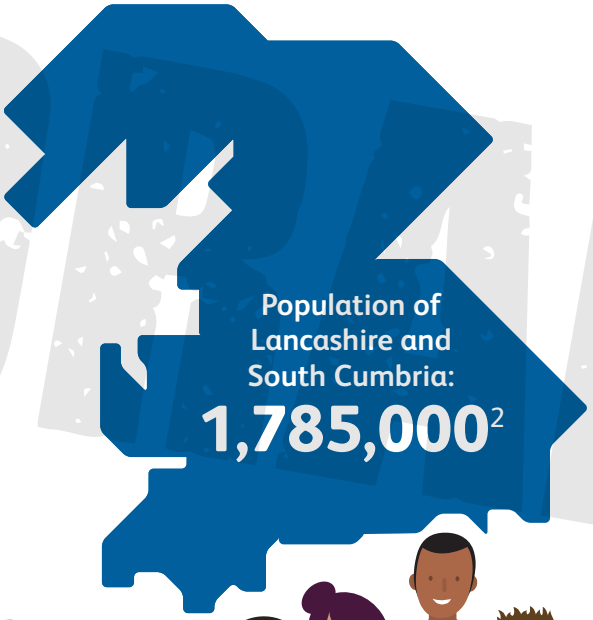
Key facts about our population and communities

We now have a good understanding of our population's health and care needs.

It will enable us to provide the right services, in the right place, at the right time to improve care and ensure the best use of resources.

This will help us to plan care more effectively and deliver better results for local people.

Our population



National average

Population over 65 **19.7%**

Percentage of population over 65 is **19.7%**, national average for England is **17.3%**[3]

One person households with people age 65+ **13.5%**

Number of one person households with people aged 65 or over is **13.5%**, national average for England is **12.4%**[4]

Rural communities **20.4%**

Percentage of population in rural communities is **20.4%**, national average for England is **17%**[5]

References

2. Source: NHS Digital. (December 2019). Patients registered at a GP practice.
3. Source: NHS Digital. (December 2019). Patients registered at a GP practice.
4. Source: ONS. Census 2011. Household composition – Households (QS113EW).
5. Source: ONS Mid-Year (2018). Resident population estimate by LSOA.

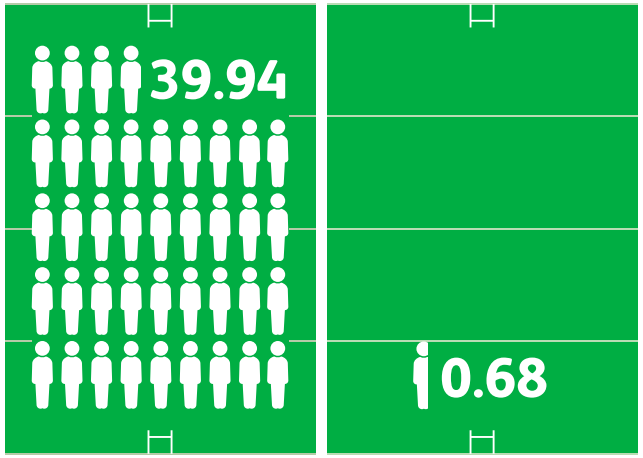
Our geography is varied across Lancashire and South Cumbria

The number of people per hectare (the size of a rugby pitch) is high in:

- Blackpool: **39.94**
- Hyndburn: **11.07**
- Blackburn with Darwen: **10.87**
- Preston: **9.97**

Compared to more rural areas:

- West Lancashire: **3.29**
- Lancaster: **2.50**
- Ribble Valley: **1.03**
- South Lakeland: **0.68**[6]



Deprivation

Nearly one third (29.1%)[7] of our residents live in some of the most deprived areas across England.

The percentage of people living in fuel poverty and unable to afford to heat their homes, is higher than the national average: **13.4% for Lancashire and South Cumbria**, national average is 10.9%[8].

A significant proportion of children experience **adverse living conditions**, including child poverty. This leads to significant variation in their development and school readiness.

The percentage of children living in poverty ranges from a low of 12% to **as high as 38% in Lancashire and South Cumbria**, the national average is 30%[9].

13.4%

of people in Lancashire and South Cumbria are living in fuel poverty.

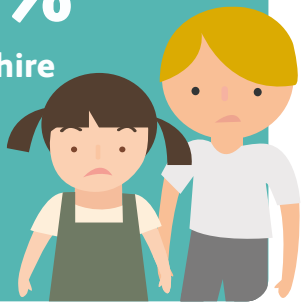
The national average is 10.9%.

Between

12 to 38%

of children in Lancashire and South Cumbria live in poverty.

The national average is 30%.



6. Source: ONS. Lower layer Super Output Area population density 2018.
7. Source: ONS Mid-Year (2018) resident population estimate by IMD 2019 quintile.
8. Source: Department for Business, Energy and Industrial Strategy. Sub-regional Fuel Poverty in England 2017.
9. Source: Stone, J and Hirsch, D. (2019). Local indicators of child poverty, 2017/18. endchildpovery.org.uk

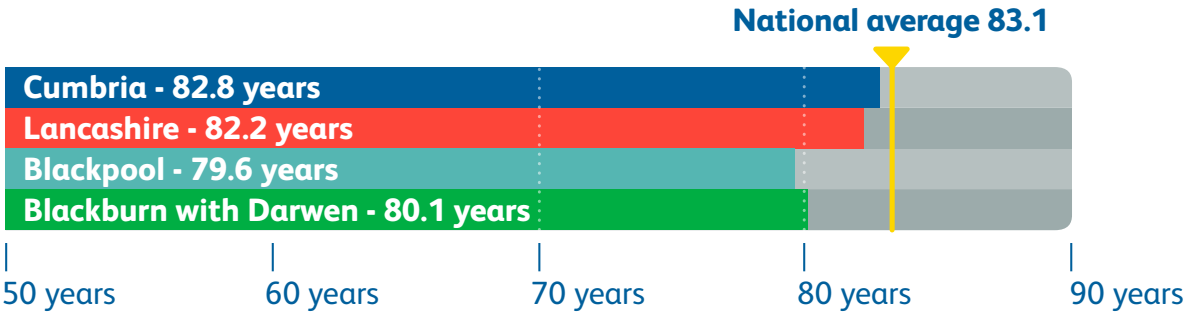
Life expectancy in Lancashire and South Cumbria is lower than the national average

There is a significant level of unwarranted variation in the number of years people can expect to live a healthy life.

Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of **68 years**[10] for children born today.

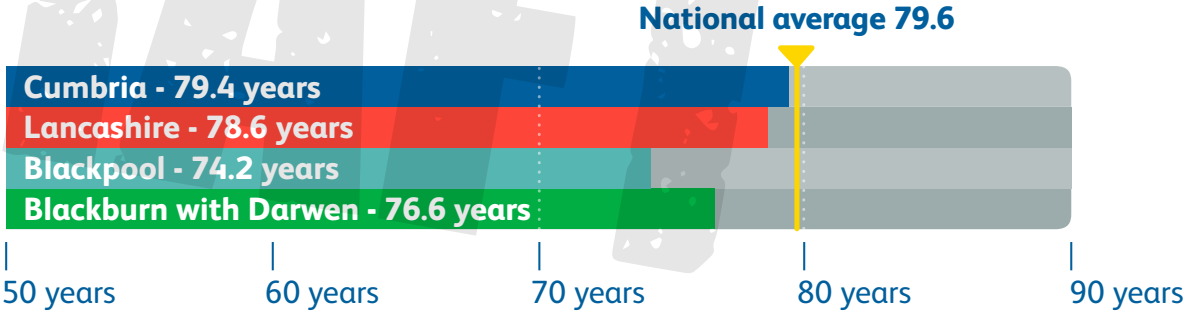
In some neighbourhoods, healthy life expectancy is just **46.5 years**[11].

Female life expectancy by council area[12]



The number of years females **live in good health** is above the national average of **63.8 years** in Cumbria (**65.4 years**) and Lancashire (**64.5 years**). It is below the national average in Blackburn with Darwen (**58.6 years**) and Blackpool (**57.8 years**).

Male life expectancy by council area[13]



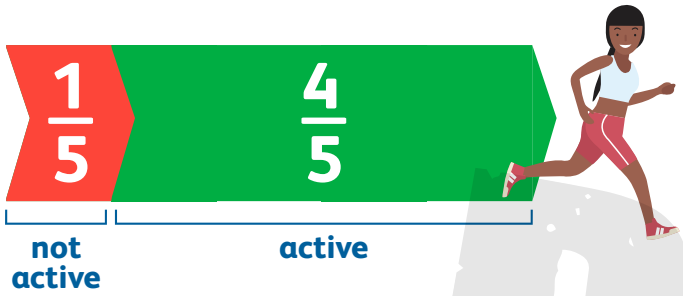
The number of years males **live in good health** is above the national average of **63.4 years** in Cumbria (**64.4 years**). It is below the national average in Lancashire, (**61.2 years**), Blackburn with Darwen (**57.3 years**) and Blackpool (**54.7 years**).

References

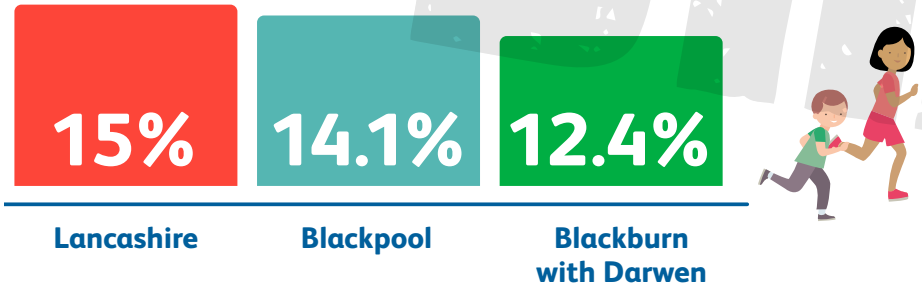
10. Source: ONS. Life expectancy at birth and healthy life expectancy at birth (2015-17).
11. Source: ONS. Life expectancy at birth and healthy life expectancy at birth (2015-17).
12. Source: Public Health England Fingertips tool
13. Source: Public Health England Fingertips tool

Health and wellbeing

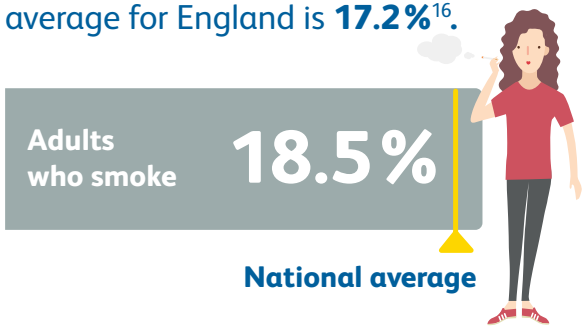
Around **a fifth**[14] of adults are not meeting the recommended levels of physical activity.



Much more needs to be done to encourage children to be active: just **15%** of young people aged 15 in Lancashire are meeting the recommended levels of physical activity, **14.1%** in Blackpool and **12.4%** in Blackburn with Darwen[15].



18.5% of adults smoke, the national average for England is **17.2%**[16].



The main causes of ill-health are cancer, cardiovascular, respiratory, mental health, and neurological conditions[17].

Suicide rates are significantly higher than the national average across Lancashire and South Cumbria, particularly in Barrow-in-Furness, Blackpool and Chorley[18].

Approximately **40%**[19] of ill-health in Lancashire and South Cumbria is due to **smoking, physical inactivity, obesity** and **substance misuse**.

14. Source: Public Health England estimates based on the Sport England Activity People's Survey 2017/18.
15. Source: 2014/15 What about YOUth survey.
16. Source: Quality outcomes framework (QOF) 2017/18.
17. Source: Local analysis and interpretation from Public Health England and local public health intelligence.
18. Source: ONS. Suicide rates (10+) 2016-18.
19. Source: The King's Fund. Time to think differently: Broader determinants of health: Future trends.

Lancashire and South Cumbria health service performance

In 2018/19, we had:

358,590
NHS 111 calls

More than
7.5million
GP appointments

More than
330,000
attendances at A&E

281,173
local planned admissions for treatment or surgery

2,880,582
outpatient appointments

...with more than
697,022
missed appointments

211,315
emergency admissions

References
Hospital activity - source: SUS Hospital activity 2018/19.
Ambulance call data - source: NHS digital. Ambulance Quality indicators 2017/18.
GP appointments - source: NHS Digital experimental statistics GP Appointments 2018/19.

The NHS in Lancashire and South Cumbria is spending more than the budget available to it

In 2020/21, the total budget for health services in Lancashire and South Cumbria is **£3,525million**.

Lancashire and South Cumbria receives around **10%** more per person in funding compared to the average for England because of the higher level of need in our communities.

Lancashire and South Cumbria will receive an average growth in funding of around **£150million** per year between 2019/20 and 2023/24.

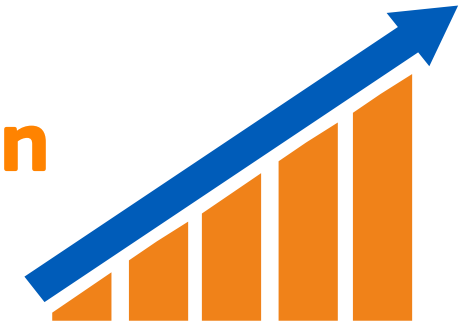
In contrast, local authority funding for county councils and unitary authorities has reduced by **around 40%** over the last decade and growth for social care and public health budgets is uncertain.

Further work needs to be completed to create a plan that will see the health services in Lancashire and South Cumbria return to financial balance.

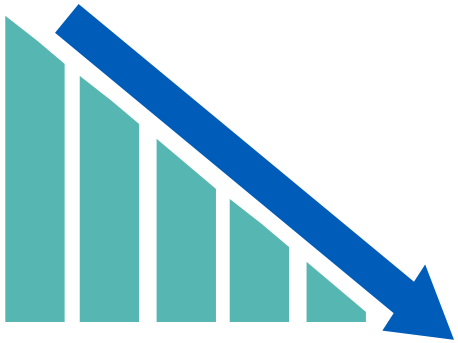
The total budget for health services in Lancashire and South Cumbria is
£3,525million

Lancashire and South Cumbria receives
10%
more funding per person

Lancashire and South Cumbria will receive
£150million
average growth in funding per year



In contrast, there has been around a
40%
reduction in local authority funding



Our neighbourhoods and local areas

To respond to what we can see in our population statistics, we have looked at how we can address the needs of our local populations within our five local areas and all of our neighbourhoods.

About our neighbourhood approach

We are defining neighbourhoods as communities where all aspects of health and care services will come together: with local people, local authorities and voluntary and community organisations.

Within each neighbourhood is a primary care network, these are a key part of the NHS Long Term Plan and are based on populations of between 30,000 and 50,000. They build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more joined-up health and social care within neighbourhoods.

There are **248 GP practices**[20] in Lancashire and South Cumbria, working in partnership within our **41 primary care networks**.

References

20. Source: NHS Digital.

Five local partnerships

There are five local health and care partnerships: Central Lancashire, Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire.

These local partnerships include primary care networks linked together with other care providers such as hospitals, care homes, mental health and community providers, local government, voluntary and community organisations – alongside health and care commissioners.

Together, these partnerships assess local need, plan how to use their collective assets and join up what they offer – including how to make best use of overall public and community resources.

You can find out more about the work of our five local partnerships at: **healthierlsc.co.uk/Local**

Numbers of people living in each area
Morecambe Bay: 352,000 people
Pennine Lancashire: 566,000 people
Fylde Coast: 354,000 people
Central Lancashire: 399,000 people
West Lancashire: 114,000 people
Total: 1,785,000 people live in Lancashire and South Cumbria[21]

Lancashire and South Cumbria Integrated Care System

The Integrated Care System is a partnership, which provides strategic leadership across our whole population.

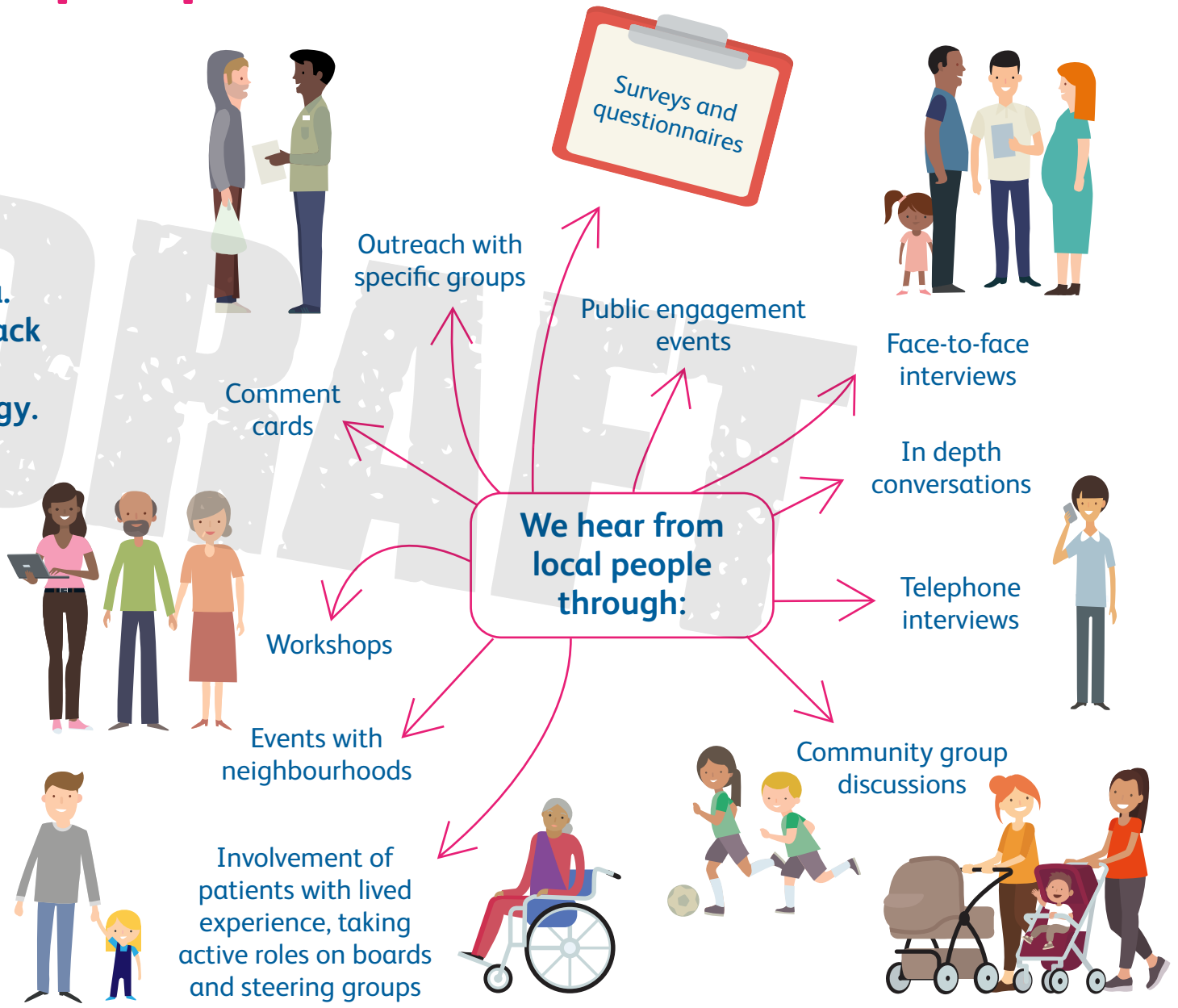
The partnership includes:

- Local authorities
- NHS organisations
- Voluntary, community, faith and social enterprise organisations
- Academic institutions, such as our universities
- Public sector organisations, such as police and other emergency services
- Our local communities.

21. Source: NHS Digital. (December 2019). Patients registered at a GP practice.

Involving local people

Our partners continue to work with, engage and involve local people in changes and new ways of delivering services in neighbourhoods, in local partnerships and across Lancashire and South Cumbria. We have listened to the feedback of local people as we have developed this five-year strategy.



Local people have told us

- They were not aware and did not recognise the changes and developments that are being made to the health and care system
- They are positive about the inclusivity of the vision but raised concerns over a focus on the elderly at the expense of younger people
- Opinion was divided over whether changes to the health and care system were a positive development, although it was evident that understanding of primary care networks and local partnerships and how they work is low
- They felt positive about links being formed between different healthcare services
- They felt positive about work taking place in some of our neighbourhoods where communities, health and care services and local organisations are working together
- They are positive about intentions to improve community services
- They feel there is a lack of support for mental health issues and lengthy waits for referrals.

Read more about our engagement with local people at **healthierlsc.co.uk/GetInvolved**

We value this feedback and have used it to shape this strategy and how we will deliver partnership working across Lancashire and South Cumbria. We are committed to continue to involve people and put them at the centre of everything we do as a partnership.

To get involved and find out what is happening in your local area, visit **healthierlsc.co.uk/Local**

Integrating health and care

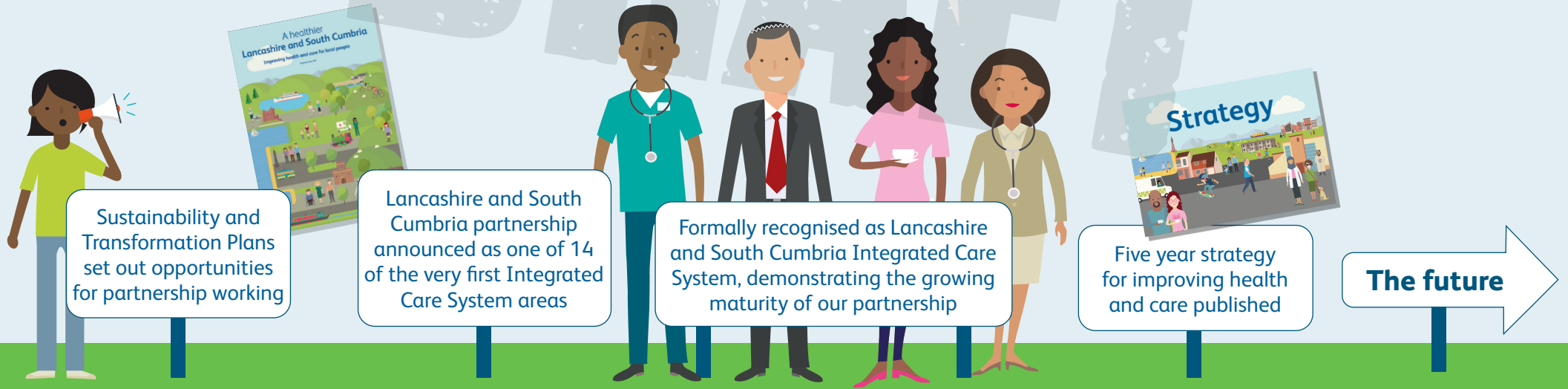
The NHS Long Term Plan, published in January 2019, set out an ambitious programme of service improvement for health and care in England. It describes how Integrated Care Systems will work in new, more coordinated ways to:

- Join up health and care for local people – especially those with multiple and long term conditions
- Be proactive about prevention – stopping people getting ill in the first place
- Make the very best use of the whole health and care resource across an area

This document builds upon the foundations of partnership working which have been developing over the past four years.

We have listened to local people and worked together with colleagues across the health and care sector to develop a five-year strategy to deliver the aims of the Long Term Plan and to address the most urgent needs of the 1.8million people living in Lancashire and South Cumbria.

Examples of how we are already successfully working in partnership are available on pages 32 to 35



Our journey towards partnership working

How we will deliver our strategy

Improving the health and wellbeing of local communities

Delivering better, joined-up care, closer to home

Delivering safe and sustainable, high quality services

Improving the health and wellbeing of local communities

We will take action to improve the underlying issues that impact health, healthy behaviours, the lifestyle choices we make and the places and neighbourhoods we live in. We will deliver care tailored to meet the needs of individuals.

Five key priorities will be our focus to improve the health of the population and to reduce health inequalities.

Giving the best start in life

National evidence tells us that development begins before birth and that the health of a baby is crucially affected at this early stage. We need to make changes to policies to eradicate health inequalities and make sure children and families receive support in the first 1,000 days after birth.

To do this, we will:

- Focus on reducing infant mortality
- Close the gap in communication skills between disadvantaged children and their classmates when they start school
- Address child poverty and its impact on the health and wellbeing of children and families
- Develop plans to get every child ready to learn at the age of three.

Healthy behaviours

Tobacco use, obesity, alcohol consumption and inactivity are issues which can result in disability and early death and directly affect physical and mental health.

We will work with communities to:

- Deliver our ambition to become smoke free in our premises across Lancashire and South Cumbria
- Reduce childhood obesity, learning from partnership work in Pennine Lancashire and spreading the learning to support local residents to have a healthy weight throughout their lives
- Improve oral health in all age groups
- Put in place alcohol care teams where they are needed
- Support the voluntary, community, faith and social enterprise sector (VCFSE) and wider partners to strengthen and expand the social prescribing offer available in communities.

Zero suicides

We have an ambitious goal of working towards having zero suicides in Lancashire and South Cumbria. The impact of suicide is far-reaching and remains with family, friends, colleagues and many others long after the individual has gone.

The bereavement is often detrimental to personal relationships, behaviour, wellbeing and work.

To achieve our ambitious goal, we will:

- Put policies and services in place to improve mental wellbeing, identify people at risk of suicide and better support families with specialist bereavement services
- Use real-time intelligence from the police, local authorities and NHS to support the partnership in taking action in the right areas to reduce suicides to zero over a number of years.

Neighbourhood development

People should be able to live, work and prosper in their neighbourhoods. Understanding what matters to people where they live and by working with them on the challenges they face can help find creative solutions to seemingly insurmountable problems.

Neighbourhoods are where people spend most of their time. We will work with local communities to co-create solutions through local partnerships where people live. In these areas, people will be supported to manage their own health and wellbeing and receive social support by integrating health and care services with local authorities and other voluntary and community groups.

To achieve this all 41 of the primary care networks will be supported to deliver care centred around the person and detect and diagnose conditions such as diabetes, cancer and heart disease early.

Work and health

Having a healthy and capable working age population has major positive benefits for local people, organisations, the local economy and wider society.

This means it is important to support people to achieve their potential in life by enabling them to work, maintain financial independence and security for themselves and their families, especially as they age. This includes people with long term conditions and disabilities, a large number of whom, want to work and live independent lives.

To achieve this, the partnership is already working with local economic partnerships, wider public sector leaders and universities to create opportunities through the development of a local industrial strategy and sharing good employment practices between large organisations in Lancashire and South Cumbria.

We will support our current and future workforce to have the best possible health, and in turn improve the local economy.

Delivering better, joined-up care, closer to home

Our neighbourhood approach aims to deliver better care planning and outcomes for local people. This builds upon positive local and national examples where GPs, community nurses, therapists, social workers, voluntary, community, faith and social enterprise sector partners and the communities themselves have worked together more closely.

This approach to working in neighbourhoods allows partners to make use of a multidisciplinary workforce and offer opportunities to create a sustainable future for primary and community services, which have been under significant pressure in recent years.

We want to use neighbourhood working to continue learning about how best to engage with local people about their health and wellbeing, using the assets of each community to do so. The aim is to make this approach one of the most recognisable characteristics of the partnership in Lancashire and South Cumbria.

We are supporting the development of the **41 primary care networks** at the heart of wider public and voluntary sector integrated neighbourhoods.

Primary care networks are a vital component of the neighbourhood model, with ambitions to:

- Stabilise general practice
- Help solve the capacity gap and improve the skills mix by growing the wider workforce
- Invest in our local communities
- Be the connection point between primary and community care
- Deliver new service improvements and achieve clear, positive, quantified impacts that benefit people.

The five local health and care partnerships are where:

- Local authorities can take an active, lead role in system redesign
- System redesign can be built on community approaches
- Integration between health and care and other sectors can be best delivered
- Political engagement and democratic input can be undertaken most effectively
- Partners can determine how they can best work together to achieve outcome improvement and system change.

You can find out more about the work of our five local partnerships at: **healthierlsc.co.uk/Local**

Each local health and care partnership is developing an integrated model of:

- Primary and community services
- Physical and mental health services
- Integration of health and social care services.

Where things are best undertaken once, we will do them in partnership across Lancashire and South Cumbria.

Delivering safe and sustainable, high quality services

It is clear that the way local NHS hospital services are delivered is both clinically and financially unsustainable. Across the four providers of acute services, there is significant variation in the quality, access and outcomes of services received by people living in Lancashire and South Cumbria. System leaders recognise that variation exists and that plans are now needed to address this.

Clinical leaders will be supported to work beyond the boundaries of their organisations to set out what the future of service delivery will look like and work together to influence how services will be delivered over the next four years and beyond.

Integrated Care System partners are working together to overcome these challenges through three key programmes:

1. **Increased collaboration between providers**
2. **Efficient and sustainable service delivery**
3. **Integrated pathways.**

1. Increased collaboration across providers

We will explore the benefits of our hospitals and community services working together as a Provider Collaborative and describe what this will mean for local people and staff. This will be to enable services to deliver the highest quality, safe and sustainable care to people in Lancashire and South Cumbria.

To achieve this, the four NHS trusts providing acute services will increasingly work more closely together, transforming the ways in which some more specialised services and patient pathways are organised. This could involve changes to current models of care, locations of care, or the number of hospitals which provide care. Local communities and stakeholders will be involved in shaping these models of care and, where appropriate, further engagement and formal consultation will take place.

Examples of early work are redesigning how services are delivered for head and neck, cancer, and vascular services, paediatrics and diagnostics.

2. Efficient and sustainable service delivery

In line with the expectations of the NHS Long Term Plan and more local analysis of unwarranted variation and efficiency opportunities, partners have identified a range of potential schemes to improve the clinical and financial sustainability of services. It is recognised that these opportunities can only be realised with the leadership and support of clinical and other professional leaders working together across the system.

The following areas will be prioritised as they demonstrate the greatest opportunities for improving efficiency:

- Outpatient appointments
- Musculoskeletal (MSK) services
- Theatre efficiency
- Back office functions
- Management of medicines
- Interventions of limited clinical value
- Innovation and quality.

3. Integrated pathways

The NHS Long Term Plan identifies integrated pathways across a number of services that are intended to enhance clinical outcomes for local people. As well as working towards the implementation of these pathways, ICS partners have identified a number of local priority pathways for redesign across Lancashire and South Cumbria.

Our priority pathways for improvement are:

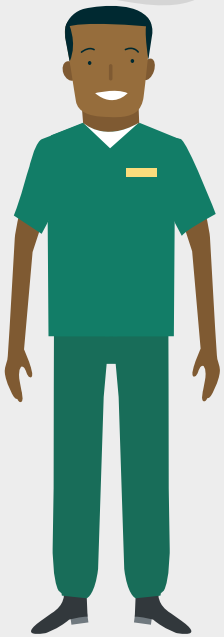
- Mental health – adults and children and young people
- Learning disabilities and autism
- Urgent and emergency care
- Cancer
- Stroke services
- Planned care
- Maternity services.

Urgent and emergency care

We are committed to providing highly responsive services for adults and children with urgent care needs, which deliver care as close to home as possible and are high quality, safe and sustainable.

This will be achieved by:

- Using the same approach across partners to collecting and using intelligence about how services are working
- Improving how ICS partners and the ambulance service share information
- Improving patient safety and experience due to quicker response times
- Using resources and teams appropriately, so that paramedic crews are able to respond to life threatening emergencies.



Cancer

We aim to improve early diagnosis for patients with cancer, offering greater opportunities to make personal decisions about cancer treatment.

We are taking forward bold actions to improve lung cancer screening, introduce rapid diagnostic centres and increase our workforce.

Stroke services

We plan to improve stroke services – right across the pathway from prevention through to rehabilitation. Our aim is to reduce the number of people having a stroke in our population, but for those who do, we need to reduce variation in the outcomes of the care that we provide.

We will work in partnership with care professionals, public health and wider partners such as the Stroke Association, and local people to reduce the likelihood of experiencing a stroke.

Mental health – adults and children and young people

Working with communities to improve the mental health, resilience and wellbeing of people in Lancashire and South Cumbria is one of our partnership priorities.

Our ambition is that mental health and wellbeing is considered of equal importance to physical health in all of our communities. When local people require more support, they should be able to access an effective range of age-appropriate mental health services. At present, there is variation in access, provision and clinical outcomes.

Learning disabilities and autism

We will redesign and deliver effective, streamlined community services and develop specialist assessment and treatment beds, community admission avoidance placements and alternatives to hospital admission for people with learning disabilities and/or autism.

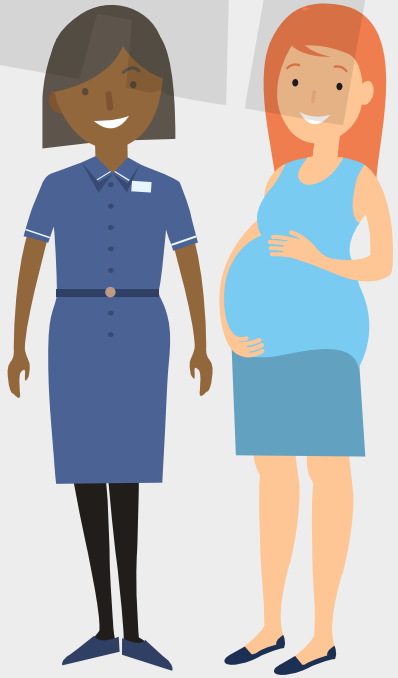
The partnership will:

- Ensure the safe and effective discharge of people who do not require the use of inpatient services
- Ensure that the right number of beds are delivered in the right places, meeting the needs of individuals
- Ensure that public sector resources are being used effectively to support people with a learning disability or autism
- Ensure that action is taken to reduce health inequalities.

Planned care

We have reviewed how all our hospital operating theatres are used to improve efficiency and reduce waiting times for patients. Across the ten specialties with the highest volume of activity, we have identified an opportunity for an additional 18,000 theatre hours per year, but recognise that there are significant challenges in achieving all of this.

We will enable earlier and more accurate diagnosis to make sure we get patients on the right planned pathway first time. To do this, we will work in partnership to deliver improved diagnostic services, which use tests and evaluations to help detect, diagnose and treat diseases, injuries and other physical conditions.



Maternity services

We aim to better deliver consistent care for families. As a partnership, we are committed to removing boundaries, improving choice, safety and experience of maternity services and improving outcomes.

This will result in:

- Reduced number of stillbirths and neonatal deaths
- Reduced number of brain injuries between labour and delivery of the placenta
- Personalised care records
- Most people receiving continuity of carer during pregnancy, birth and postnatally
- Reduced number of newborn babies separated from their parents
- Reduction in people smoking during pregnancy and at the time of delivery
- Improved support and education around infant feeding.

Making this happen

This strategy will be enabled by our plans to:

- Create a great place to work and develop
- Use technology and innovation to deliver great care
- Make the most of public sector investment
- Inform, involve and engage local people, staff, partners and stakeholders

Creating a great place to work and develop

- We are committed to developing employment opportunities for local communities within health and care services
- We will develop the volunteer workforce, which includes partnership working with the voluntary, community, faith and social enterprise sector
- We will recruit new members of staff – we want to attract new staff to the region
- We will improve the experience of staff currently working within the partnership
- We will develop new roles and skills and use technology to better support staff
- We will create stable and sustainable clinical and frontline teams working across more than one trust/site in order to ensure that there are sufficient staff to deliver quality and safety for patients.

Using technology

We will mobilise our workforce to harness the technology revolution and bring about a radical transformation, that will:

- Empower people to be more active in managing their health and wellbeing
- Enable more patients to self-care and live independently for longer
- Pinpoint, predict and prevent disease through better use of data
- Increase the amount of time for care on the frontline
- Create a flexible working environment that helps retain the workforce
- Improve operational efficiency across back office services.

Innovating to deliver great care

- The partnership will contribute to the development of the Lancashire and South Cumbria economy, promoting a wide range of benefits to the population from this approach to collaboration, mutual learning and investment in new ideas. This allows us to respond locally to the global impacts of technological, social, scientific and environmental changes.
- The partnership will establish a public service enterprise and innovation alliance, bringing together the health and care sector across Lancashire and South Cumbria with universities and economic development partners.

Making the most of public sector investment

We will significantly change the way organisations invest in, provide and manage the whole health and care system including GPs, A&Es, specialist centres, hospitals and care services.

To achieve this, we will:

- **Develop a more radical approach** to planning and making changes to services across providers. This needs to result in much faster change than partners have been able to do in the past
- **Increase our collective ability** to achieve efficiencies and services changes. We need a higher level of ambition, peer support and challenge, leadership and the application of the right techniques
- Ensure we are quick to **adopt best practice** across the whole system
- **Make the most of new ideas and opportunities**, which lead to faster change and improve the efficiency of our services.

Inform, involve and engage local people, staff, partners and stakeholders

We will involve people when designing how we deliver services and work together to improve people's experience of health and care locally.

What this means for communities and our staff

In five years' time…

Local people will be:

- More active in managing their health and wellbeing and decisions they make that affect them
- Supported to improve their long-term health and wellbeing
- Living well before they die, in the place of their choice in peace and dignity
- Using technology to manage their health
- More involved in decision making in their area
- Making best use of local housing and leisure services by connecting with integrated community teams
- Living in dynamic, empowered communities where people can live, work and thrive
- Benefiting from more coordinated and joined-up care
- Receiving care from hospitals, which provide networks of services, with sustainable staffing levels and consistent pathways
- Supported to live longer, healthier lives with earlier diagnosis of conditions and advice on prevention.

Staff will be:

- Happier, healthier and more resilient
- Provided with a wider range of roles and support to develop new skills and capabilities
- Working in integrated community teams, delivering targeted and coordinated physical and mental health care to their local neighbourhoods
- Better able to support people they care for, through greater access to data shared by partners
- Attracted into working and living in Lancashire and South Cumbria.

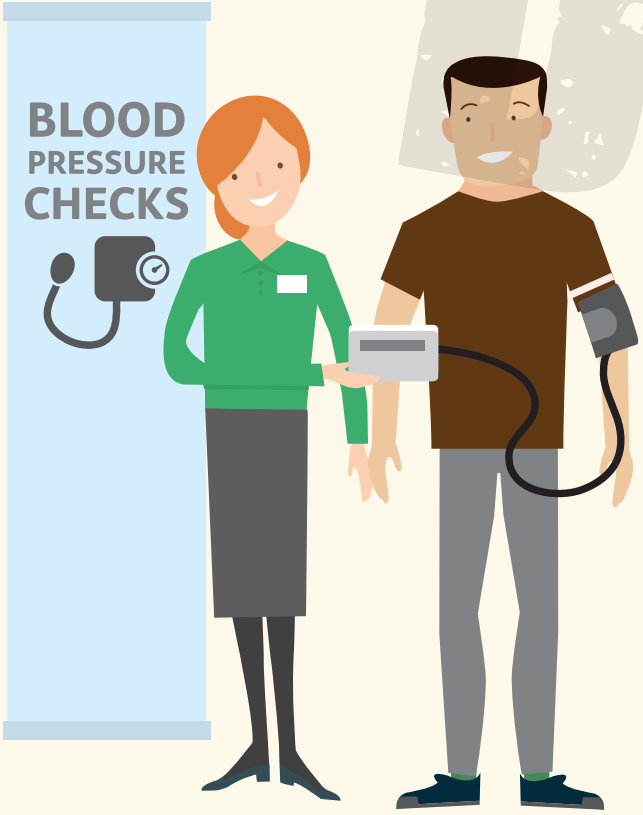
Partners will be:

- Able to demonstrate how public sector organisations have supported economic development and innovation, resulting in employing local people into new and different jobs in health and care
- Able to demonstrate that they are getting the best value health and care
- Confident in the evidence of improving life expectancy and reducing inequalities in the most deprived neighbourhoods through our approach to population health
- Able to demonstrate how health and wellbeing has been considered in public policies such as education, housing, economic development, transport and retail.

The impact of working in partnership

Lancashire and South Cumbria Integrated Care System is seen as a maturing partnership.

There is much that has already been achieved, which health and care system partners are proud of.



Early detection and prevention

- **£7.6million funding** from NHS England and NHS Improvement (NHSE/I) will help to diagnose lung cancer earlier in Blackpool and Blackburn with Darwen. Lung health checks will begin in early 2020, targeting smokers or ex-smokers between 55 and 74 years of age. In addition, **£9million** is being invested in early diagnosis of other types of cancer.
- Partners are working with the British Heart Foundation to deliver **12,000 blood pressure tests in local communities by 2021** with football clubs, leisure centres and pharmacies so that people know their numbers and what they mean. This is identifying individuals much earlier who are at risk of a heart attack, kidney disease and stroke.
- A partnership approach to **reduce suicides** has seen the development of a dashboard of live intelligence on suspected suicides. The insight is helping to identify trends, which is being used to deliver a campaign to reduce suicides by encouraging people to talk, create stigma free working environments where people can seek help and reach out to colleagues and to provide support for those bereaved by suicide.

Developing partnerships with the voluntary, community, faith and social enterprise (VCFSE) sector

- The VCFSE sector, local authorities and NHS in Lancashire and South Cumbria have worked together to develop better relationships. This has seen **consistent models of VCFSE engagement** within and across all local health and care partnerships and the development of a VCFSE leadership group across Lancashire and South Cumbria.

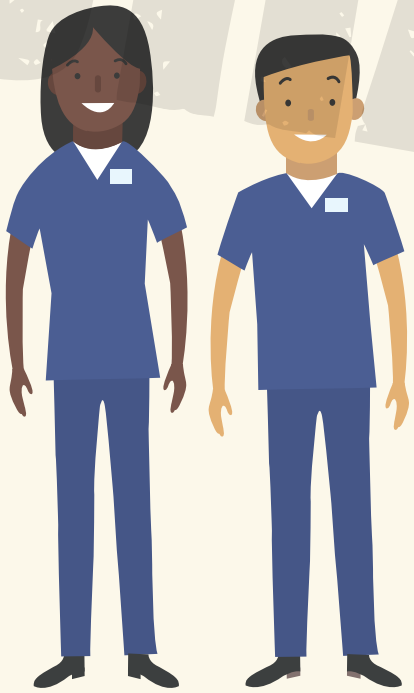
Supporting thriving local communities

Leading the way nationally in developing a population health management approach resulted in five neighbourhoods tackling issues in their communities:

- In **Blackpool**, people living in houses of multiple occupancy have been provided help related to issues with where they live and empowered to become more actively engaged in managing their own health and wellbeing.
- In **Skelmersdale**, people with respiratory conditions often have other health conditions such as diabetes or depression and anxiety. More personalised care has been provided to a group of patients by looking at the whole person rather than just one condition at a time, as well as developing group consultations to provide peer support.
- In **Chorley**, it was identified that residents known to the GP surgeries as living with frailty also needed help to have their bins collected. People have been connected with link workers who visited and interviewed them in their own homes to provide support for their mental health, physical and social needs in one assessment. This has resulted in connecting people with local groups to help combat loneliness or obtain support and tips for healthy eating.
- In **Barrow and Millom**, people most at risk of serious mental health conditions have been supported by improving the consistency and quality of the Severe Mental Illness (SMI) checks they receive.
- In **Burnley**, a group of people aged 50 and over living with frailty have benefited from their neighbourhood team using a peer-to-peer model of support. This has helped individuals to meet people with a similar condition and learn from each other how best to manage and self-care as well as getting the best from services.
- In **Fleetwood,** partners have joined initiatives together, which have contributed to a significant reduction in the number of residents attending Blackpool's A&E, down **11.5%** in a year. There has also been a reduction of **9.4%** in the number of people being admitted to hospital in an emergency. The primary care network has received multiple awards.

Strengthening the health and care workforce

- A programme called **EPIC** has been established to share and adopt best practice; celebrate the achievements of staff; and connect individuals and teams across the partners of Lancashire and South Cumbria Integrated Care System. **More than 500 staff and volunteers** from health, social care, public sector and community organisations have participated in the first two events in 2019. EPIC stands for **E**ngaging communities, **P**romoting partnerships, **I**nnovation for improvement and **C**ollaborating to develop services.
- We are continuing to recruit qualified nurses through the Health Education England Global Learners Programme into the Provider Trusts across Lancashire and South Cumbria. We are now seeing the arrival of these overseas nurses into the UK, with the majority gaining their Nursing and Midwifery Council registration to practice within two to three months of arrival. Feedback from the nurses who have arrived in the last 12 months is very positive, indicating that they have been very well supported in terms of both the pastoral and educational elements. We hope that many will choose to remain in their posts in the UK in the longer-term.



Joining up health and social care services

- **78% of our care homes** are actively using a tool that allows bed vacancies to be tracked. This is helping to reduce avoidable and unnecessary lengthy stays in hospital.
- A Lancashire-wide joined-up **response and falls lifting service** has been launched. This is designed to divert calls from ambulance services in cases where older and vulnerable people have fallen within their own home (this includes care/nursing homes and extra care sheltered housing). The service has teams based in every locality and is averaging a response time of around 30 minutes, comparing favourably to what was often a four hour plus wait.
- Partnership work across **maternity** services has resulted in **29.2%** of people being booked onto pathways, which can offer continuity of carer, exceeding the national target of 20%.

Innovations in digital health

- Almost **500,000 people** across Lancashire and South Cumbria have **downloaded an app** that helps them connect with their GP surgery. **More than one million** local people have been enabled to use **online consultation**. Patients are now able to contact their practice online to ask about a new or ongoing problem and get advice or an appointment if needed. **More than four fifths** of all GP practices across Lancashire and South Cumbria are now offering online consultations.
- A **shared care record** is now fully operational across Lancashire and South Cumbria, supporting clinical staff to deliver care to patients. Thousands of clinicians use it routinely to ensure continuity and consistent care for the people they treat. There are currently more than **2.5million care documents** available to view, with more than **100,000 new documents** published every month. This means that patients do not have to repeat information to different care teams and more joined-up care can be provided thanks to easier access to an individual's medical history.

Thank you

We would like to say a huge thank you to all the local people, staff and partners who have been involved in developing this strategy and our plans for the next five years.

We are also grateful to our universities, voluntary, community, faith and social enterprise sector, police and local Healthwatch who have all actively contributed to this strategy for the partnership.

Our next steps

We will continue to work together across health and care to develop and deliver these priorities in partnership.

This version of our strategy is a draft because we would like to get further feedback from local people and stakeholders.

To find out how to share your comments, please visit:

healthierlsc.co.uk/Strategy

Get involved

In your local area: **healthierlsc.co.uk/Local**

Visit our website: **healthierlsc.co.uk**

Join in the conversation on Twitter: **/HealthierLSC**

Like us on Facebook: **/HealthierLSC**

Email us at: **healthier.lsc@nhs.net**

Our partners

Lancashire and South Cumbria Integrated Care System is a partnership of the following organisations:

NHS organisations

- NHS Blackpool CCG
- NHS Blackburn with Darwen CCG
- NHS Chorley and South Ribble CCG
- NHS East Lancashire CCG
- NHS Fylde and Wyre CCG
- NHS Greater Preston CCG
- NHS Morecambe Bay CCG
- NHS West Lancashire CCG
- NHS Midlands and Lancashire Commissioning Support Unit
- Blackpool Teaching Hospitals NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- North West Ambulance Service NHS Trust
- NHS North West Regional Specialised Commissioning Team
- The Innovation Agency, the Academic Health Science Network (AHSN) for the North West Coast

Local authorities

Upper tier/unitary councils

- Lancashire County Council
- Blackburn with Darwen Borough Council
- Blackpool Council
- Cumbria County Council

District councils

- Preston City Council (Central Lancashire ICP)
- Chorley Council (Central Lancashire ICP)
- South Ribble Borough Council (Central Lancashire ICP)
- Fylde Council (Fylde Coast ICP)
- Wyre Council (Fylde Coast ICP)
- West Lancashire Borough Council (West Lancashire MCP)
- Barrow-in-Furness Borough Council (Morecambe Bay ICP)
- Lancaster City Council (Morecambe Bay ICP)
- South Lakeland District Council (Morecambe Bay ICP)
- Burnley Borough Council (Pennine Lancashire ICP)
- Hyndburn Borough Council (Pennine Lancashire ICP)
- Pendle Borough Council (Pennine Lancashire ICP)
- Ribble Valley Borough Council (Pennine Lancashire ICP)
- Rossendale Borough Council (Pennine Lancashire ICP)

Voluntary, Community, Faith and Social Enterprise (VCFSE)

The ICS has established strong partnerships with the VCFSE sector. A Voluntary Sector Partnership Alliance has been formed by the sector comprising chairs of VCFSE networks in each of the five local health and care partnerships.

Accessibility

If you would like this document in an alternative format, please email us at **healthier.lsc@nhs.net**

Glossary

For definitions of health and care words and phrases used in this document, please visit **healthierlsc.co.uk/glossary**

Health Scrutiny Committee
Meeting to be held on Tuesday, 4 February 2020

Electoral Division affected:
(All Divisions);

Commissioning Reform in Lancashire and South Cumbria
(Appendix 'A' refers)

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Executive Summary

At its meeting held on 9 January 2020, the Joint Committee of Clinical Commissioning Groups considered a report on Commissioning Reform in Lancashire and South Cumbria. A copy of that report is set out at appendix 'A'.

Recommendation

The Health Scrutiny Committee is asked to consider and provide feedback on commissioning reform across Lancashire and South Cumbria.

Background and Advice

The Joint Committee of Clinical Commissioning Groups at its meeting held on 9 January 2020 considered a report on the evolution of NHS commissioning in Lancashire and South Cumbria over the next two years. The report set out a case for change on how commissioning organisations could work to accelerate the development of local integrated health and care partnerships and also provided a draft terms of reference which aim to reconstitute an existing oversight group to act as a formal sub-group of the Joint Committee of Clinical Commissioning Groups to be known as the Commissioning Reform Group. The revised Group will oversee the continued development of plans for commissioning reform which could be considered by the Joint Committee of Clinical Commissioning Groups and individual Clinical Commissioning Group (CCG) governing bodies.

The report at appendix 'A' highlights that "further work will also be completed during January to develop proposals for the future delivery of commissioning functions at local place and Lancashire and South Cumbria levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process".

A period of formal engagement from February to March 2020 on commissioning reform across Lancashire and South Cumbria will take place with member practices,

Lancashire County Council

CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups.

Subject to the outcome of a Clinical Commissioning Group GP Membership vote; consideration by the Joint Committee of Clinical Commissioning Groups and sign off by [CCG] Governing Bodies, a formal merger application will be submitted to NHSE by 30 September 2020 with the aim of a single CCG for Lancashire and South Cumbria operating in shadow form from October 2020 and being fully established on 1 April 2021.

The Health Scrutiny Committee is asked to consider and provide feedback on commissioning reform across Lancashire and South Cumbria.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

The report at appendix A represents the views of the partnership known as the Lancashire and South Cumbria Integrated Care System and are not those of Lancashire County Council.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Healthier Lancashire & South Cumbria

Title of Paper	Commissioning Reform in Lancashire and South Cumbria		
Date of Meeting	Thursday 09 January 20	Agenda Item	9

Lead Author	Andrew Bennett	
Contributors	Several system leaders have contributed important observations and content during development of Case for Change.	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	x
Executive Summary	This cover paper introduces two papers which have been drafted to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (LSC) over the next two years. It introduces: • A case for change document which sets out how commissioning organisations can work to accelerate the development of local integrated health and care partnerships. • Draft terms of reference which aim to reconstitute an existing oversight group to act as a formal sub-group of the Joint Committee of CCGs. It is proposed that the revised Group will oversee the continued development of plans for commissioning reform which can be considered by the Joint Committee and individual CCG governing bodies.	
Recommendations	1 Note the contents of this report. 2 Endorse the Case for Change and ask individual CCG Governing Bodies to lead a period of formal engagement from February-March 2020 with local member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups. 3 Receive the proposed Terms of Reference for the Commissioning Reform Group and agree that this group is reconstituted to act as a formal sub-group of the Joint Committee.	

Next Steps	Complete preparations for a period of formal engagement about the Case for Change with local member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups. Convene the first meeting of the Commissioning Reform Group.		
Equality Impact & Risk Assessment Completed		No	Not Applicable
Patient and Public Engagement Completed		No	Not Applicable
Financial Implications	Yes		Not Applicable
Risk Identified	Yes		
If Yes : Risk	It is expected that the Commissioning Reform Group will review risks arising from this programme of work as part of its core agenda. Individual CCGs will continue to report risks through local assurance frameworks.		
Report Authorised by:	Andrew Bennett		

Healthier Lancashire & South Cumbria

Commissioning Reform in Lancashire and South Cumbria

1. Introduction

This cover paper introduces two documents which have been drafted to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (LSC) over the next two years. It introduces:

- A case for change document which sets out how commissioning organisations can work to accelerate the development of local integrated health and care partnerships.

- Draft terms of reference which reconstitute an existing oversight group to act as a formal sub-group of the Joint Committee of CCGs. It is proposed that the revised Group will oversee the continued development of plans for commissioning reform which can be considered by the Joint Committee and individual CCG governing bodies.

2. Case for Change

2.1 The Case for Change paper has evolved from a series of development workshops attended in recent months by CCG Chairs and Chief Officers, Directors from the Midlands and Lancashire Commissioning Support Unit and Directors working across the Integrated Care System. These development sessions have enabled commissioning leaders to:

- Review the work led by CCGs since 2013 to respond to a number of significant challenges in each local area: poor outcomes and health inequalities, fragmented services, increasing demand compounded by workforce pressures and the need for financial sustainability.
- Restate their commitment to the continued development of 4 maturing integrated health and care partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. These partnerships offer a vehicle for commissioners, providers, local authorities and other organisations to work very differently, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and bring the system back into financial balance.
- Confirm the action taken by CCGs to deploy significant resources and expectations into the early development of 41 Primary Care Networks (PCNs), building on the integrated care models which have developed in neighbourhoods. There is a clear expectation in each ICP that the clinical leadership offered by GPs and other frontline professionals should be endorsed and refocused to ensure the success of PCNs and ICPs. There is also further potential to use the development of PCNs and ICPs to encourage new approaches of integrated commissioning with our local authorities.
- Review the existing arrangements which enable CCGs to take collective decisions on pertinent issues affecting the whole of Lancashire and South Cumbria.

2.2 Based on the collective vision to continue this journey of integrated care in neighbourhoods, local places and across Lancashire and South Cumbria, commissioning leaders have identified a number of options for the commissioning arrangements which can best support this next stage of development. Each option has been assessed against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

2.3 The Case for Change document recommends Option 5 which would lead to the creation of a single CCG for Lancashire and South Cumbria. This option is also clear that the single CCG will discharge a range of its functions through place-based commissioning teams working with partners in each of the five local ICP/MCP areas.

2.4 Subject to agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February-March 2020 with member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups.

2.5 Further work will also be completed during January to develop proposals for the future delivery of commissioning functions at local place and Lancashire and South Cumbria levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process.

2.6 It is vital to emphasise that the formal decision about any option to change the number of CCGs will be taken according to each CCG's constitution through a vote of member practices. Therefore after the engagement process has been undertaken, and taking account of any feedback received, it is proposed that a GP membership voting pack will be developed and considered by the Joint Committee of CCGs and CCG Governing Bodies prior to a CCG GP Membership vote in April 2020.

2.7 Subject to the outcome of this vote, a full set of merger submission documents will be prepared in line with NHS England guidance. Following consideration by Joint Committee and sign off by Governing Bodies, a formal merger application will be submitted to NHSE by 30th September 2020 with the aim of a single CCG for L&SC operating in shadow form from October 2020 and being fully established on 1st April 2021.

3. Terms of Reference – Commissioning Reform Group

3.1 The second document attached to this paper is a draft set of Terms of Reference (ToR) for a group to be known as the Commissioning Reform Group. It is proposed that this Group replaces a pre-existing Group (the Commissioning Oversight Group) which was established in June 2018 to choreograph implementation of the earlier Commissioning Development Framework.

3.2 The terms of reference rename the group to reflect its responsibilities going forward and to create a formal accountability to the Joint Committee of CCGs. These ToR including the membership have therefore been updated to allow the Joint Committee of CCGs to oversee the implementation of the road map for commissioning reform in Lancashire and South Cumbria.

3.3 The purpose of the CRG is to act on behalf of the Joint Committee of CCGs to oversee the preparation and implementation of a programme which enables a continuing process of commissioning reform in Lancashire and South Cumbria. This will include the production of:

- A formal Programme Plan – which enables the 8 CCGs to take collective action and comply with national guidance
- Human Resources and Organisational Development Plan
- Communications and Engagement Plan

3.4 The Commissioning Reform Group will make recommendations to the Joint Committee in line with the scheme of delegation which applies to the Joint Committee.

3.5 It is proposed that the Commissioning Reform Group is chaired by the Vice Chair of the Joint Committee of CCGs.

4. Recommendations

The Joint Committee is requested to:

4 Note the contents of this report.

5 Endorse the Case for Change and ask individual CCG Governing Bodies to lead a period of formal engagement from February-March 2020 with local member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups.

6 Receive the proposed Terms of Reference for the Commissioning Reform Group and agree that this group is reconstituted to act as a formal sub-group of the Joint Committee.

Andrew Bennett

31/12/2019

Lancashire and South Cumbria CCGs

Supporting Commissioning Reform and Integrated Care in Lancashire and South Cumbria

A Case for Change

Executive Summary

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out a case for changing the way that commissioning organisations work in order to accelerate the development of local integrated health and care partnerships. These increasingly ambitious partnerships offer a vehicle for commissioners, providers, local authorities and other partners to work very differently together, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and agreeing priorities to bring the system back into financial balance.

The context for the document is the work led by CCGs since 2013 to respond to a number of significant challenges in each area: poor outcomes and health inequalities, fragmented services, increasing demand compounded by workforce pressures and the need for financial sustainability [section 1]. This work has led to a broad consensus of the need for partners to work effectively together in neighbourhoods, in local places and across Lancashire and South Cumbria.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of these integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing. As PCNs develop, they will have an increasing influence on the priorities of our evolving Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. Where there are opportunities across Lancashire and South Cumbria for collective action, learning and development, these are also being taken forwards by the wider Integrated Care System (ICS) partnership.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called "integrated care organisation" could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability. The "integrated care organisation" would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

Currently, however, the 8 CCGs in Lancashire and South Cumbria are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to

develop at the pace that is needed - and to tackle the challenges we face. This is in spite of the examples of joint decision-making and shared management arrangements which have developed over the last seven years.

In section 4, this paper begins to review the way that commissioning is currently organised and evaluates a number of potential future options against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

As a consequence of the ambitions to reform the commissioning arrangements, the option recommended is to form a new single CCG from April 2021 with aligned local commissioning teams to each Integrated Care Partnership / Multispecialty Community Provider, to support this next stage of development.

Key issues

A number of key issues have been raised by Governing Body representatives and member practices during the development work which has led to the production of this document. These issues [section 5] clarify and confirm how the process of change in commissioning arrangements would build on the existing strengths in Lancashire and South Cumbria and can be summarised as follows:

Governance, leadership and local decision-making

The single CCG will have a constitution approved by member practices across Lancashire & South Cumbria and will ensure strong local commissioning remains in each place.

It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The method of appointment to the CCG governing body and place-based commissioning teams would be agreed as part of the new constitution.

The place-based commissioning teams will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board. Local authority membership of local partnership boards will also drive this place-based approach.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

It is proposed that the new single CCG Chair and the Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP.

Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

The CCG also expects that PCN leaders will be formally represented within the ICP partnership arrangements.

Financial allocations for commissioning

There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.

Overarching financial principles would be developed and agreed as part of the engagement process, but we propose that:

- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as being in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

Commissioning general practice services

The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.

Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.

Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Engagement and Next Steps

Once this case for change has been approved, a formal process of engagement will commence with member practices, CCG staff, partner organisations, patient and public groups. [section 6] More details on the proposed timeline for this process are set out in section 7.

Contents

Introduction

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out the challenging context facing commissioners and communities. It also confirms the opportunities to continue a journey of integrated care which builds on the best work undertaken by CCGs and our partners in recent years. The document contains an options appraisal for future commissioning arrangements which is based on a number of criteria and recommends a preferred option for change. The paper also includes next steps and a high-level timeline for implementation of the preferred option.

This version of the Case for Change has been written for initial consideration by CCG governing bodies, member practices and the Joint Committee of CCGs. Wider engagement with commissioning staff, providers, local authorities and other partners will also be essential as this process develops.

Section 1: The Challenges We Face

As local commissioners, CCGs have been working with other partners since 2013 to respond to a range of familiar challenges:

Inequalities and Poor Health Outcomes

In Lancashire and South Cumbria, people in many of our communities experience ill health from an early age and die younger, especially in areas with higher levels of deprivation. There are high levels of physical and mental health problems, and we have seen increased levels of suicide in some of our communities. Cardiovascular disease, heart failure, hypertension (high blood pressure), asthma, dementia and depression are more common than the national average.

Persistent inequalities in health, employment, education and income are damaging the life chances of many citizens. There is increasing recognition that we need to support people and communities to help them to make changes in their own health and wellbeing. In future, therefore, commissioners will need to co-create a sustainable response from a range of public bodies to these issues, working with communities themselves.

Fragmented services and systems

There are multiple examples of fragmented pathways and services across the health and care system which leave patients uncertain as to where to access the most appropriate care or health professional.

At a systemic level in Lancashire and South Cumbria, the NHS model of commissioners and providers created nearly 30 years ago appears to have reinforced fragmentation in spite of the best efforts of many frontline professionals and leaders. Multiple contracts between several commissioners with the same provider e.g. for mental health services have created differential expectations and outcomes; competing organisational strategies have not enabled a clear focus on standards and outcomes. There are several examples e.g. improving stroke services, where decision-making on critical improvements has been painfully slow to achieve as individual organisations reconsider the proposals. These are not isolated examples: many have been discussed over the years in each Governing body and in our collective meetings across the whole of Lancashire and South Cumbria.

Our local providers are committed to working differently to repair this fragmentation: groups of general practices are working in neighbourhoods with other community and social care services to develop primary care networks. Attention will increase on these services with the

imminent publication of national standards/specifications for a range of community-based services.

Our major NHS providers are also exploring new models of collaboration, working firstly with general practice and community services to integrate care pathways in ICPs. They are also considering how "group" models of provision across Lancashire and South Cumbria can, for example, increase the sustainability of fragile services, create efficiencies in diagnostic and operating theatre services and improve the performance of cancer services.

Commissioners need to be working at the heart of these new models of delivery – but there is neither capacity nor resources to support these new approaches and maintain the infrastructure of eight separate CCGs.

Increasing Demand

Our health and care services are struggling to tackle the level of illness and poor overall health we face in Lancashire and South Cumbria. As demand for care increases, some people don't receive the quality of care they need and commissioners cannot afford to fund escalating levels of activity.

Workforce

Workforce pressures in the health and care sector are well documented – traditional multidisciplinary models of care are increasingly hard to sustain and this requires new thinking about workforce roles and support for frontline staff. The full benefits of new technology can only be realised if they are introduced into more integrated services, pathways and teams.

Financial Sustainability

In 2019/20 there is an estimated financial gap of £200m across the L&SC ICS, based on the allocations received by the 8 CCGs. Whilst funding for the NHS is set to increase over the next few years, tackling the challenges of persistent inequalities, fragmentation, increasing demand and workforce change is more urgent than ever. We need to consider every opportunity to streamline our systems and processes, and reduce duplication. Our aim has to be to make our financial position sustainable and our collaborative work on the Long Term Plan is progressing with that aim.

Over the last twelve months, all CCGs have been required to plan for a 20% reduction in running costs and this has already led to decisions to integrate management functions between CCGs and within ICPs/MCPs, hold staffing vacancies, review clinical leadership roles, reduce accommodation costs and work differently with the CSU.

The direction of travel towards 5 local place-based commissioning teams working through a single CCG will free up a proportion of running costs, particularly in relation to the costs of 8 Boards as well as taking further opportunities to consolidate or share management functions.

Some simple examples of where a single CCG would be more productive without affecting local clinical leadership and decision making include:

- We currently have to procure extrernal and internal auditors eight times and produce 8 sets of statutory accounts.
- As eight separate CCG's we hold collectively over 100 meetings per year to meet our statutory and constitutional duties. This could be vastly reduced freeing clinical time to focus on local place-based work.

- Commissioning areas like Ambulance services, cancer services and CHC would be much more effectively managed improving patient care and releasing savings and staff to reinvest locally.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

The table below summarises the pattern of running costs across the 8 CCGs:

Organisations	**Population**	**No. of Practices**	**2019/20 Allocation £m**	**201/20 Running Cost Allocation £m**
NHS Blackburn with Darwen CCG	177,841	23	271.3	3.5
NHS Blackpool CCG	175,012	20	333.1	3.5
NHS Chorley and South Ribble CCG	186,154	30	287.2	3.9
NHS East Lancashire CCG	387,324	50	647.6	7.8
NHS Fylde and Wyre CCG	178,682	19	310.5	3.6
NHS Greater Preston CCG	210,857	23	311.8	4.4
NHS Morecambe Bay CCG	348,208	35	570.0	7.2
NHS West Lancashire CCG	113,532	15	177.8	2.4
TOTAL	**1,777,610**	**215**	**2,909.3**	**36.3**

In summary, maintaining the costs of eight separate statutory bodies at a total cost of £36m is difficult to justify when there is such financial pressure on health spending.

Section 2: Our Journey to Develop Integrated Health & Care in Lancashire and South Cumbria

We know that tackling the challenges set out in Section 1 is not something that any single commissioning organisation can achieve in isolation. For this reason, the CCGs in Lancashire and South Cumbria have a long history of working collaboratively together and with partners across the Integrated Care System (ICS) footprint. The publication of the NHS Five Year Forward View in 2014 achieved a new level of consensus that commissioners, providers local authorities and other partners should pursue approaches to integrating health and care – joining strategies, partnerships, resources and leadership to respond to the triple aim of better health, better care, delivered sustainably.

By 2018, this journey of integrated care development was accelerating the development of 4 maturing Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. These partnerships offer a vehicle for providers, commissioners, local authorities and other organisations to work very differently, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and bring the system back into financial balance.

CCGs have also begun to deploy significant resources and expectations into the early development of 41 Primary Care Networks (PCNs), building on the integrated care models which have developed in neighbourhoods. There is a clear expectation in each ICP that the clinical leadership offered by GPs and other frontline professionals should be endorsed and refocused to ensure the success of PCNs and ICPs. There is also further potential to use the development of PCNs and ICPs to encourage new approaches of integrated commissioning with our local authorities.

At the same time, a Joint Committee of CCGs was established "to carry out the functions relating to decision-making on pertinent L&SC wide commissioning issues" arising from the ICS's main change programmes. This means the CCGs across L&SC already act together as the Commissioning Board (NHS) of the ICS. The terms of reference for the Joint Committee have recently been reviewed and updated and an annual work programme has been agreed. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or decisions arising from our main work programmes will take place.

The evolution of commissioning set out in this paper is not therefore a sudden jolt in our current arrangements. Our direction of travel builds on the place-based approaches being endorsed by CCGs in neighbourhoods, ICPs and across Lancashire and South Cumbria.

Recognising that the development of integrated care models would impact on the future of commissioning arrangements, in January 2018, the Joint Committee approved a Commissioning Development Framework for Lancashire and South Cumbria. The framework gave a system wide commitment to

- Listen to our communities about their priorities for health and wellbeing, connecting up the natural assets in each neighbourhood with the resources available across the public sector;
- Make shared, strategic decisions, with key partners and clinical leaders about the allocation of resources;
- Implement new, integrated models of service provision which can make significant improvements in the quality and outcomes of health and care;

- Streamline the way we do things to reduce waste and make the most efficient use of our resources.

Following approval of the Commissioning Framework, CCG commissioning colleagues across the system worked together to apply it to their workstreams and develop recommendations for place-based commissioning activity in the future. Their work addressed several examples of fragmented or variable commissioning in the current system which are leading to poor outcomes for many people. Examples include our approach to complex, individual packages of care, the availability of robust community services for people with learning disabilities and the variability of performance in cancer services. The Joint Committee agreed the recommendations and asked workstreams to develop operating and support models.

We have therefore made significant progress on our journey to develop integrated health and care for the people of L&SC and in doing so have established solid foundations for further development. ICPs/MCP and PCNs/neighbourhoods, are the fundamental foundations for a strong and effective health and care system going forward.

However, CCGs are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to develop at the pace that is needed - and tackle the challenges, work with our communities, improve the overall quality of our health and care services and achieve better financial outcomes.

There is significant duplication in operating eight membership councils and governing bodies and the associated governance, many CCGs have similar groups to solve the same problems. Individual members of staff are trying to maintain work on several critical priorities at the same time and the work to implement new collaborative commissioning operating models across L&SC is progressing, though slowly. We therefore need to review the way we are currently organised, building on and accelerating our joint working to date, agree how best to organise ourselves to meet our challenges and deliver our vision to create a health and care system that is fit for now and the future.

Section 3: Vision

Our published vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

At the heart of this are the following ambitions:

- We will have healthy communities
- We will have high quality and efficient services
- We will have a health and care service that works for everyone, including our staff.

Over the next 4-5 years, we expect our system to continue its journey of integrated care, joining up the priorities of health and care organisations to achieve consistent standards of service performance and improved outcomes for patients and the public.

We are placing a premium on:

- Developing partnerships across the public sector (education, employment, housing, business, local government and NHS) in order to reduce the generational inequalities in health and life chances between our communities.
- Working with each of our communities to understand the assets available which can help people to become more engaged in their own health and well being.
- Joining up primary, community, mental health and social care services in local areas whilst at the same time ensuring that sustainable and efficient models of specialised services can be offered to the whole population.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called “integrated care organisation” could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability.

The “integrated care organisation” would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

In moving towards our vision, over the next 2-3 years we will continue to strengthen our partnerships in local places and across the whole Lancashire and South Cumbria system. Our priorities here are to:

- Ensure our clinical and other frontline leaders are able to lead the work to create sustainable care models in our neighbourhoods, place-based partnerships and across Lancashire and South Cumbria.

- Demonstrate to patients and communities that the ways in which we organise health and care services are leading to improved access and outcomes.
- Tackle our most difficult challenges (workforce, finance, service resilience) by agreeing clear priorities across the ICS and the decision-making arrangements we will use.
- Sustaining an open dialogue with the public about our future models of health and care.

The proposals for commissioning reform which are laid out in this document are therefore designed to help us make the next steps on this ambitious journey.

Section 4: Options for Commissioning System Reform

In developing and considering options for future commissioning reform, it is important that we do so in the context of the challenges we face, the progress made to integrate care and our commitment to build on the partnerships which commissioners have already developed. The following criteria have therefore been developed to support these considerations. If we are going to organise ourselves differently, any new model must:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

Options Appraisal

Current Arrangements

There are currently eight CCGs within the L&SC ICS footprint with a number of CCGs operating shared commissioning arrangements that are aligned to the ICP footprints:

- NHS East Lancashire CCG and NHS Blackburn with Darwen CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements
- NHS Blackpool CCG and NHS Fylde & Wyre CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- West Lancashire CCG shares the same Accountable Officer as the two Fylde Coast CCGs (from January 2020).
- NHS Chorley & South Ribble CCG and NHS Greater Preston CCG have a single Accountable Officer, a single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- NHS Morecambe Bay CCG was formed in 2018 following a boundary change process to incorporate South Cumbria. There is a single Accountable Officer and Governing body and clinical and executives are increasingly taking "system roles" within the ICP.

Across the ICS footprint, the CCGs oversee collaborative programmes of work and are able to make joint decisions relating to L&SC-wide issues through the formally constituted Joint Committee of CCGs, in line with an agreed annual work programme. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or

decisions arising from our main work programmes will take place. The work programme is also used to seek appropriate delegations from CCG Governing Bodies into the Joint Committee where appropriate. The scope of delegation to the Joint Committee is limited at the current time.

Drawing on the criteria set out above a number of options for future commissioning system

Option 1	*No change to current arrangements*
Option 2	*Merger to create five CCGs aligned with ICP footprints*
Option 3	*Single Accountable Officer and Executive Team for all eight L&SC CCGs*
Option 4	*Single CCG (all functions)*
Option 5	*Single CCG which aligns commissioning functions to each Integrated Care **Partnership**/Multispecialty Community **Partnership***
Option 6	*Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care **Provider**/ Multispecialty Community **Provider***

reform have been generated and appraised:

A detailed appraisal of these options is set out in Appendix A. In the light of this assessment, option 5 is recommended to commence from April 2021. The details of this option are shown below.

Our Preferred Option and Benefits

Option five is our recommended option to commence from April 2021. In advance of this, shadow arrangements would be developed during 2020/21.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them

including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Merging into a unified, more strategic commissioning organisation with a strong local focus delivered through locality commissioning teams aligned to the five ICPs/MCP best supports our ambitions as described below:

1. Tackle inequalities and improve outcomes for patients

We know there are significant health inequalities across L&SC which create challenges for services and result in poorer outcomes for some of our most vulnerable and deprived communities. Our work to tackle health inequalities will be better supported by having Locality Commissioning Teams aligned to the five ICPs/MCP. This will enable us to:

- Maintain strong links and engagement with the local population;
- Ensure specialist analytics and population health capabilities can develop across L&SC and be available for each ICP/PCN to support local priorities
- Undertake service planning and targeted delivery to reflect the specific needs of local communities – working closely with local authorities;
- Ensure effective communication and engagement with local populations including seldom heard groups of people to enable them to share their views and concerns which will shape not just what services are provided but how they are delivered.

Only by organising ourselves differently can we begin to deliver the improvements that are needed for our patients

2. Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPS, MCP and (where there is value in acting collectively) across the ICS

Locality commissioning teams will be aligned to the five ICPs/MCP. They will exercise an agreed set of commissioning functions on ICP/MCP and PCN footprints, working collaboratively with partners through ICP Partnership Boards to agree plans for population health improvement, improved service quality and financial recovery. The Local Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning with the ultimate aim of supporting ICPs/MCP and PCNs to reach a level of maturity over the next 2-3 years whereby commissioning functions and budgets can be contracted for through an Integrated Care Provider Contract. The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will have specific linked roles to local ICPs and neighbourhoods.

3. Reduce duplication

There will be a significant reduction in duplication both in terms of the capacity required to support the existing eight CCG governance structures and that deployed to support commissioning activity across eight CCG footprints. We know that our commissioning workforce is finding it increasingly challenging to balance the demands of collaborative commissioning activity across L&SC with ICP/MCP commissioning work to support the development of PCNs and neighbourhoods.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

4. Support a consistent approach to standards and outcomes

As a strategic commissioner the CCG will focus on a key set of commissioning functions and activity related to standard setting for the whole population. It will focus on macro-level population health management and improving outcomes for patients.

Further development work is now being led by CCGs to set out the commissioning functions which will be exercised by Locality Commissioning Teams.

5. Be affordable, reduce running costs and support longer term financial sustainability

By streamlining our decision-making infrastructure and commissioning activity, doing things once where it makes sense to do so (e.g. finance, corporate services, committee meetings) we will reduce running costs. By re-focussing commissioning time and energy for those service areas in which recommendations have already been made to commission at L&SC level, we will make better use of clinical and managerial time and be better placed to deliver the financial efficiencies as required by NHS England and Improvement.

6. Offer the potential for further development of integrated commissioning between the NHS and Local Authorities

We will establish Locality Commissioning Teams to exercise key commissioning functions through ICP Partnership Boards, of which Local Authorities are key members. The new arrangements will support the continued journey towards more integrated health and social care at place level with ICP Partnership Boards being well placed to explore practical ways of integrating health and social care commissioning and delivery.

7. Be deliverable

Creating a single CCG with a combination of system-wide and locality-based leadership offers a deliverable and affordable model of commissioning in an integrated care system.

8. Be congruent with the NHS Long Term Plan expectation that there will typically be a single CCG for each ICS area

The NHS Long-Term Plan (LTP) is clear that each ICS will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. It talks about CCGs becoming leaner, more strategic organisations that support care providers through ICPs/MCP to partner with other local organisations to deliver population health, care transformation and implement the requirements of the LTP. It also talks about CCGs developing enhanced management capability for more specialist functions, such as estates, digital and workforce. Option five will allow us to bring together CCG clinical and managerial time to respond to the requirements of the LTP, and ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP, to support place-based commissioning, allowing time and support for ICPs/MCP maturity to further develop.

In summary, a single CCG which operates as a strategic organisation, working with well-resourced local teams aligned to each of our local partnerships is recommended for the next stage on our journey of integrated care.

Section 5: Governance and Decision Making

As indicated above, the importance of effective governance and decision-making will be a critical success factor for this next stage of commissioning development in Lancashire and South Cumbria. This is particularly the case in order to build on the legacies of existing CCGs, move away from competition to partnership models of healthcare delivery and ensure that local organisations remain accountable to their communities.

Under the option for a single CCG, this will clearly operate as a membership organisation with a formal Constitution and scheme of reservation and delegation agreed with the members and approved by NHS England.

Membership of the Governing Body of the CCG will include the roles formally required including Accountable Officer, Chief Finance Officer, Secondary Care Doctor, Nurse and Lay members.

Locality-based decision-making

In order to emphasise the importance of place-based leadership and decision-making in Lancashire and South Cumbria, the governance of the new CCG will include a formal approach to leadership and decision-making in each locality. It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director for each of the 5 places (Central Lancs, Fylde Coast, Pennine, West Lancs and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

Local authority membership of ICP/MCP partnership boards will also drive this place-based approach and working relationships are expected to become increasingly close.

Given the size of the CCG, there need to be practical arrangements for ensuring member practice involvement in the accountability arrangements and governance of the organisation, particularly as many practices also want to be engaged effectively in the development of local Primary Care Networks (on the basis of 30-50000 population) as well as in their ICPs/MCP.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

Effective clinical leadership has been at the heart of clinical commissioning in recent years. There is an explicit commitment to retain these benefits in the leadership and governance of any reformed commissioning arrangements agreed for the future.

In line with current legislation, the single CCG will remain a membership organisation with all general practices as members. We recognise that clinical leaders will continue to be involved in developing the strategy, governance and accountability of a new commissioner

(e.g. through membership of the Governing Body), as well as working with provider colleagues to drive change and improvements across the health and care system.

In the next stage of our system's development, we also know that a group of GPs and other clinicians have been asked to lead our integrated PCN models in neighbourhoods: a key driver for reorganising the resources which are currently available within CCGs. It is understood that plans are being developed in each area for PCN leads to play a full part in the governance of each ICP/MCP.

Whatever option is agreed for changes in commissioning, there will be an obligation to operate under a formal constitution with a clear model for clinical leadership which is developed and agreed with member practices.

It is proposed that the new CCG Chair and the 5 place-based Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP. Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

Finance & Allocations

As indicated above, many of the NHS organisations within the ICS are currently projecting substantial deficits. These will require effective, strategic decisions to be taken if the system is to return to a stable financial base. It is recognised that existing CCGs are in different financial positions and spending on services will be variable. Much of this will be driven by historic funding variations.

It is also understood that Governing Bodies and member practices have concerns about the impact of commissioning reform on existing allocations and commitments. At this stage, therefore, it is vital therefore that the following explicit commitments are made.

In relation to commissioning allocations:

- There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.
- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

In relation to the commissioning of general practice services:

- The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.
- Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.
- Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

- In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Section 6: Stakeholder Engagement

Since June 2019, CCG Chairs and Chief Officers have worked together with ICS colleagues to draft a roadmap and a statement of intent, setting out a direction of travel for commissioning development. These have been shared with each CCG's Governing Body and take forward a dialogue to understand concerns, answer questions and consider the options outlined in this paper. In addition, a written briefing has been cascaded to staff working in CCGs and the Midlands and Lancashire CSU which has been supported in regular staff briefings held within organisations.

It is vital that a clear approach to communication and engagement now takes place, particularly with our member practices and to ensure staff in CCGs are informed and involved at each stage. CCGs wishing to consider organisational change are also required by NHS England to demonstrate effective engagement about the plans with other key system partners and the public.

To support this process, a communications and engagement plan will be developed to deliver the following objectives:

- Demonstrate we have been able to take account of the views of key stakeholders – in particular our staff, GP membership and four local Healthwatch organisations- in developing our plans for a strategic commissioner
- Ensure key audiences are aware of our plans and in particular what this might mean for them
- Ensure stakeholders – and existing CCG staff in particular – are able to ask questions and give comments, with a robust feedback mechanism
- Ensure stakeholders – and existing CCG staff in particular – are engaged in bringing the new organisation together
- Ensure staff and members are aware of any additional roles and responsibilities they may have in helping to create the new strategic commissioner.

Our communications and engagement principles are

- The communications and engagement plan is based on clear, consistent messaging that describes both the benefits of merger and any dis-benefits
- Employing a principle of 'early communication and engagement' so there are 'no surprises' particularly amongst key stakeholders
- With effective and meaningful engagement channels to capture views, timely responses to questions and feedback and published FAQs (regularly updated)
- The plan covers both internal and external audiences across all eight CCGs, including staff, memberships and practice staff, the LMC, leaders/staff across the ICS, our regulators, Healthwatch, PPGs and engagement fora, the community/ voluntary sector, other local partners, media and wider public
- With messages and approach tailored appropriately
- Underpinned by a clear activity plan and timeline which uses existing communications/engagement channels wherever possible

Section 7: Next Steps and Timeline

This Case for Change and the Options Appraisal contained in appendix A have undergone a number of iterations during the past two months based on feedback from CCG Chairs and Chief Officers, Governing Bodies and member practices. In particular, work has been undertaken to set out a vision for the continued development of integrated care in neighbourhoods, local places and across the system. More detailed proposals have been set out relating to governance, local decision-making, clinical leadership including commitments relating to financial allocations and the commissioning of general practice services.

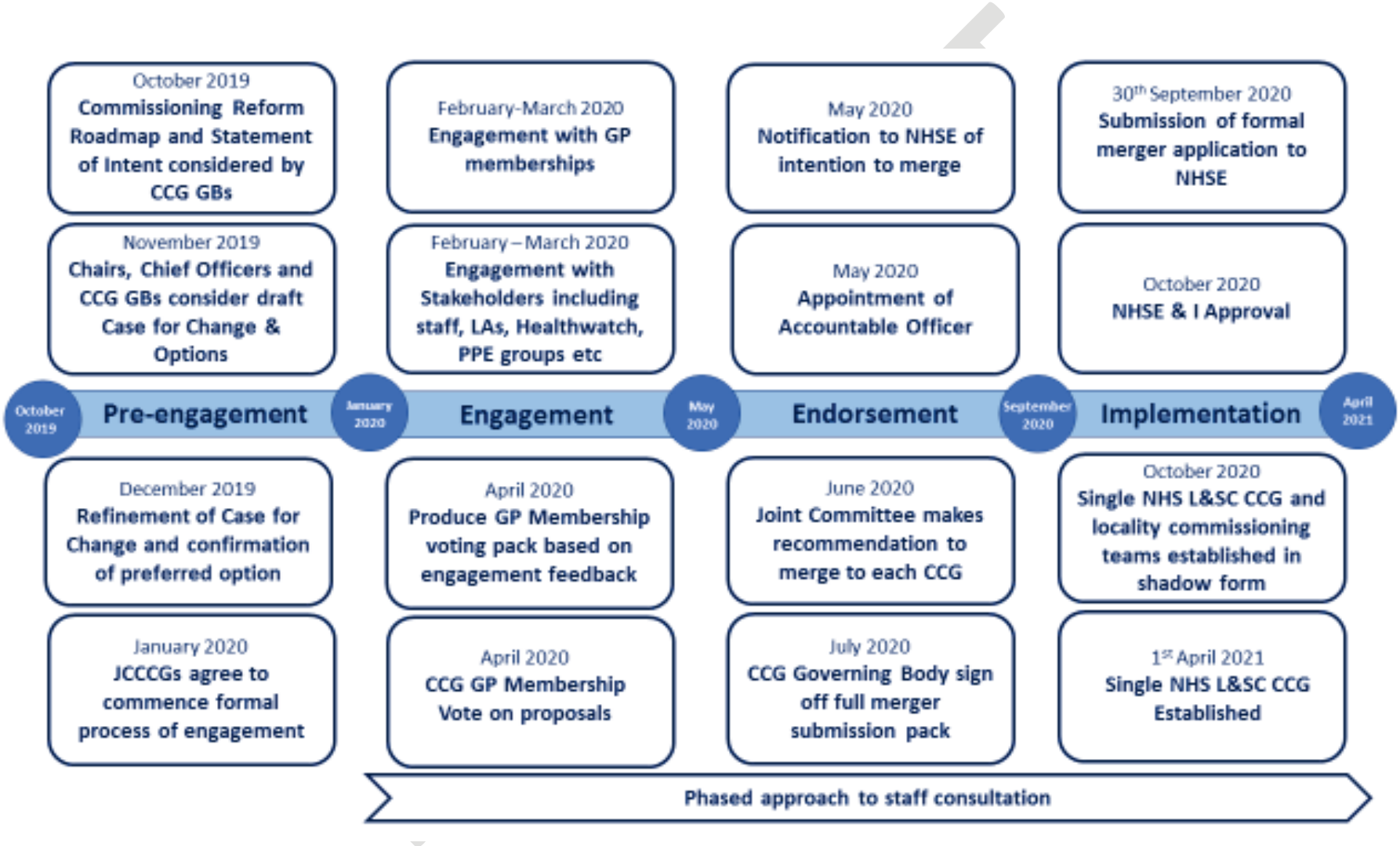
Subject to agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February-March 2020 with member practices, CCG staff and other stakeholders including Local Authorities, Healthwatch and patient/public groups.

Work will also be completed in early January to develop proposals for the future delivery of commissioning functions at place and system levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process.

Following the engagement process, and taking account of any feedback received, it is proposed that a GP membership voting pack will be developed and considered by the Joint Committee of CCGs prior to a CCG GP Membership vote in May 2020. Subject to the outcome of this vote, a full set of merger submission documents will be developed in line with NHSEI guidance. Following consideration by Joint Committee and sign off by Governing Bodies, a formal merger application will be submitted to NHSE on 30th September 2020 with the aim of a single CCG for L&SC operating in shadow form from October 2020 and being fully established on 1st April 2021.

A high-level timeline for the process described above is set out below. Work is underway to develop a detailed programme plan which will incorporate development plans for the ICPs/MCPs.

Commissioning System Reform – High Level Timeline



APPENDIX A - Commissioning System Reform Options Appraisal

Option	Number of CCG's	Pro's	Con's
1. No change to current arrangements	8	Local commissioning focus continues Minimum structural change	Continuing duplication Limits capacity to support ICP and PCN development, place-based commissioning Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning
2. Merger to create five CCGs aligned with ICP footprints	5	Local commissioning focus continues Some structural change Partial release of capacity and resource to support ICPs/MCP and PCN development and place-based commissioning Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Continuing duplication of resource maintain five CCG governance structures Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning

Option	Number of CCG's	Pro's	Con's
3. Single Accountable Officer and Executive Team for all 8 L&SC CCGs	8	Local commissioning focus continues Limited structural change May offer small efficiencies in management costs Offers potential to support a consistent approach to standards and outcomes	Continuing duplication Limits capacity to support ICP/MCP and PCN development, place-based commissioning Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning Not deliverable, unworkable for a single Exec Team to relate to eight Governing bodies
4. Single CCG (all functions)	1	Reduces duplication Supports consistent approach to standards and outcomes across L&SC Economies of scale Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Limits capacity to support ICP/MCP and PCN development, place-based commissioning Significant structural change

Option	Number of CCG's	Pro's	Con's
5. Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Significant structural change
6. Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care **Provider/** Multispecialty Community **Provider**	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP	Significant structural change Requires Integrated Care Providers /Multispecialty Community Provider to have reached a stage of maturity to be able to take on commissioning functions on behalf of the single CCG

Option	Number of CCG's	Pro's	Con's
		Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	

Option 1: No Change to Current Arrangements

The eight existing CCGs continue to take individual responsibility for their statutory functions and the operation of their local system, whilst at the same time working with other CCGs and with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would not require structural change. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option is increasingly unaffordable whilst also being inconsistent with the expectations set out in the NHS LTP. This option also holds limited potential for further development of integrated commissioning with Local Authorities.

Option 2: Merger to create five CCGs aligned with ICP footprints

A number of the existing CCGs would merge to form five CCGs across the L&SC ICS footprint which are aligned with the five ICPs/MCP:

- Morecambe Bay
- Central Lancashire
- Fylde Coast
- West Lancashire
- Pennine Lancashire

The new CCGs would continue to take individual responsibility for their statutory functions and the operation of their local system, whilst working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. Each CCG would retain a separate governing body and governance structure, AO and Executive Team.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee in line with an agreed work programme, though accountability would remain with the existing CCGs

This option would mean that commissioning activity is focussed on the local ICP footprints and offers the partial release of capacity to support ICPs/MCP and PCN/Neighbourhood development and place-based commissioning. The potential for further integration with Local Authorities would be based on sharing priorities and resources (rather than straightforward co-terminosity). This option does not support a more consistent approach to standards and outcomes across the ICS footprint and would see duplication of governance structures and commissioning activity continue. This option does not benefit from opportunities for greater collaboration and economies of scale offered by other options. In the context of expectations that all CCGs will achieve 20% running cost savings this option

would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

Option 3: Single Accountable Officer and Executive Team for all L&SC CCGs

The eight existing CCGs appoint a single Accountable Officer and Executive Team for the whole Lancashire and South Cumbria footprint. Individual CCGs would retain responsibility for the delivery of statutory functions but Accountable Officer (AO) decision making would be held at the Lancashire and South Cumbria level. The AO and Executive Team would be responsible for working with their local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. The single AO would be responsible for providing assurance to each governing body for statutory functions that continue within the CCG and for appropriate adherence to standards, targets and performance expectations.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions make through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would require limited structural change. It also offers the potential to support a more consistent approach to standards and outcomes across the ICS footprint and may offer small efficiencies in management costs. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

The key issue with this option is that it would be undeliverable in practical terms for a single AO and Executive Team to relate to eight Governing bodies.

Option 4: Merger of CCGs to form a single NHS L&SC CCG (all functions)

The eight L&SC CCGS would merge to form a single new CCG which would take responsibility for all the statutory functions of the current eight CCGs and the operation of the system across L&SC working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would be subsumed within the governance arrangements of the single CCG.

This option would see all commissioning activity focussed on the ICS footprint and would benefit from economies of scale. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP. However, with all commissioning functions focussed on ICS level activity this would limit the extent to which capacity and resource could be redirected to better support the development of PCNs/Neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to

address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. It would also require significant structural change.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Option 6: Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care Provider/ Multispecialty Community Provider

The eight L&SC CCGs would merge to form a single new CCG which would initially take responsibility for all the statutory functions of the current eight CCGs. An agreed set of commissioning functions, which it makes sense to undertake on ICP and PCN footprints, would be contracted for, alongside a capitated budget with each IC Provider/MC Provider through an Integrated Care Provider contract.

Collaborative commissioning programmes would be overseen and managed through the governance structures of the new CCG.

This option would require significant structural change. It would see the majority of commissioning activity focussed on the ICP footprint, would reduce duplication and would maximise economies of scale. It would also support a consistent approach to standards and outcomes. This option would ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at the Lancashire and South Cumbria level will retain links with local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

This option requires ICPs/MCP to have reached a level of maturity whereby integrated care provider contracts could be established and budgets delegated. At this point in time, it is proposed that further development of local partnerships is required to reach this stage of maturity.

Integrated Care System (ICS) Commissioning Reform Group (CRG)
Terms of Reference

Document Control			
Title	Terms of Reference for the ICS Commissioning Reform Group (CRG) (formerly Commissioning Oversight Group)		
Responsible Person	ICS Executive Lead for Commissioning		
Date of Approval			
Approved By			
Author	Carl Ashworth/Dawn Haworth		
Date Created	8th June 2018		
Date Last Amended	18.12.19		
Version	0.2		
Review Date			
Publish on Public Website	**Yes** ☑	**No**	
Constitutional Document	**Yes**	**No** ☑	
Requires an Equality Impact Assessment	**Yes**	**No** ☑	

Amendment History		
Version	**Date**	**Changes**
0.2	18.12.19	Updates to purpose, membership and specific roles of the Group

1	**Purpose and objectives**
1.1	These Terms of Reference (TOR) relate to the Lancashire and South Cumbria ICS Commissioning Reform Group (CRG), and set out the membership, remit, responsibilities and reporting arrangements for the Group.
1.2	During Summer and Autumn 2019, CCG Chairs, Chief Officers and Directors from the CSU held workshops to devise a roadmap for the continued evolution of commissioning across Lancashire and South Cumbria. As a consequence of the continued development of four integrated care partnerships, a multi-speciality community partnership (MCP) and the wider ICS system, a Case for Change document has been drafted. This lays out options to consult member practices and other partners about the creation a single strategic commissioner in Lancashire and South Cumbria.
1.3	The CRG replaces the Commissioning Oversight Group which was established in June 2018 to choreograph implementation of the earlier Commissioning Development Framework. The group has been re-named to reflect its responsibilities going forward and to create a formal accountability to the Joint Committee of CCGs. These ToR have therefore been updated to allow the Joint Committee of CCGs to oversee the implementation of the road map for commissioning reform in Lancashire and South Cumbria.

1.4	The purpose of the CRG is to act on behalf of the Joint Committee of CCGs to oversee the preparation and implementation of a programme which enables a continuing process of commissioning reform in L&SC. This will include the production of: • A formal Programme Plan – which enables the 8 CCGs to take collective action and comply with national guidance • Human Resources and Organisational Development Plan • Communications and Engagement Plan These and other materials will be considered as appropriate by the Joint Committee of CCGs, individual Governing Bodies and NHS England.
1.5	Commissioning reform is one of the agreed partnership priorities of the Lancashire and South Cumbria ICS and this is reflected in the leadership, membership and support for the Commissioning Reform Group.
1.6	The CRG will ensure that appropriate and effective communication and engagement with staff, partners and other key stakeholders is undertaken through the implementation period.
1.7	In undertaking the role described at section 1.4, CRG should ensure that any proposed shifts in resourcing and staff deployment associated with implementation are undertaken in line with the shared principles for change that have been agreed across the North (see appendix 1). To undertake this role, the Commissioning Reform Group will be supported by HR & OD SMEs.
1.8.	The CRG also provides a forum for further development of place-based commissioning arrangements of specialised services commissioning. Whilst this remains a function of NHS England, the opportunities to agree joint priorities, pathways and joint approaches to decision-making will be explored further.
2. Membership	
2.1	The Chair of the ICS Commissioning Reform Group will be the appointed Vice Chair of the Joint Committee of CCGs.
2.2.	The membership of the Commissioning Reform Group is proposed as follows: • Chair – (Vice Chair of the Joint Committeee of CCGs) • One CCG Executive acting as a representative from each ICP (i.e 5 representatives) • One CCG Governing body Clinician or Lay Member drawn from each ICP (i.e. 5 representatives) • Midlands and Lancashire CSU – Executive Director • ICS Chief Officer • ICS Executive Director of Commissioning • ICS Executive Director of Finance • Chair of L&SC CCGs CSU customer forum • Locality Director NHS England • Specialised Commissioning representative - NHS England • ICS Strategy and Policy Director

	• Commissioning Reform Programme manager • HR/OD Advisors • ICS Communications and Engagement lead
3	**Governance & Reporting**
3.1	The CRG will report directly to the Joint Committee of CCGs with the expectation that formal plans and materials developed will also be shared with CCG Governing Bodies and other decision-making fora.
4	**Access and Attendance**
4.1	The meetings are not held in public.
4.2	Other CCG, CSU or NHSE Directors and staff, representatives from partner organisations may be required to attend meetings to speak on specific matters.
5	**Programme and Supporting Papers**
5.1	The agenda and supporting papers will be circulated by email prior to the meeting.
5.2	Minutes will be produced. Actions will be recorded and followed up at each meeting.
5.3	Programme plans will be maintained and regular reports provided to the CRG to ensure that the group can oversee delivery of objectives and milestones, risks and issues.
6	**Meeting Arrangements**
6.1	The CRG will be held every month at 08.30am on the second Tuesday.
7	**Review**
7.1	The Joint Committee will review the CRG role, function and ToR annually or earlier if required as the ICS evolves.

Appendix A

Principles for ICS (and constituent ICP) resourcing deployment and support agreed across the North

1. Develop and use a common language for resourcing and HR issues so that all staff can understand how ICSs/ICPs are being taken forward, and their role in that in the North.

2.Recognise the skills, experience and contribution of our workforce by having a clear and transparent resourcing model to support staff to work in different, more integrated ways with partners for the benefit of patients.

3.Promote transparency and fairness with equality of opportunity for ICS/ICP roles that are recruited or seconded to. Ensure that it is clear which work and roles are aligned, assigned or embedded as appropriate as ICS/ICPs progress and as teams work in different, more integrated ways at both ICS/ICP footprint and in 'place.'

4.Minimise the number of different concurrent or consecutive changes experienced by staff by co-ordinating our work locally as we develop our ICS/ICP wherever possible.

5.Take all reasonable steps to avoid redundancies by managing establishments in the context of significant budget reductions signalled in the Next Steps on the FYFV.

6.Undertake appropriate engagement with staff side and staff to work in partnership for the benefit of staff and patients.

7.Learn from other ICS/ICPs in the North and nationally and build on our existing OD approaches to support the success of teams working across organisational boundaries.

8.Base our approach on the values set out in the NHS Constitution, and all relevant employment law.

Health Scrutiny Committee
Meeting to be held on Tuesday, 4 February 2020

Electoral Division affected: (All Divisions);

Our Health Our Care programme
(Annexes A and B refer)

Contact for further information:
Gary Halsall, Tel: (01772) 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Executive Summary

An update from the Our Health Our Care programme on the future of acute services in central Lancashire. The report from the programme is set out at annex A and seeks to address the resolution of the Health Scrutiny Committee when it met on 24 September 2019.

Recommendation

The Health Scrutiny Committee is asked to:

1. Note the contents of the report.

2. Note that the Clinical Commissioning Groups (CCG) intend to initiate a public consultation on the proposals after the Joint Committee of the CCG has considered and approved a Pre-Consultation Business Case and following the Regulator's (NHS England's) approval to proceed, because they constitute substantial variation.

3. Receive notice from the CCG that formal comments on the proposals, as covered in an approved Pre-Consultation Business Case, will be requested by 30th November 2020. Also, that the CCG will not move to formally decide on any of the proposals until the Committee's comments have been fully considered and responded to.

4. Consider, based on the clinical reference data contained in the Report, any similar clinical information it would like the CCG to consider when developing the Pre-Consultation Business Case.

Background and Advice

At its meeting held on 24 September 2019 the Health Scrutiny Committee resolved that:

Lancashire County Council

"The Health Scrutiny Committee at its meeting scheduled on 3 December 2019, receive analysis on:

1. Staffing requirements for all options;
2. Impact on neighbouring Trusts as well as the Royal Preston Hospital site;
3. Mental Health service provision for all options;
4. Financial information on all the options."

The report set out at annex A from the Our Health Our Care programme seeks to address the above resolution.

The report at annex A also provides the following appendices:

1. Final report of the Royal College of Emergency Medicine
2. Final report of the Care Professionals Board
3. Final report of the Greater Manchester, Lancashire and South Cumbria Clinical Senate (part of the North West Clinical Senates)
4. Final report of the Clinical Summit for central Lancashire
5. Our Health Our Care governance structure and Clinical Oversight Group ownership and progression of recommendations from external scrutiny engagements and action log
6. Workforce modelling report
7. Overview of potential impacts on neighbouring Trusts
8. Overview of the ongoing Mental Health improvement and transformation plans by Lancashire and South Cumbria Foundation Trust (formerly Lancashire Care Foundation Trust)
9. Report on financial modelling
10. Overview of work being undertaken to model the impact of the programme on the local population of central Lancashire.

Whilst links to appendices 1-4 have been provided in the report, the full reports have been included after appendix 10.

Annex B is a copy of a letter from the Chief Accountable Officer for Chorley and South Ribble & Greater Preston Clinical Commissioning Groups to the Chair of the Health Scrutiny Committee explaining timelines and process in detail.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

The report at annex A represents the views of the Our Health Our Care programme and are not those of Lancashire County Council.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee

Meeting to be held on Tuesday, 4 February 2020

Our Health Our Care Programme

Contact for further information:

CCG Communications Team, 01772 214 603

E-Mail via: https://www.ourhealthourcarecl.nhs.uk/contact

Executive Summary

An update from the Our Health Our Care programme on the future of acute services in central Lancashire. This update describes the progress made against the formal assurance process required by NHS England relating to proposals for significant service change (Stage 2) and serves formal notification of similar under Regulations.

The paper provides an update from the last presentation formally received by the Committee in September 2019 following the outcome of the OHOC Joint Committee meeting on 28, August 2019.

The paper seeks to address matters covered within the Resolution passed by the Committee at that meeting.

Attachments to the paper include an item of information expressly requested by the Committee, namely the Clinical Senate assurance report, and further clinical assurance reports produced namely the Royal College of Emergency Medicine Report, Care Professionals Board Report, and central Lancashire Clinical Summit Report.

These matters are reported to the Committee as being relevant to the assessment being undertaken by the OHOC Joint Committee as to which options it believes should stand part of a Public Consultation.

Recommendation:

The Health Scrutiny Committee is asked to:

1. Note the contents of the report.
2. Note that the Clinical Commissioning Groups intend to initiate a public consultation on the proposals after the Joint Committee of the CCG has considered and approved a Pre-Consultation Business Case and following the Regulator's (NHS England's) approval to proceed, because they constitute substantial variation.
3. Receive notice from the CCG that formal comments on the proposals, as covered in an approved Pre-Consultation Business Case, will be requested by 30th November 2020. Also, that the CCG will not move to formally decide on any of the proposals until the Committee's comments have been fully considered and responded to.
4. Consider, based on the clinical reference data contained in the Report, any similar clinical information it would like the CCG to consider when developing the Pre-Consultation Business Case.

Background and Advice:

A senior team of Our Health Our Care programme stakeholders will attend the meeting to present an update on the future of acute services in the Central Lancashire area, providing details of the progress being delivered with respect to the assurance milestones required by NHS England.

At its last meeting in September 2019, the Committee passed the following Resolution:

That; the Health Scrutiny Committee at its meeting scheduled on 3 December 2019, receive analysis on:

1. Staffing requirements for all options;
2. Impact on neighbouring Trusts as well as the Royal Preston Hospital site;
3. Mental Health service provision for all options;
4. Financial information on all the options.

For reference the meeting on 3 December 2019 was cancelled due to the General Election which took place on 12 December 2019.

1.0 Background: 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, (approved 13 December 2018)
- An updated Model of Care, (approved 13 March 2019)
- A defined list of service options, (approved 28 August 2019)
- A Pre-Consultation Business Case. Including shortlisting (to be considered mid-March 2020)

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.

As the programme has reached this point in the process, it is triggering the notification requirements in the 2013 Regulations as stated in the paper. The 2013 Regulations can be found here:

http://www.legislation.gov.uk/uksi/2013/218/contents/made

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 and also must comply with the Regulations.

With respect to the Our Health Our Care programme, the key assurance 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 Enhanced Clinical Scrutiny Process - Update

To support its work in the development of the programme options, and in particular the process of enhanced clinical scrutiny of all options directed by the OHOC Joint Committee, the programme has received reports from the following, which are attached to this report:

a) The **Royal College of Emergency Medicine** conducted an Invited Service Review on Wednesday, 3rd April and Thursday, 4th April. A copy of the Final Report is included as Appendix 1 to this Report. As indicated in this Report, the programme will re-engage the RCEM for its current opinion in the context of the developments and improvements to the Model of Care which have taken place since its initial visit.

b) The **Care Professionals Board** is an independent, multi-disciplinary panel covering Lancashire and South Cumbria, who's membership provide clinical subject matter reference expert panel. They conducted a review of the options initially developed by the programme, in the context of the approved Model of Care on 19th July 2019. A copy of the Final Report is included as Appendix 2 to this Report.

c) The **Greater Manchester, Lancashire and South Cumbria Clinical Senate (part of the North West Clinical Senates)** conducted a NHS Stage 2 clinical assurance review of the programme's options on the 16th and 17th September. The review panel was drawn nationally of independent, clinical subject matter experts, with specific insights, experience and knowledge relevant to the service options being considered within Our Health Our Care. The Review Panel also considered Lay Representation. A copy of the Final Report is included as Appendix 3 to this Report.

d) The **Clinical Summit for central Lancashire** took place on Thursday 3rd October as part of the Enhanced Clinical Scrutiny process. The session was externally and independently facilitated by Dr. David Ratcliffe, GP and Medical Director at North West Ambulance Service. The session brought together some 25 senior primary care, secondary care and other system clinical leaders from across the central Lancashire patch to appraise the options which had been generated as part of the programme's longlist. This complemented clinical engagement work which also took place via GP Peer Groups, Primary Care Networks, and other clinical reference forums. A copy of the Final Report is included as Appendix 4 to this Report, the title of this report is Clinical Oversight and Scrutiny of the OHOC Programme.

   The **Critical Care Operational Delivery Network (CCODN)** is an expert reference forum tasked with ensuring the development, oversight and implementation of safe, effective and sustainable protocols for care delivery locally. The programme team has contacted the CCODN for an opinion on the

options developed. The opinion will be published, once received, as part of the Pre-Consultation Business Case, and shared with the Committee at such time.

The Reports received from the above have been considered by the Clinical Oversight Group in the programme. Relevant action plans developed by the programme linked to the recommendations cited in the respective reports is contained within Appendix 5. Appendix 5 also includes a copy of the governance chart for the Our Health Our Care programme – including the relationships between the workstream groups, the Programme Oversight Group, the Integrated Care Partnership Board (one of the sub-regional boards in the Integrated Care System) and the decision-making Joint Committee of the Clinical Commissioning Groups.

The Clinical Oversight Group has been enhanced in terms of its membership number and representation, so as to ensure that the rigour applied to its assessment of the above assurance information is sufficiently robust. In particular, the Clinical Oversight Group includes representation from primary care, community services, acute care, mental health, public health, the ambulance service, and particular professional clinical disciplines (such as nursing, medical etc interests).

The Clinical Oversight Group reports to the Programme Oversight Group, which in turn reports to and has its mandate direct from the Governing Bodies of both Clinical Commissioning Groups. This forum convenes as the OHOC Joint Committee when meeting in public.

<u>This has ensured that the process of enhanced clinical scrutiny has been:</u>

- Robust and thorough,
- Clinically led and based on independent subject matter expert evidence,
- Subject to senior ownership and oversight by the programme's formal decision-makers.

2.1 Enhanced Clinical Scrutiny Process - Consideration and Impact for Modelling

The Governing Bodies took an initial decision that it was only relevant to model options which had been confirmed as being potentially viable – on a clinical basis – based on the clinical reference and assurance data received before and following the OHOC Joint Committee on 28th August 2019. This is a normal decision-making process and is within the authority of the Governing Bodies to decide upon. This reflects the Stage C shortlisting process previously reported to the Committee in the September report.

This initial decision was on the basis that, if an option is not considered to be viable, linked to substantiated and well-reasoned concerns either linked to clinical safety, and/or clinical effectiveness, and/or clinical sustainability, and/or clinical deliverability, then it should not be considered further for the purposes of a Public Consultation.

In turn, this relates to applying NHS England's assurance test, linked to there being a strong, clinically led evidence base to support each proposal/option. All proposals/options need to demonstrate sufficient evidence against each of the four (of five) assurance tests which apply to the proposals/options. Therefore, proposals/options which do not meet this clinical test cannot be put to the public as a defined option, even if to do so may be considered more popular, or it could be seen as easier to do so, for other extraneous reasons.

The same applies even if it can be argued that such proposals/options may carry stronger evidence relating to other tests, for instance consistency with current and prospective need for patient choice. This is because sufficient evidence against all of the tests is needed, linked to the needs both for the Clinical Commissioning Groups to take account of the guidance and meet their responsibilities to commission safe and effective healthcare services.

2.2 Enhanced Clinical Scrutiny Process – possibility of disagreement

The Committee should note that, if either they (or the Public) disagree with the assessment taken by the Clinical Commissioning Groups, or indeed feel that other options should be considered, then they may share these views via a Consultation process / Public Consultation process and the Clinical Commissioning Groups remain under a statutory obligation to have due regard. The CCGs also have anobligation to publish its evidence (i.e. through the Reports/Pre-Consultation Business Case) and present information in a way which supports an intelligible assessment being made (i.e. through a Consultation Summary document, and through other routes).

Having due regard from this perspective would include being provided with new, improved, or better information – likely clinically-generated and of similar / better aggregated evidential weight, which could reasonably call in to question the initial decision. However, due regard does not necessarily take in to account the weight of opposite opinion, if the effect remains that the proposal/option is still not clinically viable.

This approach balances the duty to proceed on the basis of an open mind, with a need to comply with the NHS England guidance. This approach will also allow the programme to review its considerations, clinical appraisals and assessments at the Decision-Making Business Case stage in the full light of information which emerges from consultation.

2.3 Enhanced Clinical Scrutiny - Outcomes

The assessment taken was that for an option to be demonstrated as being potentially clinically viable – on the above bases – then this would need to be demonstrated as the case both from the perspectives of the external (Reports A to C) and internal (Report D) considerations. In effect, a double lock.

This includes the multiple decision gateways identified in the enhanced clinical scrutiny process and the consideration of the material and evidence bound in each of the Reports. No other options were excluded linked to the application of financial considerations, meaning that the process of assessment was clinically directed. No new options were identified from the enhanced clinical scrutiny process.

Applying this logic, and for the reasons stated, this process reduced the options which have been modelled for further purposes to **Options 1** (Do Nothing) - comparator, **Option 4d** (Enhanced Urgent Treatment Centre with Enhanced Care Service for Critical Care) and **Option 5d** (Urgent Treatment Centre for Enhanced Care Service for Critical Care).

The clinical rationale for this reduction is extensively documented and justified. There is broad commonality of approach and findings across the assurance reports, with the exception of options 4e and 5e, which were excluded for operational clinical delivery reasons linked to the impacts on existing services such as orthopaedics. The consistency of messaging and confirmation from multiple external assurance reference points applies a higher level of evidential weight to the decision-making.

This reduction does not necessarily direct or indicate the Clinical Commissioning Groups final decision-making for the purposes of a Pre-Consultation Business Case, as consideration clearly continues. In other words, it could be the case that one of the remaining options could be excluded for another non-clinical reason, linked to another NHS England test. Option 1 will however remain on a shortlist.

However, it describes the methodology used for the purposes of agreeing which options to model. It also explains to the Committee why the modelling outputs it has requested apply to a subset and not the full, initial list of thirteen options. The Committee should note that there is not a requirement for further modelling, outside of the normal assurance processes required of the programme for the purposes of the NHS England Stage 2 gateway.

2.4 Modelling – Other Conclusions/Outcomes

Additionally, and for the purposes of identifying a comparison, the programme has produced workforce modelling to indicate the projected medical staffing deficit position, were a Type 1 Accident and Emergency facility to be created at Chorley and South Ribble District General Hospital on a 24/7 basis. Furthermore, the agreed

position relating to “seed funding,” and its possible availability for activation and delivery of a new build hospital site in the latter half (post 2025) period means that it cannot continue to form part of the programme’s short list of options.

3.0 Areas requested by the Committee

A report covering initial outputs from the workforce modelling for the relevant options is presented in Appendix 6. The workforce modelling is completed to the detail required of a Pre-Consultation Business Case for the purposes of approval/alignment with typical NHS England requirements.

A report presenting the impact of activity shifts between the two sites, and an explanation of methodologies used is presented in Appendix 7. The majority of the analysis covers the flows between Chorley and South Ribble District General Hospital and Royal Preston Hospital. The Committee should note that Chorley and South Ribble District General Hospital site becomes busier due to increased outpatient attendances and elective procedures in Options 4d and 5d, therefore the impact on both this site and the Royal Preston Hospital site is given equal consideration. The report projects impacts on neighbouring trusts and is based on accepted modelling methodologies around travel and access patterns and information being developed in conjunction with North West Ambulance Service NHS Trust for ambulance-based conveyances.

A representative from Lancashire and South Cumbria NHS Foundation Trust is available to the Committee to answer questions of concern relating to the impact of the proposals on mental health services and to give examples of current transformation programmes which are providing reciprocal benefits for users of both physical and mental health acute services in central Lancashire. Other detail is provided in Appendix 8.

Financial outputs relating to the options are presented in Appendix 9. The Committee should note that the core drivers for considering the service options are factors around quality and patient experience, in particular making best and most effective use of the resources available to local health and care services. Direct savings from the proposals are predominantly linked to two areas. First, reductions in agency staffing – with improved benefits for continuity of care. Second, the opportunities, subject to transformation work such improved length of stay and reduced delayed transfers of care, to provide more choice for elective procedures to be accessed in the NHS provider sector, compatible with current and prospective need for patient choice. Whilst a plurality model will continue, this component of the proposal seeks to improve access and patient experience, at the same time contributing to cost effectiveness. The proposals outline the strategic framework / opportunity to deliver more and better care close to home, but direct savings are not shown. This is relevant to showing the direct impact of the options for the purposes of a Pre-Consultation Business Case.

Appendix 10 lists the other areas which are being developed in terms of impact modelling. These will be published as part of the Pre-Consultation Business Case. The structure and content of the document is based on reviews of typical contents both in terms of length, depth and breadth of the information provided.

4.0 Next Steps

At the point where the Joint Committee of the Clinical Commissioning Groups (referred to as the OHOC Joint Committee) approves a Pre-Consultation Business Case around the proposals, then we will then approach the Regulator, NHS England, for permission to launch a Public Consultation on the proposals. This reflects the process/rules which we have to follow. The CCGs decision to consult reflects the duties incumbent upon the organisation linked to s14z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012, and the 2013 Regulations.

In terms of timelines, subject to the Regulator approving a Public Consultation taking place in the Summer (June to September), then we would invite formal comments on the proposals by **30th November 2020**. The CCG will then respond to your comments within 28 days. We welcome the observations of the Committee in terms of how you would prefer to conduct the Health Scrutiny process. At all stages, we are keen to work with you to follow an approach which meets the Committee's expectations.

Following this and linked to the NHS England process (which we must have regard to), the CCG will be required to develop a Decision-Making Business Case. This can only happen when we have completed a public consultation, considered and responded to any recommendations from the Committee, and undertaken a substantial analysis activity linked to all comments received. The earliest date where this could happen is the end of the next financial year. This date could vary based on the timeline associated with the earlier processes.

Approval of a Decision-Making Business Case is where the CCG would proceeding from having proposals for consideration, to having proposals for intended implementation. This assumes that we do decide to proceed with the proposals in either their current, or some amended, or improved form.

Denis Gizzi
Chief Accountable Officer

Jason Pawluk
OHOC Programme Director

27th January 2020

Appendix

Presented by the Our Health Our Care programme to Health Scrutiny Committee on Tuesday, 4 February 2020

Appendix 1- Royal College of Emergency Medicine

The Royal College of Emergency Medicine report can be accessed within the news section of the Our Health Our Care website.

https://www.ourhealthourcarecl.nhs.uk/

Appendix 2- Care Professionals Board

The Care Professionals Board report can be accessed within the news section of the Our Health Our Care website.

https://www.ourhealthourcarecl.nhs.uk/

Appendix 3- Greater Manchester, Lancashire and South Cumbria Clinical Senate

The Greater Manchester, Lancashire and South Cumbria Clinical Senate report can be accessed within the news section of the Our Health Our Care website.

https://www.ourhealthourcarecl.nhs.uk/

Appendix 4- Clinical Summit for Central Lancashire

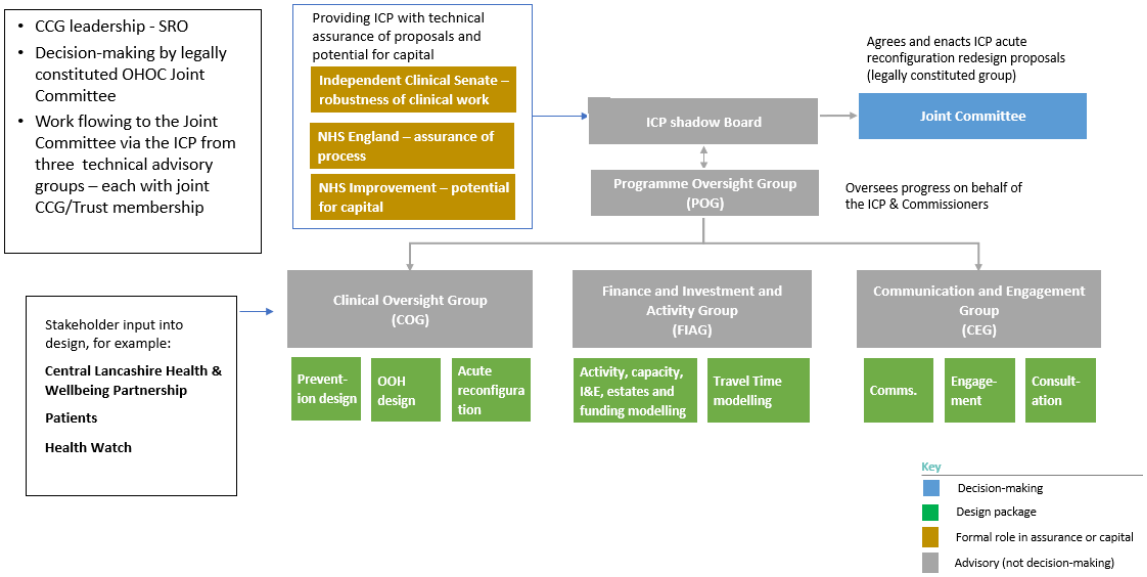
The Clinical Oversight and Scrutiny of the OHOC Programme report can be accessed within the news section of the Our Health Our Care website.

https://www.ourhealthourcarecl.nhs.uk/

Appendix 5

Presented by the Our Health Our Care programme to Health Scrutiny Committee on Tuesday, 4 February 2020

Our Health Our Care Programme Governance Structure



Clinical Oversight Group (COG): Ownership and progression of recommendations from OHOC external scrutiny engagements

1.0 Purpose

The purpose of this paper is to amalgamate the recommendations from the range of external scrutiny visits conducted as part of the Our Health Our Care (OHOC) Acute Sustainability programme.

Specifically, and in chronological order, these are:

Historical Programme reviews:

1. Upper-Tier Authority oversight of the OHOC programme led by the Lancashire Health Scrutiny Committee.
2. Independent review led by NHS England/Improvement, leading to the re-opening of Chorley A&E on a part-time basis in 2017.

Recent Programme reviews:

3. Invited service review from the Royal College of Emergency Medicine (April 2019).
4. Assessment of the Model of Care by the Lancashire and South Cumbria Care Professionals Board (July 2019).
5. Assurance visit from the North West Clinical Senate (September 2019).

In amalgamating the recommendations, the paper seeks to provide assurance to the COG as follows:

- That the programme has properly considered the recommendations arising from external assurance processes. This includes where recommendations do not necessarily align with one another across the different assurance processes.
- That, where relevant, remedial actions have been instigated with proper ownership – linked to either LTH, the CCG, a partner organisation, or the programme team.
- That the feedback from these assurance processes has influenced the development of the clinical options for change, based on the agreed Case for Change and Model of Care.

The Clinical Oversight Group for the OHOC programme is asked to take ownership of this paper and to provide a recommendation to the Governing Body on the above points noted.

2.0 Introduction

As the OHOC programme has continued to develop, the programme team have ensured that the views of independent clinical experts have been sought to provide additional scrutiny and provide objective insight that ultimately helps provide direction to the programme. The actions taken by the programme team will also help to ensure that the NHS England assurance tests linked to providing safe and clinically effective services (and avoiding pre-determined thinking) have been met.

Subsequently, several independent reviews have been undertaken to help provide this scrutiny:

2.1 Lancashire Health Scrutiny Committee: The purpose of the Health Scrutiny Committee is to *"scrutinise matters relating to health and adult social care delivered by the authority, the National Health Service and other relevant partners."*

Following the temporary downgrade of Chorley and South Ribble District General Hospital, the Health Scrutiny Committee held a series of meetings, hearing evidence from a range of relevant stakeholders, to establish recommendations. The recommendations were approved at the Health Scrutiny Committee meeting on Tuesday 20th September 2016.

2.2 Review of reopening options, NHS England/Improvement: "*The review was commissioned by NHS Improvement and NHS England with site visits planned and delivered within one working week of receipt of terms of reference. The review team was convened in the week prior to visiting and comprised of three clinical members."*

NHS England and NHS Improvement commissioned a review to establish what the options for reopening Chorley A&E may look like. An independent clinical panel was commissioned, and the review took place in August 2016. The review team were provided with a range of trust policies and data in advance of the visit. During the review, the team had the opportunity to visit Urgent and Emergency Care and Acute Medicine across both Royal Preston Hospital and Chorley and South Ribble Hospital.

Additionally, the team met with a range of staff from LTH, including senior executives, service managers, and clinicians. The final report was published on 21st September 2016. Lancashire Teaching Hospitals provided a response to the reports outlined in sections 2.1 and 2.2 of this paper at the Health Scrutiny Committee meeting on 22nd November 2016. This paper outlined the ambition to reinstate Chorley A&E 12 hours per day (8am-8pm) on 18th January 2017, when the newly commissioned 24/7 integrated urgent care centre (UCC) was scheduled to open. The UCC would help release capacity within the A&E workforce and to allow the A&E to be provided across two sites.

2.3 Care Professionals Board: *"The role of the Care Professionals Board (CPB) is to provide clinical and care professional leadership and assurance to the Lancashire and South Cumbria shadow Integrated Care System (called Healthier Lancashire and South Cumbria) ensuring it develops clinically robust, evidence-based proposals for system wide care models."*[1]

On 19th July 2019 the Lancashire and South Cumbria Integrated Care System Care Professionals Board conducted an invited informal review of the OHOC programme. In particular, the CPB were provided with details of the Case for Change and Model of Care for the programme, along with details of the long list of options developed as a result.

2.4 Royal College of Emergency Medicine: "*The College works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine."*[2]

[1] https://www.healthierlsc.co.uk/boards-and-committees/care-professionals-board
[2] https://www.rcem.ac.uk/

Following approval and publication of the model of care, the programme requested an invited service review visit from the Royal College of Emergency Medicine (RCEM) to review the sustainability of the current model of care. The visit took place on April 3rd and 4th 2019 and included an in-depth review of ongoing programme documentation, detailed clinical conversations with key individuals from the programme, and a tour of the facilities at both Royal Preston Hospital and Chorley and South Ribble District General Hospital.

This visit was endorsed by the joint committee of CCG's to provide independent, external scrutiny to programme developments and provide expert clinical opinion on future direction of travel.

2.5 Greater Manchester, Lancashire and South Cumbria Clinical Senate: ***"****The role of the Greater Manchester, Lancashire and South Cumbria Senate Council is to provide information, strategic clinical advice and guidance to inform your commissioning and healthcare decisions for the populations of Greater Manchester, Lancashire and South Cumbria (GMLSC)"*[3]*.*

A nationwide panel of external clinical experts and lay representatives conducted a review of all programme documentation, completing thorough site visits on 16th and 17th September 2019 as part of the NHS England Stage 2 assurance process. A previous informal review of the programme (Stage 1 gateway) had taken place in Summer 2018.
Following the independent clinical reviews outlined above, a number of recommendations were made to the programme for consideration in its continued development. This paper seeks to outline those recommendations and asks that the Clinical Oversight Group takes ownership of the action log presented in section 6, holding relevant parties to account where necessary.

3.0 What were the key recommendations outlined by the Health Scrutiny Committee:
Overview:
In order to help resolve the ongoing issues with Chorley A&E and develop lessons learned for the future, the Health Scrutiny Committee held a range of meetings between 26th April and 14th June 2019 and approved a list of recommendations on Tuesday 20th September 2016.
At the meetings, direct evidence was provided by:

- Lancashire Teaching Hospitals NHS Foundation Trust
- Chorley and South Ribble & Greater Preston CCG
- System Resilience Group
- Health Education England North West
- Medacs UK
- NHS Improvement
- NHS Employers
- Rt Hon Lindsay Hoyle MP
- Mark Hendrick MP
- Seema Kennedy MP
- Local Campaign Group - Protect Chorley Hospital Against Cuts and Privatisation
- Healthier Lancashire & South Cumbria Change Programme

Additional evidence was obtained from:

- Wrightington, Wigan & Leigh NHS Foundation Trust
- University Hospitals Morecambe Bay NHS Foundation Trust
- North West Ambulance Service NHS Trust

[3] https://www.nwcscnsenate.nhs.uk/clinical-senate/senate-councils/greater/

- General Medical Council
- Royal College of Emergency Medicine
- Chorley Council
- NHS England
- Local residents

3.1 Summary of recommendations:

Within the report, the Health Scrutiny Committee outlined 10 recommendations to Lancashire Teaching Hospitals (referred to as the trust):

1. "The Trust should provide the Committee with a transparent, sustainable, realistic and achievable plan for the provision of services at Chorley by 22 November 2016."

2. "The Trust should provide the Committee with detailed information on how they are addressing their inability to meet the 4-hour target for A&E attendance at Royal Preston Hospital."

3. "The Clinical Commissioning Group to provide the Committee with evidence that it is supporting the Trust to explore all methods to recruit and retain staff."

4. "NHS England should undertake a review of the national issues identified within this report, namely: a. The discrepancy between substantive and locum pay b. The need for clear guidance relating to the application and/or removal of the agency cap c. The number of emergency medicine trainee places."

5. "In the light of the failure of the Trust to communicate in a timely and effective manner with the public and their representatives in this case, NHS commissioners be asked to demonstrate how they will effectively engage and involve local residents in future service design."

6. "The System Resilience Group should develop a plan that identifies the lessons learnt from this situation, in particular how communication and resource planning is managed. It should then be shared with wider NHS and social partners and stakeholders."

7. "That the developing crisis in Emergency Care is given the required priority in the development of the Lancashire and South Cumbria Sustainability and Transformation Plan, and a plan for Emergency Care across Lancashire is developed as a key priority, and that the Lancashire Health and Wellbeing Board be asked to take responsibility for the implementation and monitoring of this priority."

8. "The Trust should make every effort to increase the Urgent Care Centre opening hours on the Chorley site to 6am – midnight as additional staff are appointed."

9. "The Trust should actively seek best practice from other Trusts regarding staffing on A&E Departments."

10. "For the future, a more open approach to the design and delivery changes to the local health economy needs to take place, working with wider public services through the Lancashire Health and Wellbeing Board to make our hospitals more sustainable and better able to serve the needs of residents."

4.0 What were the key recommendations outlined following the NHS England/NHS Improvement review:

Overview:

An independent review took place in August 2016 at the request of NHS Improvement and NHS England following the temporary downgrade of Chorley A&E. The review team were asked to consider options for reopening the department, taking note of the difficulties cited by the trust as the reasons for the initial downgrade in April 2016.

4.1: Summary of recommendations:

The review team considered three options:

OPTION 1 - ED Opening 08.00hrs – 20.00hrs (last patient 20:00hrs closing at 22:00hrs)
The review team concluded that the current provision of medical and nursing staffing levels at CSRH provides an opportunity to enable reopening of the ED.
The team highlighted that the staffing levels across both EDs would not meet Royal Colleges' best practice guidelines, however claimed that this is "not an unusual situation and many organisations are unable to do so".
The team highlighted that consultant cover at weekends needed to be addressed with more consultants needing to be provided at Chorley.
It was noted that *"in the short term this may require the current senior clinicians to perform additional sessions."*

OPTION 2 - Re-open a full 24/7 ED at CSRH
The review team stated they *"do not feel this is achievable in a safe or sustainable manner due to concerns with respect to medical staffing levels out of hours and also the impact this will have on nurse staffing with current establishments and in covering both sites."*

OPTION 3 - Continue with the present arrangement
The team recognised that the UCC was performing very well at CSRH, however the pressure created by additional ambulances at RPH was stretching an already struggling system.
The team claimed that having an ED practitioner and consultant on site was excessive for a UCC, whilst it was recognised that this was to support transition.

5.0: Historical Programme Reviews – Influence on programme direction.

As reflected in the subsequent sections, the Trust, working with the clinical commissioning groups and the Integrated Care Partnership, developed a response to each of the recommendations identified by the Health Scrutiny Committee. The NHS England/Improvement report led to the service at Chorley being re-instated to an A&E, under the principles described as option 1, intended as a temporary arrangement. At the time, the trust outlined their mobilisation plan for reinstating the 12-hour services which included a focused recruitment plan to secure additional staff; improving medical patient flow; tracking he risks to mobilisation, particularly from a staffing perspective, integrating with the Urgent Care Centre mobilisation plan; and understanding the estates enablers/limitations.
In response to the alternative recommendation that Chorley was reopened 6am – Midnight, the trust stated that it was *"not practical or safe to reopen the department on a 6am – midnight basis, as it would require both additional staff and existing staff to work excessive hours, and would compromise the major trauma centre at Preston*.
Since this time, the programme commenced the process of continued public engagement around a long-term sustainable model of care for central Lancashire, adopting the approach of proceeding through two major gateways, as referenced in the current NHSE major service change guidance – Stage 1 and Stage 2. This reflected the need to take steps to appraise and further involve the public in the future sustainable care model for central Lancashire. It also involved taking learnings from the steps taken in 2016/17 in terms of what future care model could work sustainably in the future.
The Stage 1 gateway was cleared in July 2018, the Stage 2 gateway will be approached once a pre-consultation business case has been considered and approved, reflecting the outputs of the clinical senate visit and other programme/stakeholder engagement activities.
The Major Service Change guidance and the statutory framework also provides the continuing role of the Health Scrutiny Committee in providing democratic oversight of the

change process, ensuring that the proposals are in the interests of health services in the area.

5.1 Impact of historical review for current options:

The review by NHSE/I observed, *"This review will focus on the optimum configuration of urgent and emergency care services in this local health economy for the next 12-18 months*."
The passage of time since that report is now closer to three years and so the need to re-evaluate the right care model is opportune, and future options can be realistically compared with the current service model, and the status quo ante from 2016 with respect to improving care outcomes for people in central Lancashire.
A common theme of the external programme reviews is that the existing service model is not considered to be viable in the long-term. Also, the salient, systemic issues identified in the Case for Change have either plateaued or deteriorated from the position considered at the time. Identified (or preferred options) from external programme reviews have indicated towards a requirement to consider structural change as part of a fair, honest and transparent public consultation.

This observation can be particularly established with respect to trends of operational performance against NHS Constitution measures; financial sustainability; clinical workforce supply and retention across both primary and secondary care; and the impact of running services across two operational sites. Indeed, revisiting the Case for Change approved unanimously in December 2018, based on a whole-system focus, the following key statements were agreed with:

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 above said, clearly these historical reviews have supported all partners in the programme to improve and refine the options being developed for public consultation. This can be observed in the following ways:

1. **Whole System Solution**: The NHSE/I review observed that when the A&E was closed at Chorley, the UCC worked well, but the pressure faced by RPH was significant.

The OHOC programme recognised this and is now taking a whole system approach to reconfiguration with all partners represented in the programme's clinical oversight group. Plans include not just urgent and emergency care, but also surgery, critical care, acute medicine and specialty medicine to improve flows across the hospital and help ease the pressure on A&E built by delayed transfers of care.

2. **Temporary Solution**: The OHOC programme recognises that the current Urgent and Emergency Care provision was mobilised as a temporary solution.

The programme is therefore assessing all potential future options that could improve the way care is delivered in the future.

3. **Weekend Cover**: The NHSE/I report stated that *"consultant cover at weekends needed to be addressed with more consultants needing to be provided at Chorley."*

Unfortunately, due to national staffing shortages and increasing demand, consultant cover is still not available at the Chorley site. This is being taken into consideration within programme developments as it does not guarantee patients receive quality care 7 days per week.

4. **RCEM Staffing Levels**: The NHSE/I report claimed that to provide services that do not meet RCEM guidance is *"not an unusual situation and many organisations are unable to do so".*

The OHOC programme are doing everything possible to deliver options that are much closer to the RCEM recommended staffing levels, recognising that the perspective of many clinical stakeholders is that front-line staffing accessibility needs to improve. Further, that the RCEM staffing levels have been developed from the perspective of what a long-term sustainable workforce model looks like, allowing for clinical development activities, effective supervision, and the safe implementation of transformation initiatives.

5. **Patient and Staff Engagement:** The Health Scrutiny Committee rightly noted the lack of engagement with staff and the public prior to the temporary downgrade of Chorley A&E in April 2016.

The OHOC programme has been deliberate about engaging and including patient representatives, holding public engagement events, running workshops, developing questionnaires', holding staff briefings and much more to ensure that the views of the people who use services the most are at the forefront of redesign.

6.0 What were the key recommendations outlined following the RCEM review:

6.1 Overview

As part of the ongoing desire to ensure expert clinical scrutiny of the OHOC programme, a Royal College of Emergency Medicine (RCEM) review was requested to provide recommendations which can be used to support the development of the OHOC programme. The RCEM were asked by the programme team to review programme documentation and conduct a visit to both Royal Preston Hospital and Chorley and South Ribble District General Hospital on 3rd and 4th April 2019, with a focus on the Urgent and Emergency Care.

It should be noted that since the recommendations made following the RCEM visit in April 2019, the OHOC programme has developed substantially. For example, the visit of the RCEM, the approved model of care to inform the development of a long list of options which were approved in public by the joint committee of CCG's in August 2019. This means that the OHOC programme has taken in to account the perspectives of the RCEM in the formation of programme options. As part of the contract agreed with the RCEM to conduct the invited service review, the programme team has the option of re-approaching them with respect to progress on recommendations on an informal basis. The programme team are likely to undertake this early in 2020.

6.2 Summary of findings:

The RCEM found that the current Urgent and Emergency Care configuration to be *"unsustainable in its current form",* also reflecting on the systemic workforce challenges for delivering urgent and emergency care effectively on the Chorley site.

The RCEM highlighted that current plans for reconfiguration were *"neither robust nor complete*" however did contain many positive elements. The RCEM outlined 5 potential options for service reconfiguration within the report for consideration by the programme moving forwards. Since the conclusion of the visit, the programme has developed a long list of potential options for reconfiguration, taking in to account these perspectives and seeking to be clearer and more expansive in terms of its description of the Model of Care.

Furthermore, the RCEM highlighted the risk of relying too heavily on out of hospital initiatives, also citing opportunities for more integrated working between primary and social care providers.

6.3 Summary of recommendations:

Within the findings presented by RCEM, there were a number of areas that required consideration by the trust and CCG as part of ongoing quality assurance processes.

Appendix A contains a full overview of the RCEM findings, as well as demonstrating how LTH has responded to the prioritised action areas.

This section outlines the key recommendations made by RCEM to the programme. These recommendations should be considered as part of future programme developments and are summarised further in section 6.0.

- *"We felt that the plans offered a direction of travel, rather than being either robust or complete. There was no real indication as to how the plans could and would be delivered."*

- *"There was no signed-off model for acute care"*

- *"The documents describe the 'whole pathway' problem and are a strong, if repetitive, case for change, but do not in our opinion clearly articulate a plan for the emergency and urgent care system"*

- *"Transformation plans relying upon demand management and community-based models are unlikely to succeed, particularly given the reported fragility in the local primary care system, and the lack of effective integrated working between the hospital and community. There is also a risk around the credibility of such options with the local population"*

- *"Potential roles for primary care, ambulatory emergency care, frailty and integration are all regarded as best practice and are included. Missing elements included the potential effects of any reconfiguration on the Preston site, and learning from the prior temporary closure of the ED at Chorley"*

- *"We are sceptical about plans which rely on primary care clinicians or systems reducing demand on acute facilities or increasing their capacity to offer complex care in the community."*

7.0 What were the key recommendations outlined following the CPB review:

7.1 Overview:
In July 2019, the OHOC programme team invited an informal review from the Lancashire and South Cumbria Care Professionals Board (CPB). The CPB are formulated of health and care professionals who provide assurance to the Lancashire and South Cumbria Integrated Care System (ICS).
The aim of this visit was to scrutinise ongoing work, including the approved case for change, approved model of care, and a draft long list of options that had recently been developed by the clinical oversight group. The CPB also met with key individuals and toured the current services provided at LTH.
7.2 Summary of findings:
The findings from the CPB visit centred mainly around the long list of options that had been developed. The panel felt that the programme had explored all possible options, developed the options to a good standard and that all options were in line with the NHSE 4 tests for service change. In this respect, there was evidence that the omissions and areas for development identified by the Royal College of Emergency Medicine (RCEM) had been addressed.
The panel highlighted the close working relationship with partners in the primary, community and acute systems and overall supported to direction of travel presented by the programme ahead of the formal review due to take place by the Clinical Senate.
7.3 Summary of recommendations:
The CPB provided detailed feedback on a number of key areas. This feedback is crucial to enhancing the quality of the OHOC programme and is summarised below:

- *"Acute reconfiguration will need to occur in parallel to the out of hospital workstreams of the programme, with the requisite funding and workforce "following the patient."*

- *"Proposals would need to include areas such as workforce; recruitment, training and maintaining clinical staffing skills; digital enablers; enabling contractual reform; research and innovation; and partnership working approaches with primary and community sector partners."*

- *"There are opportunities to explore relationships with the research and academic community to ensure that patients continue to get expedited access to the benefits of best practice, where available."*

- *"There is an opportunity for the local primary care networks to express how shared working roles and interfaces between the secondary care and primary care sectors could act as an enabler to challenging the issues of GP recruitment and the development of portfolio-based careers."*

- *"The programme team will need to ensure that as the proposals develop, that any extraneous and relevant changes to clinical standards framework, for instance arising from Royal College guidance are included in the proposals developed for implementation."*

- *"Where best practice is planned to be deployed, the clinical teams will benefit from visiting these areas both to acquire learning and also be able to express succinctly the clinical benefits arising from the implementation of such innovations in practice."*

- *"Within areas such as Critical Care and Surgery there are plans to develop new roles that are quite advanced. The clinical teams will need to continue their work in capturing and triangulating the potential use of technology in delivering a planned care service/site alongside new and innovative workforce roles."*

- *"The voice of the patient had also been considered and there were good plans to continue engagement on this front, to ensure that the spirit and pledges in the NHS Constitution were met."*

- *"As the proposals develop, the proposals for acute reform will need to complement the plans being developed across the health economy, including the integrated care partnership (ICP) and the clinical commissioning groups. This will help ensure how the proposals for acute reform will contribute to the overall health economy plan to respond to the NHS Long-Term Plan."*

- *"The clinical teams should consider how the governance framework for trusted triage and workforce and deeper service integration between out of hospital services and the acute trust can be further developed."*

- *"We were provided with examples of using clinical risk tools, referral thresholds, a single point of access approach to promote clinician to clinician dialogues, and the effective use of the principles of patient choice in decisions of how and where to refer services across the out of hospital and acute trust service boundaries. It will be important to continue this work and ensure that the health economy considers the governance framework as part of the implementation of its proposals."*

- *"Detailed bed modelling will need to demonstrate that the required capacity is available with each of the options so that patients can access the services with the higher standards that consolidation can bring."*

- *"The proposal of protected capacity for surgical patients will indeed support timely access the planned care, however the team must be clear on the parameters where surgery becomes better placed on a site with a more specialist range of services. There is evidence that this is already happening, but clearer service specifications and transfer policies will be required as the options mature to the point of implementation."*

- *"In terms of the clinical service specification, the proposals would benefit from describing more clearly the management plan for paediatric patients and patients with acute mental health issues."*

The CPB identified the below seven key risks that work should begin to mitigate within the developing options.

1. *"Patients will not have clarity on which site to access urgent care or emergency care. This will need to be clearly understood and communicated to avoid presentation at the wrong service. We understand that this is also a risk associated with the current service model at Chorley, as the service does not meet the requirement of a Type 1 Accident and Emergency Department. This is particularly problematic with "walk in" patients who do not use one of the existing streams to manage inappropriate activity."*

2. *"How do you make sure that everyone uses the Single Point of Access? A specific communication and mitigations plan will be needed, as this is a very difficult problem to solve."*

3. *"Part of these interdependencies rely on the primary care networks, which are new and are different levels of maturity at this stage. There will be a requirement for the primary care networks to consistently prioritise the development of a clear implementation, governance and monitoring plan, based on the activities proposed to be transferred out of the acute system. This will need to be developed alongside their respective neighbourhood care strategies and the system-wide focus on prevention but should not be a reason to delay or defer making the necessary changes to the acute system. Workforce and financial support to accommodate this activity shift will need to be developed, but again in tandem with the need to respond to changes required now to the acute system."*

4. *"The options correctly present the alternative approaches to managing acute flows and coordinating the configuration of the urgent and emergency care system, and its associated co-dependencies. The options describing an enhanced urgent treatment centre are potentially innovative.*

   Clearly, the overall proposals will develop and describe how the changes that arise from such a model match up with the reforms that the rest of the system will be able to achieve to maximise the chances of success. This will link to what role and types of activity the acute system will be required to manage in the future. It will also link to the improved streaming of patients to other partners, such as LCFT. It will also link to what support primary and community care providers can offer to the implementation of the concepts in the document – for instance in-reach medical workforce between primary and urgent care services."

5. *"The risk profile for the acute proposals and the delivery timelines should consider the possibility that co-dependent services are not matured to the point where they are able to take on the role fully of managing activities displaced from the acute system."*

6. *"The clinical team advises that the programme team should consider the interface with partner organisations such as LCFT, model some of the impact on the urgent and emergency care system outside of the Central Lancashire ICP to understand this risk."*

7. *"Staged approach to ambulatory care service development as described earlier in this report."*

8.0 What were the key recommendations outlined following the Clinical Senate review:

8.1 Summary:

The Greater Manchester, Lancashire & South Cumbria Clinical Senate conducted a formal programme review in September 2019 as part of the NHS England Stage 2 Assurance Process.

A nationwide panel of external clinical experts conducted a review of all programme documentation and subsequently visited Central Lancashire on the 16th and 17th September 2019. The panel travelled to the Royal Preston Hospital and Chorley and South Ribble Hospital to see facilities, meet key staff and gain an in-depth understanding of the challenges faced. The panel met with representatives from the OHOC Programme partners at the end of the visit and fed back their initial thoughts.

8.2 Summary of Findings:

The panel highlighted on numerous occasions during their visit that they were very pleased with the level of detailed contained within the programme documentation (including Case for Change & Model of Care), stating in their report *"The panel were unanimously impressed with the high-quality documentation they received before the review, as well as the excellent responses to their queries"*

The panel referenced the clear evidence of joined up working between the CCG's and LTH and stated *"From the paperwork received and the conversations held during the review visit, it is clear that an enormous amount of hard work and difficult conversations have taken place, and are still taking place, to provide the best possible services for the population of Central Lancashire."*

In their review of the long list of options, the clinical senate concluded that only options 4d, 4e, 5d, 5e should be further considered by the programme citing safety and sustainability for all other options.

The were "unanimous in their views that options 1, 2 and 3 are not viable (meaning that they cannot be delivered sustainably) as Emergency Department services at Chorley would not be compliant with essential clinical standards, largely due to the absence of core on site specialities in particular emergency surgery and paediatrics." The panel then explained how critical care provision was one of the main considerations for recommending that options 4a,4b, 4c, 5a, 5b and 5c are not viable.

Additionally, the senate clearly stated that Acute Medicine should be provided in a way that allows all patients to be seen by a relevant consultant within the timescales recommended by NICE and NHS seven-day working.

8.3 Summary of Recommendations:

The Clinical Senate provided a number of areas to be considered by the programme moving forward to help ensure the best quality of care is delivered to patients via a clinically sustainable model in the future:

The acute medicine service needs to be designed and configured so that patients can be seen by a relevant consultant within timescales recommended by NICE and NHS seven-day working.

- The acute medicine service needs to be designed and configured so that patients can be seen by a relevant consultant within timescales recommended by NICE and NHS seven-day working.
- Clinically, only options 4d, 4e, 5d and 5e are viable.
- OHOC partners need to be realistic about how much the PCNs can deliver and when.
- Detailed workforce and impact modelling are undertaken on the clinically feasible options.
- The trust continues to offer cross-site contracts.

- The Critical Care Network and commissioners should be involved in discussions.
- The trust reviews the current practices and establishes a system for Physician Associates to work, and be promptly paid for, bank shifts based on medical need.
- The trust employs dedicated consultants in acute medicine who are able to lead and shape the department through the forthcoming period of change.
- Greater active meaningful involvement from a range of colleagues across seniority and discipline (including both clinical and non-clinical staff) is required.
- OHOC use examples from previous successes, such as vascular and major trauma, to demonstrate to opponents of these options how they might deliver improved care and services.
- The options need to include greater investment in, and planning for, frailty services.
- OHOC should look to other systems who have done similar work to identify learning and innovation that could be beneficial in Central Lancashire.
- The infrastructure at Preston needs to be reviewed and considerably improved.
- Turn Chorley into a centre of excellence offering elective services.
- A whole system approach to frailty needs to be developed.
- The ambulatory care vision needs to be implemented with dedicated consultant leadership.
- OHOC need to consider the impacts of the options outside of the Central Lancashire footprint.
- Greater partnership working with primary care and social care takes place, particularly regarding what is realistically deliverable, when and how to mitigate the transitional period.
- Clinical champions talk to people about why these changes are the right things to do, how services will be better and use case studies to illustrate this.
- OHOC take future opportunities to involve patients and the public (including carers) meaningfully in the design of services.

9.0 Clinical Oversight Group – Action Log:
This paper has outlined the independent clinical scrutiny that has taken place as part of the OHOC programme and highlighted the key recommendations for consideration. Figure 1 is an action log that simplifies and consolidates the recommendations in a format that can be used at Clinical Oversight Group meetings to track progress.

Figure 1

Recommendation	Review	Owner	Update	RAG
Plans need to be more robust and detailed	RCEM	Programme Team	Long List agreed PCBC to be developed Validation by Clinical Senate	
Signed off Acute Model of Care required	RCEM	COG	MOC signed off in March 2019 and validated by Clinical Senate	
No clear plan for Urgent and Emergency Care System	RCEM	COG	Long List of Options approved by the JC in public August 2019. Detailed service	

			specifications for remaining options developed.	
Integration with out of hospital platform requires strengthening and a system approach to implementation required	RCEM CPB Clinical Senate	COG	COG now oversees both Acute Sustainability and WHINs. Examples of whole pathway reform – frailty and COPD shown in MOC; transformation team also working on other priorities including diabetes. Trust and CCG have identified joint system-wide transformation priorities. ICP has also developed system-wide transformation priorities.	
Evidence of WHINs progress needed to build confidence in system capabilities	RCEM	COG	Formation of WHINs Board, system priorities and deliverables; agreed methodology for service review and application of CCG transformation cycle.	
More detail about how the reconfigured system may look	RCEM	Programme Team	Long List agreed PCBC to be developed Development of key messages/expanded communication and engagement strategy.	
Proposals would need to include areas such as workforce; recruitment, training and maintaining clinical staffing skills; digital enablers; enabling contractual reform; research and innovation; and partnership working approaches with primary and community sector partners.	CPB	Programme Team	All areas to be covered in the PCBC – these will be naturally expanded and developed through the DMBC and implementation stages of the programme	
Build relationships with research and academic community	CPB	Programme Team	Engagement with the academic and research community has been developed through clinical staff engagement processes and will also form part of the consultation process. Opportunities to work with	

			an academic partner to examine benefits realisation from the model or applied best practice from elsewhere will be considered. Specific section in PCBC.	
Explore how integrated working across primary and secondary care may help primary care recruitment	CPB	COG	Review of other similar transformation programmes. Review of other regional transformation initiatives such as Healthier Fleetwood – work ongoing and be assured via COG.	
Clinical standards must be kept up to date	CPB	Programme Team	Ongoing review. Head of Nursing leads on this area, working with dedicated clinical leads in the programme.	
Clinical teams to visit best practice examples	CPB	COG	Conversations had with York Critical Care service. Also, to reference evidence from the ODN when available.	
Continue to explore the benefits of innovative technological solutions	CPB	Programme Team	Ongoing – draft PCBC identifies relevant examples and within scope of whole pathway reviews being undertaken within the WHiNs platform.	
Continue patient engagement	CPB	Programme Team	Ongoing – engagement strategy considers this and Senate feedback. Engagement with Consultation Institute in early 2020.	
Develop governance frameworks for trusted triage between out of hospital and secondary care	CPB	COG	Considered within service specification detail by Head of Nursing, working with clinical leads.	
Detailed workforce and bed modelling required	CPB/ Clinical Senate	Programme Team	In progress and will be published as part of the PCBC.	
Clear plans for surgical site provision	CPB	Clinical Leads	In progress and will be published as part of the PCBC.	

Clear transfer policies required for all specialties	CPB	Clinical Leads	Outlined in long list of options.	
Management plans for Paeds and acute mental health required	CPB	Clinical Leads	Acute mental health management plans and capacity requirements discussed via ICP and role of Lancashire NHS Foundation Trust as core member of COG. Programme team have developed working relationship with paediatric service transformation team at ICS level. Paediatric management plans considered in service specification and workforce modelling paper shared with COG.	
Clear guidelines for patients regarding “where” and “when” to receive the most appropriate care	CPB	Programme Team	Within scope of Communications and Engagement workstream. Clear national frameworks can also be used (traffic light/thermometer approaches) and Stay Well.	
Clear communication plan and promotion required for the single point of access	CPB	Programme Team	Within scope of Communications and Engagement workstream.	
Requirement for the primary care networks to consistently prioritise the development of a clear implementation, governance and monitoring plan. Workforce and financial support to accommodate this activity shift will need to be developed, but again in tandem with the need to respond to changes required now to the acute system.	CPB	COG	Ongoing dialogue between WHINs and Acute Sustainability. Primary care networks now fully established. Priorities developed by ICP and CCG.	
LTH should continue to offer cross site contracts	Clinical Senate	LTH	The trust will continue to offer this.	
The Critical Care Network and commissioners should be involved in discussions	Clinical Senate	Programme Team	Head of Nursing has initiated discussions with ODN – they have	

			indicated need for consideration sign off when proposals are fully developed.	
The trust reviews the current practices and establishes a system for Physician Associates to work, and be promptly paid for, bank shifts based on medical need	Clinical Senate	LTH	Trust to develop a relevant action plan – to be considered by COG when available.	
The trust employs dedicated consultants in acute medicine who are able to lead and shape the department through the forthcoming period of change.	Clinical Senate	LTH	Trust to develop a workforce strategy – to be considered by COG when available	
Further staff engagement (clinical and non-clinical) required	Clinical Senate	Programme Team	Ongoing through the Communications and Engagement workstream of the programme.	
OHOC to use more success stories e.g vascular and major trauma to demonstrate system potential	Clinical Senate	Clinical Leads	Ongoing through the Communications and Engagement workstream of the programme.	
Greater planning for frailty services using a whole system approach.	Clinical Senate	WHIN	To be developed via the WHINs platform.	
OHOC need to consider the impacts of the options outside of the Central Lancashire footprint.	Clinical Senate	Programme Team	Complete – travel and access and activity modelling identifies impacts on other providers.	
Develop clinical champions and broader service user involvement.	Clinical Senate	Programme Team	Part of future communications plan	

Appendix A

What has been the system response to key findings outlined in the Royal College of Emergency Medicine report?

1.0 Purpose

This paper outlines some of the key findings outlined within of the Royal College of Emergency Medicine (RCEM) report that was provided to Chorley & South Ribble and Greater Preston CCG's following the RCEM visit to Lancashire Teaching Hospitals on April 13th and 14th 2019. The findings presented in this paper are areas that required immediate consideration by the programme. As a result this paper seeks to demonstrate how the local health and care system has responded in the short term to issues identified, as well as describing how the Our Health Our Care (OHOC) Acute Sustainability programme has used,

and will continue to use, the findings of the RCEM report to develop and scrutinise care delivery options for the future.

2.0 Introduction

In 2016, the OHOC programme was formed to improve health and care delivery for the people of central Lancashire. One of the key workstreams for the OHOC programme is "Acute Sustainability". The Acute Sustainability programme was established to review the provision of care at Lancashire Teaching Hospitals (Royal Preston Hospital and Chorley and South Ribble District General Hospital). The programme is also working closely alongside the Wellbeing and Health in Integrated Neighbourhood (WHiNs) platform that encompasses out of hospital and community transformation. This whole system approach to transformation means that changes to care are not made in isolation and ensures that any changes made will deliver the best possible outcomes for local people.

In December 2018, the joint committee of CCG's approved the 'case for change' which states "why" change is needed across central Lancashire. The case for change described 5 key issues within the system which are having an adverse effect on the quality of care being delivered. These issues were:

1) **Demographics** - The number of people in central Lancashire is growing and the population is ageing. Our local hospitals aren't set up in the best way to deal with these changing needs.

2) **Lack of Alternatives** - Our patients don't have enough options for their care. This can result in increased use of the urgent and emergency care services provided by our local hospitals.

3) **Flow** - Too many people wait too long for their care and too many experience delays when they're in hospital.

4) **Workforce** - Across our health and care system, including our local hospitals, we don't have the workforce that we need in critical areas.

5) **Use of Resources** - As a health and care system we're not making best use of the resources we have

In March 2019, the joint committee of CCG's approved the 'model of care' which outlines "what" needs to change in the future. The model of care identified 7 key priorities for future change, these included:

1) Single point of access & urgent care advice hub
2) More responsive urgent care service
3) Better emergency care provision
4) More efficient critical care service
5) Separation of emergency and planned surgery
6) Modern Outpatient services
7) Highly effective discharge planning

Following approval and publication of the model of care, the programme requested a formal visit from the Royal College of Emergency Medicine (RCEM) to review the sustainability of the current model of care. The visit took place on April 3rd and 4th 2019 and included an in depth review of ongoing programme documentation, detailed clinical conversations with key individuals from the programme, and a tour of the facilities at both Royal Preston Hospital and Chorley and South Ribble District General Hospital.

This visit was endorsed by the joint committee of CCG's to provide independent, external scrutiny to programme developments and provide expert clinical opinion on future direction of travel. On 1st July 2019, the OHOC programme received the formal report from the RCEM

and this paper outlines how the programme, as well as the local health and care system, are responding to some of the key findings that require immediate consideration.

3.0 What were the key findings for immediate consideration outlined in the RCEM report?

This paper does not address findings that comment on the overarching structure of the central Lancashire health and social care system, nor does it focus on the options for future care delivery that have been recommended by the RCEM; Instead, this paper will present the key findings outlined in the Royal College of Emergency Medicine report (2019) that required immediate consideration by the programme, this may include concerns around OHOC programme developments, as well as immediate safety or workforce concerns. For ease, the findings for immediate consideration have been set out in two key themes. They are presented as follows:

1) Programme development
2) Lancashire Teaching Hospitals

3.1 Programme Development

This section provides direct quotes from the RCEM report that relate to the progress being made by the OHOC programme:

- "We have found that the current model is unsustainable in its current form and is highly vulnerable whilst decisions about alternatives are being made."

- "We felt that the plans offered a direction of travel, rather than being either robust or complete. There was no real indication as to how the plans could and would be delivered."

- "There was no signed-off model for acute care"

- "The documents describe the 'whole pathway' problem and are a strong, if repetitive, case for change, but do not in our opinion clearly articulate a plan for the emergency and urgent care system"

- "Transformation plans relying upon demand management and community-based models are unlikely to succeed, particularly given the reported fragility in the local primary care system, and the lack of effective integrated working between the hospital and community. There is also a risk around the credibility of such options with the local population"

- "Potential roles for primary care, ambulatory emergency care, frailty and integration are all regarded as best practice and are included. Missing elements included the potential effects of any reconfiguration on the Preston site, and learning from the prior temporary closure of the ED at Chorley"

- "We are sceptical about plans which rely on primary care clinicians or systems reducing demand on acute facilities, or increasing their capacity to offer complex care in the community."

3.2 Lancashire Teaching Hospitals

This section provides direct quotes from the RCEM report that raise immediate concern for Lancashire Teaching Hospitals:

- "There are significant concerns about the safety of the current model, particularly in the evenings and at weekends when there are limited senior emergency department staff on site, and given the paucity of supporting services on the Chorley site."

- "When we asked whether the ED at Chorley was currently safe, the view of senior clinicians was that it was not, particularly in the evenings and at weekends when senior cover and staffing is lighter, and access to investigations is reduced."

- "The facilities (at CSRDGH A&E) are not so much co-located as intertwined, although staffing and managerial arrangements between NHS and private providers are separated. This has caused some confusion."

- "We were told that although the Urgent Care Treatment Centre is contracted to see patients with both injuries and illness, only patients with illness are currently accepted. Minor injuries patients are therefore seen by the Emergency Department staff."

- "We were told there is a contractual and reporting anomaly whereby the Trust is not reimbursed for type 1 attendances, although the current expectation is that a consultant-led emergency facility is open to patients at the Chorley site 12 hours per day. Attendances at Chorley are not included in the Trust's type 1 reporting data against key national standards, which may have a negative effect on the overall data. The Trust's senior management feel that this situation carries both a financial and reputational penalty."

- "The Emergency Department at Preston is clearly in urgent need of redevelopment. Although there are improvements currently underway to provide a separate paediatric area the remaining facilities are inadequate to support the function of a modern emergency department in such terms of available space for numbers of patients, physical layout / ergonomics, facilities for resuscitation and high dependency patients, consideration of the needs of vulnerable groups such as the elderly or mentally ill, and consideration of working conditions for staff. There is no clinical decision unit available to support admission avoidance. Supporting facilities such as ambulatory care and assessment units are some distance from the department."

4.0 How has the system responded?

This section of the paper will outline what steps have been taken thus far to address the concerns laid out above.

4.1 Programme Development

It was noted in the report that programme plans were neither robust, nor complete, and that "there was no real indication as to how the plans could and would be delivered." It is important to stress that at the time of the RCEM visit, the programme had only developed the case for change and the model of care (the "why" and the "what") and had not yet developed any options (the "how") for this change would be delivered. Since the RCEM visit, the programme has moved into the options development phase. The options development phase has been completed in 3 stages:

- **Stage A** included agreeing the methodology, determining the outcomes we want to achieve, to ensure the specific objectives set out in case for change will be realised (through the development of a benefits realisation framework) and setting out a long list of options. Both were reviewed and finalised by the Governing Body on 26 June 2019.

- **Stage B** included a detailed review of this long-list of options to determine whether any could be undertaken without requiring major service change in Central

Lancashire. This stage was concluded in a Governing Body session on 26 June 2019.

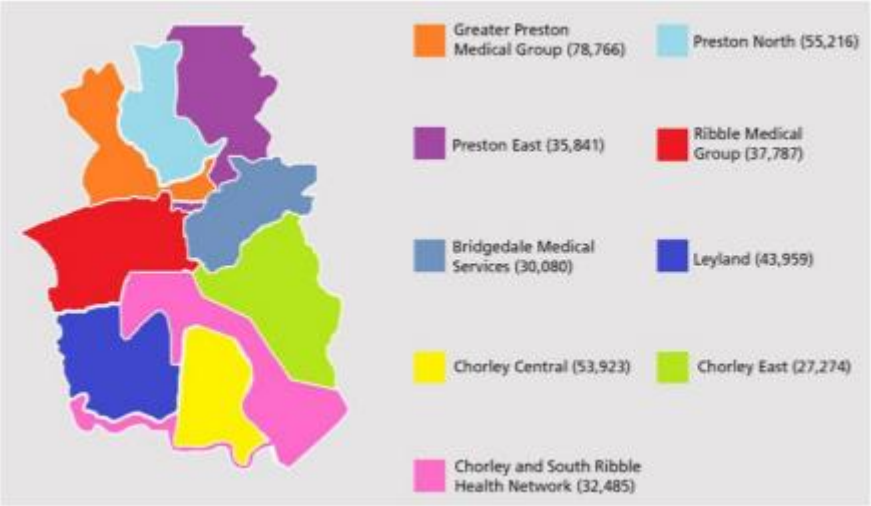
- **Stage C** included undertaking high-level clinical, activity and financial modelling on each of the options on the long list to determine whether the option would be viable from both a clinical and financial perspective; in order to create a short-list of options. Options were taken discussed in public by the joint committee of CCG's where it was decided that ALL options should remain on the table until further clinical scrutiny on the long list of options has taken place. The programme is now seeking additional clinical scrutiny and once this has been undertaken and the short list of options has been agreed, a more detailed review and appraisal on each of the options will be undertaken.

As part of the formal NHS England assurance process, a formal visit was undertaken on 16th & 17th September 2019 by a panel of clinical experts from the North West Clinical Senate to provide further independent clinical scrutiny to the OHOC programme. As part of the review, the Clinical Senate considered a range of programme outputs including the case for change, model of care, long list of options, programme timelines, RCEM report and much more. In addition, they spent time at both Royal Preston Hospital and Chorley and South Ribble District General Hospital to visit key areas, speak with staff and meet trainees. The Clinical Senate will now consider their visit and provide a formal report to the OHOC programme outlining their feedback; This feedback will be considered by the programme team and influence the development of the Pre-Consultation Business Case (PCBC).
The RCEM report also noted that a reliance on community-based models could pose difficulty due to "reported fragility in the primary care system" and "lack of effective integrated working between the hospital and community". Following the visit, the programme team have sought to further develop the clinical engagement with primary and community care colleagues to increase the level of integration within the programme and enhance the level of clinical scrutiny at each stage of the programme. To ensure our approach is robust, the governing body of CCG's approved a formal approach which focusses on three cohorts:
Cohort 1: Primary Care clinical leadership – This cohort will involve the Clinical Chairs, Clinical Directors, Primary Care Network Directors and Clinical Advisors. Cohort 1 will need to be enabled to fully understand all options and the potential consequences and impact of these options. This primary care leadership group is instrumental to the oversight and scrutiny requirements. Meetings are currently being arranged for this cohort, with meetings scheduled to take place with Clinical Directors for Primary Care Networks throughout September and October 2019. Additionally, a 'Clinical Summit' has been arranged for October 3rd. The Clinical Summit will bring together a wide range of experienced Primary Care clinicians to provide enhanced scrutiny of the options and further develop whole system relationships.
Cohort 2: This is where the primary care cohort from Cohort 1 meets with their secondary care physician colleagues to collectively provide robust clinical oversight and scrutiny of all the options.
Cohort 3: A significantly strengthened Clinical Oversight Group (COG). This will be the group that is charged with distilling the clinical views from both Cohort 1 and Cohort 2 and forming a consensus for options appraisal to narrow down the broad range to a smaller number, based on robust and sound clinical scrutiny.
The Governing Body agreed that this approach could take place concurrently with programme developments such as Joint Committee meetings and Clinical Senate visits.

4.1.1 Wellbeing and Health in Integrated Neighbourhoods (WHINs)

For the acute sustainability programme, the most important and complementary change programmes are linked to locality (or 'out of hospital' care) and prevention. They are described under the "Wellbeing and Health in Integrated Neighbourhoods" platform or

WHINs for short. As part of the WHINs platform, all existing Integrated Care Partnership (ICP) and Integrated Care System (ICS) work streams and plans have been aligned into networks. The methodology to support transformation has been agreed and is in place. Consequently, nine Primary Care Networks have been established with Directed Enhanced Services (DES) in place from 1st July 2019.



The WHINs programme plan has a number of projects within it; all projects have an identified lead, deliverables and associated timescales. The plan is being uploaded onto the CCGs PMO system for assurance and reporting purposes. There is a clear governance structure with the WHINs Board reporting progress against the plan to the Integrated Care Partnership Board.

New models of care (end to end transformation programmes) that are currently being developed within the Networks include:

- The stroke strategy board agreed the work plan for Early Supported Discharge; the specification has been agreed for delivery over Q1 and Q2 of 2019/20.
- A Social Prescribing workshop has taken place to inform the model and funding for two pilot networks in Central Lancashire to trial a social prescribing digital platform has been secured from the ICS.
- A Diabetes group has been established to implement a new model of integrated diabetes care across Central Lancashire footprint within 2019/20. Pilot extended for an additional three months to ensure that there is no gap in service provision.
- A COPD group established with a work plan to provide a multidisciplinary integrated clinic within each Network; provision of education sessions to patients on the COPD register; support practices to undertake a risk stratification process to identify patients most likely to attend or be admitted to hospital and to pilot technology that supports monitoring patients remotely.
- A Gynaecology group has been scoping work undertaken to ascertain whether additional conditions could be seen within the community. Work is being undertaken to assess how clinics would be run and maintained including:
    - Potential to develop a Directory of Service across networks
    - Introducing Care Navigation at the front-end of the service
    - Skills analysis and training needs analysis of primary care clinicians/staff
    - Estates

A series of End of Life workshops have been held to inform an action plan focussing on the following areas:

- Improved communication and timely sharing of records (including EPaCCS) across the health economy
- Supportive Palliative Care at Home Service

- Access to Anticipatory Medication and Syringe Drivers
- Focus on Palliative Care Education and Training – across the health economy
- Patient Information and signposting to services

4.2 Lancashire Teaching Hospitals

Since receipt of the RCEM report in July 2019, Lancashire Teaching Hospitals (LTH) has continued to embed and implement improvements, not just to Urgent and Emergency Care, but also across the acute system. Whilst concerning, the findings listed in the RCEM report contained nothing already noted by the trust and therefore acted as independent justification to the programmes of improvement work currently taking place.
This section of the paper outlines some of the areas of work currently being implemented across LTH:

4.2.1 A&E investment:

The RCEM report made references to Royal Preston Hospital (RPH) Emergency Department being in "urgent need of redevelopment". Lancashire Teaching Hospitals have recently improved the Emergency Department at Preston thanks to a £1.9m funding boost to improve facilities and increase capacity. Improvements made include a new rapid assessment triage space to enable ambulances to handover patients without delay, extra cubicles to treat patients with serious conditions, upgraded high acuity cubicles, a new space for frail or elderly patients, extra surgical assessment capacity, a mobile x-ray, and IT systems to improve bed management. These changes are part of a wider programme designed to improve flow throughout the hospitals, and ensure patients are transferred without delay to the most appropriate setting for their needs. The redesign has been led by our emergency department clinicians, to ensure that the changes work well in practice. Whilst these improvements had been made at the time of the RCEM visit, work continues to fully embed new working practices to fully utilise the new surroundings. A more recent visit from CQC in July 2019 found that "There had been improvements to the environment, for example the rapid assessment and treatment bays, the paediatric waiting room and assessment area, telemetry for beds and the mental health room".

4.2.2 Ambulance handover times

LTH has recently focussed on improving ambulance handover times, this saw Ambulance handovers >60 mins have reduced by 82%. The Trust has improved from the position of the lowest performer in the north of England to the top three in September 2018;
This continues to be an area of focus for the trust to ensure the benefits are fully realised across the system.
The most recent CQC visit concluded "The new triage system appeared to be working well and had improved ambulance turnover and triage times and there had been a downward trend in black breaches."

4.2.3 A&E plan on a page

The CCG held a workshop to review the effectiveness of the winter plan schemes and consequently the A&E Delivery Board plan for 2019/20 was approved on 14th June 2019. This can be found below:

Attendance avoidance	ED	Same Day Emergency Care & Assessment Model (admissions avoidance)	Acute Flow	System Flow	System Escalation (internal and external)
Maximise the use of pathways that can deflect patients (not including ambulatory care, this is under same day emergency care), and avoid unnecessary attendance to ED. Including: • Work with CCG and primary care • Mapping of alternative facilities for patients	Building on the work already underway by the department, continue to refine processes to support the flow of patients. Including: • Effective rota management • Work with UCC partners • Continued refinement of coordination processes • Patient flow processes • Breach anaailysis • Escalation tool	Continuing to build same day emergency care capacity and utilisation. Embedded clinical care which may include diagnosis observations, assessments, treatments and rehab. Including: • Capacity right sizing to validate assessment capacity required by type to support the flow of patients and optimise use of bed base • Review of all exit routes from the department with a measurement of current utilisation and plans to improve (AEC, SAU, hot clinics) • Mapping of future assessment model based on demographic and demand	Maximise efficiency from admission to patients becoming clinically optimised and ready to leave hospital. Focusing on: • Site management/bed management processes to minimise any delays in patient moves • Discharge planning processes to increase the number of definite discharges discussed at the start of the day and improve the volume of patients being discharges in the morning • Ward processes (SAFER and beyond)	Maximise efficiency for patients that become clinically optimised and ready to return to their home with support or to where they consider home or to a suitable other setting Improve utilisation of community bed base	Appropriate and timely response to pressures and efficient processes to manage escalation Agreed escalation processes and plans within Trust and to System
SRO: Emma Ince Operational lead:Kate Burgees Clinical Lead: Anitha Rangaswarny	SRO to A&E delivery board Faith Button SRO: Tina Lawrenson Deputy SRO: Rebecca Black Clinical Lead: Graham Ellis	SRO to A&E delivery board Faith Button SRO: **Adrian Griffiths Additional support** Deputy SRO: Sandra Davey Clinical Lead: TBC	SRO A&E delivery board Alisa Brotherton SRO: Michael Brown – new substantive DD replacing interims Operational lead: (PF) additional resource moved internally Clinical Lead: John Howles **External support = ESCIT to put support in x1 person 4 days a week plus other resources to be pulled in as and when required**	A&E delivery board Sue Lott SRO: Jane Kitchen Ops/clinical lead: Helen WIlliams	A&E delivery board Emma Ince SRO: Annette Frodsham Ops/clinical lead: Jane Mellngs
Responsible Group: WHIN Board **Accountable to:** Emergency and Urgent Care programme board	**Responsible Group:** ED weekly improvement meeting and breach meetings **Accountable to:** Emergency and Urgent Care programme board	**Responsible Group:** *Extension of the ambulatory care group into a wider remit and focus* **Accountable to:** Emergency and Urgent Care programme board	**Responsible Group:** Flow Operational Group **Accountable to:** Emergency and Urgent Care programme board	**Responsible Group:** **FOG** System discharge group Community flow board **Accountable to:** Emergency and Urgent Care programme board	**Responsible Group:** Flow Operational Group **Accountable to:** Emergency and Urgent Care programme board
Deliverables for 2019/20: Implementation of an integrated frailty service Develop neighbourhood networks to enable people to be better cared for in the community Unscheduled mental health 999/111 Investigate community based mental health communities to reduce attendance in ED Review of all out of hospital capacity (walk-in, hot clinics) with visibility of criteria and operating model. Clear plan from CCG to promote use of out of hospital services. Education for Trust staff on alternative services for patients	**Deliverables for 2019/20:** Identification of high impact changes required in the department following diagnostic. Improvement will include: • Focus on specialty response times- specific App solution being reviewed • Review of current flow processes in the department (post take, transfers)	**Deliverables for 2019/20:** • Right sizing activity required for Trust for assessment areas and inpatient beds to identify what is the optimum capacity based on current demand and compliance with SOP to support the flow of patients and delivery of the 4hr standard (5 week activity – end of August) • Use of right sizing to validate same day emergency CQUIN • Once the 'available demand' is known, measure current efficiency and utilisation of assessment units and use operational group to improve, reducing demand on the bed base • Use the operational group to expand the number of pathways developed and agreed across medicine and surgery for assessments, observation, hot clinics	**Deliverables for 2019/20:** SAFER Inc. Doctor/Consultant Job Plans **Weekend and criteria led discharge – ESCIT support** Development of hospital at night team to support weekend, early morning and night flow Daily simple discharge process with system escalation and tracking- **CI leading Big room methodology to deliver this** Simple discharge process embedded in divisional teams **Golden patient process refined and embedded ESCIT support – however big room methodology to support this and deliver through** Planned MADE events across the next 12 months ESCIT support Daily flow drumbeat for Matrons, operational teams and site management to ensure earlier movement of patients and a focus shift in the afternoon to tomorrows work, which in turn will support the earlier movement of pts	**Deliverables for 2019/20:** Review of CATCH Increased utilisation of Home First Community bed base right criteria Full recruitment of DFs and DANS- With clarity regarding role and comms mechanism (daily flow drumbeat) Visibility regarding what is currently available in the community and whether this type of capacity is adequate based on demand/demographic Review of current Frailty model – Frailty big room and frailty steering group Bridging the gap model to be reviewed & agreed , written up and tendered if reqd.	**Deliverables for 2019/20:** Agreed set of Trust wide OPEL responses (in place but review communication of these and tracking) Agreed escalation of system responses across senior system leaders. Ownership and accountability of response Major incident planning and exercises Gold and silver training and on call Review admission and discharging thresholds when on high OPEL 3 and internal incidents (Liverpool model)
Associated measures: Reduction in ED attendances at HRG level linked to relevant cohorts of patients e.g. minor injuries where service is identified 10% reduction Reduce emergency admissions via ED 4% reduction Reduce readmissions for intermediate care patients – 2% reduction	**Associated Measures / Indicators:** • **Reduction in non-admitted breaches – Non-admitted performance of 95% (c10 per day)** • Improvement in % of patients with DTA within 3 hours – trajectory over 4 months • Median time to treatment 20% improvement • Mean time in ED < 200 mins	**Associated Measures / Indicators:** • Current AEC utilisation by pathway – 15 to BI validated with right sizing • Hot clinic utilisation by pathway – 5% improvement • Readmission rates – <4.5% • Conversion from MAU to base ward/MAU discharge rate – 50% conversion rate • MAU occupancy and no. of admissions – c25 per day in order to increase unit LoS and discharges home rather than transfer • SAU 24 hour turnover 90% of pts	**Associated Measures / Indicators:** • **Discharges before 10.00 and 12.00 – 33% by midday** • 1 golden patient per ward each day • Improved weekend discharges (currently 50% less discharge) each ward to I.D 3 pts for CLD on a Friday. Friday planning checklist to in place • **DPTL target 126 pts (39% reduction)** • Reduction in volume of stranded pts 7+, 14+, 21+ as per DPTL (36% reduction) target • Reduction in bed occupancy – target of 90% • Use of Discharge Lounge – 20 per day • Reduction in number of outliers as a result of reduced demand and occupancy - < 30 • Reduction in moves at night < third already reduced from last year further third to reduce again	**Associated Measures / Indicators:** • Improvement in home first slot utilisation (from 4 to 8) phase 1 and then 8 to 12 phase 2 • Community occupancy 90% • **DTOC – target as agreed 3.5%** •	**Associated Measures / Indicators:** • Community bed occupancy 90% • MADE impact – increase in discharges by 10% and DTOC to plan of 3.5 % •
SUPPORT REQUIRED ✓ CCG link and nominated Trust project lead	**SUPPORT REQUIRED** ✓ App solution to ED speciality review	**SUPPORT REQUIRED** ✓ SRO additional support ✓ Analytics support through ICS CSU – request to them waiting confirmation	**SUPPORT REQUIRED** ✓ ESCIT 4 days per week concentrating on those in yellow under acute flow and 2 others to pull in when required		
✓ **Programme management support – DCOO ring fence time** ✓ **CI big room events – e.g. discharge events, VSAs (Internal CI team supporting)**					

4.3 Continuous Improvement Team (CIT)

The continuous improvement team at Lancashire Teaching Hospitals has recently focused on the design and delivery of the organisational level improvement programmes (Urgent and Emergency Care; Stroke and Patient Safety) for 2019/20, further developed the Flow Coaching Academy work and continued to implement the of the local level improvement programme (wave one) with the first ten wards/departments participating.
Some key elements of this improvement work are found below:

4.3.1 System Level Improvement Programmes

The table below outlines the progress made since June 2019 in the design and delivery of the organisational/system level improvement programmes.

System Level Improvement Programmes	Aim of the Programme	Work completed to date since April 2019
Urgent and Emergency Care	To deliver improvements in the A and E 4 hour standard as per the trajectory set by the Trust.	Work has been undertaken with the CCG and the COO to develop the high level Urgent and Emergency Care programme for Winter 2019/20. The CI team will lead on the improvements relating to internal acute flow (see Appendix 1).
Improving Stroke Care	To design and deliver world class stroke services, with leading edge research and high reliability of clinical care processes	The Director of Continuous Improvement has been invited to chair the ICS Stroke Improvement group and will also chair the Trust Stroke Steering Group. Further work has been undertaken to develop the Stroke Strategy and the Stroke team have continued to test and deliver improvements, especially in reducing the time to transfer stroke patients from ED to the acute stroke ward.
Patient Safety Collaborative	To improve Patient Safety through a patient safety collaborative (specific aim to be agreed)	Initial meetings have been held with the Deputy Divisional Nursing, Midwifery and AHP Director and senior clinical team members to undertake a scoping exercise based on clinical priorities. A full review of the data is currently underway to inform the design of the improvement programme.

4.3.2 Flow

The Trust has secured six places on the Sheffield Microsystem Coaching Academy which commences in September 2019. This mirrors the approach adopted in the Flow Coaching Academy. On completion of the training, a local microsystem coaching academy will be established to support wards and departments to deliver local level improvements.

4.3.3 Additional areas of development

The CIT have overseen the design and delivery of the organisational/system level improvement programmes. This work is focussed around 5 pathways including:

- Colorectal Cancer
- Frailty
- Inflammatory Bowel Disease
- Sepsis
- Discharge Big Room

Additionally, the CI team commenced the first wave of the local level improvement programme on 16th May 2019, with ten wards and departments participating.

- Ward 12

- Ward 18
- Ward 20
- Ward 21
- Rookwood A
- Therapy Outpatients
- Clinical Audiology
- Emergency Department
- Discharge Lounge
- Respiratory High Care Unit (Ward 23)

Teams have participated in a two-day improvement programme and completed the 30 day and 60 day follow up events, reviewing their performance data and setting ambitious improvement aims. Improvement coaching has been provided to the participating teams on their wards and departments as they test improvements.
This has been supplemented by a range of staff from across LTH being offered improvement training from regional Quality Improvement organisation, Advancing Quality Alliance (AQuA) and the Flow Coaching Academy.

Course/Programme	Delegates
Advanced Improvement Practitioner Programme (AQuA Programme)	2
Quality Improvement for Medical Leaders (AQuA programme)	1
Improvement Science for Leaders (NHS Quest programme); Improvement Project - Medication Safety	One participating team
Flow Coaching Academy	10 Coaches
Wave one of the local improvement programme	30
Introduction to Continuous Improvement session delivered as part of the Consultant Stretch Programme	10
Local session around CI tools and techniques	13 staff - library

5.0 What are the next steps?
Following the receipt of the RCEM report on 1st July 2019, significant improvement work has continued to be implemented across Lancashire Teaching Hospitals. Whilst these improvements alone will not be enough to satisfy all of the concerns highlighted in the RCEM report, this work is recognised as a step in the right direction.
The options development process and longlist of options were approved by the joint committee of CCG's at a public meeting on 28th August 2019. The joint committee were keen to ensure all options present on the longlist remained on the table until further clinical scrutiny had taken place.
The OHOC programme has made good progress in relation to a number of the concerns highlighted in the report. Work with the primary care and community sectors continues to be strengthened, with a Clinical Summit arranged for 3rd October 2019 and meetings scheduled with Primary Care Network Clinical Directors throughout September and October.
As part of the NHS England Stage 2 assurance process, the North West Clinical Senate conducted a formal review of the programme on 16th and 17th September 2019. This included a site visit to Lancashire Teaching Hospitals, a review of all programme governance

and documentation that has been produced to date and detailed interviews with key individuals involved in the process. The senate will provide recommendations in order for the programme to move forward to the next stage which would be submitting a full pre-consultation business case, also involving interaction with the Health Scrutiny Committee for Lancashire.

Appendix 6

Presented by the Our Health Our Care programme to Health Scrutiny Committee on Tuesday, 4 February 2020

Introduction

This paper presents the methodology and outputs of the initial workforce modelling of options 4d and 5d in comparison to option 1, that is to do nothing, or in other words, maintain a status quo or standstill position.

Workforce modelling is required within a Pre-Consultation Business Case (PCBC) as we may only consult with the public on options where there is a reasonable (or high) degree of confidence that all options would be capable of being delivered as proposed.

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

As deficits in clinical workforce availability have been identified as a key component within the Case for Change, the focus is on delivering innovation through workforce structures which currently are available, or could be made available, through coordinated workforce development strategies. Clearly, this indicates that the broad strength and resilience of the overall health and care clinical workforce across primary and secondary care will need to improve to support the delivery of an acute reconfiguration and this is reflected in the proposed benefits framework developed. A similar analysis could be extended to a review of the overall resilience of the health and care (including social care) workforce more broadly, taking in to account support services and non-clinical roles.

Therefore, workforce modelling for any options consulted must demonstrate that these options improve the workforce challenges as presented in the case for change. They both improve the quality of the services provided from the do nothing position and are deliverable in terms of workforce availability.

The workforce modelling for options 4d and 5d is presented in terms of the medical support required to deliver each of the options which includes senior clinical nursing input where these roles undertake the equivalent of junior doctor roles. Medical rotas consist of 3 tiers of Doctors: Consultant, Middle Grades (Senior Trust employed doctors and trainees) and Junior Doctors.

Requirements for a Pre-Consultation Business Case (PCBC)

The workforce modelling within a PCBC must be at a sufficient level of detail for the public to interrogate and form an opinion on the expected impacts in comparison to doing nothing.

A good example of this can be found from the workforce modelling performed by a similar programme led by Dorset CCG, which has recently been approved by the Secretary of State. This formed part of their option evaluation appended to their PCBC and answered through use of trend i.e. ++/-- to 3 points: scale of impact, sustainability and impact on staff attrition.

https://www.dorsetsvision.nhs.uk/wp-content/uploads/2017/10/pcbc-appendix-f.pdf

As there is no proposal in any option of altering the existing bed numbers within any of the options the existing nursing complement to support inpatient beds is assumed as being unchanged in any of the options. This is in reference to the RCN (2019) guidance on nurse staffing levels in the UK https://www.rcn.org.uk/professional-development/publications/pub-003860. This is a similar approach to that used by South and Tyneside Sunderland within their Path to Excellence PCBC https://pathtoexcellence.org.uk/wp-content/uploads/2016/11/P2E-PCBC-v2.4-FINAL-1.pdf

Therefore, the workforce modelling conducted by the programme relating to OHOC as to be presented more fully in the PCBC is at least equivalent to the assurance standards for other schemes, which have been individually considered for their merits.

Methodology

The workforce modelling has been clinically led by the 5 OHOC clinical leads who represent and have liaised with their wider teams. Involvement of trust operational managers and rota coordinators has also been important to understand the impact of the options on the complex medical rotas and compliance with training requirements and the European Working Time Directive.

The workforce modelling is overseen by the OHOC Clinical Oversight Group (COG). COG has representation from multidisciplinary clinical professions such as GPs, Allied Health Professionals (AHPs), nurses, mental health and acute care doctors from across the partner organisation of central Lancashire. The COG will make its final recommendations to the OHOC Joint Committee as part of the of evidence within the PCBC for consideration.

Outputs

One of the 5 key drivers in the case for change approved on the 13th December 2018 is workforce. Specifically, that we do not have the workforce we need in the 3 critical staffing areas of Emergency Care, Critical Care and the delivery a 7-day consultant review for patients admitted with an urgent medical need.

Analysis of options 4d and 5d for the totality of these services compared to option 1 ‘do nothing’ demonstrates that both options will have a positive impact on the ability of the system to deliver to key quality standards and current workforce availability.

Option 4d

Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	↑	↑
Junior Doctors/Advanced Care Practitioners	↑	↑
General Practitioners	→	→
Emergency/Urgent Care Practitioners	→	→

Option 5d

Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	↑	↑
Junior Doctors/Advanced Care Practitioners	↑	↑
General Practitioners	→	→
Emergency/Urgent Care Practitioners	→	→

This analysis is further broken down into the three critical staffing areas as identified within the case for change.

The Front Door

The below tables signify that for both options 4d and 5d there will be an improvement in availability and sustainability of the Emergency Care Medical workforce. Investment will be required in the recruitment and training of Advanced Care Practitioners to support the traditionally junior doctor roles sustainably. An increased number of Emergency/Urgent Care Practitioners will also be required to assess and treat minor injury enabling the medical workforce to focus on more complex assessment and treatment. Option 5d has slightly more benefit due to the increased level of consolidation onto 1 site.

Option 4d

Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	↑	↑
Junior Doctors/Advanced Care Practitioners	↑	↓
General Practitioners	→	→
Emergency/Urgent Care Practitioners	→	↓

Option 5d

Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	↑	↑
Junior Doctors/Advanced Care Practitioners	↑	↓
General Practitioners	→	→
Emergency/Urgent Care Practitioners	→	→

Critical Care

Both options 4d and 5d will improve the ability to achieve key quality standards compared to option 1, to ‘do nothing’. This is in terms of the Consultant and Nursing workforce due to consolidation of this workforce. More critical care middle grades would be available to support the critical care unit however this is offset by the presence of a 24/7 anaesthetic middle grade at Chorley and South Ribble Hospital.

Option 4d		
Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	→	→
Advanced Critical Care Practitioners	→	→
Critical Care Nurses	↑	↑

Option 5d		
Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	→	→
Advanced Critical Care Practitioners	→	→
Critical Care Nurses	↑	↑

Medicine

For both options 4d and 5d there would be a positive impact on the consultant availability to progress towards the delivery of a 7-day review of patients admitted to hospital and to deliver improved same day emergency medical care (also known as ambulatory care). The removal of 2 parallel rotas would reduce to requirement for locums and for substantive doctors to work additional hours. As there is will be no reduction in the number of beds available the ward nursing staff required will remain unchanged from the ‘do nothing’ option.

Option 4d		
Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	↑	↑
Junior Doctors/Advanced Care Practitioners	↑	↑
Nursing - Wards	→	→

Option 5d		
Role	Impact on delivery of key quality standards relating to workforce availability compared to option 1 'do nothing'	Workforce availability compared to option 1 'do nothing'
Consultants	↑	↑
Middle grades	↑	↑
Junior Doctors/Advanced Care Practitioners	↑	↑
Nursing - Wards	→	→

Next steps

Workforce modelling is, by its nature, iterative and organic in nature. Current workforce modelling activities being developed include equivalent activities and transformation plans across system partners such as North West Ambulance Service (NWAS), Primary Care Networks (PCN) and mental health services. All partners from these areas have reviewed the options being developed as part of OHOC via the Clinical Oversight Group and other engagement routes. This has led these partners to consider that the options being developed are viable from the perspective that accommodating and supporting workforce transformation solutions can be developed.

Once a strategic implementation framework becomes clearer, i.e. through a consultation process and a reasoned due regard assessment relating to comments received, the frame of workforce modelling will expand and become more granular. This includes analysing staffing requirements for wider clinical portfolio areas including nursing and allied health professionals. Operational leaders at the Trust will also be able to develop workforce plans for support services and develop plans for areas such as specialist input and rota interdependencies for senior clinical roles.

Workforce modelling estimates will also refine to take account of available operational data including trajectories for workforce supply arising from factors such as training allocations, attrition, retirement age modelling, and trends in “hard to recruit” workforce categories. As described within the Case for Change, a number of these trajectories indicate areas of either regional or national challenges - further evidenced by information published within the NHS Workforce Strategy.

This is important because it helps to demonstrate why workforce supply, resilience and retention efforts are unlikely to be successful from deploying traditional strategies, and so why service reconfiguration may need to be considered. The Trust and indeed the central Lancashire health economy more widely are far from alone, or unique in the scope and breadth of workforce challenges faced.

https://www.hee.nhs.uk/our-work/workforce-strategy

Appendix 7

Presented by the Our Health Our Care programme to Health Scrutiny Committee on Tuesday, 4 February 2020

Introduction

This paper provides an overview of the potential impacts of the OHOC Acute Sustainability programme on neighbouring hospitals across Lancashire and Greater Manchester.

This paper outlines analysis undertaken by the programme that demonstrates estimated activity impacts. This has been informed by Travel and Access Modelling as well as a review of the evidence from the downgrade of Chorley A&E department between April 2016 – January 2017. The paper presents a strategic summary of the information which will be presented in the PCBC.

Requirements for a Pre-Consultation Business Case (PCBC)

NHS England stage 2 assurance process provides clear and thorough guidance to commissioners when formulating a pre-consultation business case.

With regards to the contents of the PCBC, the guidance[4] states:

"The contents of a PCBC may vary, however they should

- *include an analysis of travelling times and distances;*
- *identify any clinical co-dependency issues, including any potential impact on the current or future commissioning or provision of specialised or other services"*

Additionally, the guidance provides information outlining expectations regarding potentially impacted neighbouring services.

"Support for proposals from providers and other commissioners impacted to a significant degree by the proposals' will be tested as part of the assurance process and where relevant, letters of support may be required as part of the assurance evidence. Your local NHS England regional team will be able to advise where and when these are required."

Crucially, the guidance states that letters of support may be required from other commissioners that may be *significantly* impacted by change proposals. This paper outlines that there should be no commissioners that are subject to significantly increased activity as a result of this programme. Although the word *significantly* is not explicitly defined, we have considered whether more than 5% of current flows

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

from Chorley and South Ribble or Greater Preston CCG would be likely to move outside of the central Lancashire region, recognising that within the current state model (status quo), a small minority of both CCGs patients already use alternative providers. This reflects clinical configuration patterns and that for some patients living in the outer boundaries of the CCG, another provider is already closer to their home address, particularly for urgent and emergency care purposes.

Methodology

The programme is able to demonstrate how neighbouring CCG's can expect minimal activity shift through a combination of robust Travel and Access modelling and historical activity data from the temporary downgrade of Chorley A&E in 2016.

Outputs

Impact on Neighbouring Hospitals

Following the temporary downgrade of the Accident and Emergency department at Chorley and South Ribble District General Hospital on 18th April 2016, the attendances at neighbouring hospitals by Greater Preston CCG and Chorley & South Ribble residents increased slightly. Six neighbouring hospitals saw relatively no impact, with The Bolton NHS Foundation Trust seeing attendances increase by less than one patient per day. Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) saw the largest increase of 5 patients on average per day.

WWL received on average 5 additional patients each day:

- With these additional patients' attendances from these two CCGs added in, the CCGs combined supplied only 2.85% of overall attendances at WWL.
- 70% of those attendances were low acuity and suitable for treatment at an Urgent Treatment Centre (UTC).
- Approximately 1 of the extra 5 attendances per day led to an admission.
- This projects to a single (4) bay of beds – based on an assumed length of stay of 4.5 days and national standard 85% targeted bed day occupancy standard, or around 1 in 200 of the Trust's existing admissions.

It is important to note that the activity shift seen in 2016 followed the acute clinical workforce challenges which necessitated the downgrade of Chorley A&E services on clinical safety grounds. Time for patient communication was distinctly limited, and the most appropriate way to access alternative services was not clear in all cases.

It is commonly accepted that, were changes to Chorley A&E (from the current state) to arise from the consultation process, that both the formal public consultation process itself, and targeted/focussed patient education initiatives will ensure that any increase in activity at neighbouring hospitals, as a proportional impact, would be limited to (and probably lower than) increases experienced in 2016.

This statement also takes account the further expansion and development of urgent care services in the interceding period. Also, that capacity planning assumptions would have much more time to be embedded and phased, with similar protocols and clinical pathways agreed with agencies such as North West Ambulance NHS Trust.

Impact on Royal Preston Hospital:

Relating to the Royal Preston Hospital, it is notable that clinical activity patterns for urgent and emergency care have not returned to a pre-2016 service baseline in terms of activity distributions between the two sites, allowing for growth caused by other factors, such as demographic based pressures. Again, the developments in urgent care infrastructures are relevant here, as is the reversion to a part-time, as opposed to 24-hour operating model for A&E services in Chorley.

Clearly, activity shifts from an expansion of the service model at Chorley from the current state would be limited to flows which are not reliant on specialist care pathways or are contingent on the Type 1 service requirements. This reflects the statements made by the Clinical Senate and others have shown that Chorley neither currently meets, nor did meet, Type 1 standards in the period before the launch of the Our Health Our Care programme. The comparator baseline is the existing service model.

The projected impact for Royal Preston Hospital is subject to further validation of clinical flows and discussions around the delivery of respective service specifications.

Option 1 presents a status quo position, which would be unlikely to relieve pressure on the Royal Preston Hospital site. For Option 4 – 89% of patients currently presenting at Chorley A&E would have the choice to still access care from this location, relating to urgent and emergency care. For Option 5, the equivalent figure is projected at 84%.

The context of these numbers should be seen in terms of the broader potential impacts and opportunities for the Chorley and Royal Preston Hospital sites, arising options other than a status quo or stand-still position. These impacts/opportunities are based on the delivery of more outpatient care at the patient's local hospital (or closer to home via primary care, telehealth, or a primary care network) where safe, practical and clinically effective; and the same in terms of the opportunity to develop the Chorley and South Ribble DGH site as a Centre of Excellence for Elective Care.

Cumulatively, these impacts would mean that, based on status quo, more care could delivered at Chorley and South Ribble DGH than it is now, and the Royal Preston Hospital site would be decompressed as a result. The current service distribution pattern inhibits this from taking place.

This is because the clinical activity volumes for urgent and emergency care are significantly lower than elective and outpatient caseloads respectively. Site configurations need to be seen, for clinical viability and other sound reasons linked to clinical guidelines, as a whole. This includes for beds, theatres and other modelling assumptions.

Therefore, it is not possible to "carve out" a model which extracts the potential urgent and emergency care shift from Chorley, whilst still creating the Centre of Excellence for Elective Care. Levelling up principles for the urgent and emergency care model at Chorley have been defined by the Clinical Senate as not viable due to clinical

workforce constraints and other clinically directed factors. In turn, this means that failing to consider options which could include reforms to urgent and emergency care structures carry significant opportunity costs, linked to patient experience, access and the possibility of improving clinical outcomes.

Travel and Access Modelling

Crucially, Travel and Access modelling for the programme estimates that 96.2% of patients receiving care in the future would either see no change in their travel time for treatment or see their travel times reduce. It is estimated that 16.3% of patients will indeed see a decrease in journey time of up to 20 minutes. This takes in to account the cumulative effect of the options, including outpatients, elective and urgent and emergency care flows. It is fully understood that this will be very important to patients and carers when responding to options.

It is understood that the approximate intra-site travel time can be around 22 minutes by car – this reflects a mid-range in off-peak conditions. This can vary upwards or downwards based on factors such as modality of transport used, time of day (off-peak and peak), and special cause variation – such as an accident on a nearby trunk road, or motorway, or congestion due to roadworks etc.

It is also recognised that, intra-site transport does not always reflect the route which patients/carers would take, and that additional conveyancing time, such as finding a car parking space needs to be taken in to account, even in so far as this is a feature in the current model.

Travel and access modelling has also considered impacts on service users without household access to a car (and ranges of car ownership based on socioeconomic factors) – for instance buses and trains, and the available provisions of intra-site transport between the two sites, as currently provided.

Excepting for special cause variation factors and anecdotal evidence, which is important, GPS tracking and isochrone mapping data indicates a likely maximum excess travel time of 45 minutes, assuming that the journey is taken in peak based conditions and is at the worst usual upper-limit of excess travel time for congestion. The reference point here is the travel time at 4.30pm in the afternoon on a weekday. This travel time is assumed to be by private car and would be significantly less in “blue light” conditions.

To be absolutely clear, this statement does not intend to fail to recognise that, on occasion, travel times could be in excess of this upper limit but also recognises that service users tend to recollect adverse travel experiences more frequently than they do travel journeys within normal ranges. For the purpose of modelling, it is important to acknowledge the variation, and the impact on people affected, but also to use outputs within accepted ranges (based on tens of thousands of actual journeys), so as to accurately plan services and inform the public.

For clarity, the Clinical Oversight Group have reviewed a range of clinical reference data relating to any prospective clinical significance of excess travel times. Most studies compare the impact of excess travel, linked to factors such as

inconvenience, with the improved access to services that are ultimately delivered in a location with improved safety and resilience. This leads to most studies to identify a lack of direct clinical evidence that excess travel time, particularly at this level, to worsened clinical outcomes. This also leads to most studies to affirm the notion that patients will continue to access urgent and emergency care where clinically required. Other studies, such as the designation of Major Trauma Centres, have directly linked care centralisation to lives being saved.

Conversely, a smaller number of studies, for instance Wei and Nicholl, interpose a relationship between travel time and outcome. However, they are limited in translatability to OHOC and it is misleading to seek to create a direct relationship, without recognising the differences and the acknowledged limitations of the studies concerned, as quoted by the respective authors. This is because they do not attempt to account for factors including differences in service provision standards in the care environment when an admission takes place in reconfigured conditions (i.e. travel further for better ultimate care).

On a methodological basis, they translate travel variances differently to than those used in OHOC and describe relationships based on particular clinical conditions, as opposed to the case mix under consideration in central Lancashire, with its particular local features.

Based on the above, the Clinical Oversight Group does not accept that there is elevated clinical risk from excess travel. Further, access and inconvenience factors are important, but can be objectively justified. The impact of excess travel, linked to factors such as access barriers and inconvenience needs to be considered from an Equalities perspective, from a mitigation perspective, and alongside other change drivers, for instance potential improvements in care access, patient experience, and service resilience/sustainability.

Therefore, the programme concludes that identified impact on travel times, coupled with expected uplift in performance of services as a result of service redesign, would be positive, in an overall sense for patients. Only limited numbers of patients to seeking treatment from neighbouring hospitals in terms of whatever change option was decided upon, apart from Option 1.

Caveats and next steps

As part of ongoing stakeholder engagement, the programme is seeking to engage with neighbouring CCG's and trusts to fully explore the work undertaken to date, inform and involve in programme planning, and ensure due regard to points of concern raised. This is a necessary part of the process at the point where proposals have been substantively developed, but not consulted or decided upon. All modelling work is subject to ongoing programme scrutiny and governance, under the authority of the Joint Committee.

Appendix 8

Presented by the Our Health Our Care programme to Health Scrutiny Committee on Tuesday, 4th February 2020

Introduction

This paper provides an overview of the ongoing Mental Health improvement and transformation plans being overseen by Lancashire & South Cumbria Foundation Trust (LSCFT) and how these align to the options being developed in OHOC. A senior manager from LSCFT will be present at the Health Scrutiny Committee meeting on 4th February 2020 to discuss and answer questions relating to the ongoing improvement plans for Mental Health in more detail.

Requirements for a Pre-Consultation Business Case (PCBC)

The scope of the OHOC Acute Sustainability PCBC is all acute services provided by Lancashire Teaching Hospitals NHS Foundation Trust (LTH). This means that LSCFT is recognised as a partner of the programme and works closely with the CCG to ensure that changes proposed to service configurations at LTH are consistent with the direction of travel for mental health services transformation. This reflects the understanding shared by all in the programme around the importance of parity of esteem and equitable focus on transforming physical, as well as mental health, services.

However, it is important to note that the options themselves are not differentiated by whether or not transformation and improvement of mental health services for patients is required, and the framework for strategic configuration for OHOC would of course guide how these changes are delivered. Equally, sub-variants of different types of mental health service transformation are not presented as discrete options and are seen as part of an overall package of change, relative to a “stand-still,” or “status quo” provision, as explained by Option 1.

Methodology

To ensure alignment between LSCFT and the OHOC acute sustainability programme, the Clinical Oversight Group for the programme contains representation from two LSCFT employees including:

- Medical Director, LSCFT
- Clinical Director, LSCFT

Attendance and input into this forum has ensured that programme developments have been aligned with plans for Mental Health transformation plans. Equally, clinical assurance of the options and the enhanced clinical scrutiny process has considered this perspective. The proposals set out for prospective substantial

variation in Options 4 and 5 have been considered as workable, from a mental health perspective.

More broadly, a representative from the Communications Department also supports the Communications and Engagement Group, providing the facility for information dissemination and shared engagement events with staff and others involved in mental health services. There is similar sharing of information for engagement purposes via the Stakeholder Reference Panel, whilst patient engagement events have also explored relevant issues in terms of improved access and co-working between mental and physical health services.

Outputs

Through the representation of LSCFT colleagues within the Clinical Oversight Group, the Acute Sustainability programme has suggested a “Care Triage” function should exist within an Enhanced Urgent Treatment centre to ensure joined up working with LSCFT, delivering improved patient experience through a systematic approach. The specification for an Enhanced Urgent Treatment Centre outlines that a care triage prioritisation of all attendees will take place via a review of the ED electronic system for key risk factors as follows:

- Patients with two or more low severity visits within a locally agreed timeframe (suggested time every six months) including those with a behavioural health diagnosis, who are not known to their Primary Care Network or have an agreed care plan.
- Patients with social factors known to create particular service access barriers (e.g. unstably housed, substance use, or socio-economic status).

If required, a care triage assessment will be completed with signposting or referral to appropriate local community or social care services.

Furthermore, LSCFT have been providing regular updates to the programme on the developments taking place within Mental Health services, for example:

- Sub-contracting arrangements with digital companies to provide digital solutions to IAPT (Improving Access to Psychological Therapies) and expand ease of access.
- The Trust works collaboratively with partners, local organisations and authorities to develop joint solutions to improve health care, which are collated into a system-wide mental health improvement plan.
- The Trust has participated in an independent system review conducted by Northumberland Tyne and Wear NHS Foundation Trust (NTW) to inform further actions and improve delivery of services.
- The Trust has delivered several significant developments in-year across its clinical networks. Within mental health services this includes a programme of work to improve inpatient accommodation and the development of a brand-new perinatal service for new mothers.

Linked to the specific themes of improved flow and patient experience, as described in the Case for Change and Model of Care, the Trust has also been able to

announce that it is opening eleven new rehabilitation beds at the Royal Preston Hospital, expanding current capacity and facilities.

The beds are expected to reduce the number of people with mental health issues being sent to other parts of the country due to bed shortages, or people with mental health issues visiting hospital accident and emergency departments.

The beds will begin operating in April this year and will be housed at the Trust's Avondale Unit. More information about ongoing improvements that are aligned with the OHOC Acute Sustainability can be found within the LSCFT Annual Report.

https://www.lscft.nhs.uk/media/Publications/Annual%20Plans-Accounts-Reports/Annual-Report-2018-19/Annual-Report-2018-19-Final.pdf

Next Steps

The programme will continue to have Mental Health representation on the Clinical Oversight Group to ensure integration and shared working arrangements moving forward and these factors will be considered in patient engagement and consultation activities. Broader strategic oversight of these issues is also delivered via the Board for the Central Lancashire Integrated Care Partnership.

Appendix 9

Presented by the Our Health Our Care programme to Health Scrutiny Committee on Tuesday, 4 February 2020

1.0 Introduction

As described in the main body of the update paper, OHOC is a clinically led programme, which aims to deliver the best possible health outcomes for the population of central Lancashire. The financial modelling is predicated on activity modelling which covers demand patterns for acute services both now and in the future. This includes reviews of demographic-based changes which affect service access; changes caused by differences in likely case mix and clinical complexity; and potential changes to primary and community care services structures which could impact acute service demand patterns in the future.

For ease of reference of the Committee, this paper provides a strategic summary of current outputs, drawn from the technical subject matter reviewed and assured within the programme governance infrastructure, linked to the requirements at this stage of the option appraisal process. This paper outlines the modelling undertaken to date to assess the affordability of proposed options within the definitions and constraints outlined.

2.0 Requirements for a Pre-Consultation Business Case (PCBC)

A PCBC reflects an aspirational framework which a system or organisation is realistically seeking to work towards. Options presented to the public in a PCBC must be presented from the perspective that a reasonable to high degree of confidence can be evidence that they could be affordable, both from a capital and revenue perspective. This can be subject to certain improvements being achieved and/or the delivery of new operating conditions, for instance a new integrated working relationship between health and social care agencies.

Assumptions within the modelling leading to these option appraisals should be both based on a clinically led process and vision for change. This is why financial appraisal follows, as opposed to precedes, the development of a clinical case for change and model of care. Activity and financial modelling should provide further support and detail into the impact of each option and help to give confidence regarding potential option viability and sustainability, including to the Regulator, NHS England.

The requirements for financial and activity modelling reflect this – they are strategically orientated and based on high-level assessments of capital and revenue affordability for all options which are being contemplated for consultation, based on

the other tests. More detailed information is neither practical, nor expected to be developed, for the purposes of a PCBC. The available data is refined, tested, and necessarily improved as the proposals are further considered.

Therefore, the current modelling, relating to each clinically appraised option, reflects how the implementation of a strategic framework could be achieved and under which operating conditions. It is also normal that assumptions within financial and activity modelling will be refreshed and refined more detail is generated.

2.1 Impact of PCBC requirements for financial option presentation

There are a number of more practical impacts arising from these definitional requirements and how they impact on financial and activity modelling presentation.

1. Transitional costs, such as double running of services, programme management costs and other non-recurrent costs are not included in financial outputs.
2. Activity modelling focusses on whether potential clinical configurations are deliverable within the available estate and bed base available to the Trust
3. Financial appraisal consider impacts from the perspective of the current resources available to the health economy more broadly, as opposed to the exclusive budget currently held by the Trust through services commissioned from the CCGs.
4. The programme must assume that no enabling capital is currently available, as, in an affirmative sense, no confirmed business case has been accepted for such enabling capital. The Wave 4 capital bid submission, to be applied against any prospective option or care scenario, was declined in December 2018. This necessarily limits the scope of sensitivity analysis.
5. The depth of financial modelling is predicated on the particular scheme objectives and change drivers.

With respect to OHOC, four of the five reasons for change, as described in the Case for Change do not exclusively relate to financially orientated factors. Instead, change drivers focus more heavily on improving clinical outcomes, managing demographically orientated changes, improving patient experience, improving flow and access, and securing necessary workforce transformations to deliver safe, effective, and sustainable acute models of care, as part of a whole-system approach. This is reflected in the scope and depth of information presented on financial factors, compared to the more significant data presented relating to clinical factors.

This also means that financial efficiencies are naturally identified within the options but are linked to the reciprocal impacts of improving care models. This reflects how OHOC, and more specifically, acute system improvements and prospective reforms are seeking to deliver a contribution to improved financial balance, as one piece of a bigger whole picture. Again, such an approach is consistent with the assurance tests and presenting a realistic view of how far the change drivers are clinically, as opposed to financially, orientated.

2.2 Opportunities to improve financial management through the options:

For the purposes of the OHOC options, these direct cost saving opportunities are defined in two areas:

1) Reduction in agency spend - this is linked to improvements in continuity of patient care and experience; and
2) Reduced net spend with Independent Providers, whilst actively promoting the principles of patient choice is linked to an acute care system where more capacity is developed to provide care within the NHS sector. For instance, improved theatre utilisation may allow more elective cases to be treated.

Other possibilities, for instance improvements in length of stay; theatre utilisation; reduced delayed transfers of care; improved working with partner agencies; improved community-based services and urgent care services; all have a financial context but focus on making better use of existing resources (non-financial benefit). On the other hand, where direct financial benefits are identified, savings can either be channelled towards reduced structural deficits, or reinvestments in enabling costs for new service models.

3.0 Methodology

Governance

Programme governance ensures all options are scrutinised thoroughly. Options are considered by two parallel governance groups. The Clinical Oversight Group (COG) assesses the clinical implications of the modelling, whereas the Financial Investment and Activity Group (FIAG) oversees the financial affordability of the options and the robustness of the modelling assumptions. This process has ensured that only options which are clinically viable could be short-listed. Financial performance of the option is a secondary consideration.

Financial principles

The FIAG approved a set of financial principles for the programme - these posed two key questions:

1) is it affordable?
2) is it value for money?

An option is affordable if it does not worsen the current financial position of the system. An option presents value for money if the benefits outweigh any additional costs of the option. Benefits may be financial or non-financial. An example of a financial benefit is a reduction in agency costs. An example of a non-financial benefit is a decrease in cancelled operations.

Activity modelling

We used Trust activity data to understand the current demand for services. We then combined this with demographic data to project the demand for services in the future. For example, if there is an increase in women of child-bearing age, this increase would be reflected in increased demand for maternity services. This allows us to understand the demand and financial implications of this if nothing changed.

Once we established the ‘do nothing’ position, we modelled the potential impact of a range of assumptions. These assumptions lead to a more efficient and cost-effective service whilst simultaneously improving either patient experience or outcomes.

- **Deflect activity away from acute settings**: This will involve better management of referrals, allowing patients who need specialist support from acute settings to access it, whilst ensuring patients where possible can be seen closer to home in a community setting. Referral management processes and demand volumes can be effectively benchmarked.
- **Improved length of stay**. By reducing the number of days patients spend in hospital it is possible to improve patient experience whilst making the hospital more efficient. These improvements can be cross-referenced against available benchmarking data, for instance where a large number of NHS trusts carry out the same procedure or operation.
- **Reduced delayed transfers of care.** A delayed transfer of care (DTOC) is when a patient is fit and no longer requires an inpatient bed but cannot be discharged as there is not appropriate support either in the community or in a social care setting. By reducing these DTOCs a hospital can work more efficiently, and the patient receives an improved experience.

These assumptions are all clinically led and directed, including specific quantifications by service line, area, and the Trust as a whole. The gains assumed to be available have been stress-tested against other similar transformational change programmes elsewhere (forecasts and estimates); other similar transformational change programmes elsewhere (delivery); and other adjustments – for instance optimism bias. This is where the scope of an available benefit is reduced to reflect unforeseen difficulties, or delays which may be experienced in progressing towards delivery.

The modelling takes account of the deliverability of the change options. All options would be implemented over a phased five-year period. This will ensure appropriate community services are in place to complement acute provision.

4.0 Outputs

The ‘do nothing’ option (Option 1) will see an increased demand for all acute services by 2024/25. It is important to reference that this option is designated both as a reasonable comparator and also to show credibly the impact of a “stand still” or status quo position. Any change proposition or consultation should show similar.

Option 1 will lead to a deterioration of the financial position. If nothing changes it is expected the underlying deficit could foreseeably be as much as £132 million by 2024/25. This presents a necessity for being willing to consider other options, in addition to the clinical change drivers.

All of the change options encompass the three assumptions included in the methodology section. The combined impact of all three assumptions is to stabilise the financial position by 2024/25, relating to Options 4 and 5 discretely, and the clinical sub-variant modelled therein.

In addition to stabilising the underlying revenue position the change options have two main financial benefits:

- By reducing length of stay, this frees up bed capacity to deliver more planned surgical activity. This provides a significant opportunity to reduce the amount of spend with the Independent Sector.
- Consolidating services will allow the Trust to reduce agency spend. Our modelling assumes a conservative estimate of a reduction of 10%. However, there is scope to reduce this further.

Broader system transformation, beyond the direct definitions of Options 4 and 5 would contribute towards a more sustainable financial position.

Options 4 and 5 also indicate that, subject to operational efficiencies, activity modelling requirements for beds, theatre utilisation, and critical care department capacity could be delivered within the accessible estate, allowing for additional investments already approved within the trust – for instance the expansion of critical care facilities.

Similar modelling indicates that Option 1 would progressively worsen the trust's current operating conditions for instance excess bed utilisation, cancelled or delayed operations, and factors impacting on flow within the acute trust.

5.0 Next steps

The financial modelling will be presented in more detail within the PCBC, subject to the definitional requirements outlined in this paper. This will also be summarised for the Public into a Consultation Summary document to help interpret the information.

Examples of the further information which will be available in the PCBC should include:

1. More detailed breakdown of efficiency assumptions, and calculation methods.
2. Evidence of clinical engagement logs and sign off of the above.
3. Evidence of clinical leadership of activities which could be safely delivered at each site, were Option 4 or 5 to be proceeded with.
4. Quantification of the current bed, theatre and critical care modelling forecasts in current state conditions, compared with the outputs of a 5-year implementation plan.
5. Relevant triangulation with workforce modelling and impact assessment assumptions.

Appendix 10

Presented by the Our Health Our Care programme to Health Scrutiny Committee on Tuesday, 4th February 2020

Introduction

This paper provides an overview of the work being undertaken to model the impact of the Acute Sustainability programme on the local population of central Lancashire, staff working throughout Lancashire Teaching Hospitals, and a range of other key stakeholders.

Requirements for a Pre-Consultation Business Case (PCBC)

NHS England guidance[5] outlines that the stage 2 assurance checkpoint must provide the following assurances relating to the impact the changes may have on the population:

Patient Choice (and EIA)	Impact on Patient choice considered	• evidence to show how you've considered patient choice when developing the options for the scheme • how you have protected against reduced choice or how you will mitigate this perhaps through Personal Health budgets, increased clinical quality etc
	Equality Impact Assessment	• Has an equality impact assessment taken place? • Has engagement taken place with any groups that may be affected? • What action will be taken to eliminate any adverse impacts identified?

Furthermore, the guidance outlines that a PCBC must:

- be explicit about the number of people affected and the benefits to them;
- include an analysis of travelling times and distances;
- outline how the proposed service changes will promote equality, tackle health inequalities and demonstrate how the commissioners have met PSED;
- demonstrate how the proposals meet the governments four tests and NHS England's test for proposed bed closures (where appropriate);

The government's four tests of service change are:

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

A fifth test was added in 2017, however, this relates to reducing bed numbers, which will not be applicable to this programme.

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

Outputs

The programme has undertaken several pieces of work to ensure that the potential impacts on the local population are fully analysed and form a key part of the option appraisal process. These documents include:

- Equality Impact Assessment (EIA) – A piece of work that determines any potential impact of the programme on our local population on staff. An EIA ensures that all protected characteristic groups are considered within the development of the programme and outlines plans for how this engagement will continue.
- Patient Impact Assessment (PIA) – A lay friendly document combining the headline information from the range of impact analysis undertaken to ensure that the public are able to easily access information outlining how they may be affected by programme proposals.
- Travel and Access Modelling – A comprehensive piece of analysis that determines the impact of the programme on the way our local population access health and care services. This piece of work models the impact by exploring how services would be accessed using a variety range of transport options in both peak and off peak conditions.

These documents will be contained within the Pre-Consultation Business Case, a proposed structure this document can be found below:

1. Foreword • Clinical lead/CCG foreword
2. Executive Summary • Briefly summarise the purpose and the main contents of the PCBC
3. Introduction • Set the scene locally
4. Why do we need to improve our hospital services? • Outline the case for change.
5. How will we know if our changes have the desired impact? • Be clear about the impact in terms of outcomes
6. What should our hospital services deliver in the future? • Analysis of demographic and other factors likely to influence future demand for services. Be explicit about the number of people affected and the benefits too them • Links to relevant JSNAs and JHWSs, and CCH and NHS England commissioning plans • Identification of any clinical co-dependency issues, including any potential impact on the current or future commissioning or provision of specialised or other services • Service reconfiguration must be evidence based and this evidence should be publicly available during the consultation and decision-making stages. This ensures service proposals are underpinned by clear clinical evidence and align with clinical guidance and best practice • Examples of service models and learning from elsewhere including national/international experience • Demonstration of how the proposals meet the five tests.
7. How have we developed the options that will deliver our future vision? • Options development and appraisal • Demonstrate the process by which the options were developed

8. How have we decided which options are viable? • Clinical viability and deliverability • Demonstrate evaluation of options against a clear set of criteria. • Demonstrate affordability and value for money (including projections on income and expenditure and capital costs/receipts for affected bodies). • Demonstrate proposals are affordable in terms of capital investment, deliverability on site (with any outline plans), and transitional and recurrent revenue impact.
9. What will be the impact of these changes on our local population? • Impact Assessments e.g. Equality Impact Assessments / Patient Impact Assessments • Include an analysis of travelling times and distances. • Outline how the proposed service changes will promote equality, tackle health inequalities and demonstrate how the commissioners have met the Public Sector Equality Duty. • Summarise information governance issues identified by the privacy impact assessment.
10. How this process has been developed by people who really matter • Pre-consultation engagement • Outline how stakeholders, patients and the public have been involved, proposed further approaches and how their views have informed options. Explain how the proposed changes impact on local government services and the response of local government.
11. What is the governance for this programme and what are the next steps? • Programme Governance • Overview of the decision-making business case (DMBC) • Overview of Consultation requirements • Updated programme timeline

Next Steps

The programme will continue to develop and scrutinise the impact of these proposals on staff and the local population, before publishing approved documentation in the PCBC.

A public consultation would provide an opportunity to further enhance this work by gathering the thoughts and opinions of key stakeholders and updating programme outputs accordingly.

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Dear Lynn Chadwick,

Please find attached the final report from the RCEM Invited Services Review at Lancashire Teaching Hospitals NHS Foundation Trust.

Thank you for hosting RCEM for this review. We hope that you find the report and recommendations useful going forwards.

Sharing the report internally
In the Terms of Reference you agreed to share the report with the following parties in a timely manner:

- Trust Board (essential)
- Emergency Department Leadership; including Clinical Lead and Nurse Director (essential)
- All staff (optional but recommended)
- The relevant regulatory body (optional but recommended)

Sharing the report externally
The report is owned by the hospital and any subsequent demand for access to the report by an external body will be handled by you (see exception below). A copy of the report will be retained in confidence by the Royal College of Emergency Medicine for reference.

EXCEPTION: The Royal College of Emergency Medicine will share a copy of the report with the relevant regulatory body in advance of their visit to the host site, unless the host informs RCEM in writing that they wish to opt out of this.

Feedback
RCEM welcomes feedback from you and any other staff involved in this review. All feedback will be reviewed by the RCEM Quality Manager and used to continuously improve our service.

Kind regards,

Dr Ian Higginson, RCEM Invited Service Review Chair

Sam McIntyre, RCEM Quality Manager

The Royal College of Emergency Medicine

Royal College of Emergency Medicine Invited Service Review visit

Lancashire Teaching Hospitals NHS Foundation Trust

Visit Date: 3-4 April 2019

Authors:

1. Dr Ian Higginson
2. Dr Steve Jones
3. Martin Rolph
4. Dr Graham Johnson
5. Sam McIntyre

Report issued: 1 July 2019

Contents

Executive summary

The Royal College of Emergency Medicine (RCEM) was invited to visit the Emergency Departments (ED) at Chorley and South Ribble Hospital and Royal Preston Hospital, part of Lancashire Teaching Hospitals NHS Foundation Trust. The visit took place on 3-4 April 2019.

We were asked to review the sustainability of the current model of care, involving a partially-opening Emergency Department at Chorley and South Ribble Hospital, and a 24/7 Emergency Department in an MTC at the Royal Preston Hospital site.

We have found that the current model is unsustainable in its current form, and is highly vulnerable whilst decisions about alternatives are being made. There are significant concerns about the safety of the current model, particularly in the evenings and at weekends when there are limited senior emergency department staff on site, and given the paucity of supporting services on the Chorley site.

Clinical and managerial staff feel that they have been asked to adopt a current model with which they do not feel comfortable, at least partly as a result of political and public reactions to a previous downgrading of the ED at Chorley.

Future plans are neither robust nor complete, although they contain many positive elements.

Transformation plans relying upon demand management and community-based models are unlikely to succeed, particularly given the reported fragility in the local primary care system, and the lack of effective integrated working between the hospital and community. There is also a risk around the credibility of such options with the local population.

The Trust is in an extremely difficult situation, caught between two unsustainable future options around the configuration of the Emergency Departments and Urgent Treatment Centres, and three options which require investment and reconfiguration particularly on the Preston site. These options exist within a system with one site that is currently extremely challenged with regard to patient flow, where the capability of community-based services to successfully mitigate effects is in doubt, and where reconfiguration of services is likely to prove unpopular.

The format of the visit is detailed in Appendix 2. During the site visits the RCEM review team met with CCG & LTH execs, senior clinicians and a significant range of front line staff involved in delivering urgent & emergency care services and co-dependencies. We would like to extend or thanks to the staff at the Trust for making us welcome, and for engaging openly and honestly with the ISR.

We were provided with extensive documentation prior to our visit, a list of which is provided in Appendix 1.

Responses to the questions specifically raised in the TOR

1) **Current transformation plans**: We were asked to what extent we felt that the current transformation plans were robust and complete, taking sufficient account of best practice
    a. We were impressed with the amount of effort that had clearly gone into the plans that we saw
    b. The plans are to some extent unsurprising, and what we have come to expect from such documents: this is not a reflection on the authors but more of a reflection of the culture within the NHS where senior managers and clinicians are expected to produce relatively formulaic material, rather than articulating what they might actually think, or what might actually be achievable
    c. We felt that the plans offered a direction of travel, rather than being either robust or complete. There was no real indication as to how the plans could and would be delivered
    d. Potential roles for primary care, ambulatory emergency care, frailty and integration are all regarded as best practice and are included. Missing elements included the potential effects of any reconfiguration on the Preston site, and learning from the prior temporary closure of the ED at Chorley.
    e. There was no signed-off model for acute care
    f. We are sceptical about plans which rely on primary care clinicians or systems reducing demand on acute facilities, or increasing their capacity to offer complex care in the community.

2) **Sustainability and Quality:** We were asked whether the circumstances which led to the previous NHSI review of emergency care in central Lancashire, and the reopening of the ED at Chorley, are still valid. It is not possible for us to answer this question since we were not there at the time. However, we do feel that the current arrangements are unsustainable, whilst clinicians are clearly expressing concerns about safety.

3) **Emergency Department service adjacencies:** We were asked about service integration and clinical adjacencies in the emergency departments. As far as Chorley is concerned it is clear that services on site are the bare minimum, and that any further reduction will render the ED non-viable. Services at the Preston site are appropriate although we are told that the need to duplicate services across both sites results in curtailment of ambulatory care support at the Preston site, and is causing significant management problems in terms of

staffing and supporting Emergency Medicine, Acute Medicine, and Critical Care.

4) **Focused:** We were asked for our opinion around prioritisation for transformation activity in the field of reducing unnecessary demand. We found this difficult to answer since it implied that the Trust is relying on demand management strategies which are vulnerable to failure, in the context of weak current model of care. Our recommendation would be to focus on improving discharge and integrated care at the back end of the pathway, along with admission avoidance and ambulatory care strategies, and improved care of patients with mental health problems and who frequently attend (may be an overlapping group). These may be more likely to yield results than demand management strategies, for which there is little evidence of efficacy.

5) **Future Proofed:** We were asked if the proposed model is future-proofed against future clinical standards. It is not possible to answer this question given the uncertainty surrounding future clinical indicators.

Review team

Lead Reviewer: Dr Ian Higginson

Reviewer: Dr Steve Jones

Reviewer: Dr Graham Johnson (3 April 2019 only)

Lay Reviewer: Martin Rolph

RCEM Admin: Sam McIntyre

Terms of Reference

Visit Objectives

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.

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 we specifically examine issues around training and education.

Background to the visit

There are currently two Emergency Departments operating at the Trust.

1) A type 1 Emergency Department at the Royal Preston Hospital. This site is a 24/7 unit, and the hospital is a major trauma centre. The department receives both adults and children. This department sees 70905 patients per year. Of these approx. 10000 are children. There is a co-located 24/7 Urgent Treatment Centre operated by gtd healthcare which sees a further 32543 patients per year.

2) An Emergency Department at Chorley and South Ribble Hospital. This site is open to patients as a type 1 Emergency Department 12 hours per day (staffed 14 hours a day), with consultants on site 8 hours per day, 5 days per week. Ambulance bypass is in operation for major trauma, ST elevation myocardial infarction, stroke, children, and crew discretion. The ED currently sees 24317 patients per year. Of these approx. 4750 are children. There is also a 24/7 co-located Urgent Treatment Centre operated by gtd healthcare, seeing a further 29686 patients per year. The Chorley site is not currently recognised for advanced training in Emergency Medicine, although trainees do go there as part of their ACCS (EM) rotation

Royal Preston Hospital has full facilities on site. At Chorley there is no acute surgery (including orthopaedics), and no paediatric medicine. Both sites have on site acute medicine, with ambulatory care units operating 5 days per week, 0800-1800 at Preston and 1000-1800 at Chorley. There is a small ICU in Chorley, with a large ICU at Preston undergoing expansion.

We understand that there was a 24/7 ED at Chorley which was downgraded in April 2016 over safety and sustainability concerns, with the main driver being middle grade staffing. There was pressure from a number of sources to reopen the department and following an external review of options the current arrangement was put in place from January 2017. There was a suggestion at the time that this was a trial arrangement to last some 12-18 months.

Present position of the service

The Trust is currently consulting around future options for the configuration of emergency care. Local Emergency Departments / Trusts which may be affected by reconfiguration decisions include Blackburn, Wigan, and Bolton.

Medical staffing in the ED

Current staffing levels (Emergency Departments across both sites)

- Consultants: 20 (16.4 WTE)
- Middle Grades: 14 establishment, 11.8 in post
- Junior Doctors: 25 establishment, with no current vacancies (rotational vacancies supporting by locums). Work across both sites
- ACPs: 2.8 ACP, 1 PA, 2 ESP, all at Preston
- ENPs: 11 WTE, 9.7 in post. All currently at Chorley

Nursing staffing in the ED

Grade	Est Preston	In post Preston	Est Chorley	In post Chorley	Overall vacancy
Unit manager	1	1	1	1	0
B7	12.8	12.2	4.5	2.8	2.3
B6	11	4.2	2.6	2	7.4
B5	39.2	37.6	11.6	12	2
B3	23	14.8	3.4	2.2	9.3

Relevant notes from walk-arounds

Chorley

The Emergency Department and Urgent Care Treatment Centre at Chorley are located in a redeveloped facility. We found the physical facilities to be bright and modern, although the design would make visual management difficult were the unit to operating as a single ED.

There is no separated paediatric area within the facility and no clinical decision unit.

We understand that following the downgrading in 2016 the facility was reconfigured to meet the needs of the remaining urgent care provision. The facility has not been re-reconfigured since the ED reopened to patients for 12 hours per day, and is rather awkwardly shared by the urgent care provider and the ED team, as well as the ambulatory care team. The facilities are not so much co-located as intertwined, although staffing and managerial arrangements between NHS and private providers are separated. This has caused some confusion.

Examples of confusion

- The reception area is a single desk offering three different registration options for patients, who are expected to know which one to choose when they turn up.
- Triage systems used by different providers in the same facility are different
- Computer systems are separate so there is no single way of seeing which patients are where, and what is happening to them
- Handover points are vulnerable (for instance when the ED "closes")
- The staff we spoke to were unable to describe exactly what sort of facility they are working in

We were told that although the Urgent Care Treatment Centre is contracted to see patients with both injuries and illness, only patients with illness are currently accepted. Minor injuries patients are therefore seen by the Emergency Department staff.

We were told there is a contractual and reporting anomaly whereby the Trust is not reimbursed for type 1 attendances, although the current expectation is that a consultant-led emergency facility is open to patients at the Chorley site 12 hours per day. Attendances at Chorley are not included in the Trust's type 1 reporting data against key national standards, which may have a negative effect on the overall data. The Trust's senior management feel that this situation carries both a financial and reputational penalty.

Preston

The Emergency Department at Preston is clearly in urgent need of redevelopment. Although there are improvements currently underway to provide a separate paediatric area the remaining facilities are inadequate to support the function of a modern emergency department in such terms of available space for numbers of patients, physical layout / ergonomics, facilities for resuscitation and high dependency patients, consideration of the needs of vulnerable groups such as the elderly or mentally ill, and consideration of working conditions for staff. There is no clinical decision unit available to support admission avoidance. Supporting facilities such as ambulatory care and assessment units are some distance from the department.

The 4-hour performance data supports the narrative from staff that the department suffers from toxic crowding with all its associated effects on patients and staff. There were concerns expressed by many staff about the engagement and ability of both the rest of the organisation, and the wider community, to address this problem.

Sustainability of the current model at Chorley

The Emergency Department at Chorley and South Ribble Hospital is unusual in both its size and supporting services.

Size

It has low numbers of attendances during its limited, seven day a week opening. Currently a Minor Injury Service is provided within the Emergency Department by Emergency Nurse Practitioners supported by the medical staff. We were told that the Minor Injury service will eventually transfer to the adjacent Urgent Care Treatment Centre, resulting in a further fall in the attendance numbers at the Emergency Department. This would leave the Emergency Department providing a service to a reduced number of patients with illness only. The management team of the Urgent Care Treatment Centre were of the opinion that they had the capability to run a safe and effective service if the Emergency Department were to close. The Emergency Department clinicians did not disagree with this.

Support

On-site specialist support to the Emergency Department is currently limited, only being provided by an Acute Medicine unit and Critical Care Medicine. There were no acute surgical services, Paediatrics or medically lead Obstetrics on site. The utilisation of the Critical Care Unit on site was extremely low (we were told less then 30%), and at the time of our visit there were no patients being treated on the unit. This results in inefficient use of highly trained medical and nursing staff. For instance, when a patient is admitted to Chorley Critical Care staff are drafted from the Preston site.

The lack of on-site support for the Emergency Department has resulted in some formal arrangements for ambulance diversion to specialist units (Major Trauma, Stroke and ST elevation myocardial infarction). However, it is common practice for the ambulance service to bypass Chorley with other cases for which the ED was considered unsuitable (children, acute surgical and orthopaedic emergencies). The volume of ambulance arrivals at Chorley and acuity of cases is therefore low. Despite this, the staff described risks and the potential for delayed treatment in relation to some types of self-presentation or in instances where ambulance crews were not aware of local capabilities (particularly critically ill children).

It should be noted that were either Critical Care, or the Medical units, to close at Chorley then the ED would immediately become non-viable

Staffing

We were told that although the nursing workforce was below establishment, it was considered that there would be little difficulty recruiting and retaining further nurses to staff the Emergency Department.

The Emergency Department at Chorley is not recognised for advanced EM training, although trainees do go there as part of the ACCS(EM) rotation. The current medical workforce model consists of a Consultant for 8 hours a day, five days a week, non-training doctors and Emergency Nurse Practitioners. At the weekend the service is highly dependant on non-training middle grade doctors, with off-site consultant support. As in many Trusts nationally, there has been significant difficulty recruiting and retaining these doctors. A lack of these doctors has already resulted in temporary closure of the service and at other times the use of agency locums at very high cost. There have been extensive, although unsuccessful, attempts to recruit substantively to these positions and the review team feel it is highly unlikely that the Trust would be able to recruit permanently in the foreseeable future.

The Trust is able to recruit Consultants; however their impact in a department seeing low numbers of patients of relatively low acuity is likely less than their impact if this resource were moved to Preston.

Safety

When we asked whether the ED at Chorley was currently safe, the view of senior clinicians was that it was not, particularly in the evenings and at weekends when senior cover and staffing is lighter, and access to investigations is reduced.

Proposed model of care

The documentation pack associated with the ISR was very substantial. Clearly, a lot of work has gone into recognising, analysing, presenting and engaging around the issues and broader vision for healthcare provision within Central Lancashire. They correctly consider the whole system of which the emergency and urgent care components are small but important parts.

The documentation associated with the provision of emergency and urgent care pathways was very similar to the other systems around the UK including those of the ISR team. This is not a surprise and is reflective of the caseload presenting to these departments.

What is less clear from the documentation is information of the 'size' of the emergency and urgent care problem. It is very difficult to tease out how many people attend each department and, of those arrivals, which service they are there to see. It would also be useful to understand what level of care the patients actually needed e.g. type 1 care, primary care etc.

The documents describe the 'whole pathway' problem and are a strong, if repetitive, case for change, but do not in our opinion clearly articulate a plan for the emergency and urgent care system. From our review it is clear that the core components of emergency and urgent care are being delivered in a fractured way across the health economy and that change is required.

The effect of dividing resources between two sites

One of the main dilemmas faced by the Trust and its staff is that they are trying to provide full capability services for Emergency Medicine, Acute and General Medicine, and Critical Care, across two sites. This is a particular problem with respect to medical staffing, although there are shortages in some nursing groups. For all services this is regarded as undesirable, since all struggle to provide safe senior staffing and clinical care during the required times. Neither site is currently capable of operating 7 day working for ambulatory care, and weekend staffing is stretched across all services. For patients there is inequality of access to some services, for instance specialist support, endoscopy for GI bleeds, and advanced imaging; all of which are less present at the Chorley site, particularly out of the normal 9-5 working week.

However, it was apparent that the Preston site would struggle to cope with the workload were Emergency Medicine and Acute /General Medicine services to be moved to that site. This is because of the quality and configuration of the estate, and the current difficulties with patient flow through the site (multifactorial). Chorley current acts as a decompressor and safety valve for the Preston site. This effect would be compounded if all services currently provided at Chorley were to stop running.

Options

After visiting the sites and conducting the review, we consider the Trust to have five options:

1) Reopen a 24/7 Emergency Department at Chorley supported by Medicine and Critical Care +/- other services
2) Continue with the current model of a 12/7 Emergency Department, specified correctly as a Type 1 facility, co-located with the Urgent Care Centre
3) Close the Emergency Department at Chorley, and establish a fully configured Urgent Treatment Centre in line with national guidance. Leave a medical assessment unit taking GP admissions and critical care support in some form on site
4) Close the Emergency Department at Chorley, moving all acute medical and critical care services to Preston. Leave a fully configured Urgent Treatment Centre at Chorley
5) Close all Emergency Department and Urgent Treatment facilities at Chorley and re-provide all emergency and urgent care at the Preston site

Option 1: Reopen a 24/7 Emergency Department at Chorley

Pros:

- Population growth in the Chorley area is likely to continue, increasing the need for provision of emergency services. In future there may be a need for improved emergency facilities.
- Likely support from the local population for services that are closer to home
- Decompresses the Preston site, which is under pressure from demand into both its Emergency Department and Medical / Critical Care bed base and which suffers from poor patient flow

Cons:

- Current staffing will not allow this and national / local context looks unlikely to change. A limited Emergency Department service with on-site admissions only to medical specialties would not be recognised for training and would be reliant on career grade medical staff. If some way were found to staff a 24/7 ED, our view is that it would rapidly prove unsustainable and would fail
- On-site services such as medicine and radiology are not configured to support this
- Continued confusion over role of the ED vs the Urgent Care Treatment Centre
- Service does not meet some current and future requirements for a type 1 ED (e.g.) separate facilities for children, facilities for patients with mental health problems. The department would require a significant upgrade to provide appropriate facilities.
- The likely case mix would be low numbers of low acuity patients
- Inefficient use of available medical and nursing staff covering two sites
- Negative strategic impact in terms of the hot-cold split model being considered by the Trust
- Opportunities to achieve improved safety and quality of services by centralising staff to one site would be lost

Option 2: Current Model

Pros:

- Population growth in the Chorley area is likely to continue, increasing the need for provision of emergency services. In future there may be a need for improved emergency facilities.
- Likely support from the local population
- Decompresses the Preston site, which is under pressure from demand into both its Emergency Department and Medical / Critical Care bed base and which suffers from poor patient flow

Cons:

- Unsustainable in its current form and already highly vulnerable to staffing shortages. This is the case both in the ED and for the medical assessment facilities
- Continued confusion for patients and staff over the role of the ED vs the Urgent Care Treatment Centre
- Service does not meet some current and future requirements for a type 1 ED (e.g.) separate facilities for children, facilities for patients with mental health problems. The department would require a significant upgrade to provide appropriate facilities.
- The likely case mix would be low numbers of low acuity patients
- Inefficient use of available medical and nursing staff covering two sites
- Negative strategic impact in terms of the hot-cold split model being considered by the OHOC (Our Health Our Care) programme
- Opportunities to achieve improved safety and quality of services by centralising staff to one site would be lost

Option 3: The ED ceases to function as such. Establish a fully configured Urgent Treatment Centre in line with national guidance, but leave a medical assessment unit taking GP admissions and the critical care support on site

Pros:

- Improved clarity over role of acute facilities on site, although some confusion will remain around acute medical presentations
- Decompresses the Preston site with regard to acute and ambulatory medicine, and critical care
- Some "local" options remain for patients with lower acuity medical presentations
- Equality of access to specialist advice / treatment for patients presenting to the remaining ED
- Consolidation of Emergency Medicine workforce improves resilience of staffing and efficient use of available staff

Cons:

- Concerns over future-proofing in the face of population growth
- Likely unpopular with the local population
- Longer travel times for some patients, with uncertain impact on a small proportion with high acuity problems. However for ambulance patients, diversion strategies are already in place so this effect is partly mitigated and the existing ED now receives few ambulances. Effect on local ambulance service will need to be understood.
- Overload of the Emergency Department at Preston, with downstream effects on other services (medicine in particular)
- Possible negative impact on other EDs in the region, especially Wigan
- Medical Assessment services at Chorley would remain vulnerable to staffing issues, and likely pressure to consolidate supporting services such as acute radiology at the Preston site.

Option 4: Establish a fully configured Urgent Treatment Centre, and move all acute medical and critical care services to Preston

Pros:

- Definitive clarity over the role of acute facilities on site
- Consolidation of acute services at Preston site improves resilience around staffing and efficient use of available staff
- Facilitates strategic goals of OHOC (Our Health Our Care) programme around the hot-cold split

Cons:

- Concerns over future-proofing in the face of population growth
- Likely unpopular with the local population
- Longer travel times for some patients, with uncertain impact on a small proportion with high acuity problems. However for ambulance patients diversion strategies are already in place so this effect is partly mitigated and the existing ED now receives few ambulances. Effect on local ambulance service will need to be understood.
- Possible negative impact on other EDs in the region, especially Wigan
- Overload of the Emergency Department, MAU, ambulatory facilities, and bed base at Preston, with downstream effects on other services

Option 5: Close all Emergency Department and Urgent Treatment facilities at Chorley

Pros:

- Definitive solution
- Consolidation of acute services at Preston site improves resilience around staffing and efficient use of available staff
- Facilitates strategic goals of OHOC (Our Health Our Care) programme around the hot-cold split
-

Cons:

- Concerns over future-proofing in the face of population growth
- Likely politically unacceptable
- Unlikely to gain support in local population
- Longer travel times for many patients, with uncertain impact on a small proportion with high acuity problems. However for ambulance patients, diversion strategies are already in place so this effect is partly mitigated and the existing ED now receives few ambulances. Effect on local ambulance service will need to be understood.
- Possible negative impact on other EDs in the region, especially Wigan
- Leaves current non-elective bed base at Chorley isolated
- Overload of the Emergency Department, MAU, ambulatory facilities, and bed base at Preston, with downstream effects on other services. It is hard to see how the Preston site could cope with the likely increase in numbers in both emergency and urgent patients.

We cannot make a firm recommendation on your choice. Models mixing type 1 EDs and urgent care centres exist elsewhere, as do models whereby Urgent Treatment Centres have been established at the site of former EDs. Such models require partnership between providers/commissioners as well as clear (clinical) governance structures. This developing relationship was evident on our visit. The publication of the Long Term Plan has taken the emergency and urgent care themes of the Five Year Forward View and moved them on. There is the opportunity within the Central Lancashire system to adopt the Urgent Treatment Centre model to tie together the primary and acute models of care.

Our view is that options 3,4 and 5 would not be possible without various degrees of redevelopment / reconfiguration of the Emergency Department, Ambulatory Care and MAU facilities at Preston, and without significant improvements in patient flow through the Preston site.

We note that the emerging ideas of the CCG assume, in effect, a big step forward in prevention and primary care. What we were told by various people on our visit suggested that there is a reality gap between the current and predicted capability

of primary healthcare services in the area, and the vision for what it can achieve. This is exacerbated by the lack of integration between hospital and community services in parts of the patch. Combined with evidence about the efficacy of such initiatives, we believe that any plans relying on demand management to mitigate the effects of concentration of acute services on a single site are likely to represent wishful thinking. Brief discussions with local commissioners confirmed their own concerns given current and foreseen problems in the local primary care system

It is possible that the local population is more aware of frailties in primary care than in secondary care. This would expose the Trust to credibility issues if plans for reconfiguration of acute services are based on aspirations about capability in primary care.

This places the Trust in an extremely difficult situation. It is caught between two options which we would regard as unsustainable, and three options which require investment and reconfiguration. These options exist within a system with one site that is currently extremely challenged with regard to patient flow, and where the capability of community-based services to successfully mitigate effects is in doubt. At the same time the Trust is considering strategic options that are politically sensitive and which are potentially unpopular with the local population in the context of their desire to maintain full services at hospitals close to where they live.

Learning from the previous closure

It should be remembered that there has been a natural trial of closure of the ED at Chorley, during the previous crisis. We were told that the learning from this period included:

- There was improved medical staffing at Preston, particularly in the middle grade tier
- Nursing development was improved and nurses were able to make a clear choice between working in an ED or in the urgent care centre environment
- Patients are reported to have "voted with their feet" and at least some chose to go to Chorley for non-emergency problems. The urgent care centre at Chorley was thought to work effectively during this period
- At the same time patient who perceived themselves as having urgent problems are also reported to have "voted with their feet" and presented to Preston ED when asked to attend Chorley as part of the effort to divert appropriate GP referrals to that site
- There were no recorded clinical incidents or incidents of patient harm, and there was reportedly limited impact on other EDs in the region
- Ambulance bypass rules were more formalised where previously they had been informal. These are reported to have continued despite the partial reopening of the Chorley ED

We were impressed by how bruised many senior hospital staff felt as a result of the public and political response to events. It has clearly coloured their approach to trying to find a solution, and their ability to hold a full and frank discussion with key stakeholders has to some extent been compromised by their sensitivity to some of the behaviours that they have witnessed. We were left with the impression that for the clinicians and managers the previous solution felt appropriate, but that they felt they were put under inappropriate pressure to revert to the current state despite their own professional judgements.

It is worth noting that many of the managerial and clinical staff we met during our visit disagreed with some of the factual content in the external report, and with its conclusions. They also feel that they are contending with expectations around the level of function at Chorley ED which have never been met (for instance paediatric capability) and that the arguments may lack balance.

Responses to the questions specifically raised in the TOR

1) **Current transformation plans**: We were asked to what extent we felt that the current transformation plans were robust and complete, taking sufficient account of best practice
    a. We were impressed with the amount of effort that had clearly gone into the plans that we saw
    b. The plans are to some extent unsurprising, and what we have come to expect from such documents: this is not a reflection on the authors but more of a reflection of the culture within the NHS where senior managers and clinicians are expected to produce relatively formulaic material, rather than articulating what they might actually think, or what might actually be achievable
    c. We felt that the plans offered a direction of travel, rather than being either robust or complete. There was no real indication as to how the plans could and would be delivered
    d. Potential roles for primary care, ambulatory emergency care, frailty and integration are all regarded as best practice and are included. Missing elements included the potential effects of any reconfiguration on the Preston site, and learning from the prior temporary closure of the ED at Chorley.
    e. There was no signed-off model for acute care
    f. We are sceptical about plans which rely on primary care clinicians or systems reducing demand on acute facilities, or increasing their capacity to offer complex care in the community.

2) **Sustainability and Quality:** We were asked whether the circumstances which led to the previous NHSI review of emergency care in central Lancashire, and the reopening of the ED at Chorley, are still valid. It is not possible for us to answer this question since we were not there at the time. However, we do feel that the current arrangements are unsustainable, whilst clinicians are clearly expressing concerns about safety.

3) **Emergency Department service adjacencies:** We were asked about service integration and clinical adjacencies in the emergency departments. As far as Chorley is concerned it is clear that services on site are the bare minimum, and that any further reduction will render the ED non-viable. Services at the Preston site are appropriate although we are told that the need to duplicate services across both sites results in curtailment of ambulatory care support at the Preston site, and is causing significant management problems in terms of staffing and supporting Emergency Medicine, Acute Medicine, and Critical Care.

4) **Focused:** We were asked for our opinion around prioritisation for transformation activity in the field of reducing unnecessary demand. We found this difficult to answer since it implied that the Trust is relying on demand management strategies which are vulnerable to failure, in the context of weak current model of care. Our recommendation would be to focus on improving discharge and integrated care at the back end of the pathway, along with admission avoidance and ambulatory care strategies, and improved care of patients with mental health problems and who frequently attend (may be an overlapping group). These may be more likely to yield results than demand management strategies, for which there is little evidence of efficacy.

5) **Future Proofed:** We were asked if the proposed model is future-proofed against future clinical standards. It is not possible to answer this question given the uncertainty surrounding future clinical indicators.

Appendix 1 - Documentation considered prior to the visit and any relevant material following the visit

ESSENTIAL

1. Organisation lead for this review
2. Signed terms of reference
3. Signed terms of business
4. Completed self-assessment questionnaire
5. Previous external reports
    - Item E CQC Evidence Report – October 2018

DESIRABLE

Domain 1: Workload

Suggested information	Submitted information
1. A one page summary from the Clinical Director of strengths, weaknesses, opportunities and challenges to the EM service at present	1.1 Summary of LTHTR Emergency Medicine services at present See also the Terms of Reference
2. Details of annual attendances and casemix breakdown	1.2 Attendances

Domain 2: Configuration of services

Suggested information	Submitted information
1. An overview of the local emergency care system (with a one page pictorial summary of flows). This should include service delivery models for adult and paediatric EM	2.1 Case for change – Central Lancashire acute sustainability , including the remainder of the OHOC Programme and the work of community-based transformation 2.1 Our Model of Care - Improving Hospital Services and Clinical Outcomes in Central Lancashire, including the remainder of the OHOC Programme and the work of community-based transformation

	2.1 Junior doctor staffing 2.1 Staff events – September 2018 2.1 – Welcome to the ED – careers are made here
2. Outline of your departmental patient flow policies	2.2 Medicine Division 12hr Bed Escalation 2.2 Opel levels and bed use 2.2 ED policy
3. Models of care delivery during the night, weekends and periods of extensive service demands ie. bank holidays	2.3 Overnight ED Coordination and Safety Process
4. Overview of departmental integration with Primary Care services and/or co-located services. This should include any streaming strategies for GP referrals for direct admission	
5. Documented evidence of integrated Minor Injuries streams including governance/training/service delivery	2.5 Report of the Independent review of Emergency Nurse Practitioner service Lancashire Teaching Hospitals NHS Foundation Trust
6. Summary of mental health and alcohol liaison services present with your ED	2.6 Enhancing our approach to Mental Health at Lancashire Teaching 2.6 Emergency Department referral pathway to Mental Health Liaison Team 2.6 Alcohol use disorder policy
7. Information detailing co-location of inter-disciplinary elderly care/frailty units – including. medicine for the elderly	2.7 LIFT pathway 2.7 Introducing the Lancashire Integrated Frailty Team 2.7 RCEM visit statement LIFT
8. Documented evidence of support from in-hospital specialty for ED and any co-located service activity	2.8 Emergency Department to Ambulatory Care Referral Guideline – Presentation with Suspected anaemia 2.8 Ambulatory Care Referral Pathway for Suspected Cardiac Chest Pain

	2.8 Ambulatory Care Referral Summary Guideline – First Seizure 2.8 Ambulatory Care Referral Pathway - Acute Headache 2.8 Ambulatory Care Referral – Low Risk Upper GI Bleed 2.8 Medical Ambulatory Care Triage Tool 2.8 Ambulatory Care Referral Summary Guideline – Syncope and Collapse
9. Summary of key services required to support a Type 1 ED: 1) Critical Care 2) Acute Medicine 3) Imaging 4) Laboratory Services 5) Paediatrics 6) Orthopaedics 7) General Surgery	2.9 Summary of LTHTR key services

Domain 3: Commissioning

Suggested information	**Submitted information**
1. Your Trust's strategic overview & objectives for Emergency Medicine (EM)	3.1 Our Big Plan, Strategy 2019 3.1 Our Values Pack 2018 3.1 Business plan for medicine 3.1 March big plan launch
2. Local commissioning strategy for EM (or equivalent)	

Domain 4: Observation Medicine and ambulatory emergency care

Suggested information	**Submitted information**
1. Processes for ambulatory emergency care AEC systems and if present observation units	4.1 Emergency Department to Ambulatory Care Referral Guideline Presentation with suspected Anaemia

	4.1 Ambulatory Care Referral Pathway for Suspected Cardiac Chest pain 4.1.ED Observation area criteria 4.1.Ambulatory Care Referral Summary Guideline– First Seizure 4.1 Acute Headache 4.1 Low risk upper GI bleed 4.1 Ambulatory Care Referral Summary Guide - Syncope and collapse 4.1.Medical Ambulatory triage tool

Domain 5: Medical Staffing in the ED

Suggested information	Submitted information
1. An overview of your senior consultant workforce. This should include 1) Consultant staffing figures 2) Consultant positions held ie lead responsibilities and teaching duties 3) A full Consultant rota 4) An overview of how programmed activities are determined and allocation of supporting professional activities 5) Trust policies for remuneration of consultant out of hours work	5.1.1 - 5.1.4 Consultant Workforce 5.1.5 Medical and Dental Extra Duty Payment Policy
2. A summary of your middle grade workforce. This should include 1) Middle Grade staffing figures 2) Middle Grade rotas	5.2 MG Staffing
3. A summary of your training grade workforce. This should include	5.3 Junior doctor staffing

	a. Training Grade staffing figures b. Example Training Grade rotas	
4.	GMC Training review for the EM service	5.4 Copy of ED GMC 2018 results and action plan
5.	Deanery Training review for the EM service	

Domain 6: Safety and governance

Suggested information	**Submitted information**
1. Outline of your departmental patient flow policies	6.1 ED SOP 6.1 Service Standards between the ED, Specialty Te…port Services 6.1 Surge and Capacity Plan ED 6.1 Transfer of Paed Patients from Chorley ED
2. Summary of patient pathways within your ED	6.3 Copy of Escalation trigger tool v5 6.3 Surge and Capacity Plan ED
3. Evidence of management tools utilised	6.4 CRM
4. Relevant Clinical Governance activity & summary	6.5 -6.8.Risk Register 6.5-6.8 Division of Medicine Risk report 6.5-6.8 Incident Risk presentation.ppt 6.5-6.8 Latest Divisional Safety and Quality Minutes 6.5-6.8 Latest ED Chairs report 6.5 Quality and safety report (children) - Oct 2018
5. Evidence of safety governance. This should include:	6.5 Audit meeting – Sept 2018 6.5 Quality and safety report – Feb 2019 6.5 ED newsletter – Nov 2018 6.5 Escalation trigger tool 6.5 Hospital handover LS3 story board template

	6.5 Medicine risk report (excluding critical care, paediatrics, & core therapies) 6.5 Quality and safety report – Jan 2019 6.5 STAR visit report – January 2019 6.5 STAR visit report – February 2019
6. Relevant Clinical Governance activity & summary 1) Relevant reporting on the ED from Risk Management 2) Clinical risk register for the ED 3) Incident reporting processes 4) Identified Safety Lead 5) Details of any projects to optimise safer care	
7. Relevant reporting on the ED from Risk Management	
8. Clinical risk register for the ED	

Domain 7: Nursing staff and skillmix

Suggested information	**Submitted information**
1. An overview of your nursing grade staff. This should include 1) Nursing staff figures including a breakdown of grades 2) Summary of varying nursing responsibilities within your ED	7.1 Nursing Workforce

	3) Example nursing rotas	
2.	Service delivery models for ENPs and ANPs. This should include o Relevant staffing figures for ENP & ANP workforce o Location of service ie ED or ambulatory care pathways	7.2 ED Nurse Practitioners 7.2 ENP training
3.	Service delivery models for Physician Associates. This should include o Relevant staffing figures for Physician Associates o Location of service ie ED or ambulatory care pathways	7.3 Physician Associates and Physiotherapists

Domain 8: Tariffs and informatics systems

Suggested information		**Submitted information**
1.	An overview of the information system used within your ED	8.1 Escalation trigger tool 8.1 Information systems used in ED
2.	A summary of your departmental coding systems	

Domain 9: Clinical quality indicators of care

Suggested information	**Submitted information**
1. Documentation of quality improvement programmes	9.1.QIP Plan 9.1 Continuous improvement annual report 2018/19 9.1 Urgent and emergency care improvement action plan 9.1 continuous improvement update – Nov 2018

2. Key Performance Indicators from the last 3 years. For example: 1) Quality Indicators 2) CQUINs or equivalent 3) Serious Incidents 4) Complaints 5) Staff turnover (EM Consultants, middle-grades & Nurse bands 5-7) 6) Annual sickness levels (EM Consultants, middle-grades & Nurse bands 5-7)	9.2.1 Quality Indicators 9.2.3. Copy of ED Level 2 and 3 incidents 2016-2019 9.2.4. Complaints 9.2.4. STAR Visit Report FINAL ED CYP CDH February 2019 9.2.4. Star Accreditation Final 3rd visit September 2018 9.2.4.STAR visit report - FINAL - ED RPH 4th Visit Jan…2019 FINAL

Domain 10: The patient experience

Suggested information	Submitted information
1. Guidance for local population on where best to access urgent and emergency care	11.1 RATS - Experienced Nurse Dec 18 11.1. RATS - HCA Role Dec 1 11.1. RATS - Poster RATS Dec 18 Team Roles & Responsibilities 11.1. RATS - Senior Decision Maker (SDM) Dec 18 11.1.RATS - Role of Admin Support Dec 18
2. Overview of departmental systems for collecting and reviewing patient and relative feedback	
3. Documented evidence of patient and relative experience	10.3. Copy of Unify Report 01_04_2018 to 08_03_2019 10.3.Copy of FFT_Comments_Report

Appendix 2 – Format of the Invited Service Review

Timetable for Invited Service Review 3-4 April 2019

3 April: Chorley Hospital

Time	Room	Meeting	Notes
11.45 – 13.00	Lecture Hall Education Centre 3 CDH	Meet & Greet Senior Clinicians, Executives, Senior Nursing staff	Lecture Hall booked for the whole day
13.00 – 13.45	Lecture Hall EC3 CDH	Working Lunch	
13.45 – 15.15	Walking tour of site		
15.15 – 15.30	Coffee Break		
15.30 – 16.00	Training Room ED	Discussion with Middle Grade Doctors	Split Panel
15.30 – 16.00	Nurses office	Discussion with Nursing Staff	Split Panel
16.00 – 16.30	Training Room ED	Discussion with Local Clinicians	Full Panel
16.30 – 17.00	Training Room ED	Discussion with Service Managers	Full Panel

4 April: Royal Preston Hospital

Time	Room	Meeting	Notes
09.00 – 10.00	Seminar Room 2 Education Centre 1	Meet & Greet Senior Clinicians / Execs / Senior Nursing staff	Room available until 11.00am
10.00 – 10.15	Walk from EC1 to front of hospital		
10.15 – 11.45	Tour of RPH site ED/Urgent Care/Critical Care/Ambulatory Care etc		
11.45 – 12.00	Walk from hospital back EC1		
12.00 – 13.15	Lecture Room 3 Education Centre 1	Discussion with LTH Execs & Senior Clinicians	Room available until 2.00pm

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The Royal College of Emergency Medicine

Royal College of Emergency Medicine Invited Service Review visit to Lancashire Teaching Hospitals NHS Foundation Trust

Annex 1

Visit Date: 3-4 April 2019

Authors:

1. Dr Ian Higginson
2. Dr Steve Jones
3. Martin Rolph
4. Dr Graham Johnson
5. Sam McIntyre

Report issued: 24 June 2019

Annex 1 - Executive members and staff that RCEM met on the visit

Please note that this is an annex to the main report listing the staff that RCEM met during the site visits.

Wednesday 3rd April 2019

Executive Meet & Greet

Surname	Name	Title
Bishop	Kelly	Head of Nursing - OHOC/TU
Dickinson	Lindsey	GP Director - Chorley & South Ribble CCG
Goode	Sue	Senior Sister - ED
Earley	Tracy	ADMD Surgery - OHOC Clinical Lead Surgery
Havey	Paul	Finance Director LTHTR – Executive Team
Pawluk	Jason	Our Health Our Care Programme Director - OHOC/TU
Sime	Lynn	Matron - ED
Skailes	Gerry	Medical Director LTHTR
Stewart	Michael	ED Consultant - OHOC Clinical Lead ED
Kirkham	Anne	Our Health Our Care Clinical Leand WHIN's Platform - OHOC/CCG
Kumar	Somnath	Consultant - OHOC Clinical Lead Specialist Medicine
Lawrenson	Tina	Clinical Business Manager Acute Medicine
Twamley	Huw	Consultant Critical Care - OHOC Clinical Lead Critical Care

Chorley & South Ribble & Great Preston CCGs

Surname	Name	Title
Bangi	Gora	Chair Chorley & South Ribble CCG
Curtis	Helen	Director of Quality & Performance CCGs
Gizzi	Denis	Chief Officer CCGs
Mellor	Jayne	Director of Transformation & Delivery CCGs
Mukerji	Sumantra	Chair Greater Preston CCG

Nursing Staff

Surname	Name	Title
Sime	Lynn	Matron ED
Good	Sue	Senior Sister ED
Clayton	Sarah	Matron Ambulatory Care
McAllen	Yvonne	Staff nurse ED
Wallace	Debbie	ENP

Local Clinicians

Surname	Name	Title
Drake	Ian	Consultant Gastroenterologist
Davis	Kate	Consultant ED
Howell	Simon	Consultant Diabetes & Endocrine
Kumar	Somnath	Consultant Cardiologist
Watson	Michael	Senior Clinical Fellow Ambulatory Care
Olatoya	Ayo	Consultant MAU
Cottle	Daniel	Consultant (CD) Critical Care
Nipah	Robert	Consultant Acute Medicine

Senior Managers

Surname	Name	Title
Lawrenson	Tina	Clinical Business Manager
Shakespeare	David	Divisional Medical Director
Sansbury	Rachel	Divisional Nursing Director Medicine

Thursday 4th April 2019

Executive Meet & Greet

Surname	Name	Title
Stewart	Michael	ED Consultant - OHOC Clinical Lead ED
Bishop	Kelly	Head of Nursing - OHOC/TU
Pawluk	Jason	Our Health Our Care Programme Director - OHOC/TU
Gregory	Scott	
Skailes	Gerry	Medical Director LTHTR
Whittaker	Jon	ED Consultant
Sykes	Alison	ED Consultant
Tabone	Dianne	ED Consultant
Earley	Tracy	ADMD Surgery - OHOC Clinical Lead Surgery
Purgh	Mark	Consultant Critical Care, Co-Dependency lead for OHOC
Sime	Lynn	Matron – ED
Ellis	Graham	ED Consultant and Clinical Director
Lawrenson	Tina	Clinical Business Manager
Curran	Andy	ED Consultant
Chadwick	Lynn	Our Health Our Care Programme
Roberts	Moira	Head of continuous improvement
Button	Faith	Chief Operating Officer
Naylor	Gail	Executive Director Nursing & Midwifery
Partington	Karen	Chief Executive

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Healthier Lancashire & South Cumbria

Lancashire and South Cumbria Care Professionals Board invited review of the Our Health Our Care model of care and proposed options for delivery

Review date: 19th July 2019

Report issued: 7th August 2019

Contents

Executive Summary

On 19th July 2019 the Lancashire and South Cumbria Integrated Care System Care Professionals Board (CPB) conducted an invited informal review of the Our Health Our Care (OHOC) programme. In particular, the Care Professionals Board were provided with details of the Case for Change and Model of Care for the programme, along with details of the long list of options developed as a result. This included the initial recommendation from the programme's Clinical Oversight Group (COG) as to which of the options it believed were compatible with the Model of Care developed.

The CPB understood that the information that it received relating to the programme options was in a developmental and formative state. Further modelling and assurance information would be developed in the period before and following the visit of the North West Clinical Senate on 16th and 17th September. This further modelling and assurance information would support the programme with the development of its revised Pre-Consultation Business Case.

Summary Findings:

A. The review panel feels that the programme has developed and explained the options relating to acute sustainability programme of Our Health Our Care to a good standard. There is no relevant contra-indication to inviting the North West Clinical Senate to provide an independent clinical appraisal of the options developed, as scheduled in September.

B. The review panel considers that all possible options, relevant to the redesign and improvement of the acute system, working in conjunction with its partners, have been explored in the long list. The approach of using the clinical standards and co-dependency frameworks as an initial route to assessing viability or otherwise of the options is reasonable.

C. The level of clinical engagement with partners in the primary, community and acute systems towards the development and co-production of the options has been relevant and effective. The programme has also identified within its Model of Care how public engagement outcomes have influenced the development of the options.

D. The options identified within the longlist of options are in line with the 4 below tests as determined by the "*Planning, assuring and delivering service change for patients guidance"* (NHS England, 2018).

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support for proposals from clinical commissioners.

In terms of the 5th test, this is relevant to proposals that include the closure of beds. No option presented proposes any reduction in beds and therefore this test is not relevant in this case.

Clinicians tell a passionate and well thought out narrative that supports the proposals and provide further assurance as to them being both deliverable and the right thing to do. A focus on 5 key areas of learning and deploying best practice (including technology), partnership working, keeping momentum and stakeholder engagement, managing areas of potential risk and interdependency management will further enhance the proposals in readiness for decision making.

Overall, the CPB review team support the direction of travel as presented and the submission of more detailed proposals for formal review by the Clinical Senate.

Review Team

Jackie Hanson - Director of Nursing & Care Professionals NHSE/LSC, ICS Review Team Chair

Dr Mark O'Donnell - Medical Director Blackpool Teaching Hospitals NHS FT

Dr Gareth Wallis - Deputy Medical Director NHSE/I

Caroline Baines - Clinical Senate Manager (NW)

Kath Gulson - CEO Local Pharmaceutical Committee

Lynne Wyre - Director of Nursing University Hospitals of Morecambe Bay NHS FT

Dr Amanda Thornton - Digital Health Clinical Lead HLSC ICS

Dr Paul Dean - Consultant Anaesthesia & Critical Care Medicine Royal Blackburn Teaching Hospital

Dr David Ratcliffe - Urgent Care Clinical Lead for Greater Manchester Health and Social Care Partnership and Clinical Advisor (NWAS), GP with Special interests (ED)

Elaine Johnstone - Service Director CSU

Shirley Goodhew - Acting Consultant in Public Health Blackburn with Darwen Council

Dr Shirley Jackson - GP NHS East Lancashire CCG

Terms of Reference

Visit objectives

To conduct an informal review of the Our Health of Care Model of Care and proposed options, including providing opinion if all options resulting from the approved Model of Care have been considered in response to the Case for Change. The review team were specifically asked to consider the below 8 key lines of enquiry as is described within the West Midlands Clinical Senate Stage 2 Clinical Assurance Evidence Framework (2017).

1. Do these proposals deliver real benefits to patients?
    a. Do the proposals reflect the goals of the OHOC benefits framework?
    b. To what extent do local clinicians believe the proposals will deliver real benefits for service users and carers in the affected populations?

2. Is there evidence that the proposals will improve the quality, safety and sustainability of care?
    a. Is there clinical and other evidence which support the proposals?
    b. Where new technology is key to the delivery of proposals, is there evidence of its existence, functionality and effectiveness?
    c. Do the proposals demonstrate compliance with national guidance on workforce requirements including setting out their sustainability in terms of clinical workforce?

3. Do proposals reflect up to date clinical guidelines and national and international best practice?

4. Do the proposals reflect the goals of the NHS Outcomes Framework?
    a. Preventing people from dying prematurely
    b. Enhancing quality of life for people with long-term conditions
    c. Helping people to recover from episodes of ill health or following injury
    d. Ensuring that people have a positive experience of care
    e. Treating and caring for people in a safe environment and protecting them from avoidable harm

5. Do the proposals reflect the rights and pledges in the NHS constitution?
    a. rights about access to health services
    b. rights about quality of care and environment
    c. rights about patient choice
    d. rights about your own involvement in your healthcare

6. Is there a clinical risk analysis of the proposals and is there a plan to mitigate identified risks?
    a. The safety, effectiveness or experience of patient care
    b. The deliverability of the proposals - potential adverse impacts on related/co-dependent services (including destabilisation of services)
    c. Proposed physical solutions

d. The accuracy of activity, capacity, workforce projections and workforce risks
e. Formal modelling of any impact on Emergency Preparedness, Resilience and Response (EPRR) plans with mitigation where required.

7. Do the proposals demonstrate good alignment with the development of other health and care services?
    a. Do the options demonstrate how any changes to the configuration and delivery of services in the acute sector will be compatible and enabling of equivalent changes in primary care, partner organisations and community services (therefore demonstrating a whole system approach) and the wider ICS.

8. Do the proposals support better integration of services?

Background to the review

On 13 December 2018 the OHOC Joint Committee approved the programme's Case for Change. The Case for Change described the 5 key challenges that the OHOC programme should seek to act upon in its proposals for reform of the acute system, working with partners across the broader health economy, as part of a whole-system approach to transformation.

- **Workforce -** across our health and care system, including our local hospitals, we do not have the workforce that we need in critical areas.
- **Flow -** too many people wait too long for their care and too many people experience delays when they are in hospital.
- **Lack of Alternatives -** our patients do not have enough options for their care. This can result in increased use of urgent and emergency care services provided by our local hospitals.
- **Demographics -** the number of people in Central Lancashire is a growing and the population is ageing. Our local hospitals are not set up in the best way for the future to deal with these changing needs
- **Use of Resources -** as a health system, we are not making best use of the resources we have.

Following approval of the subsequent model of care on 13 March 2019 the programme was provided with the mandate to progress to the next stage of the programme, that is, to develop the options.

The formal stage 2 clinical senate review is scheduled for 16 and 17 September 2019 whereby a formal clinical review of the Pre-Consultation Business Case (PCBC) will take place. Discussions with the senate and programme team have advised that an informal review, comprising a subset of the whole senate remit, would support the OHOC Joint Committee in making its decision to submit the PCBC to the senate.

The CPB have been requested to undertake the informal review.

This report will advise if the options are responsive to the 5 above key challenges identified within the Case for Change, and if the options developed are open minded and take proper account of the agreed Model of Care, Clinical Standards and Co-Dependency Framework.

Documentation considered prior to the review visit

The review team received the below documents prior to their visit on 19th July 2019

1. Approved Case for Change
2. Approved Model of Care
3. OHOC Benefits framework draft version 0.5

4. Clinical viability of the options draft version 2
5. Financial evaluation of options 4 and 5 draft version 2
6. Approved review terms of reference

Summary Feedback from the Discussion Sessions

Do these proposals deliver real benefits to patients?

The review team found that the proposals reflected the benefits as expressed within the benefits framework. They aim to provide care closer to home while supporting consolidation of more specialist services, where this is required to achieve and maintain compliance with core national standards.

The clinicians interviewed all demonstrated a clear passion and support for change, involving working together with partners in primary, community and social care, for the common benefit of delivering transformed care outcomes for patients. They communicated clear frustrations relating to the time involved in the assurance process and the challenges of maintaining safe and effective clinical service delivery whilst proposals for the future are developed. Further, how the concepts of urgency and momentum was considered in the approach being taken to assurance and option refinement, so that benefits to patients could be accelerated and that adverse consequences for patients arising from delay, could be avoided. Clinicians described their frustrations with the lack of access to capital monies to improve care for patients, but described that the proposals must be developed now, and without further delay.

They acknowledged that to maximise significant benefits for the patients the transformation proposals developed within the Out of Hospital platform and existing Lancashire Teaching Hospital (LTH) improvement initiatives will also need to be realised. This would be part of a transformed vision about the role of the acute hospitals in delivering care to local communities. This would need to focus on preventing, as well as treating ill health, and delivering more care outside of the hospital system, in part facilitated by changing the relationship between hospital specialists and their primary and social care partners.

The clinicians involved in the review also cited some examples as to what they felt were positive components of working together across organisational boundaries.

<u>Examples of good work included:</u>

- Good evidence was presented with regards to the present Central Allocation Team for Community and Social Services (CATCH) and the ambulatory care service provided at Chorley Hospital, with evidence of uptake and good auditing of impact and outcomes. This great work should be developed further supporting greater integration of the services to realise an efficient single point of access / care streaming service.

- The home first scheme has successfully reduced admissions into community beds achieving a 2 hour response time form the CATCH team initial nursing / therapist review. Good relationships with LTH has developed. The service has a less than 5% return rate and 93% remain at home on day 5: this demonstrates the great benefits to patients already happening and should be celebrated.

- There are some early plans to rotate staff between NWAS and the hospital to support Pre-hospital/in-hospital integration. The proposals described some great opportunities for shared workforce roles and integration between the partners in the programme.

We agree that these do represent examples of positive working across organisational boundaries.

We feel that although many positive benefits can be realised through implementation of the out of hospital transformation schemes, and that these must form part of the way forward, they will not in themselves be sufficient to overcome the challenges within the hospital and as described within the Case for Change. Therefore, acute services need to be reconfigured and restructured in order for optimal changes in the full pathway to be achieved. This will need to occur in parallel to the out of hospital workstreams of the programme, with the requisite funding and workforce "following the patient."

The clinical teams clearly expressed to us that, of the options developed on the longlist, those described under number four are likely to deliver the greatest benefits for patients and there is an open-mindedness to consider variants including 4a, 4c, and 4d in particular. They would act as an enabler to quality and innovation.

We heard some evidence that movement on clinical workforce supply, training and development; working practices and structures; and innovations in practice would all be needed to make these a reality for patients. Those options developed under number five (5a, 5c and 5d) in particular would represent a "fall back" position, should these be not realisable, but the loss of access to ambulatory care could be perceived as a "step backwards."

The clinical teams we spoke to were not satisfied that options described under number three would present part of a viable, long-term sustainable to health care services in Central Lancashire, because the prevailing issues of delivery against core clinical standards, delivering economies of scale, and workforce accessibility could not be addressed. From their perspective, this would need to take precedence over alternative considerations such as current/forecast population size and planned demographic change, and some concerns held by the public relating to access times for healthcare. Overall, the clinical teams felt that beyond urgent and emergency care focusses, the broader proposals for outpatient, elective, and out of hospital care would significantly move more care closer to home, thereby improving population access.

Although not discussed in detail with the review team itself the clinical team have advised the programme team that there is no significant evidence that the population catchment for the combined populations of Chorley, Greater Preston and South Ribble would require local

access to either two or more Type 1 Accident and Emergency departments in the future, as described under option three. The clinical teams reported concerns that the existing service model was non-compliant with core standards for service availability and access. The present model for informally differentiating take for emergency care flows was not sustainable to reducing risk in the long-term.

During the course of the visit we did not acquire specific evidence relating to the effect of the service model developed from 2017 onwards. Therefore, we were unable to identify if this model had acted as a direct enabler to improvements in acute flow, patient experience, or the ability of the trust to attract, retain and develop clinical workforce teams in core areas. However, the public performance data still indicates challenges alongside reciprocal impacts linked to elective and non-elective pathway performance data. We formed an overall impression that delivering service models according to the current approach remained highly challenging and was not considered to be compatible with delivering improved flow, patient experience and operational performance.

Is there evidence that the proposals will improve the quality, safety and sustainability of care?

The relevant standards are clearly presented within the model of care, the delivery of which will be contingent on more detailed plans being developed around the shortlisted options to explain how these standards are going to be achieved. This will need to be developed before the final decision-making stage. Proposals would need to include areas such as workforce; recruitment, training and maintaining clinical staffing skills; digital enablers; enabling contractual reform; research and innovation; and partnership working approaches with primary and community sector partners.

In terms of the current proposals, good evidence was presented with regards to the present CATCH and the ambulatory care service provided at Chorley Hospital, with evidence of uptake and good auditing of impact and outcomes. This great work should be developed further supporting greater integration of the services to realise an efficient single point of access / care streaming service.

The programme has indicated that the existing commissioning arrangements for services are likely to continue within the framework of the current proposals which have been developed. These will change, over time, with the development of primary care networks, linked to broader national reform. At the decision-making stage, the programme will need to consider this in terms of the overarching governance structure. This will be important to ensure that there is an effective governance structure available to oversee improvements in safety, quality and sustainability arising from the proposals developed.

The clinical teams described concerns about their ability to deliver ambulatory care services on two sites with failed recruitment of acute physicians. The present GP referred ambulatory care service is only available at Chorley Hospital and feedback appears positive of this service across both CCG areas. The CPB suggests that consideration should be considered to a staged approach, whereby a full service is developed at the Chorley site for the wider

population in the more immediate term, and that this is replicated across both sites as medical recruitment allows. This will also depend on how far the agreement on the options to proceed with acts as an enabler to attract, develop and retain the necessary clinical workforce infrastructure.

The review team considered that although the use of technology, such as, remote monitoring and virtual approaches to delivering outpatient care has been considered this could be further explored within the proposals. In particular to improve communication structures between primary, community and secondary care, use of shared care records, and the use of new treatment technologies, such as robotics, should be identified for use where possible. There will be an opportunity to extend this thinking with the proposals developed, and also an opportunity to create partnership working opportunities with the research and academic community to ensure that patients continue to get expedited access to the benefits of best practice, where available.

The proposals described some opportunities for shared workforce roles and integration between the partners in the programme. For instance, there are some early plans to rotate staff between NWAS and the hospital to support Pre-hospital/in-hospital integration. There is an opportunity for the local primary care networks to express how shared working roles and interfaces between the secondary care and primary care sectors could act as an enabler to challenging the issues of GP recruitment and the development of portfolio-based careers.

Do proposals reflect up to date clinical guidelines and national and international best practice?

The review team found the clinical standard references to be up to date and relevant to the proposals presented. The programme team will need to ensure that as the proposals develop, that any extraneous and relevant changes to clinical standards framework, for instance arising from Royal College guidance are included in the proposals developed for implementation.

The proposals are formed on the basis of implementing care pathways. The clinical teams we spoke to recognised that in some instances, senior clinicians will continue to need be exercise their judgement for patients where their clinical presentation, history, and proposed management plan does not align with standard care pathways. This includes examples where actual diagnoses conflict with initial presentation and referral reason. We endorse the work that the clinical teams are doing to be flexible in their approach to the management of such patients.

The clinical teams provided examples of planned or actual deployment of clinical best practice within their services. Examples provided included enhanced recovery after surgery (ERAS+), the Post-Operative Care Unit at York, and the deployment of a respiratory assessment service. Where best practice is planned to be deployed, the clinical teams will benefit from visiting these areas both to acquire learning and also be able to express succinctly the clinical benefits arising from the implementation of such innovations in practice.

Within areas such as Critical Care and Surgery there are plans to develop new roles that are quite advanced. The clinical teams will need to continue their work in capturing and triangulating the potential use of technology in delivering a planned care service/site alongside new and innovative workforce roles.

Do the proposals reflect the goals of the NHS Outcomes Framework and the rights and pledges within the NHS constitution?

The review team were pleased to see that the proposals were clearly clinically led and had been developed arising from a good level of clinical engagement involving relevant partners. The voice of the patient had also been considered and there were good plans to continue engagement on this front, to ensure that the spirit and pledges in the NHS Constitution were met.

The proposals stem from a desire to deliver the best care possible within the available resources and the use of evidence to develop the proposals supports improved outcomes.

The proposals are aligned well to the goals of the NHS outcomes framework, although the review team further understood that the programme team had not used this approach specifically to present their ideas. This is acceptable, but as the proposals develop, the proposals for acute reform will need to complement the plans being developed across the health economy, including the integrated care partnership (ICP) and the clinical commissioning groups. This will help ensure how the proposals for acute reform will contribute to the overall health economy plan to respond to the NHS Long-Term Plan.

As the health economy moves towards a coordinated and integrated plan for delivering the outcomes and policy direction specified in the NHS Long-Term Plan, in practical terms, this will mean that the clinical teams will need to re-evaluate the traditional interfaces between out of hospital services and the acute trust. The clinical teams should consider how the governance framework for trusted triage and workforce and deeper service integration between out of hospital services and the acute trust can be further developed.

We were provided with examples of using clinical risk tools, referral thresholds, a single point of access approach to promote clinician to clinician dialogues, and the effective use of the principles of patient choice in decisions of how and where to refer services across the out of hospital and acute trust service boundaries. It will be important to continue this work and ensure that the health economy considers the governance framework as part of the implementation of its proposals.

Detailed bed modelling will need to demonstrate that the required capacity is available with each of the options so that patients can access the services with the higher standards that consolidation can bring. The proposal of protected capacity for surgical patients will indeed support timely access the planned care, however the team must be clear on the parameters where surgery becomes better placed on a site with a more specialist range of services. There is evidence that this is already happening, but clearer service specifications and transfer policies will be required as the options mature to the point of implementation.

In terms of the clinical service specification, the proposals would benefit from describing more clearly the management plan for paediatric patients and patients with acute mental health issues. The clinical team identified with us that the management plan for acutely unwell paediatric patients on the Chorley site was based on a stabilise and transfer model and that this risk should not be tolerated in the long-term with the proposals developed. Similarly, the existing infrastructure for supporting patients with acute mental health issues was better on the Preston site than it was on the Chorley site. On the latter point, the review team were pleased to see that Lancashire Care Foundation Trust (LCFT) were involved in the clinical development of the proposals. However, more consideration is needed on these points as the process of developing the options in more detail matures.

Is there a clinical risk analysis of the proposals and is there a plan to mitigate identified risks?

There is no clinical risk analysis at this stage, which will need to be developed as proposals mature alongside plans for Emergency Preparedness, Resilience and Response (EPRR).

We were impressed by a clear open culture of staff to learn from their service outcomes and being able to use raw data to drive service provision. For example, if a patient referral is refused, the team look into it in more detail to understand why.

We have identified the below seven key risks that work should begin to mitigate within the developing options.

1. Patients will not have clarity on which site to access urgent care or emergency care. This will need to be clearly understood and communicated to avoid presentation at the wrong service. We understand that this is also a risk associated with the current service model at Chorley, as the service does not meet the requirement of a Type 1 Accident and Emergency Department. This is particularly problematic with “walk in” patients who do not use one of the existing streams to manage inappropriate activity.

2. How do you make sure that everyone uses the Single Point of Access? A specific communication and mitigations plan will be needed, as this is a very difficult problem to solve.

3. Part of these interdependencies rely on the primary care networks, which are new and are different levels of maturity at this stage. There will be a requirement for the primary care networks to consistently prioritise the development of a clear implementation, governance and monitoring plan, based on the activities proposed to be transferred out of the acute system. This will need to be developed alongside their respective neighbourhood care strategies and the system-wide focus on prevention but should not be a reason to delay or defer making the necessary changes to the acute system. Workforce and financial support to accommodate this activity shift will need to be developed, but again in tandem with the need to respond to changes required now to the acute system

4. The options correctly present the alternative approaches to managing acute flows and coordinating the configuration of the urgent and emergency care system, and its

associated co-dependencies. The options describing an enhanced urgent treatment centre are potentially innovative.

Clearly, the overall proposals will develop and describe how the changes that arise from such a model match up with the reforms that the rest of the system will be able to achieve to maximise the chances of success. This will link to what role and types of activity the acute system will be required to manage in the future. It will also link to the improved streaming of patients to other partners, such as LCFT. It will also link to what support primary and community care providers can offer to the implementation of the concepts in the document – for instance in-reach medical workforce between primary and urgent care services.

5. The risk profile for the acute proposals and the delivery timelines should consider the possibility that co-dependent services are not matured to the point where they are able to take on the role fully of managing activities displaced from the acute system.

6. The clinical team advises that the programme team should consider the interface with partner organisations such as LCFT, model some of the impact on the urgent and emergency care system outside of the Central Lancashire ICP to understand this risk.

7. Staged approach to ambulatory care service development as described earlier in this report.

Do the proposals demonstrate good alignment with the development of other health and care services and support better integration of services?

During our visit we met with staff from both the acute sustainability and WHiNs platform as well as NWAS. This demonstrated they are working together with particularly good work progressing between the CATCH and Single Point of Access (SPOA) teams.

The review team considered that your proposals would benefit from describing more clearly the benefits realised from the existing whole pathway reforms which have been implemented across the out of hospital areas, and how this work can be accelerated linked to your longer-term strategic plans. This will improve the confidence around using this approach to redesign care on other pathways.

We feel that a focus on plans for Step Up and Step down processes should be a focus for the team as these are the key aspects that directly impact on admission avoidance and timely discharge from hospital care. Plans for staff rotation are really good and will support integration and understanding of services at the delivery level.

Conclusion

The review team feels that all options have been explored and support that the options identified within the shortlist are in line with the 4 below tests as determined by NHSE (2018) Planning, assuring and delivering service change for patients guidance, in particular tests 2 and 3 falling within the scope of this review.

1. Strong public and patient engagement

2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support for proposals from clinical commissioners.

Examples of good work was described such as the innovative plans to use their workforce differently as well as use technology to support the Critical Care service. There is some great work also already happening within the continually developing CATCH and SPOA Services and the use of raw data to drive service provision. More detail around existing transformation within the proposals would support any future conversation with the public and their confidence in them.

We have heard that the patients like ambulatory care if they know they are getting a good service and that they are willing to travel to it. Clinically the enhanced urgent treatment centre option is the preferred choice of the clinicians we spoke to yet there are concerns about how you can staff ambulatory services on 2 sites if you don't have the workforce to do this now.

The way that ambulatory care unit works is different at two sites currently. Preston is more of an acute assessment unit rather than ambulatory care unit and the team must think about the feasibility of providing a full service on 2 sites with their current workforce challenges. A staged approach may be more beneficial ensuring a full service is available to the population that really works as the priority step. This would need careful consideration as is a balance between local delivery, especially for elderly medical patients and its interaction with community urgent care versus deliverability of a service that is clearly the right thing to do.

Clinicians tell a passionate and well thought out narrative that if captured better supports the proposals and will provide further assurance as to them being both deliverable and the right thing to do. They communicate clear frustrations relating to the time involved in the assurance process and the challenges of maintaining safe and effective clinical service delivery whilst proposals for the future are developed.

We feel that proposals could be further enhanced by telling the story that reflects the rich discussions we had during this review with a focus on 5 key areas of learning and deploying best practice (including technology), partnership working, keeping momentum and stakeholder engagement, managing areas of potential risk and interdependency management will further enhance the proposals in readiness for decision making.

The Care Professionals Board review team support the direction of travel as presented and the submission of more details proposals for a formal review by the Clinical Senate.

Appendix 1 - Format of the Invited Review Visit

Time	Room	Item	Review Team /other
10.00 – 10.45	Lecture Room 3 EC1	Pre-meet CPB review team	All review team
10.00 – 10.45	Lecture Room 1 EC1	Pre-Meet LTH clinicians and wider OHOC team	
10.45 – 11.30	Lecture Room 3	Specialty discussion – Single Point of Access, Catch and the Front Door	Gareth Wallis – Group Chair Shirley Goodhew Sheila Jackson David Ratcliffe
10.45 – 11.30	Seminar Room 9	Specialty discussion – Medicine and the WHiNs platform	Mark O'Donnell – Group Chair Amanda Thornton Caroline Baines Kath Gulson
10.45 – 11.30	Seminar Room 2	Specialty discussion – Surgery and Critical Care	Lynn Wyre – Group Chair Paul Dean Jackie Hanson Elaine Johnstone
11.30 – 12.00	Lecture Room 3	Panel review of the morning and collate initial feedback	All review team
12.00 – 12.30	Seminar Room 9	Executive discussion	Review team group chairs Jackie Hanson Lynn Wyre Gareth Wallis Mark O'Donnell
12.30 – 13.00	Lecture Room 3 EC1	Informal Feedback session	All review team and attendees

Clinical Senate Review of the Central Lancashire Acute Sustainability Workstream

Written for:
Greater Preston and Chorley & South Ribble CCGs
by
Greater Manchester, Lancashire & South Cumbria Clinical Senate

September 2019

Chairs' Foreword

Greater Preston Clinical Commissioning Group (CCG) and Chorley & South Ribble CCG commissioned Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate to undertake an independent clinical review, in line with the NHS England stage 2 assurance process, of the proposed "Our Health Our Care" acute models of care for Central Lancashire.

From the paperwork received and the conversations held during the review visit, it is clear that an enormous amount of hard work and difficult conversations have taken place, and are still taking place, to provide the best possible services for the population of Central Lancashire. The commitment of staff, who continue to provide good care in difficult circumstances, should be congratulated.

We would like to thank the clinicians and managers in Central Lancashire who contributed to this review. The passion to provide great patient care and to make the best of any situation was clearly apparent.

We offer our sincere thanks to the clinical senate review team who travelled from across England and Wales to provide their time and advice freely. We are grateful to members of the Clinical Senate for their ongoing support and commitment to the provision of robust clinical advice.

The clinical advice and recommendations within this report are given in good faith and with the intention of supporting commissioners. This report sets out the methodology and findings of the review. It is presented with the offer of continued assistance should it be needed.

Professor Donal O'Donoghue
Clinical Senate Chair / Review Panel Co-Chair

Dr Jaydeep Sarma
Review Panel Co-Chair

Contents

1. Introduction

1.1. "Our Health Our Care" (OHOC) is the joint system transformation programme for health and care services in Greater Preston, Chorley and South Ribble (referred to as "Central Lancashire"). The aim of the programme is to deliver transformational change that leads to improved health outcomes for the populations served. The lead partners are:

- NHS Chorley and South Ribble CCG (CSRCCG)
- NHS Greater Preston CCG (GPCCG)
- Lancashire Teaching Hospital NHS Foundation Trust (LTH)
- Lancashire Care NHS Foundation Trust (LCFT)
- Lancashire County Council (LCC)

Working closely with:

- Central Lancashire district councils (Chorley, South Ribble and Preston)
- NHS England, including specialised commissioning

1.2. As with many health and care systems, the area covered by OHOC is facing a number of significant challenges in their acute system, including:

- Changing population demographics
- Health inequalities
- Limited workforce
- High and inconsistent bed occupancy
- Unwarranted variation in standards
- Decreased planned surgery

1.3. Consequently, the acute sustainability workstream has been established in the OHOC programme to focus on four key areas, with a specific view on the interdependencies with specialty medicine:

- Acute and General Medicine
- Critical Care
- Planned Surgery
- Urgent and Emergency Care

1.4. The aim of this review was to undertake an independent clinical review of the proposed "Our Health Our Care" acute models of care for Central Lancashire with a focus as described in 1.3, in line with the NHS England stage 2 assurance process.

1.5. The Terms of Reference for the review include the following objectives:

1.5.1. Do the options reflect relevant clinical guidelines and best practice?

1.5.2. Are the options sustainable in terms of the clinical capacity to implement them?

1.5.3. Do the plans identify mechanisms to address organisational and cultural challenges?

1.5.4. Has the workforce impact, including impact on education, recruitment, retention been considered in each of the options?

1.5.5. Have the clinical staff that may be affected by the changes, been involved in their development?

1.5.6. Is the proposed workforce adequate for the service needs of each option?

1.5.7. Do the options deliver the current and future health and care needs of the target population?

1.5.8. Do the options maintain access to services for the population? (e.g. have waiting times and travel for patients and their families been considered?)

1.5.9. Have innovations and improvements that would improve quality and outcomes been considered?

1.5.10. Are there unintended consequences/interdependencies of the options that need to be taken into account? (E.g adult social care, medically unexplained, primary care)

1.5.11. Have the risks and consequences of sustaining the options been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?

1.5.12. Does the risk register identify key programme risks and have robust mitigation plans?

1.5.13. Have patients and carers been involved meaningfully in the design of options?

1.5.14. To what extent have the views and experiences of patients and carers been included in the options?

1.5.15. Are the plans for IT and interoperability robust, realistic and able to deliver the requirements of the options?

1.6. A copy of the full Terms of Reference is included as Appendix 1.

1.7. The Clinical Senate Review Team members were:

NAME	JOB TITLE	ORGANISATION
Professor Donal O'Donoghue	Consultant Renal Physician, Clinical Senate Chair and Review Panel Co-Chair	Salford Royal NHS Foundation Trust (FT)
Dr Jaydeep Sarma	Consultant Interventional Cardiologist and Review Panel Co-Chair	Manchester University NHS FT
Dr Mary Backhouse	GP Partner	Tyntesfield Medical Group, North Somerset
Dr Mark Holland	Consultant Physician in Acute Medicine	Salford Royal NHS FT
Gill Johnson	Nurse Consultant	Manchester University NHS FT
Dr Akram Khan	GP & Lead CCG Clinician	Bradford City CCG
Ian Linford	Patient and Public Representative	Cheshire & Merseyside Clinical Senate Council
Dr Niall Lynch	Consultant Clinical Radiologist	Stockport Foundation NHS Trust
Julie McCabe	Assistant Director for Quality and Safety	NHS Wales
Mr Kirt Patel	Consultant General Surgeon	Sheffield Teaching Hospitals NHS FT
Mr Andrew Simpson	Consultant in Emergency Medicine	North Tees and Hartlepool NHS FT
Dr Adam Wolverson	Clinical Director (Theatre / Anaesthetics)	United Lincolnshire Hospital NHS Trust

1.8.1 Managerial and business support to the panel was provided by Caroline Baines (Senate Manager) and Pamela Bailey (Senate Project Manager) from the NW Clinical Senates management support team.

2. Background

2.1 Our Health Our Care (OHOC) is a whole system transformation programme with a clear vision to deliver the best possible clinical outcomes for the people of central Lancashire. The programme spans three pillars of working – prevention and public health, community services and the acute sustainability programme. Although the focus of this review was acute sustainability, the connections to the wider system are essential.

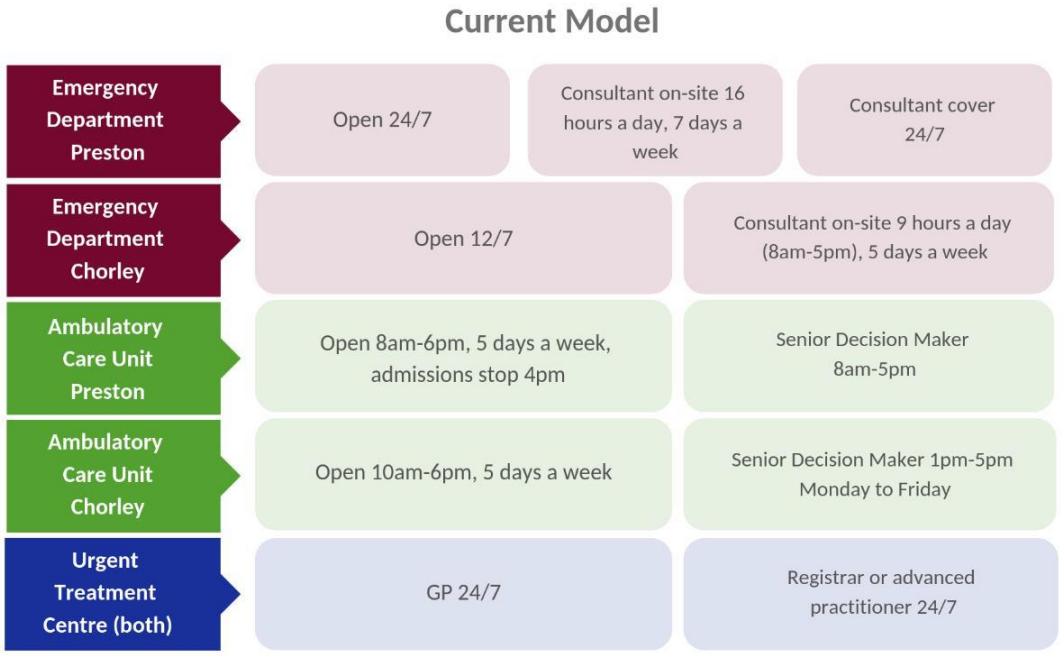
2.2 Central Lancashire covers Greater, Preston, Chorley and South Ribble. It is one of five areas that form part of the Lancashire and South Cumbria Integrated Care System (ICS). Central Lancashire's population is approximately 392,000 people, who reside in a mixture of inner city, town and rural village locations.

2.3 There are two Clinical Commissioning Groups (CCGs) in central Lancashire: CSRCCG and GPCCG, which work closely together and share a management team, staff, operational plan and strategic plan. The populations served by each CCG are approximately 182,000 and 210,000 respectively, and their 18/19 budgets were £274.4million and £299.9million respectively. The two CCGs conduct their business for the OHOC programme through the Joint Committee of CCGs (JCCCG).

2.4 There are two acute hospitals serving Central Lancashire, both run by LTH: Royal Preston Hospital (referred to as "RPH" or "Preston") and Chorley and South Ribble District General Hospital (referred to as "CSR" or "Chorley"). According to Google maps, there are 13.6 miles between the two sites with a journey time of 22 minutes. The figure of 22 minutes is taken based on private car transport in standard, off-peak conditions. This means the expected middle range figure for a journey which takes place outside of the morning (0730-0930) or afternoon (1630-1830) weekday heavier traffic periods. More details of travel times and alternative modes of transport are being developed by the programme in its travel and access modelling using specific software.

2.5 The current model of care is shown in Figure 1:

Figure 1: Current Model of Care



2.6 The constitutional standard performance position delivered by the trust generally depict a declining or systemically worsening position, with notable exceptions. The trust indicates that causal factors include increasing demand for acute care, increasing pressures on inpatient capacity arising from delayed transfers of care and workforce deficits, particularly across medical, and nursing disciplines.

2.7 In response to these hospital pressures, and those within the wider system (described in Paragraph 1.2), OHOC have developed 13 service options.

2.7.1 **Option 1:** Do nothing. Continue with 12 hours a day, Monday to Friday only, ED provision at Chorley. Keep existing configuration of other services including surgery and acute medicine.

2.7.2 **Option 2:** Do nothing with hospital configuration as with Option 1 but fully implement system transformation programmes. This would include initiatives through the enhanced care home service, frequent flyers and 111 to reduce A&E demand and emergency admissions.

2.7.3 **Option 3:** Provide a Type 1 ED at Chorley which complies with the national service specification or extend the existing non-Type 1 compliant model to a 24/7 operating model.

2.7.4 **Options 4a-e:** Provide an enhanced Urgent Treatment Centre[1] (UTC) at Chorley with a number of variants (a-e) as described below

[1] An enhanced urgent treatment centre provides a level of care which is in excess of the national service requirements for an Urgent Treatment Centre (or Type 3 A&E) but does not meet all of the requirements for a Type 1 A&E."

2.7.4a **Option 4a** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. Chorley will also have a level three critical care unit, medical assessment beds (MAU) and specialty/general medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure.

2.7.4b **Option 4b** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit and medical assessment beds (MAU) but no general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure.

2.7.4c **Option 4c** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit but no medical assessment beds (MAU) or specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.4d **Option 4d** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will also have a level one Post-Operative Care Unit (POCU) and no MAU or general/specialty medicine beds. The co-dependency framework states that a hospital site cannot support acute medical beds without level three critical care. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.4e **Option 4e** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will not have a critical care unit or a Post-Operative Care Unit (POCU). There will be no MAU or general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.5 **Options 5a-e:** Provide an UTC at Chorley as defined by the national specification. The variants for Options 5a-e are the same as those for Options 4a-e, as described below.

2.7.5a **Option 5a** is the provision of an urgent treatment centre at Chorley with observation beds. Chorley will also have a level three critical care unit, medical assessment beds (MAU) and specialty/general medicine beds.

As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure.

2.7.5b **Option 5b** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit and medical assessment beds (MAU) but no general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of specialist medical patients and fewer patients requiring elective and day case surgery.

2.7.5c **Option 5c** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit but no medical assessment beds (MAU) or specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.5d **Option 5d** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will also have a level 1 Post-Operative Care Unit (POCU) and no MAU or general/specialty medicine beds. The co-dependency framework states that a hospital site cannot support acute medical beds without level three critical care. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.5e **Option 5e** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will not have a critical care unit or a Post-Operative Care Unit (POCU). There will be no MAU or general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.8 The OHOC Joint Committee decided at its last meeting in public on the 28th August to keep all thirteen options on the table, alongside proposals to consider a new build site. A process of enhanced clinical scrutiny was requested. As part of this enhanced clinical scrutiny, the OHOC Joint Committee has asked the Clinical Senate to provide an independent expert clinical view on all thirteen in line with the objectives in Paragraph 1.5.

3. Methodology

3.1 Numerous teleconferences, meetings and attendances at Senate Council took place between the Clinical Senate and the Our Health Our Care programme in the period from May 2017 to September 2019 to develop, iterate and agree the Terms of Reference for the review (Appendix 1).

3.2 Provisional review information was provided by OHOC colleagues on 26th July 2019. Panel members reviewed these independently, then shared provisional findings during two teleconferences in the week of 19th August 2019. Subsequently a number of requests were made for additional information. The responses to these requests were provided prior to and during the review.

3.3 The review panel visited Central Lancashire on the 16th and 17th September 2019 (see Appendix 2 for full itinerary). The panel travelled to the Royal Preston Hospital and Chorley and South Ribble Hospital to see facilities, meet key staff and gain an in-depth understanding of the challenges faced. The panel met with representatives from the OHOC Programme partners at the end of the visit and fed back their initial thoughts.

3.4 A draft report was sent to commissioners for accuracy checks on 25th October 2019 with feedback received by 3rd November 2019. The final report was ratified remotely by the GMLSC Senate Council on 25th November 2019 and sent to the review commissioners on 26th November 2019.

4. Discussion

The sub-sections below contain summary findings, conclusions and recommendations in line with the review objectives. These are based on the panel's discussions and deliberations. They are not intended to capture the totality of the conversations. Recommendations are highlighted in bold text and summarised in Table 1 in Section 5.

4.1 Do the options reflect relevant clinical guidelines and best practice?

The methodology used by the OHOC programme to develop the options utilises a broad range of the relevant guidelines across the range of specialties in scope of this review. These have been well-considered and appraisal of each of the options against these is apparent.

The acute medicine service needs to be designed and configured to ensure that patients can be seen by a relevant consultant within the timescales recommended by NICE and NHS seven-day working.

The Society for Acute Medicine, NHS seven-day guidance[2] and NICE[3] all advocate that this timescale should be a maximum of 14 hours of the time of arrival at hospital or within 12 hours of the decision to admit. In practical terms, this would require the workforce, especially consultant workforce, to have a shop-floor presence which extends beyond the current provision of 9am to 8pm. The panel stresses that this a maximum time for unwell patients to wait to see a consultant.

The panel are unanimous in their views that options 1, 2 and 3 are not viable (meaning that they cannot be delivered sustainably) as Emergency Department services at Chorley would not be compliant with essential clinical standards, largely due to the absence of core on site specialities in particular emergency surgery and paediatrics.

Additionally, the panel are clear that for critical care, options 4a,4b, 4c, 5a, 5b and 5c are not viable in addition to options 1-3 inclusive. This is due to the unsustainability of the critical care services at Chorley. Currently the service is losing £1 million per year and sees one of the lowest, if not the lowest, number of patients of any critical care service in the country. The patient throughput is not sufficient to allow staff to maintain and develop their skills. None of the options would be likely to increase that utilisation, and most would reduce utilisation.

Due to the compelling clinical evidence that options 1, 2, 3, 4a, 4b, 4c, 5a, 5b and 5c are not clinically viable, due to safety and sustainability issues, the remainder of this report will only consider options 4d, 4e, 5d and 5e in its

[2] https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
[3] https://www.nice.org.uk/guidance/qs174/chapter/quality-statement-3-consultant-assessment-and-review#quality-statement-3-consultant-assessment-and-review

analysis and recommendations. **The panel recommends that, clinically, these four options should be short-listed for further work and public consultation.**

4.2 Are the options sustainable in terms of the clinical capacity to implement them?

Looking from an Emergency Department perspective all of the sub-options from options 4 and 5 are possible. However, the lack of clinical capacity to sustain critical care under options 4a-c and 5a-c inclusive, along with the interdependencies of ED with critical care, render options 4a-c and 5a-c unsustainable from an ED perspective as well.

There is a lack of nursing information within the documentation and the trust seems to have had mixed success with ACPs, ranging from only two qualified and two in training for ED to a number of keen and motivated ICU ACPs. The trust seems to lack ambition and be missing opportunities with its ACCP / ACP workforce, with them being part of the tier 1 rota. In other trusts ACCPs form part of the tier 2 rotas. This has helped them in part to address the widening gaps in the supply and retention of the consultant medical and middle grade workforce, a problem which is experienced nationally.

Concerns that closing Chorley ED would lead to Preston, or neighbouring trusts such as Wrightington, Wigan & Leigh, Bolton, Southport & Ormskirk, or the broader Greater Manchester health system, being overwhelmed did not materialise when there was a temporary closure previously. Therefore, it seems highly likely that any of the clinically viable options would lead to a strengthening of the ED workforce at Preston by bringing the Chorley workforce in to strengthen the existing fragile staffing situation.

The transformation of the wider system is, in part, reliant upon the Primary Care Networks (PCNs) being able to support the hospital by increasing the volume and type of out of hospital care. **OHOC partners need to be realistic about how much the PCNs can deliver and when, as they are currently largely immature in their development.** The programme advised the panel that all of the options anticipate a phased implementation plan through up to and including the 2024/5 financial year (i.e. five years).

4.3 Do the plans identify mechanisms to address organisational and cultural challenges?

Cultural challenges are frequently present when there are services operating over more than one site. This would certainly be expected between two hospitals such as Preston and Chorley where the former is a large busy tertiary centre and the latter a quieter DGH. Despite these differences, the panel felt that there were some excellent examples of cross-site, joined-up working, particularly in critical care. There remain opportunities to extend this good practice in to other specialties.

The panel were struck by how many of the conversations they had were focussed on WHERE services would be provided and not HOW based on a whole-pathway approach. It seems as though the years of uncertainty regarding the future delivery of services has led to this and may be stifling innovation in looking at how services can be delivered differently.

4.4 Has the workforce impact, including impact on education, recruitment and retention, been considered in each of the options?

A strategic workforce document was provided with the pre-review documentation. This document included details of the trust's recruitment and retention strategy, examples of the creation of new workforce roles and skill-mix and the development of the Education Centre and partnership working between the trust and academic institutions. However, detailed workforce modelling of each option has not been undertaken due to the scale of the long-list. **The panel recommends that detailed workforce impact modelling is undertaken on the "feasible" options (4d, 4e, 5d, 5e).**

There has clearly been consideration of some of the workforce issues, but not all. It is encouraging to hear that new staff contracts include cross-site working. Although there will be existing staff who will not move, this is a good approach for the long term. **Therefore, the panel recommends that the trust continues to offer cross-site contracts.**

Overall, medical vacancies have fallen in the last couple of years, and critical care have had no vacancies or staffing issues other than losing people to community services. The panel thought the success in critical care may be a result of considerable thought and planning going into changing the way staff work in ICU. There was evidence of good educational options for both doctors and nurses in this area. However, care must be taken in the wider decision-making to ensure that Chorley is still seen as an attractive place to work. Some current practices do not reflect this, such as ICU nurses being seconded to wards when they are not busy. Additionally, some nurses in critical care don't want to progress to band 6 or above because they do not want to go to Chorley: it must be made clear that this is more because of the exposure they feel at Chorley rather than the experience of working at Chorley itself. **The Critical Care Network and commissioners should be involved in these discussions if they are not currently, as their endorsement will be needed**.

ACP roles are beneficial, and it is good to see that there is ambition to recruit, train and employ more across disciplines. Success in this has been somewhat mixed by discipline to date, and the panel recommends that this is examined for reasons why and initiatives implemented to increase uptake.

There is no organisational bank system for Physician Associates (PAs) wanting to work over their contracted hours. When overtime is worked, it can be difficult and convoluted for these staff to get paid. Additionally, there was some reported disagreement between consultants and managers regarding

the use of PAs to cover bank shifts on weekends and bank holidays. **The panel recommends that the trust reviews the current practices and establishes a system for PAs to work, and be promptly paid for, bank shifts based on medical need**. The report *"An employer's guide to physician associates[4]"* should be of assistance. This would make the role of PA more attractive to other colleagues and LTH a more attractive trust to work in as a PA.

In Acute Medicine, there are no dedicated consultants and a lack of frailty provision and expertise. The opportunities for staff education and development were also lacking with one member of staff not having been aware of any quality improvement or audit taking place within the last three years. **The panel recommends that the trust considers employing dedicated consultants in acute medicine and who are able to lead and shape the department through the forthcoming period of change.**

Preston is a Major Trauma Centre and the Major Trauma System in existence in England has been shown to save lives. Consequently, it is essential that the Emergency Department, and all supporting specialties, meet the staffing requirements of a Major Trauma Centre.

4.5 Have the clinical staff that may be affected by the change been involved in their development?

The panel saw evidence from their conversations that some senior medical staff had been involved in the development of options. However, there was less evidence of a wider range of staff involvement, including more junior medical staff, nurses, PAs, AHPs, support staff, etc. There was evidence of staff involvement being attempted, although this had not generally been very successful. An air of "change fatigue" was evident in some areas which was understandable given that there has been uncertainty regarding the future of services for quite some time.

The panel felt they were given a good view of the services at present but not clear clinical visions and aspirations. The clinical leaders clearly know the best options to ensure safe and sustainable future services in their disciplines. It is important that any "noise" either outside of the programme or in the wider health and care system does not detract from the ability of the clinical voice to direct both WHERE and most crucially HOW services are best provided in future.

The panel therefore recommend that **greater active meaningful involvement from a range of colleagues across seniority and discipline (including both clinical and non-clinical staff) is required**.

[4] Royal College of Physicians / Faculty of Physician Associates. (2017). *An employer's guide to physician associates.* www.fparcp.co.uk/employers/guidance

4.6 Is the proposed workforce adequate for the service needs of each option?

Workforce modelling has not been undertaken for each of the options, so the panel were unable to comment on this objective. **The panel recommends that detailed workforce modelling is done on the four clinically viable options (4d, 4e, 5d, 5e).**

4.7 Do the options deliver the current and future needs of the target population?

The target population is diverse with wide-ranging needs. The population is projected to grow (particularly in the Chorley area) and, as with most areas, experience a significant ageing effect. For these plans to be successful and sustainable in the long-term, there needs to be major transformation of primary care, community and public health provision. There is evidence of a lot of work and planning being done in these areas, but there are concerns regarding when they will come to fruition to deliver benefits to the system (such as reduced admissions).

The four clinically viable options deliver what is needed to modernise the local processes and services, but not what all of the population want to see. **The panel recommends that the OHOC programme uses examples from previous successes, such as vascular and major trauma, to demonstrate to opponents of these options how they might deliver improved care and services.**

The options need to include greater investment in, and planning for, frailty services.

The panel recommends that OHOC look to other systems who have done similar work to identify learning and innovation that could be beneficial in central Lancashire.

4.8 Do the proposals maintain access to services for the population? (e.g. having waiting times and travel for patients and their families been considered?)

The focus of this programme needs to ensure that patients can access the right services first time rather than having to face numerous transfers in care. To do this successfully in clinical terms, there are four viable options as described. This will necessitate further travel times for some patients in some cases and less travel for others depending upon the place of residence and the nature of the medical condition.

This population does not meet the definitions of a “rural community”, and therefore associated considerations should not be applied here. During the

visit the programme identified that the population growth projections for central Lancashire for the next 25 years would not create a default population health requirement for two or more accident and emergency services, based on the formula last developed by the Royal College of Surgeons in 2006.

The panel believes that any increase in travel times will be offset by improved quality of services, improved outcomes, reduced transfers and reduced waiting times. It is also clear that some parts of the care pathway will be delivered closer to home across all of the options where clinically viable, for instance outpatient care at the local hospital or outside of the acute environment.

By focussing on consolidation of services, there is scope to develop Chorley to be a centre of excellence for certain services, which will improve both access and quality of service to the local population for conditions such as orthopaedic day surgery and frailty services.

4.9 Have innovations and improvements that would improve quality and outcomes been considered?

One option not on the list is to build a new hospital on a new site in between Chorley and Preston. There is a strong case for this option in terms of access, consolidating and strengthening the workforce, building a modern fit for purpose facility and improving health and care outcomes. The obvious hurdle to this option is cost. It is also clear that a new hospital would take between 7 and 12 years to develop, depending on the process followed. This means that such a solution would not provide a short to medium term answer to the issues with current services as reported to the panel.

There were some pockets of innovation identified, such as the “COPD singing” group.

The panel recommends the following approaches are considered to maximise the improvement of quality and outcomes:

- **The infrastructure at Preston needs to be reviewed and considerably improved to support delivery of first-class services. This is particularly pertinent to ED and critical care, both of which the panel found to be inadequate, for patients and staff. Despite these significant challenges, staff are providing excellent services and this is a credit to them.**
- **Changes have been made within the confined footprint of the ED to increase capacity and ease flow, however, in order to future proof the service a new ED is absolutely essential. This would not only make the care of patients easier but would also attract more staff of all grades and professions.**
- **A whole system approach to frailty**

- **The ambulatory care vision needs to be listened to and implemented with dedicated consultant leadership.**

4.10 Are there unintended consequences/interdependencies of the model that need to be taken into account? (E.g. adult social care, medically unexplained, primary care)

There has been a lot of thought and consideration given to the consequences and interdependencies within the hospitals. This includes with NWAS who have clearly been involved in the planning.

There did not appear to have been much thought regarding the exact impacts of the options on neighbouring trusts / areas, which may become busier if Chorley ED is downgraded. The pre-review documentation indicated that a high proportion of care for central Lancashire residents is delivered in central Lancashire and the numbers of patients accessing care out of area is modest. When the service was previously downgraded, neighbouring services were not overwhelmed. However, **OHOC need to consider the impacts outside of the Central Lancashire footprint.**

Some of the less viable options would have an impact on the infrastructure and surrounding area at Preston Hospital, such as busier roads causing access issues for ambulances, staff, patients and the general public travelling in the area. However, the panel are not recommending these options, and so this is unlikely to be a concern.

There needs to be greater partnership working with primary care and social care, particularly regarding what is realistically deliverable, when and how to mitigate the transitional period. The panel were concerned that there was an unrealistic expectation on these services.

There are some actions that could be taken in the short-term to improve access without the need for restructure, including access to mental health provision in ED and the development of a system-wide frailty approach.

4.11 Have the risks and consequences of sustaining the options been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?

The risks and consequences of maintaining the current approach are well-documented and well-articulated. The mitigating actions have so far worked well, due to the commitment and dedication of staff, but they are not sustainable.

Depending on which option is implemented, the risks may be reputational and political rather than clinical. This certainly applies to the four options that the panel is supporting.

4.12 Does the risk register identify key programme risks and have robust mitigation plans?

The risk register was not made available to the panel prior to the review. However, it was disseminated after and comments were received. The panel view is that the documents are comprehensive, including the key risks and mitigations that would be expected for a redesign programme. It is clearly not possible to identify and mitigate all risks as transformational work such as this is somewhat unpredictable in nature. The risks are reported through the programme governance process.

4.13 Have patients and carers been involved meaningfully in the design of options?

There has clearly been a lot of work done to engage with a broad range of groups, and this was particularly apparent in the session that some of the panel members had with representatives from the communications team. The panel felt these methods may have been a little too traditional at times (e.g. large public meetings which only a small minority of people attend) and seemed to be reactive to the vocal MP and pressure groups, rather than always proactive. Indeed, these groups have at times dominated events that were planned to be genuine engagement opportunities.

The panel was pleased to hear that OHOC will be working with the Consultation Institute in the near future, who they are sure will support them to conduct further engagement and consultation activities to a targeted "good practice" standard, including ensuring that the reach of the communications and engagement activities is further broadened.

The panel recommends that clinical champions talk to people about why these changes are the right things to do and services will be better. This can be done by using evidence of where they have already made changes that have benefitted patients (e.g. major trauma centre and stroke care at Preston) and saved lives. Also, OHOC should use case studies to illustrate this.

The panel recommends that OHOC adopt some more modern approaches to their engagement, such as campaigns on YouTube and purchasing targeted advertising on Facebook/Twitter/Google. The panel were impressed with the video they saw at the start of Day One, so there is clearly expertise to do this within the area.

4.14 To what extent have the views and experiences of patients and carers been included in the options?

Work has been ongoing for some years and there have been feedback loops to different groups. “However, the voice of the patient is not wholly clear in the way in which the developed options have been communicated to date, particularly in terms of “why would this be better for me”. A patient impact assessment may help so that the programme can continue to meaningfully co-design the proposals with the patients and carers. The panel recognises that the options have not yet been formally consulted on and that this will occur as part of the forthcoming public consultation process. However, they would like to have seen some more tangible examples and evidence.

The panel recommends that OHOC take future opportunities to involve patients and the public (including carers) meaningfully in the design of services.

4.15 Are the plans for IT and interoperability robust, realistic and able to deliver the requirements of the options?

The Digital Plan shared with the panel is a high-level document, and consequently provides little to no reassurance that the IT infrastructure will be able to deliver as required. There are different systems in the hospital and primary care, and the hospital is the only trust using their electronic patient record. This was described as “clunky” by many colleagues during the visit and it seems as though it is robust but not popular.

The Trust is willing to consider a new system as part of an ICS level solution, though the timing of that and the timing of the implementation of the preferred service option is not clear.
There is an excellent PACS system in place within the trust.

5. Conclusions and Recommendations

5.1 The panel were unanimously impressed with the high-quality documentation they received before the review, as well as the excellent responses to their queries.

5.2 The panel would like to give recognition to the staff in the ED and Critical Care departments at Preston, who were delivering good services and were very enthusiastic and positive despite working in very difficult circumstances and inadequate infrastructure.

5.3 There are some excellent examples of cross-site working evident across Preston and Chorley.

5.4 There is clearly a joined-up approach to this work across the CCGs and LTH at the most senior levels.

5.5 Due to safety, sustainability and clinical capacity issues, only options 4d, 4e, 5d and 5e are included in further discussion. The panel's preferred model is 4d.

5.6 There are opportunities to improve services for the population by developing acute medicine and frailty services, and by turning Chorley into a centre of excellence for a number of elective services.

5.7 The panel makes the following recommendations in Table 1 which are intended to be supportive and constructive.

Table 1: Summary of Recommendations

1) The acute medicine service needs to be designed and configured so that patients can be seen by a relevant consultant within timescales recommended by NICE and NHS seven-day working.

2) Clinically, only options 4d, 4e, 5d and 5e are viable.

3) OHOC partners need to be realistic about how much the PCNs can deliver and when.

4) Detailed workforce and impact modelling are undertaken on the clinically feasible options.

5) The trust continues to offer cross-site contracts.

6) The Critical Care Network and commissioners should be involved in discussions.

7) The trust reviews the current practices and establishes a system for Physician Associates to work, and be promptly paid for, bank shifts based on medical need.

8) The trust employs dedicated consultants in acute medicine who are able to lead and shape the department through the forthcoming period of change.

9) Greater active meaningful involvement from a range of colleagues across seniority and discipline (including both clinical and non-clinical staff) is required.

10) OHOC use examples from previous successes, such as vascular and major trauma, to demonstrate to opponents of these options how they might deliver improved care and services.

11) The options need to include greater investment in, and planning for, frailty services.

12) OHOC should look to other systems who have done similar work to identify learning and innovation that could be beneficial in Central Lancashire.

13) The infrastructure at Preston needs to be reviewed and considerably improved.

14) Turn Chorley into a centre of excellence offering elective services.

15) A whole system approach to frailty needs to be developed.

16) The ambulatory care vision needs to be implemented with dedicated consultant leadership.

17) OHOC need to consider the impacts of the options outside of the Central Lancashire footprint.

18) Greater partnership working with primary care and social care takes place, particularly regarding what is realistically deliverable, when and how to mitigate the transitional period.

19) Clinical champions talk to people about why these changes are the right things to do, how services will be better and use case studies to illustrate this.

20) OHOC take future opportunities to involve patients and the public (including carers) meaningfully in the design of services.

Appendices

Appendix 1 - Terms of Reference

1. STAKEHOLDERS

Title: Our Health Our Care – Acute Sustainability Workstream

Sponsoring Commissioning Organisation: Greater Preston CCG and Chorley & South Ribble CCG

Lead Clinical Senate: Greater Manchester, Lancashire and South Cumbria

Terms of reference agreed by: Prof Donal O'Donoghue (Senate Chair) and Denis Gizzi (Accountable Officer of Sponsoring Commissioning Organisation)

Date: May 2019 (agree Terms of Reference) – November 2019 (final report)

Panel Chair: Prof Donal O'Donoghue, Consultant in Renal Medicine, Salford Royal NHS FT

Deputy Panel Chair: Dr Jaydeep Sarma, Consultant Interventional Cardiologist, Manchester University NHS FT

Citizen Representatives: Ian Linford, Cheshire & Merseyside Clinical Senate Council

Clinical Senate Review Team Members:

NAME	JOB TITLE	ORGANISATION
Dr Mary Backhouse	GP Partner	Tyntesfield Medical Group, North Somerset
Dr Mark Holland	Consultant Physician in Acute Medicine	Salford Royal NHS FT
Gill Johnson	Nurse Consultant	Manchester University NHS FT
Dr Akram Khan	GP & Lead CCG Clinician	Bradford City CCG
Julie McCabe	Network Director, Programme Director	NW Neonatal ODN
Mr Kirt Patel	Consultant General Surgeon	Sheffield Teaching Hospitals NHS FT
Dr Andrew Simpson	Consultant in Emergency Medicine	North Tees and Hartlepool NHS FT
Dr Adam Wolverson	Clinical Director (Theatre/Anaesthetics)	United Lincolnshire Hospital NHS Trust
Dr Niall Lynch	Consultant Clinical Radiologist	Stockport Foundation NHS Trust

2. QUESTION & METHODOLOGY

Aim of Review:
To undertake an independent clinical review (in line with NHS England & Improvement's Stage 2 assurance process) of the proposed "Our Health Our Care" acute models of care for Central Lancashire with a focus upon the following aspects of acute sustainability:

- Acute Medicine
- Critical Care
- Planned Surgery Performance
- Urgent and Emergency Care

Main objectives of the clinical review:

1. Do the options reflect relevant clinical guidelines and best practice?
2. Are the options sustainable in terms of the clinical capacity to implement them?
3. Do the plans identify mechanisms to address organisational and cultural challenges?
4. Has the workforce impact, including impact on education, recruitment, retention been considered in each of the options?
5. Have the clinical staff that may be affected by the changes, been involved in their development?
6. Is the proposed workforce adequate for the service needs of each option?
7. Do the options deliver the current and future health and care needs of the target population?
8. Do the options maintain access to services for the population? (e.g. have waiting times and travel for patients and their families been considered?)
9. Have innovations and improvements that would improve quality and outcomes been considered?
10. Are there unintended consequences/interdependencies of the options that need to be taken into account? (E.g adult social care, medically unexplained, primary care)
11. Have the risks and consequences of sustaining the options been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?
12. Does the risk register identify key programme risks and have robust mitigation plans?
13. Have patients and carers been involved meaningfully in the design of options?
14. To what extent have the views and experiences of patients and carers been included in the options?
15. Are the plans for IT and interoperability robust, realistic and able to deliver the requirements of the options?

Scope of the review:

In scope: Services within the acute sustainability workstream of the Our Health Our Care programme, namely, the provision at Chorley Hospital and Royal Preston Hospital of:

- General and Specialty Medicine
- Critical Care
- Planned Surgery
- Urgent and Emergency Care

Out of scope: Community services, mental health services, maternity and paediatric services[5], regional specialist services

Outline methodology:

A formal review will be undertaken on 16th and 17th September 2019 to support the NHS England & Improvement Stage 2 assurance process. The methodology for this review will comprise a desktop review of paperwork, face to face conversations with key clinical and managerial colleagues and site visits of the two acute sites within scope.

Reporting arrangements:

The formal review panel will be led by Professor Donal O'Donoghue, Chair of the Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate. The panel will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the media handling of the report and subsequent publication of findings will be agreed within 3 months of delivery.

[5] Maternity and paediatrics services have already been consolidated on a single site at Royal Preston Hospital.

3. KEY PROCESS AND MILESTONES

Process	Timescale
Information for formal review submitted by Commissioner and distributed to review panel	26th July 2019
Review panel initial Meeting/WebEx/Teleconference and requests for clarification/further information from Commissioners	w/c 9th August 2019
Formal review panel / site visits – interviews and overview	16th-17th September 2019
Panel submit initial findings	22nd September 2019
1st draft sent to panel for checks	27th September 2019
Panel submit final edits for submission	13th October 2019
Final draft sent to commissioners for accuracy checks	25th October 2019
Feedback on accuracy of report from OHOC	3rd November 2019
Final report completed	8th November 2019
Ratification of final report by Clinical Senate Council	22nd November 2019
Final report provided by Senate to commissioner	25th November 2019 (assuming ratified)

4. REPORT HANDLING

A draft clinical senate report will be made to the sponsoring organisation for fact checking prior to publication on 25th October 2019.

Comments/corrections from Commissioners to be received by the senate on 3rd November 2019. The final report will be submitted by the Clinical Senate to the sponsoring organisation by 25th November 2019, assuming it is ratified by the Clinical Senate Council on 22nd November 2019.

5. COMMUNICATION AND MEDIA HANDLING

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made.

All media enquiries will be handled by the sponsoring organisation.

Name of Communication Lead Sponsoring Commissioner: Jason Pawluk

The detailed arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

6. RESOURCES

The clinical senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.
The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

7. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the North Region Clinical Senates accountability and governance structure.
The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.
The sponsoring commissioning organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

8. FUNCTIONS, RESPONSIBILITIES & ROLES

The sponsoring organisation will:

1. Provide the clinical review panel relevant information, this may include: the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, service specifications. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two- and five-year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the clinical review team.
2. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
3. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
4. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisation will:

1. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.
2. Appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
3. Advise on and endorse the terms of reference, timetable and methodology for the review.
4. Consider the review recommendations and report (and may wish to make further recommendations).
5. Provide suitable support to the team and
6. Submit the final report to the sponsoring organisation.

Clinical review team will:

1. Undertake its review in line with the methodology agreed in the terms of reference.
2. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

3. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
4. Publish lists of documents we are provided with, those which we request that are unavailable and those not provided to the review team.
5. Keep accurate notes of meetings.

Clinical review team members will undertake to:

1. Commit fully to the review and attend all briefings, meetings, interviews, panels, etc that are part of the review (as defined in methodology).
2. Contribute fully to the process and review report.
3. Ensure that the report accurately represents the consensus of opinion of the clinical review team.
4. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare any potential conflicts, to the chair or lead member of the review panel.

Appendix 2 - Programme for visit on 16th and 17th September 2019

DAY 1: Monday 16th September 2019 – Chair: Professor Donal O'Donoghue

Time	Item	Details
10.00 – 10.30	Review Panel meet for initial discussions prior to the start of the review	Meeting Room, Macdonald Tickled Trout Hotel
10.30 – 11.00	Minibus to collect panel members for travel to Royal Preston Hospital	Macdonald Tickled Trout Hotel, Preston New Road, Salmesbury, Preston, PR5 0UJ
11:00 – 13.00	Welcome & Introductory Sessions • Background Presentation • Group Discussion	Programme Director/Clinical Directors/Team Representation **(followed by lunch)** Seminar Room 3 EC1
13.00 - 14.30	Walking tour of Royal Preston Hospital - Opportunity to speak to clinical teams / nursing staff	
	Groups 1: ICU and Surgery	**Group 2: ED, MAU and Ambulatory Care**
14:30 – 15:00	Discussion with Trainees	Seminar Room 2 EC1
15.00 - 15.30	Travel to Chorley Hospital	Minibus to collect panel at 15:00
15.30 – 15.45	Arrival & Meet & Greet	Chorley Hospital, Preston Road, Chorley, PR7 1PP Clinical Team Representation - Meet & Greet / Coffee Break Seminar Room C EC3
15.45 – 16.15	Discussion with Trainees	Seminar Room D EC3
16.15- 17.15	Walking tour of Chorley Hospital - Opportunity to speak to clinical teams / nursing staff / trainees	
	Group 1: ICU and Surgery	**Group 2: ED, MAU and Ambulatory Care**
17:30 – 17:45	Minibus to collect panel from Chorley Hospital at 17:30 and return to Macdonald Tickled Trout Hotel	Free time at hotel / check-in
18:30 – 20:30	Review Panel Discussion and Feedback including evening meal	Meeting Room (t.b.c.) Macdonald Tickled Trout Hotel

DAY 2: Tuesday 17th September 2019 – Chair: Dr Jaydeep Sarma

Time	Item	Details
08.30 - 9.00	Minibus to collect panel members at 8.30am from Macdonald Tickled Trout Hotel to go to Royal Preston Hospital	
09:00 – 09:30	Discussion with Communication Leads/Confidential Drop in session	Seminar Room 4/ Confidential drop in session room tbc
09:30 – 10:30 **10:30 – 11:30** **11:30 – 12:00**	Discussion with Clinical Teams Discussion with Executive Teams Discussion with Clinical Teams and Exec Teams	Seminar Room 4
12.00 – 13.15	Review Panel Discussion & Reflections over light working lunch	Seminar Room 4
13:15 – 13.45	Conclusions, Feedback and Next Steps: Panel to commissioners and other stakeholders as per commissioners' wishes	Seminar Room 4
13:45 – 14:15	Minibus to take panel members from Royal Preston Hospital to Macdonald Tickled Trout Hotel at 14.15	

Group 1 ICU & SURGERY	Group 2 ED, MAU & AMBULATORY CARE
Jaydeep Sarma	Donal O'Donoghue
Akram Khan	Gill Johnson
Kirtik Patel	Ian Linford
Adam Wolverson	Mary Backhouse
Niall Lynch	Julie McCabe
	Andrew Simpson
	Mark Holland

Clinical Oversight and Scrutiny of the OHOC Programme: Update for OHOC Governing Body: 13th November 2019

1.0 Executive Summary

This paper identifies the outputs of the enhanced clinical scrutiny process and a proposed way forward. As context, on 28th August, the Joint Committee discussed the long list of options at a meeting held in public directing that enhanced clinical scrutiny on the longlist of options needed to take place to enable them to make a clear, evidence-based decision on which options to progress to a short list. This included re-visiting the case for a new build as a preferred approach.

The Chief Officer of the CCG's and the SRO for the OHOC programme provided a schedule of enhanced clinical scrutiny, circulated for comment to all members of the Governing Body. This schedule included a broad, continuing range of activities comprising of:

Cohort 1: Primary care clinical leadership – This needs to involve the Clinical Chairs, Clinical Directors, Primary Care Network Directors and Clinical Advisors. This included sessions with the Joint Executive Meeting (JEM), individual contact with network leadership teams and collective engagement via the Peer Groups.

Cohort 2: Secondary care clinical colleagues (including nursing, AHP, partners/others) meeting with primary care clinical leadership to collectively provide robust clinical oversight and scrutiny of all the options. This included the development of a Clinical Summit in October.

Cohort 3: A significantly strengthened COG (Clinical Oversight Group). This will be the group that is charged with distilling the clinical views from both Cohort 1 and Cohort 2 and forming a consensus options appraisal to narrow down the broad range to a smaller number, based on robust and sound clinical scrutiny. This included a refresh of the terms of reference and membership of the group, and steps towards the appointment of an independent clinical director for the programme, who would also chair the group.

The Clinical Oversight Group (COG) also produced a more detailed paper titled "Clinical Oversight and Scrutiny of the OHOC Programme", covering the approach followed to date and more details of the proposal. This was approved by the SRO.

External assurance on the quality of outputs from Cohorts 1, 2 and 3 took place in two ways. First, a nationwide panel of external clinical experts and lay representatives (North West Clinical Senate) conducted a review of all programme documentation, completing thorough site visits on 16th and 17th September 2019 as part of the NHS England Stage 2 assurance process. This operated further to the reviews convened with the Royal College of Emergency Medicine and the Care Professionals Board. Second, the programme engaged the Health Scrutiny Committee for Lancashire as a statutory consultee.

The programme was also able to secure a visit from the Secretary of State for Health, Rt Hon Matt Hancock MP, as part of a tour of health services in Lancashire on week commencing 14th October. This provided an opportunity for senior clinicians and corporate to push the case for a new build in central Lancashire and secure written commitment around central policy intent.

This correspondence arising, as requested by the Joint Committee, referred to "seed funding" to explore a competitive business case for a new build site from 2025-30 onwards but was complemented with both a verbal expectation that a shorter-term, enabling solution for acute sustainability in the OHOC programme was necessary in the short to medium term. Further, there would be an expectation that enabling capital for one or more of the options currently under consideration, similar to the parameters of the Wave 4 capital funding application from last year would follow a consultation outcome.

The paper identifies the outcomes of the clinical scrutiny process followed from the Joint Committee meeting. The six salient points are as follows:

1. **Need to make progress:** the uncertainty around the acute sustainability programme needs to come to an end; weariness, change fatigue and uncertainty are common and there is an increasing expectation that the public should be allowed to have their say without further delay. Without change, patient experience will continue to deteriorate.
2. **Workforce Supply:** the points made in the Case for Change are broadly supported - the issue of clinical workforce (supply, retention and age) needs to be promoted more as a change driver from a primary and secondary care perspective. A degree of centralisation will be necessary to provide safe, effective and sustainable care.
3. **No major missing options:** the clinical consensus received would indicate that from the perspective of the acute sustainability programme forming part of a broad transformation approach, there are no substantive missing options from those initially presented on the longlist – a point supported by the Clinical Senate.
4. **Whole System approach:** Acute system reform provides an opportunity to galvanise efforts in terms of prevention, public health and integration, including the partnership working with mental health, social care and local authorities. Clinicians displayed concern that primary care is not currently in a place to accept significant re-profiling of activity away from the acute system and that networks are in their infancy, however, had some assurance that the five year phased implementation timeline would give sufficient opportunity for networks to mature, providing that contract reform and the delivery trajectory for the WHiNs platform followed.
5. **"New build"** hospital was seen as the best way to ensure sustainable, quality care, also expressing that the opportunity for significant capital investment in the central Lancashire system should have a primary care, community and acute care focus. However, it was accepted that this is clouded in political uncertainty and will take more than 10 years to come to fruition – it is not realistic to wait.
6. **Expectations on LTH:** The appetite (and acceptance of the need) to consider "difficult" change is there, but it must follow, as part of any conditions for any option, that the breadth of recruitment, retention and staff development approaches are tested, and that existing in-house transformation programmes are stretched to their full potential.

2.0 Enhanced Clinical Scrutiny: Key Themes

As indicated in the Executive Summary, to ensure that the programme gathered enough information to ensure enhanced clinical scrutiny had taken place, the following has been scheduled and delivered by the programme since the Joint Committee in August.

Cohort 1:

- ✓ One to one meetings' with six Primary Care Network Directors and leadership teams, others preferring to engage in the professional group scrutiny functions offered by the GP Peer Group and Clinical Summit discussions.
- ✓ Scrutiny from Clinical Advisors at the OHOC Clinical Summit.
- ✓ Scrutiny from other senior clinical leaders at respective CCG GP peer groups.

Cohort 2:

- ✓ A Clinical Summit event, held at Farrington Lodge Hotel on 3rd October 2019 comprising of 25 senior clinical system leaders, including Acute Consultants, GP's, Nurses, Allied Health Professionals and staff side representatives. This event was independently chaired by Dr. David Ratcliffe, a GP and Medical Director.
- ✓ Working discussions with each of the OHOC Clinical Leads, developing more specific details on workforce models, activity data and alignment between the options and essential clinical standards. This has also included work to broaden front-line staffing awareness of the options.

Cohort 3:

- ✓ Expanded clinical oversight group membership to ensure greater system representation and scrutiny for the programme.
- ✓ Ongoing recruitment of an independent clinical director.
- ✓ Support and oversight to the North West Clinical Senate visit on 16th and 17th September.

Together, these three cohorts of enhanced clinical scrutiny identify how clinicians from across central Lancashire, as well as independent clinical experts from the NW Clinical Summit have positively influenced the assessment of the long list of options, as requested by the Governing Body and agreed by the SRO. This has provided the programme with further expert clinical opinion and consequently helped to shape the route forward for the programme. For ease, conclusions drawn from this process have been placed into two categories below; feedback on the long list of options, and recommendations for future programme development.

2.1 Feedback on the longlist of options:

- There was broad support for the range of options included within the long list, with no alternative options being offered at any of the additional scrutiny engagements.

- It is clear that an **Enhanced Urgent Treatment Centre (Option 4)** commanded the most, although important to add, not universal support across this period of enhanced scrutiny,

taking in to account the accepted need for change and the strength of the clinical argument, particularly relating to workforce supply.

- **Option 4d** (an Enhanced Urgent Treatment Centre with a Post-Operative Care Unit and ringfenced elective surgery beds) was the highest ranked option at the clinical summit.

- **Option 3** was noted on many occasions throughout the clinical scrutiny process and through the different cohorts to be the 'ideal' solution, particularly in terms of local access, but most clinicians recognised that the workforce requirements to deliver this model effectively were 'impossible' to achieve due to external factors.

- These external factors were accepted as being, at least in part, driven from regional and national issues and were outside of the direct control of LTH. Safety and sustainability issues were frequently referenced from a clinical perspective.

- Chorley GP's provided feedback that it would be better for patient access if Chorley and South Ribble District General Hospital has a Medical Assessment Unit.

- There was also a view that the opportunity to deliver more elective surgery on the Chorley site should be pursued, that the utilisation of the Chorley site needed to be maximised, and that there was an opportunity to consider how system resilience in terms of intermediate care access and/or rehabilitation could stand part of an option.

- This would be important in terms of framing how Chorley could be developed as a centre of excellence in particular specialties.

- Most clinicians took the view that, whilst the **Option 4 model** would see modest displacement of activity from the Chorley to the Preston site, access would be improved through the availability of more outpatient and elective surgery care closer to home. The additional transport requirements would require careful attention but could be clinically justified based on the improvements in patient care, experience and improved sustainability which would result.

- A "new build" option again commanded significant support, across a long-term delivery horizon. Clinicians recognised that this is only viable as a long-term strategy, with the OHOC Acute Sustainability programme requiring expedited progress so as to help the system deliver better patient care in the short to medium term.

- A number of clinicians expressed a view that the ongoing duplications of service provision across the sites and the inabilities to focus existing job plans on areas such as training, development and research were acting as "push" factors away from effective recruitment and retention activities for the LTH sites in key clinical roles. The ongoing uncertainties around future service provision models were also a contributory factor.

- Clinicians were keen for micro system transformation to be a key part of any option, with GPs citing many administrative issues as currently being inefficient. There was a clear view expressed that system-preparedness for transformation via the WHiNs platform needed to be ensured, and a network development pathway established, broaching the five-year implementation timeline for any of the options.

- There was also an expectation that the expectations being made of LTH as a provider to pursue available improvements in operational performance, such as delayed transfers of care, improved integrated working with primary care, length of stay improvements, better ambulatory care, and improved focus on acute medicine must all stand part of an option.

- There was a view provided to the programme team that there is at least general consistency in terms of the feedback provided by the Care Professionals Board, Royal College of Emergency Medicine and the NW Clinical Senate's verbal feedback in terms of appropriate clinical configuration models to consider further. Most clinicians could see evidence of co-working and co-production in the options between the acute system and partners across social care, mental health and other areas of the health economy.

2.2 Recommendations for future programme development

- Clinicians highlighted the need to develop the options in more detail to make them easier to interpret for lay clinicians and the public. Using example pathways and the impacts on workforce and safety would translate the need for service change into a way which would identify with patient preference and help further with meaningful involvement.

- Clinicians wanted to understand more about the travel impacts, and what was being done to make travel between the two sites easier.

- There is a need to better convey the impact of the options on the North West Ambulance Service (NWAS).

- Clinicians would like to understand the impact the options may have on the acute trusts within neighbouring localities and further the transport impacts at network level.

- Primary Care Network Directors indicated that at a later stage, the programme needed to work up detailed integrated pathways within the following areas:

    - Diabetes
    - Respiratory
    - End of Life
    - Gynae
    - Mental Health

3.0 Recommendations

The Governing Body are asked to review the findings of this document alongside the full NW Clinical Senate report and the recommendations presented by the enhanced Clinical Oversight Group. They are asked to confirm if the direction set by the Joint Committee in terms of the enhanced clinical scrutiny has been met and to consider the feedback received from Cohorts 1, 2, and 3.

It is important that over the coming months, the programme team take note of the programme feedback gathered throughout the recent scrutiny period and ensure the programme is tailored to the wishes of the clinical community:

- Developing a simpler way of explaining the options to all audiences, showing the impact on both LTH sites.
- Ensuring we have a public friendly document explaining the expected impact of any changes on other local hospitals, matched alongside a narrative explaining how these changes fit in to broader system-wide change.
- Develop a clear outline of the expected impacts of the short-listed options on the North West Ambulance Service.
- Develop and deliver an enhanced communications strategy.

4.0 Next Steps

Completion of this detailed modelling will provide the Joint Committee with the information it requires to make an informed decision the options that maybe progressed to a public consultation.

This decision will be included in the development of a Pre-Consultation Business Case (PCBC) which brings together all of the key work products that have been developed by the programme so far (case for change, model of care, options development, engagement) into a single document. This will be updated from the information initially supplied to it and to the NW Clinical Senate.

The PCBC will provide the reader with a walkthrough of the OHOC programme and why particular options are recommended to be progressed to a public consultation. The PCBC will require formal approval by the Joint Committee and subsequently be submitted to NHS England to be ratified.

The appendix to the paper provides more detail of the feedback received from each component/cohort of the Enhanced Clinical Scrutiny process.

5.0Appendix

Additional clinical oversight and scrutiny as requested by the Joint Committee of CCGs

5.1 Clinical Summit

The programme held a "clinical summit" event entitled "**OHOC Clinical Summit: Scrutiny of the Programme Options"** on 3rd October 2019 at Farrington Lodge Hotel. This session was independently facilitated by Dr David Ratcliffe, a GP with special interest in Emergency Medicine. The session brought together 25 clinical leaders and staff representatives from across the local health and care sector to ensure that the options were considered from a whole system perspective, including those which relate to the broader Integrated Care System, as well as the Integrated Care Programme for Central Lancashire. The attendee list included CCG GP Chairs, CCG Executives, General Practitioners, Nurses, CCG Clinical Advisors, Wellbeing and Health in Integrated Neighbourhoods Representatives, LMC Representatives, Integrated Care System Representatives and LTH Consultants.

The summit achieved the following objectives:

- Examine the existing work done in relation to the development of the options plus existing plans around WHINs,
- Understand what work and analysis will be needed to indicate viability of the options
- Provide an open and honest forum for constructive challenge around the options and the future direction of the programme.

Key themes
Each table was allocated a facilitator and a scribe for the clinical scrutiny discussion that took place. Each scribe compiled a comprehensive range of notes, with the key themes that consistently emerged are outlined in figure 1.

Figure 1: Key Themes identified from the clinical summit

Option	Key themes
1	• Lowest average ranking. • Already failing as an option, this is why change is being considered. • Not clinically deliverable due to workforce requirements.

	• Strong feeling that existing service model is not sustainable in the long-term and is driving poor operational performance and patient experience. • Needs to be honestly described to the public by means of a comparison i.e. why change will be better for the people of Chorley, South Ribble and Greater Preston.
2	• Preferable only to a “do nothing” option • Clinically unsustainable in the long-term due to workforce requirements, in terms of job plans, lack of opportunity for effective training, development and research, service duplication. • Does not resolve the issue of under-utilised critical care facilities and workforce infrastructures at the Chorley site. • Would limit the scope of some structural transformation that could occur between the sites because care would need to be duplicated across core services and essential clinical adjacencies, thereby limiting what can be achieved for patients. • Demand management activities have had some impact, but the system is highly vulnerable to peaks in patient demand for urgent, emergency and elective care. • No evidence that the system has been able to manage over the last three years, why would this change over the next five? • Very unlikely to resolve the recruitment and retention issues alone, particularly from the acute perspective. • Does not resolve the fundamental point that the existing service model is not Type 1 compliant and there are clinical risk considerations arising from walk in attendances for certain categories of acutely unwell patients.
3	• A good model in principle but undeliverable due to Workforce shortages in Urgent and Emergency Care, Surgery, Specialty Medicine. • Workforce shortages identifiable across medical, nursing, scientific and technical and allied health professional staffing categories. • Workforce issues are felt nationally as well as locally – there is no evidence to indicate that this will improve in the short term. • Emergency Surgery and Paediatrics would have to be put back on two sites and therefore be much less efficient if a Type 1 was at Chorley • Even if we had the funding, there are not enough staff available. • In some areas, there is a strong view of the demand not being available for higher volume working, associated with improved consistency, care quality and clinical outcomes. • Could actually make things worse by destabilising the care structures at the Preston site. • Not necessary as emergency provision is available at Preston, Wigan, Blackburn, Bolton and not aligned with Royal College of Surgeons guidance for current/future population coverage.
4a	• The workforce supply issue (recruitment and impact of retirement/attrition) is a significant factor against delivering this model

	• Scope to do a lot, but duplication remains. • Would this really direct whole system transformation? • Does this model avoid conversations around difficult, but clinically necessary change? • Does this model, to the contrary, maximise Chorley service access and provision. • Elective surgery is not protected in this model – potential deteriorations in access, quality and performance, could these be mitigated. • Notable that the service model is not supported by the NW Clinical Senate.
4b	• High risk to patient safety • Workforce issue – specialty medicine cannot provide MAU ward rounds • Not clinically sustainable due to workforce. • Should be excluded from consideration.
4c	• Not a good use of critical care resources, will become even less efficient than it is now and create more issues across both sites • Surgical Patients could be vulnerable without 24/7 medical support after being in a level 3 critical care. • For largely the same reasons as 4a and 4b, should be excluded from consideration.
4d	• Clinically deliverable • The best model for workforce efficiency and maximising local access. • Improved experience for patients due to ringfenced elective beds and adequate front door provision • Significant evidence of workforce innovation and skill mixing relating to ED cover, critical care utilisation and elective surgery provision. • Would the Royal Preston site have enough medical bed capacity available to deliver this? Enabling capital would be particularly helpful for this model.
4e	• Won't maximise use of Chorley site, limiting capacity due to no critical care provision • Clinically deliverable due to workforce efficiencies
5a	• Same thoughts as 4a, apart from UTC which: o Less likely to reduce A&E burden as can only see a lower acuity of patients o Lack of ambulatory care is not ideal for Chorley residents
5b	• Same thoughts as 4b, apart from UTC which: o Less likely to reduce A&E burden as can only see a lower acuity of patients o Lack of ambulatory care is not ideal for Chorley residents
5c	• Same thoughts as 4c, apart from UTC which: o Less likely to reduce A&E burden as can only see a lower acuity of patients o Lack of ambulatory care is not ideal for Chorley residents
5d	• Same thoughts as 4d, apart from UTC which:

	○ Less likely to reduce A&E burden as can only see a lower acuity of patients ○ Lack of ambulatory care is not ideal for Chorley residents
5e	• Same thoughts as 4e, apart from UTC which: ○ Less likely to reduce A&E burden as can only see a lower acuity of patients ○ Lack of ambulatory care is not ideal for Chorley residents
New Build	• Would provide a good model for the future • Lots of support • Recognition across the system that this is the long-term solution (8-10+ years) only.

At the end of the session, attendees were asked to individually rank the long list of options in order of clinical viability and preference to ensure all views were captured. The results of this exercise can be found in figures 2 and 3 respectively. Some tables decided to complete this exercise as a group, therefore the number of votes does not necessarily correlate to the number of attendees.

Figure 2: Clinical Viability Votes

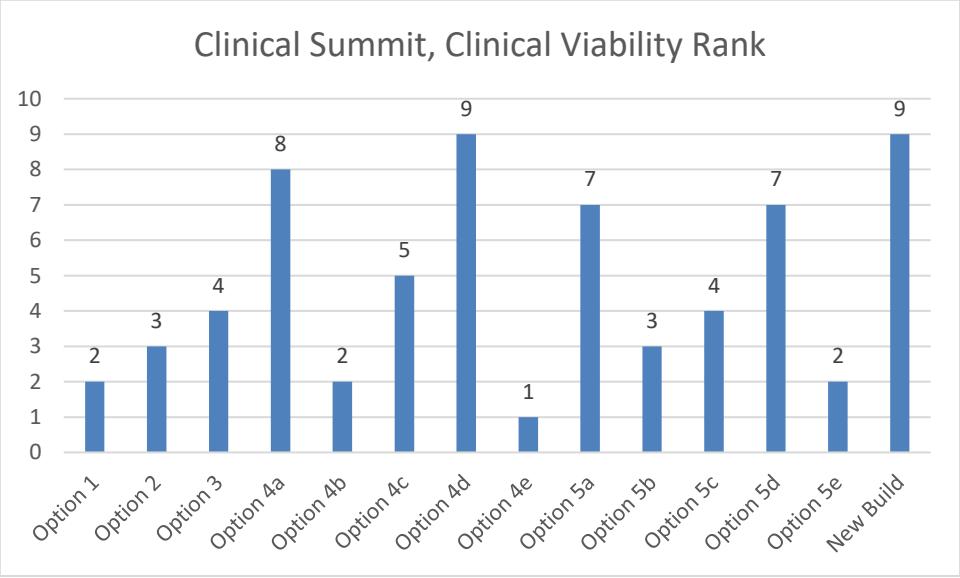


Figure 2 clearly displays that option 4d was viewed as the most viable with 9 votes, followed closely by 4a(8) 5a(7) and 5d(7). The “new build option” was also popular with 9 but following the site visit by the secretary of state for health, it is clear this is part of a long-term strategy, whereas OHOC is required to improve care additionally in the short to medium term.

It is interesting to note that there was less local enthusiasm for the “e” models (4e) and (5e) due to operational deliverability. Conversely, there was more enthusiasm for the “a” model and a greater acceptance of the need to consider Option 5 as a framework, as well as option 4.

Figure 3: Ranking of long list of options

Option	Rank	Average score (1 = high)
Option 4d	1	1.9
Option 4a	2	2.4
Option 4c	3	3.4
New Build	4	3.6
Option 5a	5	5
Option 5d	6	5
Option 4b	7	5.2
Option 5b	8	6
Option 5c	9	6.2
Option 2	10	7.3
Option 3	11	7.7
Option 4e	12	7.7
Option 5e	13	8
Option 1	14	13

Figure 3 shows a similar pattern to figure 2, with the results of the “rank in order of preference” exercise showing strong support for option 4d. The “New Build” option was not prioritised highest because a number of the clinical delegates questioned whether or not this would work with whole system redesign and the lag time involved in developing a new build was plainly not compatible with the current timelines around OHOC.

5.2 Interactions with Network Leadership

The programme team has approached each of the formed primary care networks for in depth discussions about the long list of options formed by the programme, and their aspirations for matched reform of the primary care agenda. Individual sessions have been offered to all network directors with 6 having taken place so far, with one being arranged. The remaining directors have showed preference for providing their input via the GP peer group meetings and Clinical Summit. A summary of the meetings that have taken place can be found below:

Figure 4: Meeting Schedule

NAME	ORGANISATION	LOCALITY	MEETING INVITE SENT	RESPONSE RECIEVED?	MEETING DETAILS
Dr Joegy Shah	Ryan Medical Centre	Bridgedale Medical Services LTD	YES	Yes	Attended Chorley Peer Group
Dr Shashidar Khandavalli	The Chorley Surgery	Chorley Central	YES	Yes	Being rearranged
Mahtab Siddiqui	Withnell Health Centre/Clayton Brook Surgery	Chorley East	YES	Yes	11/10/2019 - 1200 Clayton Brook Surgery
Dr Jeremy Hann	Park View Surgery	Greater Preston Medical Group	YES	No	27/09/19 - 0845 cottom lane surgery
Dr Amrit Ryatt	Sandy Lane Surgery	Leyland	YES	Yes	02/10/2019 - 1130 Sandy Lane Surgery,Sandy Lane, Leyland,Lancs, PR25 2EB
Dr Steve Griffin	Berry Lane Medical Centre	Preston East	YES	Yes	30/10/2019 - 1430 Berry Lane Medical Centre
Dr Zakir Habib Patel	Issa Medical Centre	Preston North	YES	No	24/09/2019 1100
Dr Partha Ganguli	Fishergate Hill Surgery	Ribble Medical group	YES	Yes	24/09/19 - 0930 Chorley House
Dr Nimal Muttu	NM Health Innovation	The Chorley and South Ribble Health Network	YES	No	

Key Themes Identified from meetings

Each meeting that has taken place so far has explored two main areas:

1) Current development of the relevant Primary Care Networks to help determine how the OHOC programme can align future developments,
2) A walk through and discussion about the current long list of options.

The key themes that have emerged from these discussions is outlined below:

5.2.1 Network Development

1) Networks are still relatively embryonic in development but should be fully formed and delivering system efficiencies prior to the delivery of the Acute Sustainability programme. All networks are now delivering extended access and have reported working well together to assess and plan future priorities
2) Future priorities for integrated pathways that were frequently mentioned include:
    - Diabetes
    - Respiratory
    - End of Life
    - Gynae
    - Mental Health
3) Networks have reported that contracting is still an issue and needs rectifying

5.2.2 Long List of Options

1) GP's engaged with thus far were supportive of the breadth of options included on the long list, with no additional options suggested.

2) Option 3 was noted as the “ideal” solution but there was also widespread understanding it was undeliverable due to workforce issues caused by further separation of care provision across two sites. This could consequently make patient care worse.
3) Option 4 gained the most support of all the options, with clinicians recognising that an Enhanced Urgent Treatment Centre was innovative and would provide a better option for patients than a standard Urgent Treatment Centre.
4) The “new build” option was widely supported. Clinicians understood that this was a long-term solution and the system needs to deliver change sooner.
5) There were concerns raised about Chorley patients requiring access to MAU
6) GP’s made clear it would be good to have choice about where to refer their patients e.g. Preston or Chorley Ambulatory Care/MAU
7) GP’s wanted to know more about the impact on capacity at each site, it was explained that this would be available once a short list was agreed.
8) It would be useful to show the impact of each option on each LTH site once a shortlist has been agreed

5.3 Enhanced Role and Membership of the Clinical Oversight Group

The terms of reference and membership of the OHOC Clinical Oversight Group (COG) have been fully reviewed and enhanced to include a wider range of clinical representation from across the health and care sector. The first meeting with the new enhanced membership will take place on 6th November 2019.

The independent clinical director will chair the clinical oversight group once appointed. Recruitment for this post is ongoing (see 5.4).

5.4 Appointment of an independent Clinical Director

It was agreed at both at the informal meeting of the Our Health Our Care (OHOC) Governing Body on 14th August 2019 that a Clinical Director would be appointed to support the ongoing progress of the OHOC programme. The Clinical Director would be the senior clinical advisor for both the Well-being and Health Integrated Neighbourhoods (WHiNs) and Acute Sustainability Platforms ensuring alignment of plans that support better integration of services, care closer to home and a focus on ill-health prevention.

Responsible for communicating the voice of the wider clinical workforce the Clinical Director will report to the 2 Programme SROs, providing constructive challenge where required and fronting the clinical voice in communicating with staff, the public and the media.

It is proposed that the Clinical Director would Chair the OHOC Clinical Oversight Group. Via this robust recruitment process the Clinical Director would be considered both competent and independent.

A job description was circulated amongst the central Lancashire clinical workforce by Gerry Skailes, Madeleine Bird, and Stephanie Ward. We are currently working to identify suitable candidates, as the initial expressions of interest process, circulated amongst senior clinical leaders across the Integrated Care System garnered little interest.

5.5 Continued other involvement

Further to the enhanced clinical scrutiny activities that have taken place, the programme has taken advantage of opportunities to engage with stakeholders from across the system to request further scrutiny on the long list of options.

The following section of this paper outlines some of the key activities that have taken place and summarises the feedback received

5.5.1 Established Peer Group Meetings

The programme team have attended the recent peer group meetings for both Greater Preston and Chorley & South Ribble GP's on the 1st October 2019 and 16th October 2019 respectively.

The sessions were used as an opportunity to update the GP networks on the options development phase, including providing an overview of the approved longlist. GP colleagues then held facilitated discussions about their views on the longlist and how the programme could ensure alignment with network priorities moving forwards.

Key themes from the two sessions can be found below:

5.5.1.1 Greater Preston

- No additional options were proposed for the long list.
- GP's were happy with the breadth of options
- GP's wanted to see the options presented in a different way, showing the impacts on both sites, once a short list had been agreed
- Patients need to be better educated/informed on the most appropriate options available to them, dependent on circumstance
- Staff need to be trained/educated on how to direct patients to the most appropriate service
- Safety and quality is the top priority, with everything else coming after this
- Need clarification on pathways for the Centres of Excellence – how will flow of patients work?

- Digital interoperability would help to encourage working together with the same intentions

5.5.1.2 Chorley and South Ribble

- No additional options were proposed for the long list.
- GP's were happy with the breadth of options
- Benefits of each option needs to be clearly communicated. E.G travel times
- Patients need to be better educated/informed on the most appropriate options available to them, dependent on circumstance
- NWAS impact needs considering and clearly communicating
- Transport of patients between sites need to be considered in more detail
- Staff need to be trained/educated on how to direct patients to the most appropriate service
- Safety and quality is the top priority, with everything else coming after this
- Need clarification on pathways for the Centres of Excellence – how will flow of patients work?
- Digital interoperability would help to encourage working together with the same intentions

5.5.2 Local Medical Committee

The Local Medical Committee have requested assurance on the options process and the durability of the options to reflect changes in the decision-making landscape with the future of primary care networks. This would be provided by the programme team on a bi-monthly basis, at the direction of the Chair. The next Local Medical Committee meeting is due to take place on the 13th of November 2019.

5.6 Additional scrutiny as part of the NHSE assurance process

5.6.1 Clinical Senate Visit

As a key milestone of the NHS England stage 2 assurance process, the north west clinical senate conducted an independent clinical review of the OHOC programme on 16th and 17th September 2019. The senate panel were provided with a range of programme documentation prior to the visit, with the programme team verbally updating that it was incredibly comprehensive and detailed.

In addition to a full documentation review, the visit would involve the panel meeting with clinical leads for the OHOC programme, discussing current working practices with ward staff

and trainees, conducting a full site visit of both LTH hospital sites, and discussing programme plans with relevant individuals.

The Terms of Reference for the review included the following objectives:

- 1.5.1. Do the options reflect relevant clinical guidelines and best practice?
- 1.5.2. Are the options sustainable in terms of the clinical capacity to implement them?
- 1.5.3. Do the plans identify mechanisms to address organisational and cultural challenges?
- 1.5.4. Has the workforce impact, including impact on education, recruitment, retention been considered in each of the options?
- 1.5.5. Have the clinical staff that may be affected by the changes, been involved in their development?
- 1.5.6. Is the proposed workforce adequate for the service needs of each option?
- 1.5.7. Do the options deliver the current and future health and care needs of the target population?
- 1.5.8. Do the options maintain access to services for the population? (e.g. have waiting times and travel for patients and their families been considered?)
- 1.5.9. Have innovations and improvements that would improve quality and outcomes been considered?
- 1.5.10. Are there unintended consequences/interdependencies of the options that need to be taken into account? (E.g adult social care, medically unexplained, primary care)
- 1.5.11. Have the risks and consequences of sustaining the options been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?
- 1.5.12. Does the risk register identify key programme risks and have robust mitigation plans?
- 1.5.13. Have patients and carers been involved meaningfully in the design of options?
- 1.5.14. To what extent have the views and experiences of patients and carers been included in the options?
- 1.5.15. Are the plans for IT and interoperability robust, realistic and able to deliver the requirements of the options?

The Clinical Senate team provided informal feedback that the visit was extremely well organised, and the programme documentation was comprehensive.

Sent via email to:-

Cllr Peter Britcliffe
Chair, Lancashire County Council Health Scrutiny Committee
County Hall
Preston
PR1 8RL

27 January 2020

Dear Cllr Britcliffe

Re: Our Health Our Care Update to the Committee on 4 February 2020

As SRO for the Our Health Our Care (OHOC) programme, it has been suggested to me by the Senior Democratic Services Officer (Overview and Scrutiny) that a letter should be sent to you in your capacity as Chair of the Committee, accompanying the written update paper that has been provided, initially on Thursday 23 January 2020. This letter refers to your Committee's Resolution of 24 September 2019.

This suggestion to send a letter has been shared with us as being a more helpful way of describing a number of the recommendations we intended to make to the Committee, aiding discussions which we will have on 4 February 2020. We are, of course, happy to oblige. We are also happy for the information in this letter to be shared in any way you feel appropriate.

2013 Regulations - Notification Requirements:
Please accept this letter, in my capacity as Chief Accountable Officer, from the Clinical Commissioning Groups representing Chorley and South Ribble and Greater Preston respectively, that notice under paragraph 1 of Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 is being given to the Committee. In particular, the update paper includes plans for substantial variation of health services which are under active consideration - however no decision to proceed with the proposals has yet been taken.

These proposals include acute hospital services currently provided at Chorley and South Ribble Hospital and the Royal Preston Hospital, under the management of Lancashire Teaching Hospitals NHS Foundation Trust. These also include other acute hospital services commissioned by the Chorley and South Ribble and Greater Preston CCGs at third-party providers within central Lancashire. These services are commonly described as the acute sustainability workstream within the Our Health Our Care programme.

Joint Committee/NHS England Process:
At the point where the Joint Committee of the Clinical Commissioning Groups (referred to as the OHOC Joint Committee) approves a Pre-Consultation Business Case around the proposals, then we will then approach the Regulator, NHS England, for permission to launch a Public Consultation on the proposals. This reflects the process/rules which we have to follow.

We intend to do this prior to the start of the Regulated Period for the Local Government elections, allowing the CCG to follow the principles of Purdah. Should our timeline be delayed, then we will of course respect these provisions.

The CCGs decision to consult reflects the duties incumbent upon our organisation linked to s14z2 of the NHS Act 2006, as amended by the Health and Social Care Act 2012, and associated legislation. Also, an acceptance that paragraph 2 of the 2013 Regulations cannot be deemed to apply to the current proposals in the Our Health Our Care programme i.e. based on the options, we must consult the public.

Timelines for Requesting Comments:
As you will be aware, the Regulations require us to specify a timeline for receiving comments on the proposals. In terms of timelines, subject to the Regulator approving a Public Consultation taking place in the Summer (June to September), we would invite formal comments on the proposals by **30 November 2020**. The CCG will then respond to your comments within 28 days, as per the Regulations. We welcome the observations of the Committee in terms of how you would prefer to conduct the Health Scrutiny process. We are keen to work with you to follow an approach which meets the Committee's expectations.

We appreciate fully that how the process takes place is for the Committee and not the CCG to determine. However, our suggested approach would be to develop a discrete consultation period, across October and November, which will allow us to provide the Committee with details of initial public consultation outputs, so as to support your considerations and comments to us.

We would be happy to supply details of relevant witnesses/organisations that you may wish to hear evidence from and support you logistically in any way that you are happy for us to do so. We would also like to emphasise that the CCG will, at all stages, do all that it can to support your Committee's considerations of these proposals and request the same from its partners.

We recognise that you may wish to proceed sooner than October this year. From any point where the Regulator gives approval to proceed with a public consultation and after Purdah, we would also be able to support any earlier process that the Committee prefers. However, we will only know the full outputs of a public consultation, when this activity has been completed. This means that the information we can supply will be limited to what we know at the relevant time about the public / other stakeholder responses.

Timeline for deciding if we are to proceed with the proposals:
The Regulations also require us to specify the point where we would intend to decide whether or not to proceed with the proposals.

Linked to the NHS England process (which we must have regard to), the CCG will be required to develop a Decision-Making Business Case. This can only happen when we have completed a public consultation, considered and responded to any recommendations from the Committee, and undertaken a substantial analysis activity linked to all comments received. The earliest date where this could happen is the end of the next financial year.

In our view, this point, i.e. the Decision-Making Business Case being approved, is where we see the programme proceeding from having proposals for consideration, to having proposals for implementation, assuming that we do decide to proceed with the proposals in either their current, or some amended form.

Amendments to Timelines:
The Regulations require us to advise you if our timelines for receiving comments change.

We hope to maintain the programme outlined above. However, these timelines may vary (backwards) based on any deferral of the decision by the Joint Committee to approve a PCBC; any decision by the Regulator to refuse / defer approval to launch a Public Consultation; any further advice that we may receive around extending the consultation period; linked to advice from bodies such as the Consultation Institute. Other factors, such as the provision of capital investment could also occur, should any opportunities materialise which are not currently available. If any of these apply, then I will write to you at the earliest opportunity.

I trust that the above information is helpful. However, please do not hesitate to contact me if I can be of further assistance.

Yours sincerely

Denis Gizzi
Chief Accountable Officer
Chorley and South Ribble & Greater Preston Clinical Commissioning Groups

cc. Mr Gary Halsall, Senior Democratic Services Officer, LCC (email)

Health Scrutiny Committee
Meeting to be held on Tuesday, 4 February 2020

Electoral Division affected:
(All Divisions);

Report of the Health Scrutiny Steering Group

Contact for further information:
Debra Jones, Tel: 01772 537996, Democratic Services Officer,
Debra.Jones@lancashire.gov.uk

Executive Summary

Overview of matters presented and considered by the Health Scrutiny Steering Group at its meetings held on 20 November 2019 and 18 December 2019.

Recommendation

The Health Scrutiny Committee is asked to receive the report of its Steering Group.

Background and Advice

The Steering Group is made up of the Chair and Deputy Chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Labour Groups.

The main purpose of the Steering Group is to manage the workload of the Committee more effectively in the light of increasing number of changes to health services which are considered to be substantial. The main functions of the Steering Group are listed below:

1. To act as a preparatory body on behalf of the Committee to develop the following aspects in relation to planned topics/reviews scheduled on the Committee's work plan:
    - Reasons/focus, objectives and outcomes for scrutiny review;
    - Develop key lines of enquiry;
    - Request evidence, data and/or information for the report to the Committee;
    - Determine who to invite to the Committee;

2. To act as the first point of contact between Scrutiny and the Health Service Trusts and Clinical Commissioning Groups;

3. To liaise, on behalf of the Committee, with Health Service Trusts and Clinical Commissioning Groups;

Lancashire County Council

4. To make proposals to the Committee on whether they consider NHS service changes to be 'substantial' thereby instigating further consultation with scrutiny;

5. To act as mediator when agreement cannot be reached on NHS service changes by the Committee. The conclusions of any disagreements including referral to Secretary of State will rest with the Committee;

6. To invite any local Councillor(s) whose ward(s) as well as any County Councillor(s) whose division(s) are/will be affected to sit on the Group for the duration of the topic to be considered;

7. To develop and maintain its own work programme for the Committee to consider and allocate topics accordingly.

It is important to note that the Steering Group is not a formal decision making body and that it will report its activities and any aspect of its work to the Committee for consideration and agreement.

Meeting held on 20 November 2019

- **North West Ambulance Service: Rota Review - Lancashire Area Consultations**

Peter Mulcahy, Head of Service Cumbria and Lancashire Area, North West Ambulance NHS Trust presented a report providing an update regarding the recent review of staffing levels and shift patterns affecting all frontline staff at the Trust.

The following points were highlighted:

- The new Ambulance Response Programme now required ambulance services to reach 100% of life threatening cases within seven minutes. In order that this be met it had been necessary to review clinical resources to ensure they were sufficient to meet demand. The review had resulted in an increase of ambulance cover of 519 hours per week in Lancashire (689 including south Cumbria who supported north Lancashire), supported by funding of £8.3 million. These hours were for double crewed ambulances of one driver and one technician in Lancashire only.

- The Trust would be subject to a £1 million fine by the commissioner if the required changes to enable targets to be met were not made. In addition the Trust would be held accountable for any inappropriate referrals to hospital.

- It had been identified that some delayed responses were as a result of staffing levels and additional recruitment had been undertaken to address this. Paramedic roles now required a three year degree course plus a year of mentorship. It was noted that there was a national shortage of paramedics, however the Trust had a good reputation as an employer.

- The Trust had commissioned a management consultancy company to carry out a demand analysis of attendance data over last three years. They had identified

projections taking into account changes to the local demographic and had established a suitable model of delivery to meet anticipated needs.

- The changes required to meet the delivery model included a review of the traditional 12 hour shift patterns. Staff had been consulted on preferred shift patterns and this would be accommodated where choices met legislative requirements and demand. All staff would be given the opportunity to vote on the proposed shift pattern during a six month consultation and implementation was planned from April 2020.

- Other measures employed to meet demand included: the conversion of a number of rapid response cars to fully equipped ambulances and staff responsible for low acuity vehicles (used for admissions discharges and transfers) had been given the opportunity to attend fast track training to technician level.

In response to questions from members the following information was clarified:

- The additional hours would be fulfilled by a mix of new shift patterns and new ambulances. Currently 90% of vehicles were in use for 24 hours 7 days a week on two 12 hour shifts, however demand was not spread equally over that time. There was a nationwide commonality of demand over a day, whereby need was high in a morning, followed by a significant surge early afternoon, during GP opening times, and in the evening. The service adapted to demands and known patterns of need. The Trust maintained a pool of spare vehicles and all were maintained to a higher specification than manufacturer recommendation. Pre-planned maintenance was scheduled every six weeks.

- The volunteers mentioned in the report, referred to paid staff who were part of the collaborative working parties liaising with staff to agree the new way of working. However the Trust did buy in services from the voluntary sector and actively encouraged volunteers to apply for jobs.

- In terms of waiting times for an ambulance, once an emergency call had been received the first step was to identify the priority of the call and the most suitable level of support required. For some types of calls the standard agreed time was a three hour response. Calls where there was a protracted delay in arriving were monitored and if any harm resulted from that delay, an investigation would be undertaken and patients would be contacted under the duty of candour. The Trust continued to raise awareness on the 'hear and treat' (resolved on the phone) and 'see and treat' (resolved on site, no admission to hospital required) initiatives. Recent data was shared where over a quarter of incidents were dealt with without admission to hospital. This programme was supported by employing nurse and paramedic skills in the call centre to ensure that the vast majority admitted to hospital were on the correct pathway.

- Busy periods over the year were identified and planned for by reducing leave, budgeting and making additional ambulances available.

Resolved: That the report detailing the recent review of staffing levels and shift patterns affecting all frontline staff at the Trust be noted.

❖ **Terms of Reference for the proposed Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)**

The steering group discussed the request from the Health Scrutiny Committee to amend the terms of reference for the proposed Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS). It was highlighted that the request to have three Lancashire district council members with voting rights would be constitutionally inconsistent for Lancashire as district council members on the Lancashire Health Scrutiny Committee were non-voting.

Early indication from the other local authorities involved was that they would agree to the additional seats but only as non-voting. The group in considering this point further recommended that the membership of the terms of reference should be revised as follows:

1. Amendment: Each local authority to appoint on the basis of two members from the administration and one opposition member.
2. Addition: Up to three non-voting district council members from the Lancashire County Council Health Scrutiny Committee.

Resolved: That the Chair of the Health Scrutiny Committee writes to the relevant local authorities to seek formal responses to the Committee's requests and the Steering Group's suggestion.

❖ **Suicide Prevention in Lancashire Progress Report**

Lancashire County Council officers: Dr Sakthi Karunanithi, Director of Public Health and Chris Lee, Public Health Specialist for Behaviour Change presented an update on the initiatives undertaken to prevent suicide in Lancashire.

The following points were highlighted:

- The report detailed the substantial work programme in place from December 2017 when the Healthier Lancashire and South Cumbria Integrated Care Strategy (ICS) received funding to reduce suicide rates in the area. Although the numbers in the ICS had fallen, a spike in 2018 and improved rates in other areas had moved the ICS from fourth to third for highest number of deaths by suicide in England for both sexes.

- A Lancashire wide suicide prevention and self-harm partnership had been established which enhanced information sharing and learning and was well attended. It was initially anticipated that this would be driven locally once embedded, however that was yet to take place.

- There was now a focus on real time surveillance, capturing raw data of suspected suicides or drug related death, via the police form completed for the coroner. This allowed for targeted data analysis allowing for more precise tracking of specific places of death. This enabled cluster evaluation, including trends of methodology, age and areas, which would drive prevention work. For example 'hardening' high risk target areas for suicide by installing barriers and signposts for such services as the Samaritans and using technology to alert services for identified high risk individuals. It was explained that last minute interventions to engage the person, such as a text or prompt to reach out could effectively pause suicidal thoughts or actions.

- Training had been commissioned by the county council including Mental Health First Aid, Safe Talk and ASIST (Applied Suicide Intervention Skills Training). The ICS national funding was short term so this was in preparation for when this concluded. Training had also been made available for county councillors and the Public Health team were looking to target district members to raise awareness and secure champions for the agenda. The campaign across the ICS, involving people who had been at risk was highlighted.

- Other initiatives included: bereavement support for families affected by suicide; emergent work for young people at risk of suicide and the subsequent risk of clustering; funding allocated to small organisations to promote an innovative approach to prevention work at a local level; campaigns to promote workplace health and wellbeing and work in schools and colleges for both students and staff.

In response to questions the following information was clarified:

- Bereavement support was specific for suicide and was not extended to bereavements connected with deaths generally.

- The team was aware of the core drivers for suicide and the impact of local weather had not been considered. Deprivation was a key factor as was age, however incidents occurred across all ages and in all areas.

- The team was hoping to review the depression care pathway to address reported difficulties of accessing mental health services.

- The innovative preventative groups listed in the report did not include those groups already providing support. It was acknowledged that sports initiatives such as those delivered by Active Lancashire were valuable for promoting good mental health.

Resolved: That an update regarding suicide rates for the Lancashire and South Cumbria Integrated Care Strategy and the impact of prevention initiatives and real time data analysis be presented to the Health Scrutiny Committee Steering Group in November 2020.

❖ **Committee Work Programme**

Gary Halsall, Senior Democratic Services Officer, Democratic Services advised the steering group that the item deferred from the November Health Scrutiny Committee meeting and the items from the cancelled 3 December 2019 meeting would need to be rescheduled on the work 2019/20 programme. In addition there was a request for a report on Disabled Facilities Grants to be scheduled in accordingly.

Resolved: That the work programme be adjusted to accommodate the agenda items from the cancelled 3 December 2019 Health Scrutiny meeting, keeping to a maximum of two main items per meeting.

Meeting held on 18 December 2019

❖ Review of Primary Care Networks and Neighbourhoods Across Lancashire Consultations

The following points were highlighted and discussed:

- The development of the Primary Care Networks and Neighbourhoods was within the context of NHS Long Term Plan's proposals to deliver local services. The terms Primary Care Networks and Neighbourhoods were often used interchangeably, however there were subtle differences. The overarching concept was to bring GPs together to allow them to work together at scale.

  In response to a request for further clarification it was explained that GPs were becoming increasingly isolated, and this was a way of sharing some areas of work between groups. For example, administrative functions, sharing staff and other resources. This could mean merging practices, working together in a federation, or collaborating to share best practice.

  Those practices that were already working together as Neighbourhoods became Primary Care Networks. Other practices came together for the first time from 1 July 2019, by comparison to other Primary Care Networks that had been established as much as three or four years ago. The new way of working in Primary Care Networks presented new challenges and significant variability regarding leadership.

- Members queried the 'significant ambitions' of NHS England and it was clarified that the expectations were that in the first year the networks would be established with a minimum of at least one social prescribing link worker and one clinical pharmacist. The five national service specifications target for April 2020 were: the introduction of structured medication reviews, enhanced health in care homes, anticipatory care (with community services), personalised care and supporting early cancer diagnosis. The remaining two objectives for 2021 were: cardiovascular disease case-finding and locally agreed action to tackle inequalities. The Integrated Care Partnerships already had some services in place for care homes and that would be developed further by looking at national best practice. Work was underway with regard to cancer diagnosis models, again comparing to national best practice and implementation was anticipated in February 2020. The others would not be in place by April 2020.

- The implementation of some wider staffing roles within GP surgeries, e.g. paramedics employed in response to the shortage of GPs, had been successful across the Fylde and Wyre areas. The embedding of other nationally identified and funded roles that would support the agenda was underway, however the workforce was not readily available and more training and time was needed to shape the roles to meet both the expectations of agenda, and the needs of the service users. There were currently not enough trained staff in the required wider roles.

  In response to a question it was confirmed that funding was available for the training, provided by Health Education England.

- It was confirmed that although they were currently separate, it was a requirement for primary community health care teams such as community mental health providers to integrate into Primary Care Networks.

- Collaborative work with Lancashire County Council colleagues regarding the population health management approach was underway. This was a key feature that would drive Primary Care Networks forward to support a change in structure and provision.

- It was explained that the networks were a vehicle for provision of services and were not commissioners. The networks would interface with the Integrated Care Partnership and this may be done differently for each one. The Clinical Directors were under pressure to deliver the objectives for the Primary Care Networks and it would be necessary to manage the expectations of NHS England, as most were at the start of their journey. The contract for delivery was five years and it was confirmed that it would take that and longer for networks to develop. Each network was at a different stage on the maturity journey and the aim was to move each one to the same level.

- There were 220 GP practices in Lancashire and South Cumbria with 41 Primary Care Networks. To date, three practices from West Lancashire had not joined a network, as their location sat across multiple networks.

  In response to a question it was confirmed that it was hoped that this situation could be resolved, as being part of a network was a benefit to patients.

  NHS England expected between 30,000 to 50,000 service users per network, however five were lower than 30,000. For example, practices in Fleetwood had already been working together as a community for five years so it would not be practical to move them to a network outside their natural geographies and so a case was made to NHS England not to change their current arrangement. In areas of dense conurbation like Blackpool, networks were arranged in their natural communities.

Dr John Miles, the Clinical Director for the Wyre and Fylde Rural Extended Primary Care Network updated the steering group on the network's progress to date and next steps.

The following points were highlighted and discussed:

- Each network had a Clinical Director, for which the sole responsibility was to the practices within it. Since inception, the emphasis had been on building relationships with the practices, understanding the range of population challenges and looking at ways to address shared practice based challenges.

- The Fylde Coast Integrated Care Partnership consisted of eight Primary Care Networks. Examples of the work underway with the networks was shared, such as population health management. For example, using health based and community data to interpret local population issues such as the physical condition of housing and isolation as having a direct impact on health and wellbeing. This

related to the work of the Social Prescribing Link worker as a gateway to link population identified needs with what appropriate support was available in the community. There would not be a single solution that was suitable for the Primary Care Networks' needs, however there would be common elements.

- Fleetwood was already a mature collaboration, who had been engaging with the community on a very broad large scale for several years. Examples of developing links and initiatives in place that have proven successful, were shared with the group.

- The aim was to establish Neighbourhood Care Teams, which put the patient at the centre and allowed access to a range of care providers to meet their health and wellbeing needs. It was noted that this model worked well when all services in the team worked together and was currently a success in Garstang. The goal was to implement this across all Primary Care Networks over the next 2-3 years.

  In response to a question it was clarified that the challenge was to build relationships between the services in the Neighbourhood Care Team and to ensure that the most relevant person was in the collaboration. Each service would have different processes and needs, and the model would need to be adaptable. There were also practical considerations such as aligning computer records. In other networks, the mental health and social care relationships in the team needed more work, this relationship was in place in the Garstang Primary Care Network but not in others. The model would need to fit in with the needs of the area.

Members made the following challenges:

- There was a lack of political involvement, councillors had a good insight into community needs and issues and it was clear that there was a lack of public knowledge regarding the work and development of the networks.

  Members were advised that a Citizens Enquiry had been held in Blackpool, when the public were interviewed to gain a greater insight into their needs and understanding of services.
  The Primary Care Network details, including the Clinical Director information, would be shared with councillors, so they could be aware of what services were set up within their constituency.

- There were issues for some rural residents of Lancashire having access to Health Centres and this impacted on emergency services at hospitals. This emphasised the lack of understanding by the public regarding what was available. It was suggested that integrated service provision worked best when teams were co-located and supported by suitable estate. Preston and South Ribble estate needed more investment.

  It was confirmed that Integrated Care Partnerships had been tasked to improve access for patients, including providing extended hours and services tailored to the local population based on their specific challenges.

In response to further comments it was agreed that services needed to work more closely with authorities and businesses. It was noted that funding was available to support the voluntary, community and faith sector going forward that would facilitate this. However consistency with funding was a risk for the sector.

- In response to a question it was confirmed that the Clinical Director role included: improving access to general practice, integration of services, workforce development and developing relationships with the community and district councils. However each Clinical Director role would be different and there was no set model for the networks.

- Members asked how duplication of work was avoided and how best practice was shared between networks, as some services would be the same for all demographics.

  It was confirmed that each Integrated Care Partnership had a monthly networking meeting and a three monthly meeting was held for all 41 Primary Care Networks in the Integrated Care Strategy. There was a digital platform available to share good practice, and development funding of £1.3 million was available for Lancashire and South Cumbria to support networks in their engagement with communities and building leadership.

- In response to a query regarding using community venues and pharmacists to provide easier access to services, it was confirmed that the development of the networks was an opportunity to take an innovative and pragmatic approach to make changes and improve service delivery.

- It was clarified that Primary Care Networks were a group of GPs working together, whereas Neighbourhoods described GPs working with all community providers.

Resolved: That the Steering Group receive an overview on the work currently being undertaken by the County Council's Public Health team on Primary Care Networks and Neighbourhoods at its meeting scheduled for 19 February 2020.

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel
None		

Reason for inclusion in Part II: N/A

Health Scrutiny Committee
Meeting to be held on Tuesday, 4 February 2020

Electoral Division affected:
(All Divisions);

Health Scrutiny Committee Work Programme 2019/20
(Appendix A refers)

Contact for further information:
Debra Jones, Tel: 01772 537996, Democratic Services Officer,
Debra.Jones@lancashire.gov.uk

Executive Summary

The work programme for both the Health Scrutiny Committee and its Steering Group is set out at appendix A.

Recommendation

The Health Scrutiny Committee is asked to note and comment on the report.

Background and Advice

A statement of the work and potential topics to be undertaken and considered by the Health Scrutiny Committee and its Steering Group for the remainder of the 2018/19 municipal year is set out at appendix A, which includes the dates of all scheduled Committee and Steering Group meetings. The work programme is presented to each meeting for information.

The work programme is a work in progress document. The topics included were identified by the Steering Group at its meeting held on 19 June 2018.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Lancashire County Council

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee Work Programme 2019/20

The Health Scrutiny Committee Work Programme details the planned activity to be undertaken over the forthcoming municipal year through scheduled Committee meetings, task group, events and through use of the 'rapporteur' model.

The items on the work programme are determined by the Committee following the work programming session carried out by the Steering Group at the start of the municipal year in line with the Overview and Scrutiny Committees terms of reference detailed in the County Council's Constitution. This includes provision for the rights of County Councillors to ask for any matter to be considered by the Committee or to call-in decisions.

Coordination of the work programme activity is undertaken by the Chair and Deputy Chair of all of the Scrutiny Committees to avoid potential duplication.

In addition to the terms of reference outlined in the Constitution (Part 2 Article 5) for all Overview and Scrutiny Committees, the Health Scrutiny Committee will:

- To scrutinise matters relating to health and adult social care delivered by the authority, the National Health Service and other relevant partners.
- In reviewing any matter relating to the planning, provision and operation of the health service in the area, to invite interested parties to comment on the matter and take account of relevant information available, particularly that provided by the Local Healthwatch
- In the case of contested NHS proposals for substantial service changes, to take steps to reach agreement with the NHS body
- In the case of contested NHS proposals for substantial service changes where agreement cannot be reached with the NHS, to refer the matter to the relevant Secretary of State.
- To refer to the relevant Secretary of State any NHS proposal which the Committee feels has been the subject of inadequate consultation.
- To scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under the Health and Social Care Act 2012.

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- To request that the Internal Scrutiny Committee establish as necessary joint working arrangements with district councils and other neighbouring authorities.

- To draw up a forward programme of health scrutiny in consultation with other local authorities, NHS partners, the Local Healthwatch and other key stakeholders.

- To acknowledge within 20 working days to referrals on relevant matters from the Local Healthwatch or Local Healthwatch contractor, and to keep the referrer informed of any action taken in relation to the matter.

- To require the Chief Executives of local NHS bodies to attend before the Committee to answer questions, and to invite the chairs and non-executive directors of local NHS bodies to appear before the Committee to give evidence.

- To invite any officer of any NHS body to attend before the Committee to answer questions or give evidence.

- To recommend the Full Council to co-opt on to the Committee persons with appropriate expertise in relevant health matters, without voting rights.

- To establish and make arrangements for a Health Steering Group the main purpose of which to be to manage the workload of the full Committee more effectively in the light of the increasing number of changes to health services.

The Work Programme will be submitted to and agreed by the Scrutiny Committees at each meeting and will be published with each agenda.

The dates are indicative of when the Health Scrutiny Committee will review the item, however they may need to be rescheduled and new items added as required.

Health Scrutiny Committee work programme

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers/organisations	Proposed Date(s)	Recommendations	Progress
Committee					
Healthier Lancashire and South Cumbria Integrated Care System - five year local strategy	Feedback on draft five year strategy	Dr Amanda Doyle, Healthier Lancashire and South Cumbria	24 September 2019 and 4 February 2020	The published five year strategy be presented to the Health Scrutiny Committee at its next scheduled meeting on 5 November 2019.	Deferred
Our Health Our Care Programme	Update on the future of acute services in central Lancashire	Dr Gerry Skailes, Lancashire Teaching Hospitals; Denis Gizzi, Greater Preston and Chorley and South Ribble CCGs and Jason Pawluk, NHS Transformation Unit	24 September and 4 February 2020	The Health Scrutiny Committee at its meeting scheduled on 3 December 2019, receive analysis on: 1. Staffing requirements for all options; 2. Impact on neighbouring Trusts as well as the Royal Preston Hospital site; 3. Mental Health service provision for all options;	In progress

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers/organisations	Proposed Date(s)	Recommendations	Progress
Committee					
				4. Financial information on all the options.	
Impact of recruitment of additional Occupational Therapists	Update on the recruitment of additional OTs and impact on waiting times	Tony Pounder, LCC	5 November 2019	That: 1. The report be noted. 2. The improvements seen in the performance of the Lancashire County Council Occupational Therapy Service be welcomed. 3. A further report on the differing allocations of Disabled Facilities Grants to district councils in Lancashire with a focus on discretionary grants be	In progress

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers/organisations	Proposed Date(s)	Recommendations	Progress
Committee					
				presented to a future meeting.	
Urgent Mental Health Pathway	Improvement journey of LSCFT	Caroline Donovan, Chief Executive, LSCFT (incl. LCC officers)	31 March 2020		
Transforming Care (Calderstones)	Model of care for CCG commissioned learning disability beds To receive a written report and action plan on performance against targets for the trajectory for discharge rates, annual health checks (AHC) and Learning Disabilities Mortality Reviews (LeDeR).	Rachel Snow-Miller, Director for Commissioning for All-age Mental Health, Learning Disabilities and Autism, Healthier Lancashire and South Cumbria	31 March 2020		
Social Prescribing	Update on progress with the programme of work	Linda Vernon, Healthier Lancashire and South Cumbria and Michelle Pilling, East Lancs CCG	12 May 2020		

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers/organisations	Proposed Date(s)	Recommendations	Progress
Committee					
Cessation of the Lancashire Wellbeing Service	Impact of decommissioning the service. Tracking of service users	Dr Sakthi Karunanithi, CC Shaun Turner, LCC	12 May 2020		
Tackling period poverty	To report back on the activities of the Government's joint taskforce on period poverty in the UK	CC Nikki Hennessy (rapporteur)	tbc		

Other topics to be scheduled

- Improved/Better Care Fund – and the transformational impact
- Vascular Service Improvement – New Model of Care for Lancashire and South Cumbria (Joint Committee)
- Pooling health and social care budgets (Joint Committee?)
- Continuing Healthcare Assessments – to be scheduled
- Housing with Care and Support Strategy 2018-2025 - Update on the implementation of the strategy (Cabinet Members S Turner and G Gooch, Louise Taylor, Joanne Reed, Craig Frost, Julie Dockerty, LCC) 12 September 2020

Health Scrutiny Steering Group work programme

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
Work programming workshop	workshop on the priorities of the ICS and work programming for 2019/20	CCs S Turner and G Gooch, and Dr Sakthi Karunanithi, LCC (10:30am), Healthier Lancashire and South Cumbria (11:30am) and Oliver Pearson, Healthwatch	19 June 2019	-	-
Delayed Transfers of Care	Progress update and learning from ECIST event.	Sue Lott, LCC Faith Button and Emma Ince, GPCCG and CSRCCG	17 July 2019 (11:15am)	-	-
Head and Neck	Improving quality and access to head and neck services	Tracy Murray, Healthier Lancashire and South Cumbria, and Sharon Walkden, NHS Midlands and Lancashire Commissioning Support Unit (CSU)	17 July 2019 (12noon)	-	-
Our Health Our Care	Update on the future of acute services in central Lancashire	Jason Pawluk, NHS Transformation Unit	17 July 2019 (10:30am)	-	-

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Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
Social Prescribing	Council for Voluntary Services across Lancashire	Linda Vernon, Healthier Lancashire and South Cumbria; with Christine Blythe, BPR CVS, Joe Hannett, Community Futures and Lynne Johnstone, LCC	11 September 2019		
Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)	Draft Terms of Reference	Gary Halsall, LCC	11 September 2019		
Stroke Programme	Improvement, and the position on Hyper Acute Stroke Services	Gemma Stanion, Healthier Lancashire and South Cumbria and Elaine Day, NHS England	11 September 2019		
Joint Health Scrutiny Committee for the Lancashire and South Cumbria Integrated Care System (ICS)	Draft Terms of Reference	Members and scrutiny support officers from Lancashire, Cumbria, Blackburn and Blackpool Councils	16 October 2019		
Suicide Prevention in Lancashire	Progress report/annual update on outcomes set out in the Logic Model	Dr Sakthi Karunanithi/Clare Platt and Chris Lee, LCC	20 November 2019		

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
North West Ambulance Service (NWAS)	Trust wide rota review	Peter Mulcahy	20 November 2019		
Review of Primary Care Networks and Neighbourhoods	Themed review for 2019/20 - reviewing impact at local level and accessibility of health care services and provision of local facilities (capital and estates strategy – opportunities and constraints)	Peter Tinson, FWCCG and Stephen Gough, NHS England and Dr John Miles, Garstang Medical Practice	18 December 2019		
Review of Primary Care Networks and Neighbourhoods	Themed review for 2019/20	Public Health, LCC	19 February 2020		
Cessation of the Lancashire Wellbeing Service	Exit plan to identify possible mitigating actions for service users	Dr Sakthi Karunanithi, CC Shaun Turner, LCC	19 February 2020		

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
Review of Primary Care Networks and Neighbourhoods	Themed review for 2019/20		11 March 2020		
NHSE – Quality Surveillance Group	Overview and relationships with scrutiny	Sally Napper, NHSE, Lisa Slack, LCC	11 March 2020 (tbc)		
Review of Primary Care Networks and Neighbourhoods	Themed review for 2019/20		16 April 2020		
Quality Accounts Preparations for responding to NHS Trusts Quality Accounts	Continued focus on Lancashire and South South Cumbria Foundation Trust and Lancashire Teaching Hospitals Foundation Trust	Oliver Pearson, Healthwatch Lancashire	16 April 2020		
Transforming hospital services and care for people in Southport, Formby & West Lancs	Update on the Trust's key targets	Trish Armstrong-Child, Southport and Ormskirk Hospital Trust	27 May 2020		
Review of Primary Care Networks and Neighbourhoods	Themed review for 2019/20		27 May 2020		

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Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers	Proposed Date(s)	Recommendations	Progress
Steering Group					
Health in All Policies Briefing note	Embedding spatial planning and economic determinants	Dr Aidan Kirkpatrick and Andrea Smith, LCC	-		Pending

Other topics to be scheduled:

- Sexual health – commissioning LSCFT and Young Person's Clinics
- Integrated Care Partnerships (ICP) – Central Lancashire; Fylde Coast; Morecambe Bay; Pennine; West Lancashire
- Chorley A&E, GTD Healthcare and CCGs – performance
- Delayed Transfers of Care - Update on performance (Sue Lott, LCC and Faith Button, Ailsa Brotherton, Lancashire Teaching Hospitals, Emma Ince, GPCCG and CSRCCG) 24 June 2020

Standing items:

- Health and Wellbeing Board update
- Lancashire Safeguarding Boards Annual Report
- Adult Social Care annual update; Winter Plan; and Complaints Annual Report