Annex 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.

This has ensured that the process of enhanced clinical scrutiny has been:

- 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	**Jason Pawluk**
Chief Accountable Officer	**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

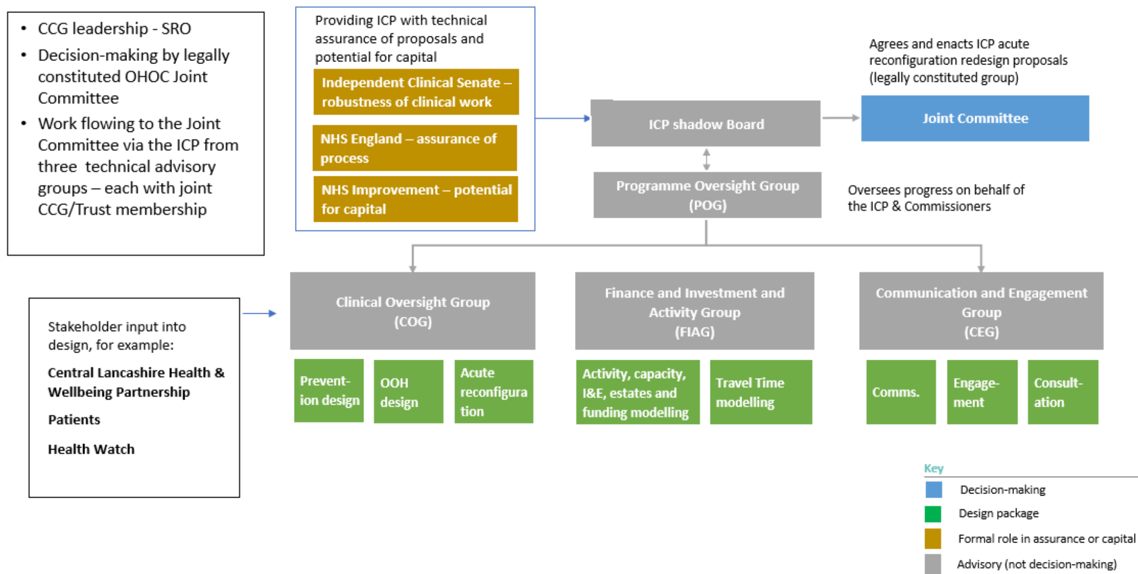
The Clinical Oversight and Scrutiny of the OHOC Programme report can be accessed within the news section of the Our Health Our Care website.

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.

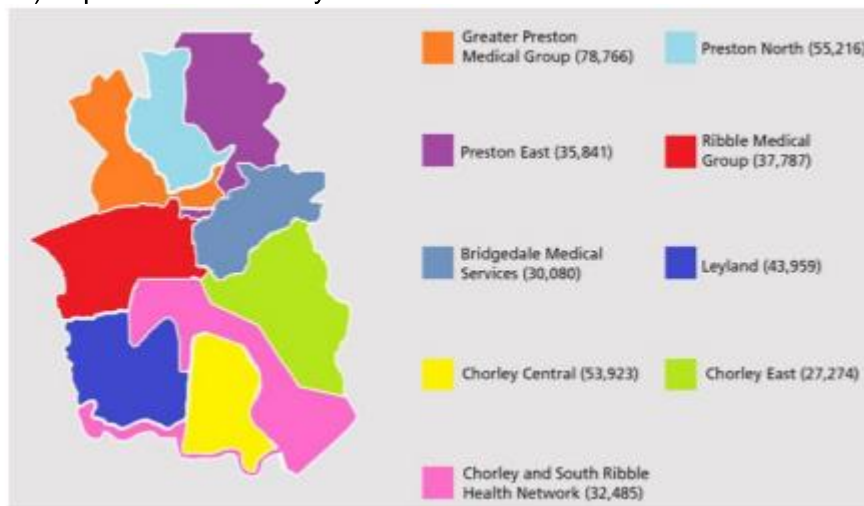
- **Stage C** included undertaking high-level clinical, activity and financial modelling on each of the options on the long list to determine whether the option would be viable from both a clinical and financial perspective; in order to create a short-list of options. Options were taken discussed in 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 Rangaswamy	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 Melings
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.