Appendix 1

The Royal College of Emergency Medicine

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Dear Lynn Chadwick,

Please find attached the final report from the RCEM Invited Services Review at Lancashire Teaching Hospitals NHS Foundation Trust.

Thank you for hosting RCEM for this review. We hope that you find the report and recommendations useful going forwards.

Sharing the report internally
In the Terms of Reference you agreed to share the report with the following parties in a timely manner:

- Trust Board (essential)
- Emergency Department Leadership; including Clinical Lead and Nurse Director (essential)
- All staff (optional but recommended)
- The relevant regulatory body (optional but recommended)

Sharing the report externally
The report is owned by the hospital and any subsequent demand for access to the report by an external body will be handled by you (see exception below). A copy of the report will be retained in confidence by the Royal College of Emergency Medicine for reference.

EXCEPTION: The Royal College of Emergency Medicine will share a copy of the report with the relevant regulatory body in advance of their visit to the host site, unless the host informs RCEM in writing that they wish to opt out of this.

Feedback
RCEM welcomes feedback from you and any other staff involved in this review. All feedback will be reviewed by the RCEM Quality Manager and used to continuously improve our service.

Kind regards,

Dr Ian Higginson, RCEM Invited Service Review Chair

Sam McIntyre, RCEM Quality Manager

The Royal College of Emergency Medicine

Royal College of Emergency Medicine Invited Service Review visit

Lancashire Teaching Hospitals NHS Foundation Trust

Visit Date: 3-4 April 2019

Authors:

1. Dr Ian Higginson
2. Dr Steve Jones
3. Martin Rolph
4. Dr Graham Johnson
5. Sam McIntyre

Report issued: 1 July 2019

Contents

Executive summary

The Royal College of Emergency Medicine (RCEM) was invited to visit the Emergency Departments (ED) at Chorley and South Ribble Hospital and Royal Preston Hospital, part of Lancashire Teaching Hospitals NHS Foundation Trust. The visit took place on 3-4 April 2019.

We were asked to review the sustainability of the current model of care, involving a partially-opening Emergency Department at Chorley and South Ribble Hospital, and a 24/7 Emergency Department in an MTC at the Royal Preston Hospital site.

We have found that the current model is unsustainable in its current form, and is highly vulnerable whilst decisions about alternatives are being made. There are significant concerns about the safety of the current model, particularly in the evenings and at weekends when there are limited senior emergency department staff on site, and given the paucity of supporting services on the Chorley site.

Clinical and managerial staff feel that they have been asked to adopt a current model with which they do not feel comfortable, at least partly as a result of political and public reactions to a previous downgrading of the ED at Chorley.

Future plans are neither robust nor complete, although they contain many positive elements.

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

The Trust is in an extremely difficult situation, caught between two unsustainable future options around the configuration of the Emergency Departments and Urgent Treatment Centres, and three options which require investment and reconfiguration particularly on the Preston site. These options exist within a system with one site that is currently extremely challenged with regard to patient flow, where the capability of community-based services to successfully mitigate effects is in doubt, and where reconfiguration of services is likely to prove unpopular.

The format of the visit is detailed in Appendix 2. During the site visits the RCEM review team met with CCG & LTH execs, senior clinicians and a significant range of front line staff involved in delivering urgent & emergency care services and co-dependencies. We would like to extend or thanks to the staff at the Trust for making us welcome, and for engaging openly and honestly with the ISR.

We were provided with extensive documentation prior to our visit, a list of which is provided in Appendix 1.

Responses to the questions specifically raised in the TOR

1) **Current transformation plans**: We were asked to what extent we felt that the current transformation plans were robust and complete, taking sufficient account of best practice
    a. We were impressed with the amount of effort that had clearly gone into the plans that we saw
    b. The plans are to some extent unsurprising, and what we have come to expect from such documents: this is not a reflection on the authors but more of a reflection of the culture within the NHS where senior managers and clinicians are expected to produce relatively formulaic material, rather than articulating what they might actually think, or what might actually be achievable
    c. We felt that the plans offered a direction of travel, rather than being either robust or complete. There was no real indication as to how the plans could and would be delivered
    d. Potential roles for primary care, ambulatory emergency care, frailty and integration are all regarded as best practice and are included. Missing elements included the potential effects of any reconfiguration on the Preston site, and learning from the prior temporary closure of the ED at Chorley.
    e. There was no signed-off model for acute care
    f. We are sceptical about plans which rely on primary care clinicians or systems reducing demand on acute facilities, or increasing their capacity to offer complex care in the community.

2) **Sustainability and Quality:** We were asked whether the circumstances which led to the previous NHSI review of emergency care in central Lancashire, and the reopening of the ED at Chorley, are still valid. It is not possible for us to answer this question since we were not there at the time. However, we do feel that the current arrangements are unsustainable, whilst clinicians are clearly expressing concerns about safety.

3) **Emergency Department service adjacencies:** We were asked about service integration and clinical adjacencies in the emergency departments. As far as Chorley is concerned it is clear that services on site are the bare minimum, and that any further reduction will render the ED non-viable. Services at the Preston site are appropriate although we are told that the need to duplicate services across both sites results in curtailment of ambulatory care support at the Preston site, and is causing significant management problems in terms of

staffing and supporting Emergency Medicine, Acute Medicine, and Critical Care.

4) **Focused:** We were asked for our opinion around prioritisation for transformation activity in the field of reducing unnecessary demand. We found this difficult to answer since it implied that the Trust is relying on demand management strategies which are vulnerable to failure, in the context of weak current model of care. Our recommendation would be to focus on improving discharge and integrated care at the back end of the pathway, along with admission avoidance and ambulatory care strategies, and improved care of patients with mental health problems and who frequently attend (may be an overlapping group). These may be more likely to yield results than demand management strategies, for which there is little evidence of efficacy.

5) **Future Proofed:** We were asked if the proposed model is future-proofed against future clinical standards. It is not possible to answer this question given the uncertainty surrounding future clinical indicators.

Review team

Lead Reviewer: Dr Ian Higginson

Reviewer: Dr Steve Jones

Reviewer: Dr Graham Johnson (3 April 2019 only)

Lay Reviewer: Martin Rolph

RCEM Admin: Sam McIntyre

Terms of Reference

Visit Objectives

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

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

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

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

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

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

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

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

Background to the visit

There are currently two Emergency Departments operating at the Trust.

1) A type 1 Emergency Department at the Royal Preston Hospital. This site is a 24/7 unit, and the hospital is a major trauma centre. The department receives both adults and children. This department sees 70905 patients per year. Of these approx. 10000 are children. There is a co-located 24/7 Urgent Treatment Centre operated by gtd healthcare which sees a further 32543 patients per year.

2) An Emergency Department at Chorley and South Ribble Hospital. This site is open to patients as a type 1 Emergency Department 12 hours per day (staffed 14 hours a day), with consultants on site 8 hours per day, 5 days per week. Ambulance bypass is in operation for major trauma, ST elevation myocardial infarction, stroke, children, and crew discretion. The ED currently sees 24317 patients per year. Of these approx. 4750 are children. There is also a 24/7 co-located Urgent Treatment Centre operated by gtd healthcare, seeing a further 29686 patients per year. The Chorley site is not currently recognised for advanced training in Emergency Medicine, although trainees do go there as part of their ACCS (EM) rotation

Royal Preston Hospital has full facilities on site. At Chorley there is no acute surgery (including orthopaedics), and no paediatric medicine. Both sites have on site acute medicine, with ambulatory care units operating 5 days per week, 0800-1800 at Preston and 1000-1800 at Chorley. There is a small ICU in Chorley, with a large ICU at Preston undergoing expansion.

We understand that there was a 24/7 ED at Chorley which was downgraded in April 2016 over safety and sustainability concerns, with the main driver being middle grade staffing. There was pressure from a number of sources to reopen the department and following an external review of options the current arrangement was put in place from January 2017. There was a suggestion at the time that this was a trial arrangement to last some 12-18 months.

Present position of the service

The Trust is currently consulting around future options for the configuration of emergency care. Local Emergency Departments / Trusts which may be affected by reconfiguration decisions include Blackburn, Wigan, and Bolton.

Medical staffing in the ED

Current staffing levels (Emergency Departments across both sites)

- Consultants: 20 (16.4 WTE)
- Middle Grades: 14 establishment, 11.8 in post
- Junior Doctors: 25 establishment, with no current vacancies (rotational vacancies supporting by locums). Work across both sites
- ACPs: 2.8 ACP, 1 PA, 2 ESP, all at Preston
- ENPs: 11 WTE, 9.7 in post. All currently at Chorley

Nursing staffing in the ED

Grade	Est Preston	In post Preston	Est Chorley	In post Chorley	Overall vacancy
Unit manager	1	1	1	1	0
B7	12.8	12.2	4.5	2.8	2.3
B6	11	4.2	2.6	2	7.4
B5	39.2	37.6	11.6	12	2
B3	23	14.8	3.4	2.2	9.3

Relevant notes from walk-arounds

Chorley

The Emergency Department and Urgent Care Treatment Centre at Chorley are located in a redeveloped facility. We found the physical facilities to be bright and modern, although the design would make visual management difficult were the unit to operating as a single ED.

There is no separated paediatric area within the facility and no clinical decision unit.

We understand that following the downgrading in 2016 the facility was reconfigured to meet the needs of the remaining urgent care provision. The facility has not been re-reconfigured since the ED reopened to patients for 12 hours per day, and is rather awkwardly shared by the urgent care provider and the ED team, as well as the ambulatory care team. The facilities are not so much co-located as intertwined, although staffing and managerial arrangements between NHS and private providers are separated. This has caused some confusion.

Examples of confusion

- The reception area is a single desk offering three different registration options for patients, who are expected to know which one to choose when they turn up.
- Triage systems used by different providers in the same facility are different
- Computer systems are separate so there is no single way of seeing which patients are where, and what is happening to them
- Handover points are vulnerable (for instance when the ED "closes")
- The staff we spoke to were unable to describe exactly what sort of facility they are working in

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

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

Preston

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

The 4-hour performance data supports the narrative from staff that the department suffers from toxic crowding with all its associated effects on patients and staff. There were concerns expressed by many staff about the engagement and ability of both the rest of the organisation, and the wider community, to address this problem.

Sustainability of the current model at Chorley

The Emergency Department at Chorley and South Ribble Hospital is unusual in both its size and supporting services.

Size

It has low numbers of attendances during its limited, seven day a week opening. Currently a Minor Injury Service is provided within the Emergency Department by Emergency Nurse Practitioners supported by the medical staff. We were told that the Minor Injury service will eventually transfer to the adjacent Urgent Care Treatment Centre, resulting in a further fall in the attendance numbers at the Emergency Department. This would leave the Emergency Department providing a service to a reduced number of patients with illness only. The management team of the Urgent Care Treatment Centre were of the opinion that they had the capability to run a safe and effective service if the Emergency Department were to close. The Emergency Department clinicians did not disagree with this.

Support

On-site specialist support to the Emergency Department is currently limited, only being provided by an Acute Medicine unit and Critical Care Medicine. There were no acute surgical services, Paediatrics or medically lead Obstetrics on site. The utilisation of the Critical Care Unit on site was extremely low (we were told less then 30%), and at the time of our visit there were no patients being treated on the unit. This results in inefficient use of highly trained medical and nursing staff. For instance, when a patient is admitted to Chorley Critical Care staff are drafted from the Preston site.

The lack of on-site support for the Emergency Department has resulted in some formal arrangements for ambulance diversion to specialist units (Major Trauma, Stroke and ST elevation myocardial infarction). However, it is common practice for the ambulance service to bypass Chorley with other cases for which the ED was considered unsuitable (children, acute surgical and orthopaedic emergencies). The volume of ambulance arrivals at Chorley and acuity of cases is therefore low. Despite this, the staff described risks and the potential for delayed treatment in relation to some types of self-presentation or in instances where ambulance crews were not aware of local capabilities (particularly critically ill children).

It should be noted that were either Critical Care, or the Medical units, to close at Chorley then the ED would immediately become non-viable

Staffing

We were told that although the nursing workforce was below establishment, it was considered that there would be little difficulty recruiting and retaining further nurses to staff the Emergency Department.

The Emergency Department at Chorley is not recognised for advanced EM training, although trainees do go there as part of the ACCS(EM) rotation. The current medical workforce model consists of a Consultant for 8 hours a day, five days a week, non-training doctors and Emergency Nurse Practitioners. At the weekend the service is highly dependant on non-training middle grade doctors, with off-site consultant support. As in many Trusts nationally, there has been significant difficulty recruiting and retaining these doctors. A lack of these doctors has already resulted in temporary closure of the service and at other times the use of agency locums at very high cost. There have been extensive, although unsuccessful, attempts to recruit substantively to these positions and the review team feel it is highly unlikely that the Trust would be able to recruit permanently in the foreseeable future.

The Trust is able to recruit Consultants; however their impact in a department seeing low numbers of patients of relatively low acuity is likely less than their impact if this resource were moved to Preston.

Safety

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

Proposed model of care

The documentation pack associated with the ISR was very substantial. Clearly, a lot of work has gone into recognising, analysing, presenting and engaging around the issues and broader vision for healthcare provision within Central Lancashire. They correctly consider the whole system of which the emergency and urgent care components are small but important parts.

The documentation associated with the provision of emergency and urgent care pathways was very similar to the other systems around the UK including those of the ISR team. This is not a surprise and is reflective of the caseload presenting to these departments.

What is less clear from the documentation is information of the 'size' of the emergency and urgent care problem. It is very difficult to tease out how many people attend each department and, of those arrivals, which service they are there to see. It would also be useful to understand what level of care the patients actually needed e.g. type 1 care, primary care etc.

The documents describe the 'whole pathway' problem and are a strong, if repetitive, case for change, but do not in our opinion clearly articulate a plan for the emergency and urgent care system. From our review it is clear that the core components of emergency and urgent care are being delivered in a fractured way across the health economy and that change is required.

The effect of dividing resources between two sites

One of the main dilemmas faced by the Trust and its staff is that they are trying to provide full capability services for Emergency Medicine, Acute and General Medicine, and Critical Care, across two sites. This is a particular problem with respect to medical staffing, although there are shortages in some nursing groups. For all services this is regarded as undesirable, since all struggle to provide safe senior staffing and clinical care during the required times. Neither site is currently capable of operating 7 day working for ambulatory care, and weekend staffing is stretched across all services. For patients there is inequality of access to some services, for instance specialist support, endoscopy for GI bleeds, and advanced imaging; all of which are less present at the Chorley site, particularly out of the normal 9-5 working week.

However, it was apparent that the Preston site would struggle to cope with the workload were Emergency Medicine and Acute /General Medicine services to be moved to that site. This is because of the quality and configuration of the estate, and the current difficulties with patient flow through the site (multifactorial). Chorley current acts as a decompressor and safety valve for the Preston site. This effect would be compounded if all services currently provided at Chorley were to stop running.

Options

After visiting the sites and conducting the review, we consider the Trust to have five options:

1) Reopen a 24/7 Emergency Department at Chorley supported by Medicine and Critical Care +/- other services
2) Continue with the current model of a 12/7 Emergency Department, specified correctly as a Type 1 facility, co-located with the Urgent Care Centre
3) Close the Emergency Department at Chorley, and establish a fully configured Urgent Treatment Centre in line with national guidance. Leave a medical assessment unit taking GP admissions and critical care support in some form on site
4) Close the Emergency Department at Chorley, moving all acute medical and critical care services to Preston. Leave a fully configured Urgent Treatment Centre at Chorley
5) Close all Emergency Department and Urgent Treatment facilities at Chorley and re-provide all emergency and urgent care at the Preston site

Option 1: Reopen a 24/7 Emergency Department at Chorley

Pros:

- Population growth in the Chorley area is likely to continue, increasing the need for provision of emergency services. In future there may be a need for improved emergency facilities.
- Likely support from the local population for services that are closer to home
- Decompresses the Preston site, which is under pressure from demand into both its Emergency Department and Medical / Critical Care bed base and which suffers from poor patient flow

Cons:

- Current staffing will not allow this and national / local context looks unlikely to change. A limited Emergency Department service with on-site admissions only to medical specialties would not be recognised for training and would be reliant on career grade medical staff. If some way were found to staff a 24/7 ED, our view is that it would rapidly prove unsustainable and would fail
- On-site services such as medicine and radiology are not configured to support this
- Continued confusion over role of the ED vs the Urgent Care Treatment Centre
- Service does not meet some current and future requirements for a type 1 ED (e.g.) separate facilities for children, facilities for patients with mental health problems. The department would require a significant upgrade to provide appropriate facilities.
- The likely case mix would be low numbers of low acuity patients
- Inefficient use of available medical and nursing staff covering two sites
- Negative strategic impact in terms of the hot-cold split model being considered by the Trust
- Opportunities to achieve improved safety and quality of services by centralising staff to one site would be lost

Option 2: Current Model

Pros:

- Population growth in the Chorley area is likely to continue, increasing the need for provision of emergency services. In future there may be a need for improved emergency facilities.
- Likely support from the local population
- Decompresses the Preston site, which is under pressure from demand into both its Emergency Department and Medical / Critical Care bed base and which suffers from poor patient flow

Cons:

- Unsustainable in its current form and already highly vulnerable to staffing shortages. This is the case both in the ED and for the medical assessment facilities
- Continued confusion for patients and staff over the role of the ED vs the Urgent Care Treatment Centre
- Service does not meet some current and future requirements for a type 1 ED (e.g.) separate facilities for children, facilities for patients with mental health problems. The department would require a significant upgrade to provide appropriate facilities.
- The likely case mix would be low numbers of low acuity patients
- Inefficient use of available medical and nursing staff covering two sites
- Negative strategic impact in terms of the hot-cold split model being considered by the OHOC (Our Health Our Care) programme
- Opportunities to achieve improved safety and quality of services by centralising staff to one site would be lost

Option 3: The ED ceases to function as such. Establish a fully configured Urgent Treatment Centre in line with national guidance, but leave a medical assessment unit taking GP admissions and the critical care support on site

Pros:

- Improved clarity over role of acute facilities on site, although some confusion will remain around acute medical presentations
- Decompresses the Preston site with regard to acute and ambulatory medicine, and critical care
- Some "local" options remain for patients with lower acuity medical presentations
- Equality of access to specialist advice / treatment for patients presenting to the remaining ED
- Consolidation of Emergency Medicine workforce improves resilience of staffing and efficient use of available staff

Cons:

- Concerns over future-proofing in the face of population growth
- Likely unpopular with the local population
- Longer travel times for some patients, with uncertain impact on a small proportion with high acuity problems. However for ambulance patients, diversion strategies are already in place so this effect is partly mitigated and the existing ED now receives few ambulances. Effect on local ambulance service will need to be understood.
- Overload of the Emergency Department at Preston, with downstream effects on other services (medicine in particular)
- Possible negative impact on other EDs in the region, especially Wigan
- Medical Assessment services at Chorley would remain vulnerable to staffing issues, and likely pressure to consolidate supporting services such as acute radiology at the Preston site.

Option 4: Establish a fully configured Urgent Treatment Centre, and move all acute medical and critical care services to Preston

Pros:

- Definitive clarity over the role of acute facilities on site
- Consolidation of acute services at Preston site improves resilience around staffing and efficient use of available staff
- Facilitates strategic goals of OHOC (Our Health Our Care) programme around the hot-cold split

Cons:

- Concerns over future-proofing in the face of population growth
- Likely unpopular with the local population
- Longer travel times for some patients, with uncertain impact on a small proportion with high acuity problems. However for ambulance patients diversion strategies are already in place so this effect is partly mitigated and the existing ED now receives few ambulances. Effect on local ambulance service will need to be understood.
- Possible negative impact on other EDs in the region, especially Wigan
- Overload of the Emergency Department, MAU, ambulatory facilities, and bed base at Preston, with downstream effects on other services

Option 5: Close all Emergency Department and Urgent Treatment facilities at Chorley

Pros:

- Definitive solution
- Consolidation of acute services at Preston site improves resilience around staffing and efficient use of available staff
- Facilitates strategic goals of OHOC (Our Health Our Care) programme around the hot-cold split
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Cons:

- Concerns over future-proofing in the face of population growth
- Likely politically unacceptable
- Unlikely to gain support in local population
- Longer travel times for many patients, with uncertain impact on a small proportion with high acuity problems. However for ambulance patients, diversion strategies are already in place so this effect is partly mitigated and the existing ED now receives few ambulances. Effect on local ambulance service will need to be understood.
- Possible negative impact on other EDs in the region, especially Wigan
- Leaves current non-elective bed base at Chorley isolated
- Overload of the Emergency Department, MAU, ambulatory facilities, and bed base at Preston, with downstream effects on other services. It is hard to see how the Preston site could cope with the likely increase in numbers in both emergency and urgent patients.

We cannot make a firm recommendation on your choice. Models mixing type 1 EDs and urgent care centres exist elsewhere, as do models whereby Urgent Treatment Centres have been established at the site of former EDs. Such models require partnership between providers/commissioners as well as clear (clinical) governance structures. This developing relationship was evident on our visit. The publication of the Long Term Plan has taken the emergency and urgent care themes of the Five Year Forward View and moved them on. There is the opportunity within the Central Lancashire system to adopt the Urgent Treatment Centre model to tie together the primary and acute models of care.

Our view is that options 3,4 and 5 would not be possible without various degrees of redevelopment / reconfiguration of the Emergency Department, Ambulatory Care and MAU facilities at Preston, and without significant improvements in patient flow through the Preston site.

We note that the emerging ideas of the CCG assume, in effect, a big step forward in prevention and primary care. What we were told by various people on our visit suggested that there is a reality gap between the current and predicted capability

of primary healthcare services in the area, and the vision for what it can achieve. This is exacerbated by the lack of integration between hospital and community services in parts of the patch. Combined with evidence about the efficacy of such initiatives, we believe that any plans relying on demand management to mitigate the effects of concentration of acute services on a single site are likely to represent wishful thinking. Brief discussions with local commissioners confirmed their own concerns given current and foreseen problems in the local primary care system

It is possible that the local population is more aware of frailties in primary care than in secondary care. This would expose the Trust to credibility issues if plans for reconfiguration of acute services are based on aspirations about capability in primary care.

This places the Trust in an extremely difficult situation. It is caught between two options which we would regard as unsustainable, and three options which require investment and reconfiguration. These options exist within a system with one site that is currently extremely challenged with regard to patient flow, and where the capability of community-based services to successfully mitigate effects is in doubt. At the same time the Trust is considering strategic options that are politically sensitive and which are potentially unpopular with the local population in the context of their desire to maintain full services at hospitals close to where they live.

Learning from the previous closure

It should be remembered that there has been a natural trial of closure of the ED at Chorley, during the previous crisis. We were told that the learning from this period included:

- There was improved medical staffing at Preston, particularly in the middle grade tier
- Nursing development was improved and nurses were able to make a clear choice between working in an ED or in the urgent care centre environment
- Patients are reported to have "voted with their feet" and at least some chose to go to Chorley for non-emergency problems. The urgent care centre at Chorley was thought to work effectively during this period
- At the same time patient who perceived themselves as having urgent problems are also reported to have "voted with their feet" and presented to Preston ED when asked to attend Chorley as part of the effort to divert appropriate GP referrals to that site
- There were no recorded clinical incidents or incidents of patient harm, and there was reportedly limited impact on other EDs in the region
- Ambulance bypass rules were more formalised where previously they had been informal. These are reported to have continued despite the partial reopening of the Chorley ED

We were impressed by how bruised many senior hospital staff felt as a result of the public and political response to events. It has clearly coloured their approach to trying to find a solution, and their ability to hold a full and frank discussion with key stakeholders has to some extent been compromised by their sensitivity to some of the behaviours that they have witnessed. We were left with the impression that for the clinicians and managers the previous solution felt appropriate, but that they felt they were put under inappropriate pressure to revert to the current state despite their own professional judgements.

It is worth noting that many of the managerial and clinical staff we met during our visit disagreed with some of the factual content in the external report, and with its conclusions. They also feel that they are contending with expectations around the level of function at Chorley ED which have never been met (for instance paediatric capability) and that the arguments may lack balance.

Responses to the questions specifically raised in the TOR

1) **Current transformation plans**: We were asked to what extent we felt that the current transformation plans were robust and complete, taking sufficient account of best practice
    a. We were impressed with the amount of effort that had clearly gone into the plans that we saw
    b. The plans are to some extent unsurprising, and what we have come to expect from such documents: this is not a reflection on the authors but more of a reflection of the culture within the NHS where senior managers and clinicians are expected to produce relatively formulaic material, rather than articulating what they might actually think, or what might actually be achievable
    c. We felt that the plans offered a direction of travel, rather than being either robust or complete. There was no real indication as to how the plans could and would be delivered
    d. Potential roles for primary care, ambulatory emergency care, frailty and integration are all regarded as best practice and are included. Missing elements included the potential effects of any reconfiguration on the Preston site, and learning from the prior temporary closure of the ED at Chorley.
    e. There was no signed-off model for acute care
    f. We are sceptical about plans which rely on primary care clinicians or systems reducing demand on acute facilities, or increasing their capacity to offer complex care in the community.

2) **Sustainability and Quality:** We were asked whether the circumstances which led to the previous NHSI review of emergency care in central Lancashire, and the reopening of the ED at Chorley, are still valid. It is not possible for us to answer this question since we were not there at the time. However, we do feel that the current arrangements are unsustainable, whilst clinicians are clearly expressing concerns about safety.

3) **Emergency Department service adjacencies:** We were asked about service integration and clinical adjacencies in the emergency departments. As far as Chorley is concerned it is clear that services on site are the bare minimum, and that any further reduction will render the ED non-viable. Services at the Preston site are appropriate although we are told that the need to duplicate services across both sites results in curtailment of ambulatory care support at the Preston site, and is causing significant management problems in terms of staffing and supporting Emergency Medicine, Acute Medicine, and Critical Care.

4) **Focused:** We were asked for our opinion around prioritisation for transformation activity in the field of reducing unnecessary demand. We found this difficult to answer since it implied that the Trust is relying on demand management strategies which are vulnerable to failure, in the context of weak current model of care. Our recommendation would be to focus on improving discharge and integrated care at the back end of the pathway, along with admission avoidance and ambulatory care strategies, and improved care of patients with mental health problems and who frequently attend (may be an overlapping group). These may be more likely to yield results than demand management strategies, for which there is little evidence of efficacy.

5) **Future Proofed:** We were asked if the proposed model is future-proofed against future clinical standards. It is not possible to answer this question given the uncertainty surrounding future clinical indicators.

Appendix 1 - Documentation considered prior to the visit and any relevant material following the visit

ESSENTIAL

1. Organisation lead for this review
2. Signed terms of reference
3. Signed terms of business
4. Completed self-assessment questionnaire
5. Previous external reports
    - Item E CQC Evidence Report – October 2018

DESIRABLE

Domain 1: Workload

Suggested information	Submitted information
1. A one page summary from the Clinical Director of strengths, weaknesses, opportunities and challenges to the EM service at present	1.1 Summary of LTHTR Emergency Medicine services at present See also the Terms of Reference
2. Details of annual attendances and casemix breakdown	1.2 Attendances

Domain 2: Configuration of services

Suggested information	Submitted information
1. An overview of the local emergency care system (with a one page pictorial summary of flows). This should include service delivery models for adult and paediatric EM	2.1 Case for change – Central Lancashire acute sustainability , including the remainder of the OHOC Programme and the work of community-based transformation 2.1 Our Model of Care - Improving Hospital Services and Clinical Outcomes in Central Lancashire, including the remainder of the OHOC Programme and the work of community-based transformation

	2.1 Junior doctor staffing 2.1 Staff events – September 2018 2.1 – Welcome to the ED – careers are made here
2. Outline of your departmental patient flow policies	2.2 Medicine Division 12hr Bed Escalation 2.2 Opel levels and bed use 2.2 ED policy
3. Models of care delivery during the night, weekends and periods of extensive service demands ie. bank holidays	2.3 Overnight ED Coordination and Safety Process
4. Overview of departmental integration with Primary Care services and/or co-located services. This should include any streaming strategies for GP referrals for direct admission	
5. Documented evidence of integrated Minor Injuries streams including governance/training/service delivery	2.5 Report of the Independent review of Emergency Nurse Practitioner service Lancashire Teaching Hospitals NHS Foundation Trust
6. Summary of mental health and alcohol liaison services present with your ED	2.6 Enhancing our approach to Mental Health at Lancashire Teaching 2.6 Emergency Department referral pathway to Mental Health Liaison Team 2.6 Alcohol use disorder policy
7. Information detailing co-location of inter-disciplinary elderly care/frailty units – including. medicine for the elderly	2.7 LIFT pathway 2.7 Introducing the Lancashire Integrated Frailty Team 2.7 RCEM visit statement LIFT
8. Documented evidence of support from in-hospital specialty for ED and any co-located service activity	2.8 Emergency Department to Ambulatory Care Referral Guideline – Presentation with Suspected anaemia 2.8 Ambulatory Care Referral Pathway for Suspected Cardiac Chest Pain

	2.8 Ambulatory Care Referral Summary Guideline – First Seizure 2.8 Ambulatory Care Referral Pathway - Acute Headache 2.8 Ambulatory Care Referral – Low Risk Upper GI Bleed 2.8 Medical Ambulatory Care Triage Tool 2.8 Ambulatory Care Referral Summary Guideline – Syncope and Collapse
9. Summary of key services required to support a Type 1 ED: 1) Critical Care 2) Acute Medicine 3) Imaging 4) Laboratory Services 5) Paediatrics 6) Orthopaedics 7) General Surgery	2.9 Summary of LTHTR key services

Domain 3: Commissioning

Suggested information	**Submitted information**
1. Your Trust's strategic overview & objectives for Emergency Medicine (EM)	3.1 Our Big Plan, Strategy 2019 3.1 Our Values Pack 2018 3.1 Business plan for medicine 3.1 March big plan launch
2. Local commissioning strategy for EM (or equivalent)	

Domain 4: Observation Medicine and ambulatory emergency care

Suggested information	**Submitted information**
1. Processes for ambulatory emergency care AEC systems and if present observation units	4.1 Emergency Department to Ambulatory Care Referral Guideline Presentation with suspected Anaemia

	4.1 Ambulatory Care Referral Pathway for Suspected Cardiac Chest pain 4.1.ED Observation area criteria 4.1.Ambulatory Care Referral Summary Guideline– First Seizure 4.1 Acute Headache 4.1 Low risk upper GI bleed 4.1 Ambulatory Care Referral Summary Guide - Syncope and collapse 4.1.Medical Ambulatory triage tool

Domain 5: Medical Staffing in the ED

Suggested information	Submitted information
1. An overview of your senior consultant workforce. This should include 1) Consultant staffing figures 2) Consultant positions held ie lead responsibilities and teaching duties 3) A full Consultant rota 4) An overview of how programmed activities are determined and allocation of supporting professional activities 5) Trust policies for remuneration of consultant out of hours work	5.1.1 - 5.1.4 Consultant Workforce 5.1.5 Medical and Dental Extra Duty Payment Policy
2. A summary of your middle grade workforce. This should include 1) Middle Grade staffing figures 2) Middle Grade rotas	5.2 MG Staffing
3. A summary of your training grade workforce. This should include	5.3 Junior doctor staffing

	a. Training Grade staffing figures b. Example Training Grade rotas	
4.	GMC Training review for the EM service	5.4 Copy of ED GMC 2018 results and action plan
5.	Deanery Training review for the EM service	

Domain 6: Safety and governance

Suggested information	**Submitted information**
1. Outline of your departmental patient flow policies	6.1 ED SOP 6.1 Service Standards between the ED, Specialty Te…port Services 6.1 Surge and Capacity Plan ED 6.1 Transfer of Paed Patients from Chorley ED
2. Summary of patient pathways within your ED	6.3 Copy of Escalation trigger tool v5 6.3 Surge and Capacity Plan ED
3. Evidence of management tools utilised	6.4 CRM
4. Relevant Clinical Governance activity & summary	6.5 -6.8.Risk Register 6.5-6.8 Division of Medicine Risk report 6.5-6.8 Incident Risk presentation.ppt 6.5-6.8 Latest Divisional Safety and Quality Minutes 6.5-6.8 Latest ED Chairs report 6.5 Quality and safety report (children) - Oct 2018
5. Evidence of safety governance. This should include:	6.5 Audit meeting – Sept 2018 6.5 Quality and safety report – Feb 2019 6.5 ED newsletter – Nov 2018 6.5 Escalation trigger tool 6.5 Hospital handover LS3 story board template

	6.5 Medicine risk report (excluding critical care, paediatrics, & core therapies) 6.5 Quality and safety report – Jan 2019 6.5 STAR visit report – January 2019 6.5 STAR visit report – February 2019
6. Relevant Clinical Governance activity & summary 1) Relevant reporting on the ED from Risk Management 2) Clinical risk register for the ED 3) Incident reporting processes 4) Identified Safety Lead 5) Details of any projects to optimise safer care	
7. Relevant reporting on the ED from Risk Management	
8. Clinical risk register for the ED	

Domain 7: Nursing staff and skillmix

Suggested information	**Submitted information**
1. An overview of your nursing grade staff. This should include 1) Nursing staff figures including a breakdown of grades 2) Summary of varying nursing responsibilities within your ED	7.1 Nursing Workforce

	3) Example nursing rotas	
2.	Service delivery models for ENPs and ANPs. This should include o Relevant staffing figures for ENP & ANP workforce o Location of service ie ED or ambulatory care pathways	7.2 ED Nurse Practitioners 7.2 ENP training
3.	Service delivery models for Physician Associates. This should include o Relevant staffing figures for Physician Associates o Location of service ie ED or ambulatory care pathways	7.3 Physician Associates and Physiotherapists

Domain 8: Tariffs and informatics systems

Suggested information		**Submitted information**
1.	An overview of the information system used within your ED	8.1 Escalation trigger tool 8.1 Information systems used in ED
2.	A summary of your departmental coding systems	

Domain 9: Clinical quality indicators of care

Suggested information	**Submitted information**
1. Documentation of quality improvement programmes	9.1.QIP Plan 9.1 Continuous improvement annual report 2018/19 9.1 Urgent and emergency care improvement action plan 9.1 continuous improvement update – Nov 2018

2. Key Performance Indicators from the last 3 years. For example: 1) Quality Indicators 2) CQUINs or equivalent 3) Serious Incidents 4) Complaints 5) Staff turnover (EM Consultants, middle-grades & Nurse bands 5-7) 6) Annual sickness levels (EM Consultants, middle-grades & Nurse bands 5-7)	9.2.1 Quality Indicators 9.2.3. Copy of ED Level 2 and 3 incidents 2016-2019 9.2.4. Complaints 9.2.4. STAR Visit Report FINAL ED CYP CDH February 2019 9.2.4. Star Accreditation Final 3rd visit September 2018 9.2.4.STAR visit report - FINAL - ED RPH 4th Visit Jan…2019 FINAL

Domain 10: The patient experience

Suggested information	Submitted information
1. Guidance for local population on where best to access urgent and emergency care	11.1 RATS - Experienced Nurse Dec 18 11.1. RATS - HCA Role Dec 1 11.1. RATS - Poster RATS Dec 18 Team Roles & Responsibilities 11.1. RATS - Senior Decision Maker (SDM) Dec 18 11.1.RATS - Role of Admin Support Dec 18
2. Overview of departmental systems for collecting and reviewing patient and relative feedback	
3. Documented evidence of patient and relative experience	10.3. Copy of Unify Report 01_04_2018 to 08_03_2019 10.3.Copy of FFT_Comments_Report

Appendix 2 – Format of the Invited Service Review

Timetable for Invited Service Review 3-4 April 2019

3 April: Chorley Hospital

Time	Room	Meeting	Notes
11.45 – 13.00	Lecture Hall Education Centre 3 CDH	Meet & Greet Senior Clinicians, Executives, Senior Nursing staff	Lecture Hall booked for the whole day
13.00 – 13.45	Lecture Hall EC3 CDH	Working Lunch	
13.45 – 15.15	Walking tour of site		
15.15 – 15.30	Coffee Break		
15.30 – 16.00	Training Room ED	Discussion with Middle Grade Doctors	Split Panel
15.30 – 16.00	Nurses office	Discussion with Nursing Staff	Split Panel
16.00 – 16.30	Training Room ED	Discussion with Local Clinicians	Full Panel
16.30 – 17.00	Training Room ED	Discussion with Service Managers	Full Panel

4 April: Royal Preston Hospital

Time	Room	Meeting	Notes
09.00 – 10.00	Seminar Room 2 Education Centre 1	Meet & Greet Senior Clinicians / Execs / Senior Nursing staff	Room available until 11.00am
10.00 – 10.15	Walk from EC1 to front of hospital		
10.15 – 11.45	Tour of RPH site ED/Urgent Care/Critical Care/Ambulatory Care etc		
11.45 – 12.00	Walk from hospital back EC1		
12.00 – 13.15	Lecture Room 3 Education Centre 1	Discussion with LTH Execs & Senior Clinicians	Room available until 2.00pm

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The Royal College of Emergency Medicine

Royal College of Emergency Medicine Invited Service Review visit to Lancashire Teaching Hospitals NHS Foundation Trust

Annex 1

Visit Date: 3-4 April 2019

Authors:

1. Dr Ian Higginson
2. Dr Steve Jones
3. Martin Rolph
4. Dr Graham Johnson
5. Sam McIntyre

Report issued: 24 June 2019

Annex 1 - Executive members and staff that RCEM met on the visit

Please note that this is an annex to the main report listing the staff that RCEM met during the site visits.

Wednesday 3rd April 2019

Executive Meet & Greet

Surname	Name	Title
Bishop	Kelly	Head of Nursing - OHOC/TU
Dickinson	Lindsey	GP Director - Chorley & South Ribble CCG
Goode	Sue	Senior Sister - ED
Earley	Tracy	ADMD Surgery - OHOC Clinical Lead Surgery
Havey	Paul	Finance Director LTHTR – Executive Team
Pawluk	Jason	Our Health Our Care Programme Director - OHOC/TU
Sime	Lynn	Matron - ED
Skailes	Gerry	Medical Director LTHTR
Stewart	Michael	ED Consultant - OHOC Clinical Lead ED
Kirkham	Anne	Our Health Our Care Clinical Leand WHIN's Platform - OHOC/CCG
Kumar	Somnath	Consultant - OHOC Clinical Lead Specialist Medicine
Lawrenson	Tina	Clinical Business Manager Acute Medicine
Twamley	Huw	Consultant Critical Care - OHOC Clinical Lead Critical Care

Chorley & South Ribble & Great Preston CCGs

Surname	Name	Title
Bangi	Gora	Chair Chorley & South Ribble CCG
Curtis	Helen	Director of Quality & Performance CCGs
Gizzi	Denis	Chief Officer CCGs
Mellor	Jayne	Director of Transformation & Delivery CCGs
Mukerji	Sumantra	Chair Greater Preston CCG

Nursing Staff

Surname	Name	Title
Sime	Lynn	Matron ED
Good	Sue	Senior Sister ED
Clayton	Sarah	Matron Ambulatory Care
McAllen	Yvonne	Staff nurse ED
Wallace	Debbie	ENP

Local Clinicians

Surname	Name	Title
Drake	Ian	Consultant Gastroenterologist
Davis	Kate	Consultant ED
Howell	Simon	Consultant Diabetes & Endocrine
Kumar	Somnath	Consultant Cardiologist
Watson	Michael	Senior Clinical Fellow Ambulatory Care
Olatoya	Ayo	Consultant MAU
Cottle	Daniel	Consultant (CD) Critical Care
Nipah	Robert	Consultant Acute Medicine

Senior Managers

Surname	Name	Title
Lawrenson	Tina	Clinical Business Manager
Shakespeare	David	Divisional Medical Director
Sansbury	Rachel	Divisional Nursing Director Medicine

Thursday 4th April 2019

Executive Meet & Greet

Surname	Name	Title
Stewart	Michael	ED Consultant - OHOC Clinical Lead ED
Bishop	Kelly	Head of Nursing - OHOC/TU
Pawluk	Jason	Our Health Our Care Programme Director - OHOC/TU
Gregory	Scott	
Skailes	Gerry	Medical Director LTHTR
Whittaker	Jon	ED Consultant
Sykes	Alison	ED Consultant
Tabone	Dianne	ED Consultant
Earley	Tracy	ADMD Surgery - OHOC Clinical Lead Surgery
Purgh	Mark	Consultant Critical Care, Co-Dependency lead for OHOC
Sime	Lynn	Matron – ED
Ellis	Graham	ED Consultant and Clinical Director
Lawrenson	Tina	Clinical Business Manager
Curran	Andy	ED Consultant
Chadwick	Lynn	Our Health Our Care Programme
Roberts	Moira	Head of continuous improvement
Button	Faith	Chief Operating Officer
Naylor	Gail	Executive Director Nursing & Midwifery
Partington	Karen	Chief Executive

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