**Appendix 4**

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# Clinical Oversight and Scrutiny of the OHOC Programme: Update for OHOC Governing Body: 13th November 2019

## 1.0 Executive Summary

This paper identifies the outputs of the enhanced clinical scrutiny process and a proposed way forward. As context, on 28th August, the Joint Committee discussed the long list of options at a meeting held in public directing that enhanced clinical scrutiny on the longlist of options needed to take place to enable them to make a clear, evidence-based decision on which options to progress to a short list. This included re-visiting the case for a new build as a preferred approach.

The Chief Officer of the CCG's and the SRO for the OHOC programme provided a schedule of enhanced clinical scrutiny, circulated for comment to all members of the Governing Body. This schedule included a broad, continuing range of activities comprising of:

**Cohort 1: Primary care clinical leadership** – This needs to involve the Clinical Chairs, Clinical Directors, Primary Care Network Directors and Clinical Advisors. This included sessions with the Joint Executive Meeting (JEM), individual contact with network leadership teams and collective engagement via the Peer Groups.

**Cohort 2: Secondary care clinical colleagues** (including nursing, AHP, partners/others) meeting with primary care clinical leadership to collectively provide robust clinical oversight and scrutiny of all the options. This included the development of a Clinical Summit in October.

**Cohort 3: A significantly strengthened COG (Clinical Oversight Group).** This will be the group that is charged with distilling the clinical views from both Cohort 1 and Cohort 2 and forming a consensus options appraisal to narrow down the broad range to a smaller number, based on robust and sound clinical scrutiny. This included a refresh of the terms of reference and membership of the group, and steps towards the appointment of an independent clinical director for the programme, who would also chair the group.

The Clinical Oversight Group (COG) also produced a more detailed paper titled "Clinical Oversight and Scrutiny of the OHOC Programme", covering the approach followed to date and more details of the proposal. This was approved by the SRO.

External assurance on the quality of outputs from Cohorts 1, 2 and 3 took place in two ways. First, a nationwide panel of external clinical experts and lay representatives (North West Clinical Senate) conducted a review of all programme documentation, completing thorough site visits on 16th and 17th September 2019 as part of the NHS England Stage 2 assurance process. This operated further to the reviews convened with the Royal College of Emergency Medicine and the Care Professionals Board. Second, the programme engaged the Health Scrutiny Committee for Lancashire as a statutory consultee.

The programme was also able to secure a visit from the Secretary of State for Health, Rt Hon Matt Hancock MP, as part of a tour of health services in Lancashire on week commencing 14th October. This provided an opportunity for senior clinicians and corporate to push the case for a new build in central Lancashire and secure written commitment around central policy intent.

This correspondence arising, as requested by the Joint Committee, referred to "seed funding" to explore a competitive business case for a new build site from 2025-30 onwards but was complemented with both a verbal expectation that a shorter-term, enabling solution for acute sustainability in the OHOC programme was necessary in the short to medium term. Further, there would be an expectation that enabling capital for one or more of the options currently under consideration, similar to the parameters of the Wave 4 capital funding application from last year would follow a consultation outcome.

The paper identifies the outcomes of the clinical scrutiny process followed from the Joint Committee meeting. The six salient points are as follows:

1. **Need to make progress:** the uncertainty around the acute sustainability programme needs to come to an end; weariness, change fatigue and uncertainty are common and there is an increasing expectation that the public should be allowed to have their say without further delay. Without change, patient experience will continue to deteriorate.
2. **Workforce Supply:** the points made in the Case for Change are broadly supported - the issue of clinical workforce (supply, retention and age) needs to be promoted more as a change driver from a primary and secondary care perspective. A degree of centralisation will be necessary to provide safe, effective and sustainable care.
3. **No major missing options:** the clinical consensus received would indicate that from the perspective of the acute sustainability programme forming part of a broad transformation approach, there are no substantive missing options from those initially presented on the longlist – a point supported by the Clinical Senate.
4. **Whole System approach:** Acute system reform provides an opportunity to galvanise efforts in terms of prevention, public health and integration, including the partnership working with mental health, social care and local authorities. Clinicians displayed concern that primary care is not currently in a place to accept significant re-profiling of activity away from the acute system and that networks are in their infancy, however, had some assurance that the five year phased implementation timeline would give sufficient opportunity for networks to mature, providing that contract reform and the delivery trajectory for the WHiNs platform followed.
5. **"New build"** hospital was seen as the best way to ensure sustainable, quality care, also expressing that the opportunity for significant capital investment in the central Lancashire system should have a primary care, community and acute care focus. However, it was accepted that this is clouded in political uncertainty and will take more than 10 years to come to fruition – it is not realistic to wait.
6. **Expectations on LTH:** The appetite (and acceptance of the need) to consider "difficult" change is there, but it must follow, as part of any conditions for any option, that the breadth of recruitment, retention and staff development approaches are tested, and that existing in-house transformation programmes are stretched to their full potential.

## 2.0 Enhanced Clinical Scrutiny: Key Themes

As indicated in the Executive Summary, to ensure that the programme gathered enough information to ensure enhanced clinical scrutiny had taken place, the following has been scheduled and delivered by the programme since the Joint Committee in August.

**Cohort 1:**

- ✓ One to one meetings' with six Primary Care Network Directors and leadership teams, others preferring to engage in the professional group scrutiny functions offered by the GP Peer Group and Clinical Summit discussions.
- ✓ Scrutiny from Clinical Advisors at the OHOC Clinical Summit.
- ✓ Scrutiny from other senior clinical leaders at respective CCG GP peer groups.

**Cohort 2:**

- ✓ A Clinical Summit event, held at Farrington Lodge Hotel on 3rd October 2019 comprising of 25 senior clinical system leaders, including Acute Consultants, GP's, Nurses, Allied Health Professionals and staff side representatives. This event was independently chaired by Dr. David Ratcliffe, a GP and Medical Director.
- ✓ Working discussions with each of the OHOC Clinical Leads, developing more specific details on workforce models, activity data and alignment between the options and essential clinical standards. This has also included work to broaden front-line staffing awareness of the options.

**Cohort 3**:

- ✓ Expanded clinical oversight group membership to ensure greater system representation and scrutiny for the programme.
- ✓ Ongoing recruitment of an independent clinical director.
- ✓ Support and oversight to the North West Clinical Senate visit on 16th and 17th September.

Together, these three cohorts of enhanced clinical scrutiny identify how clinicians from across central Lancashire, as well as independent clinical experts from the NW Clinical Summit have positively influenced the assessment of the long list of options, as requested by the Governing Body and agreed by the SRO. This has provided the programme with further expert clinical opinion and consequently helped to shape the route forward for the programme. For ease, conclusions drawn from this process have been placed into two categories below; feedback on the long list of options, and recommendations for future programme development.

### 2.1 Feedback on the longlist of options:

- There was broad support for the range of options included within the long list, with no alternative options being offered at any of the additional scrutiny engagements.

- It is clear that an **Enhanced Urgent Treatment Centre (Option 4)** commanded the most, although important to add, not universal support across this period of enhanced scrutiny,

taking in to account the accepted need for change and the strength of the clinical argument, particularly relating to workforce supply.

- **Option 4d** (an Enhanced Urgent Treatment Centre with a Post-Operative Care Unit and ringfenced elective surgery beds) was the highest ranked option at the clinical summit.

- **Option 3** was noted on many occasions throughout the clinical scrutiny process and through the different cohorts to be the 'ideal' solution, particularly in terms of local access, but most clinicians recognised that the workforce requirements to deliver this model effectively were 'impossible' to achieve due to external factors.

- These external factors were accepted as being, at least in part, driven from regional and national issues and were outside of the direct control of LTH. Safety and sustainability issues were frequently referenced from a clinical perspective.

- Chorley GP's provided feedback that it would be better for patient access if Chorley and South Ribble District General Hospital has a Medical Assessment Unit.

- There was also a view that the opportunity to deliver more elective surgery on the Chorley site should be pursued, that the utilisation of the Chorley site needed to be maximised, and that there was an opportunity to consider how system resilience in terms of intermediate care access and/or rehabilitation could stand part of an option.

- This would be important in terms of framing how Chorley could be developed as a centre of excellence in particular specialties.

- Most clinicians took the view that, whilst the **Option 4 model** would see modest displacement of activity from the Chorley to the Preston site, access would be improved through the availability of more outpatient and elective surgery care closer to home. The additional transport requirements would require careful attention but could be clinically justified based on the improvements in patient care, experience and improved sustainability which would result.

- A "new build" option again commanded significant support, across a long-term delivery horizon. Clinicians recognised that this is only viable as a long-term strategy, with the OHOC Acute Sustainability programme requiring expedited progress so as to help the system deliver better patient care in the short to medium term.

- A number of clinicians expressed a view that the ongoing duplications of service provision across the sites and the inabilities to focus existing job plans on areas such as training, development and research were acting as "push" factors away from effective recruitment and retention activities for the LTH sites in key clinical roles. The ongoing uncertainties around future service provision models were also a contributory factor.

- Clinicians were keen for micro system transformation to be a key part of any option, with GPs citing many administrative issues as currently being inefficient. There was a clear view expressed that system-preparedness for transformation via the WHiNs platform needed to be ensured, and a network development pathway established, broaching the five-year implementation timeline for any of the options.

- There was also an expectation that the expectations being made of LTH as a provider to pursue available improvements in operational performance, such as delayed transfers of care, improved integrated working with primary care, length of stay improvements, better ambulatory care, and improved focus on acute medicine must all stand part of an option.

- There was a view provided to the programme team that there is at least general consistency in terms of the feedback provided by the Care Professionals Board, Royal College of Emergency Medicine and the NW Clinical Senate's verbal feedback in terms of appropriate clinical configuration models to consider further. Most clinicians could see evidence of co-working and co-production in the options between the acute system and partners across social care, mental health and other areas of the health economy.

**2.2 Recommendations for future programme development**

- Clinicians highlighted the need to develop the options in more detail to make them easier to interpret for lay clinicians and the public. Using example pathways and the impacts on workforce and safety would translate the need for service change into a way which would identify with patient preference and help further with meaningful involvement.

- Clinicians wanted to understand more about the travel impacts, and what was being done to make travel between the two sites easier.

- There is a need to better convey the impact of the options on the North West Ambulance Service (NWAS).

- Clinicians would like to understand the impact the options may have on the acute trusts within neighbouring localities and further the transport impacts at network level.

- Primary Care Network Directors indicated that at a later stage, the programme needed to work up detailed integrated pathways within the following areas:

    - Diabetes
    - Respiratory
    - End of Life
    - Gynae
    - Mental Health

## 3.0 Recommendations

The Governing Body are asked to review the findings of this document alongside the full NW Clinical Senate report and the recommendations presented by the enhanced Clinical Oversight Group. They are asked to confirm if the direction set by the Joint Committee in terms of the enhanced clinical scrutiny has been met and to consider the feedback received from Cohorts 1, 2, and 3.

It is important that over the coming months, the programme team take note of the programme feedback gathered throughout the recent scrutiny period and ensure the programme is tailored to the wishes of the clinical community:

- Developing a simpler way of explaining the options to all audiences, showing the impact on both LTH sites.
- Ensuring we have a public friendly document explaining the expected impact of any changes on other local hospitals, matched alongside a narrative explaining how these changes fit in to broader system-wide change.
- Develop a clear outline of the expected impacts of the short-listed options on the North West Ambulance Service.
- Develop and deliver an enhanced communications strategy.

## 4.0 Next Steps

Completion of this detailed modelling will provide the Joint Committee with the information it requires to make an informed decision the options that maybe progressed to a public consultation.

This decision will be included in the development of a Pre-Consultation Business Case (PCBC) which brings together all of the key work products that have been developed by the programme so far (case for change, model of care, options development, engagement) into a single document. This will be updated from the information initially supplied to it and to the NW Clinical Senate.

The PCBC will provide the reader with a walkthrough of the OHOC programme and why particular options are recommended to be progressed to a public consultation. The PCBC will require formal approval by the Joint Committee and subsequently be submitted to NHS England to be ratified.

The appendix to the paper provides more detail of the feedback received from each component/cohort of the Enhanced Clinical Scrutiny process.

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## 5.0Appendix

## Additional clinical oversight and scrutiny as requested by the Joint Committee of CCGs

### 5.1 Clinical Summit

The programme held a "clinical summit" event entitled "**OHOC Clinical Summit: Scrutiny of the Programme Options"** on 3rd October 2019 at Farrington Lodge Hotel. This session was independently facilitated by Dr David Ratcliffe, a GP with special interest in Emergency Medicine. The session brought together 25 clinical leaders and staff representatives from across the local health and care sector to ensure that the options were considered from a whole system perspective, including those which relate to the broader Integrated Care System, as well as the Integrated Care Programme for Central Lancashire. The attendee list included CCG GP Chairs, CCG Executives, General Practitioners, Nurses, CCG Clinical Advisors, Wellbeing and Health in Integrated Neighbourhoods Representatives, LMC Representatives, Integrated Care System Representatives and LTH Consultants.

The summit achieved the following objectives:

- Examine the existing work done in relation to the development of the options plus existing plans around WHINs,
- Understand what work and analysis will be needed to indicate viability of the options
- Provide an open and honest forum for constructive challenge around the options and the future direction of the programme.

**Key themes**
Each table was allocated a facilitator and a scribe for the clinical scrutiny discussion that took place. Each scribe compiled a comprehensive range of notes, with the key themes that consistently emerged are outlined in figure 1.

*Figure 1: Key Themes identified from the clinical summit*

| Option | Key themes |
|---|---|
| 1 | • Lowest average ranking.<br>• Already failing as an option, this is why change is being considered.<br>• Not clinically deliverable due to workforce requirements. |

| | |
|---|---|
| | • Strong feeling that existing service model is not sustainable in the long-term and is driving poor operational performance and patient experience.<br>• Needs to be honestly described to the public by means of a comparison i.e. why change will be better for the people of Chorley, South Ribble and Greater Preston. |
| 2 | • Preferable only to a "do nothing" option<br>• Clinically unsustainable in the long-term due to workforce requirements, in terms of job plans, lack of opportunity for effective training, development and research, service duplication.<br>• Does not resolve the issue of under-utilised critical care facilities and workforce infrastructures at the Chorley site.<br>• Would limit the scope of some structural transformation that could occur between the sites because care would need to be duplicated across core services and essential clinical adjacencies, thereby limiting what can be achieved for patients.<br>• Demand management activities have had some impact, but the system is highly vulnerable to peaks in patient demand for urgent, emergency and elective care.<br>• No evidence that the system has been able to manage over the last three years, why would this change over the next five?<br>• Very unlikely to resolve the recruitment and retention issues alone, particularly from the acute perspective.<br>• Does not resolve the fundamental point that the existing service model is not Type 1 compliant and there are clinical risk considerations arising from walk in attendances for certain categories of acutely unwell patients. |
| 3 | • A good model in principle but undeliverable due to Workforce shortages in Urgent and Emergency Care, Surgery, Specialty Medicine.<br>• Workforce shortages identifiable across medical, nursing, scientific and technical and allied health professional staffing categories.<br>• Workforce issues are felt nationally as well as locally – there is no evidence to indicate that this will improve in the short term.<br>• Emergency Surgery and Paediatrics would have to be put back on two sites and therefore be much less efficient if a Type 1 was at Chorley<br>• Even if we had the funding, there are not enough staff available.<br>• In some areas, there is a strong view of the demand not being available for higher volume working, associated with improved consistency, care quality and clinical outcomes.<br>• Could actually make things worse by destabilising the care structures at the Preston site.<br>• Not necessary as emergency provision is available at Preston, Wigan, Blackburn, Bolton and not aligned with Royal College of Surgeons guidance for current/future population coverage. |
| 4a | • The workforce supply issue (recruitment and impact of retirement/attrition) is a significant factor against delivering this model |

| | |
|---|---|
| | • Scope to do a lot, but duplication remains.<br>• Would this really direct whole system transformation?<br>• Does this model avoid conversations around difficult, but clinically necessary change?<br>• Does this model, to the contrary, maximise Chorley service access and provision.<br>• Elective surgery is not protected in this model – potential deteriorations in access, quality and performance, could these be mitigated.<br>• Notable that the service model is not supported by the NW Clinical Senate. |
| 4b | • High risk to patient safety<br>• Workforce issue – specialty medicine cannot provide MAU ward rounds<br>• Not clinically sustainable due to workforce.<br>• Should be excluded from consideration. |
| 4c | • Not a good use of critical care resources, will become even less efficient than it is now and create more issues across both sites<br>• Surgical Patients could be vulnerable without 24/7 medical support after being in a level 3 critical care.<br>• For largely the same reasons as 4a and 4b, should be excluded from consideration. |
| 4d | • Clinically deliverable<br>• The best model for workforce efficiency and maximising local access.<br>• Improved experience for patients due to ringfenced elective beds and adequate front door provision<br>• Significant evidence of workforce innovation and skill mixing relating to ED cover, critical care utilisation and elective surgery provision.<br>• Would the Royal Preston site have enough medical bed capacity available to deliver this? Enabling capital would be particularly helpful for this model. |
| 4e | • Won't maximise use of Chorley site, limiting capacity due to no critical care provision<br>• Clinically deliverable due to workforce efficiencies |
| 5a | • Same thoughts as 4a, apart from UTC which:<br>    o Less likely to reduce A&E burden as can only see a lower acuity of patients<br>    o Lack of ambulatory care is not ideal for Chorley residents |
| 5b | • Same thoughts as 4b, apart from UTC which:<br>    o Less likely to reduce A&E burden as can only see a lower acuity of patients<br>    o Lack of ambulatory care is not ideal for Chorley residents |
| 5c | • Same thoughts as 4c, apart from UTC which:<br>    o Less likely to reduce A&E burden as can only see a lower acuity of patients<br>    o Lack of ambulatory care is not ideal for Chorley residents |
| 5d | • Same thoughts as 4d, apart from UTC which: |

| | |
|---|---|
| | ◦ Less likely to reduce A&E burden as can only see a lower acuity of patients<br>◦ Lack of ambulatory care is not ideal for Chorley residents |
| 5e | • Same thoughts as 4e, apart from UTC which:<br>◦ Less likely to reduce A&E burden as can only see a lower acuity of patients<br>◦ Lack of ambulatory care is not ideal for Chorley residents |
| New Build | • Would provide a good model for the future<br>• Lots of support<br>• Recognition across the system that this is the long-term solution (8-10+ years) only. |

At the end of the session, attendees were asked to individually rank the long list of options in order of clinical viability and preference to ensure all views were captured. The results of this exercise can be found in figures 2 and 3 respectively. Some tables decided to complete this exercise as a group, therefore the number of votes does not necessarily correlate to the number of attendees.

*Figure 2: Clinical Viability Votes*

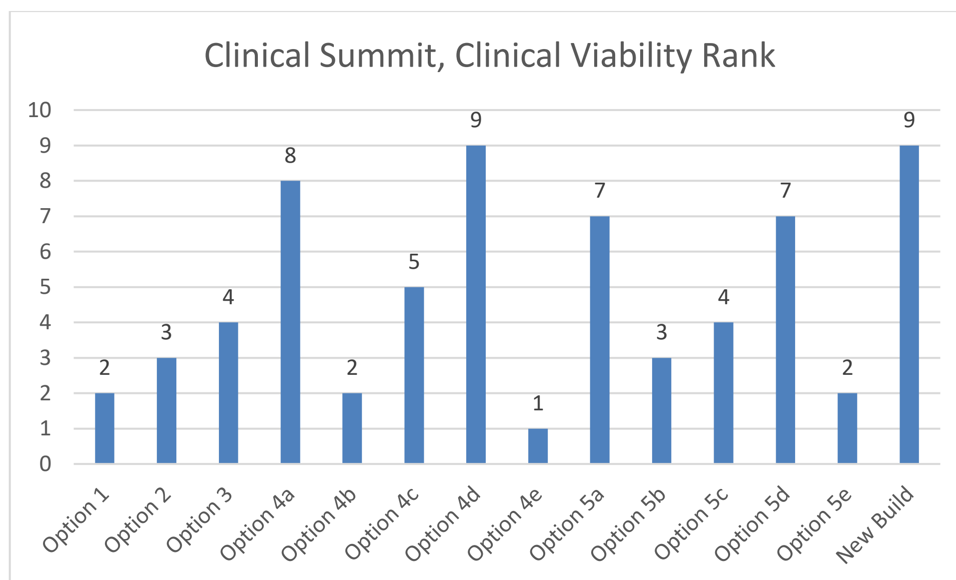


Figure 2 clearly displays that option 4d was viewed as the most viable with 9 votes, followed closely by 4a(8) 5a(7) and 5d(7). The “new build option” was also popular with 9 but following the site visit by the secretary of state for health, it is clear this is part of a long-term strategy, whereas OHOC is required to improve care additionally in the short to medium term.

It is interesting to note that there was less local enthusiasm for the “e” models (4e) and (5e) due to operational deliverability. Conversely, there was more enthusiasm for the “a” model and a greater acceptance of the need to consider Option 5 as a framework, as well as option 4.

*Figure 3: Ranking of long list of options*

| Option | Rank | Average score (1 = high) |
|---|---|---|
| Option 4d | 1 | 1.9 |
| Option 4a | 2 | 2.4 |
| Option 4c | 3 | 3.4 |
| New Build | 4 | 3.6 |
| Option 5a | 5 | 5 |
| Option 5d | 6 | 5 |
| Option 4b | 7 | 5.2 |
| Option 5b | 8 | 6 |
| Option 5c | 9 | 6.2 |
| Option 2 | 10 | 7.3 |
| Option 3 | 11 | 7.7 |
| Option 4e | 12 | 7.7 |
| Option 5e | 13 | 8 |
| Option 1 | 14 | 13 |

Figure 3 shows a similar pattern to figure 2, with the results of the “rank in order of preference” exercise showing strong support for option 4d. The “New Build” option was not prioritised highest because a number of the clinical delegates questioned whether or not this would work with whole system redesign and the lag time involved in developing a new build was plainly not compatible with the current timelines around OHOC.

## 5.2 Interactions with Network Leadership

The programme team has approached each of the formed primary care networks for in depth discussions about the long list of options formed by the programme, and their aspirations for matched reform of the primary care agenda. Individual sessions have been offered to all network directors with 6 having taken place so far, with one being arranged. The remaining directors have showed preference for providing their input via the GP peer group meetings and Clinical Summit. A summary of the meetings that have taken place can be found below:

*Figure 4: Meeting Schedule*

| NAME | ORGANISATION | LOCALITY | MEETING INVITE SENT | RESPONSE RECIEVED? | MEETING DETAILS |
|---|---|---|---|---|---|
| Dr Joegy Shah | Ryan Medical Centre | Bridgedale Medical Services LTD | YES | Yes | Attended Chorley Peer Group |
| Dr Shashidar Khandavalli | The Chorley Surgery | Chorley Central | YES | Yes | Being rearranged |
| Mahtab Siddiqui | Withnell Health Centre/Clayton Brook Surgery | Chorley East | YES | Yes | 11/10/2019 - 1200 Clayton Brook Surgery |
| Dr Jeremy Hann | Park View Surgery | Greater Preston Medical Group | YES | No | 27/09/19 - 0845 cottom lane surgery |
| Dr Amrit Ryatt | Sandy Lane Surgery | Leyland | YES | Yes | 02/10/2019 - 1130 Sandy Lane Surgery,Sandy Lane, Leyland,Lancs, PR25 2EB |
| Dr Steve Griffin | Berry Lane Medical Centre | Preston East | YES | Yes | 30/10/2019 - 1430 Berry Lane Medical Centre |
| Dr Zakir Habib Patel | Issa Medical Centre | Preston North | YES | No | 24/09/2019 1100 |
| Dr Partha Ganguli | Fishergate Hill Surgery | Ribble Medical group | YES | Yes | 24/09/19 - 0930 Chorley House |
| Dr Nimal Muttu | NM Health Innovation | The Chorley and South Ribble Health Network | YES | No | |

## Key Themes Identified from meetings

Each meeting that has taken place so far has explored two main areas:

1) Current development of the relevant Primary Care Networks to help determine how the OHOC programme can align future developments,
2) A walk through and discussion about the current long list of options.

The key themes that have emerged from these discussions is outlined below:

### 5.2.1 Network Development

1) Networks are still relatively embryonic in development but should be fully formed and delivering system efficiencies prior to the delivery of the Acute Sustainability programme. All networks are now delivering extended access and have reported working well together to assess and plan future priorities
2) Future priorities for integrated pathways that were frequently mentioned include:
    - Diabetes
    - Respiratory
    - End of Life
    - Gynae
    - Mental Health
3) Networks have reported that contracting is still an issue and needs rectifying

### 5.2.2 Long List of Options

1) GP's engaged with thus far were supportive of the breadth of options included on the long list, with no additional options suggested.

2) Option 3 was noted as the “ideal” solution but there was also widespread understanding it was undeliverable due to workforce issues caused by further separation of care provision across two sites. This could consequently make patient care worse.
3) Option 4 gained the most support of all the options, with clinicians recognising that an Enhanced Urgent Treatment Centre was innovative and would provide a better option for patients than a standard Urgent Treatment Centre.
4) The “new build” option was widely supported. Clinicians understood that this was a long-term solution and the system needs to deliver change sooner.
5) There were concerns raised about Chorley patients requiring access to MAU
6) GP’s made clear it would be good to have choice about where to refer their patients e.g. Preston or Chorley Ambulatory Care/MAU
7) GP’s wanted to know more about the impact on capacity at each site, it was explained that this would be available once a short list was agreed.
8) It would be useful to show the impact of each option on each LTH site once a shortlist has been agreed

### 5.3 Enhanced Role and Membership of the Clinical Oversight Group

The terms of reference and membership of the OHOC Clinical Oversight Group (COG) have been fully reviewed and enhanced to include a wider range of clinical representation from across the health and care sector. The first meeting with the new enhanced membership will take place on 6th November 2019.

The independent clinical director will chair the clinical oversight group once appointed. Recruitment for this post is ongoing (see 5.4).

### 5.4 Appointment of an independent Clinical Director

It was agreed at both at the informal meeting of the Our Health Our Care (OHOC) Governing Body on 14th August 2019 that a Clinical Director would be appointed to support the ongoing progress of the OHOC programme. The Clinical Director would be the senior clinical advisor for both the Well-being and Health Integrated Neighbourhoods (WHiNs) and Acute Sustainability Platforms ensuring alignment of plans that support better integration of services, care closer to home and a focus on ill-health prevention.

Responsible for communicating the voice of the wider clinical workforce the Clinical Director will report to the 2 Programme SROs, providing constructive challenge where required and fronting the clinical voice in communicating with staff, the public and the media.

It is proposed that the Clinical Director would Chair the OHOC Clinical Oversight Group. Via this robust recruitment process the Clinical Director would be considered both competent and independent.

A job description was circulated amongst the central Lancashire clinical workforce by Gerry Skailes, Madeleine Bird, and Stephanie Ward. We are currently working to identify suitable candidates, as the initial expressions of interest process, circulated amongst senior clinical leaders across the Integrated Care System garnered little interest.

### 5.5 Continued other involvement

Further to the enhanced clinical scrutiny activities that have taken place, the programme has taken advantage of opportunities to engage with stakeholders from across the system to request further scrutiny on the long list of options.

The following section of this paper outlines some of the key activities that have taken place and summarises the feedback received

### 5.5.1 Established Peer Group Meetings

The programme team have attended the recent peer group meetings for both Greater Preston and Chorley & South Ribble GP's on the 1st October 2019 and 16th October 2019 respectively.

The sessions were used as an opportunity to update the GP networks on the options development phase, including providing an overview of the approved longlist. GP colleagues then held facilitated discussions about their views on the longlist and how the programme could ensure alignment with network priorities moving forwards.

Key themes from the two sessions can be found below:

#### 5.5.1.1 Greater Preston

- No additional options were proposed for the long list.
- GP's were happy with the breadth of options
- GP's wanted to see the options presented in a different way, showing the impacts on both sites, once a short list had been agreed
- Patients need to be better educated/informed on the most appropriate options available to them, dependent on circumstance
- Staff need to be trained/educated on how to direct patients to the most appropriate service
- Safety and quality is the top priority, with everything else coming after this
- Need clarification on pathways for the Centres of Excellence – how will flow of patients work?

- Digital interoperability would help to encourage working together with the same intentions

#### 5.5.1.2 Chorley and South Ribble

- No additional options were proposed for the long list.
- GP's were happy with the breadth of options
- Benefits of each option needs to be clearly communicated. E.G travel times
- Patients need to be better educated/informed on the most appropriate options available to them, dependent on circumstance
- NWAS impact needs considering and clearly communicating
- Transport of patients between sites need to be considered in more detail
- Staff need to be trained/educated on how to direct patients to the most appropriate service
- Safety and quality is the top priority, with everything else coming after this
- Need clarification on pathways for the Centres of Excellence – how will flow of patients work?
- Digital interoperability would help to encourage working together with the same intentions

### 5.5.2 Local Medical Committee

The Local Medical Committee have requested assurance on the options process and the durability of the options to reflect changes in the decision-making landscape with the future of primary care networks. This would be provided by the programme team on a bi-monthly basis, at the direction of the Chair. The next Local Medical Committee meeting is due to take place on the 13th of November 2019.

## 5.6 Additional scrutiny as part of the NHSE assurance process

### 5.6.1 Clinical Senate Visit

As a key milestone of the NHS England stage 2 assurance process, the north west clinical senate conducted an independent clinical review of the OHOC programme on 16th and 17th September 2019. The senate panel were provided with a range of programme documentation prior to the visit, with the programme team verbally updating that it was incredibly comprehensive and detailed.

In addition to a full documentation review, the visit would involve the panel meeting with clinical leads for the OHOC programme, discussing current working practices with ward staff

and trainees, conducting a full site visit of both LTH hospital sites, and discussing programme plans with relevant individuals.

**The Terms of Reference for the review included the following objectives:**

- 1.5.1. Do the options reflect relevant clinical guidelines and best practice?
- 1.5.2. Are the options sustainable in terms of the clinical capacity to implement them?
- 1.5.3. Do the plans identify mechanisms to address organisational and cultural challenges?
- 1.5.4. Has the workforce impact, including impact on education, recruitment, retention been considered in each of the options?
- 1.5.5. Have the clinical staff that may be affected by the changes, been involved in their development?
- 1.5.6. Is the proposed workforce adequate for the service needs of each option?
- 1.5.7. Do the options deliver the current and future health and care needs of the target population?
- 1.5.8. Do the options maintain access to services for the population? (e.g. have waiting times and travel for patients and their families been considered?)
- 1.5.9. Have innovations and improvements that would improve quality and outcomes been considered?
- 1.5.10. Are there unintended consequences/interdependencies of the options that need to be taken into account? (E.g adult social care, medically unexplained, primary care)
- 1.5.11. Have the risks and consequences of sustaining the options been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?
- 1.5.12. Does the risk register identify key programme risks and have robust mitigation plans?
- 1.5.13. Have patients and carers been involved meaningfully in the design of options?
- 1.5.14. To what extent have the views and experiences of patients and carers been included in the options?
- 1.5.15. Are the plans for IT and interoperability robust, realistic and able to deliver the requirements of the options?

The Clinical Senate team provided informal feedback that the visit was extremely well organised, and the programme documentation was comprehensive.