



Case for change



Our Health Our Care

Central Lancashire

Acute Sustainability



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Our ambition: The ambition of all organisations commissioning and providing healthcare for the population of Greater Preston, Chorley and South Ribble is simple and crystal clear: we want to achieve the best possible outcomes for patients.

The problem: Right here, right now, our urgent and emergency care system is not delivering consistently in terms of timely access and operational performance. This is not good enough for patients. It is holding us back from delivering our ambition. Most importantly, because as we are failing to deliver the best experience and clinical outcomes possible for our patients using our current resources, we are not meeting their fair expectations as local citizens and as taxpayers. This problem needs a Case for change.

So, why is our urgent and emergency care system not delivering for patients? Whilst this appears to be a simple question, we believe that it is a very complex problem. Solving it will require an open-minded approach with all partners across our health system working together towards our overall ambition.

The issues - We believe that there are five key issues:

1. **Workforce:** We do not have the workforce we need in critical staffing areas. Our urgent and emergency care system workforce is stretched—a symptom of the issues with recruitment and retention being experienced right across our health system and more widely in the NHS.
2. **Flow:** We are not delivering effective patient flow in our hospitals. In short, this means that too many patients are waiting too long for their care, whether their care is either planned or unplanned. Too many patients are experiencing delays to be discharged. Our hospitals are struggling to balance the needs of patients with urgent and emergency care issues (including critical care) with those receiving planned care, including day cases and outpatients. They are not running as efficiently as they could do.
3. **Lack of alternatives:** We do not have a comprehensive range of alternative options available to using the urgent and emergency care system at all times. This means that too many patients are using urgent and emergency care services because they either do not know the best alternative to use, or because that alternative is not available to them at a time and place to best meet their needs. This is a problem right across our health system – we recognise that the problem does not start at the front door of our hospitals' Emergency Departments.
4. **Demographics:** We are serving a growing and ageing population which continues to experience inequalities in health status, reflected in different clinical outcomes. In

short, this means some local people have worse life expectancy than others; some people are more likely to have chronic and complex long-term conditions than others; and some people are making additional use of urgent and emergency care services because they do not know the best alternative to use. This includes community-based and self-care alternatives.

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

Our Case for change: This Case for change rightly focusses on the problem of delivering an urgent and emergency care system that works best for patients and will help us to deliver our overall ambition. Our approach will be open-minded, and all options will be considered. Our approach will focus on the benefits for patients that can be delivered by providing high quality, integrated care, which is delivered at the right time and in places that best meets their diverse needs.

In explaining the realities of our existing urgent and emergency care system, we will show how our approach to transforming urgent and emergency care will also involve better prevention and self-care. Community, primary care, and acute services will need to work more closely together. We must break down the remaining barriers across our health and social care system, including mental health provision.

In the future, the facts are that our hospitals will serve more local people. Our people will be older. They will have more complex and chronic health care needs. Faced with this reality, the people of Chorley, South Ribble and Greater Preston are right to expect that their commissioners engage both with them and local clinicians to plan care which is sustainable in the long term. This includes learning from best practice. All patients deserve care provided according to the standards set out in the NHS Constitution.

They are right to expect that we plan for a better urgent and emergency care system now, as part of a broader strategy, focussing on their needs, both now and in the future.

They are right to demand that we remain unwavering in our ambition, even where this may require us to consider radical change.

Dr. Gora Bangi
Chair, Chorley and South Ribble CCG

Dr. Sumantra Mukerji
Chair, Greater Preston CCG

Why We Need to Change

Put simply, if we do not change, then we will not deliver our ambition for our patients. However, we recognise that any proposed changes to local healthcare services can act as a catalyst for significant concern and potential opposition from people who understandably feel passionate about how local health services are provided. This is why the starting point for our Case for change is both what patients want and what they need:

Patients are right to expect that:

- ✓ Their services can be delivered closer to home where this is both safe and practical;
- ✓ They can experience the benefits of new technologies, research, learning, and ways of working in the NHS;
- ✓ They can access cost-effective care as taxpayers in line with the standards set out in the NHS Constitution;
- ✓ They can be supported to make the right choices about the best places to receive care and advice;
- ✓ They will be encouraged to make practical choices and lifestyle decisions which help them to use NHS services in a sustainable way;
- ✓ Their commissioners are committed to taking decisive action to reduce health inequalities and improve their clinical outcomes;

Our current ways of working are not delivering these expectations across the urgent and emergency care services we commission from our local hospitals. Until we can demonstrate that they do so, there is a need for change.

As explained in the foreword, the need for change arises from five key issues linked to the themes of delivering the best quality, patient experience, and use of resources.

The five key issues:

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is either planned or unplanned. Too many patients are experiencing delays to be discharged. Our hospitals are struggling to balance the needs of patients with urgent and emergency care need (including critical care) with those receiving planned care, including day cases and outpatients. They are not running as efficiently as they could do.

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The lead partners involved in Our Health Our Care are all focussed on delivering the best possible outcomes for patients, which meets their expectations as taxpayers and as citizens.

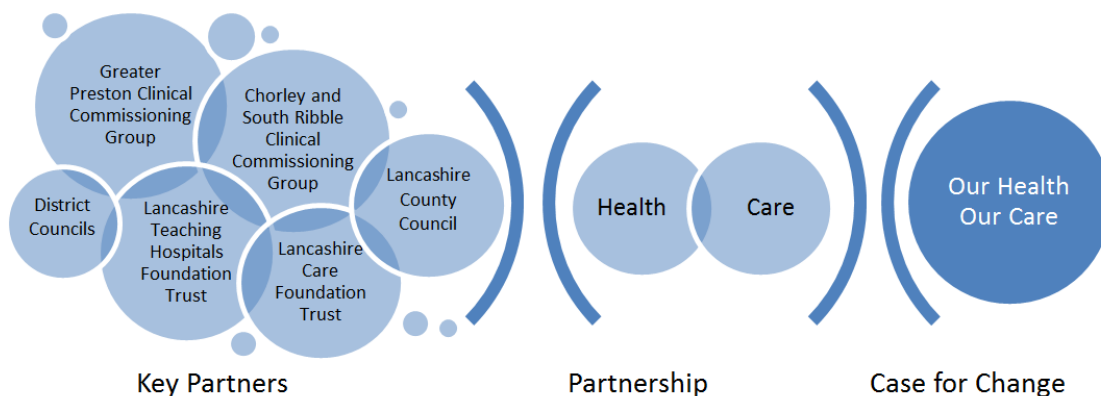
The lead partners in the Our Health Our Care programme are:

- NHS Chorley and South Ribble Clinical Commissioning Group
- NHS Greater Preston Clinical Commissioning Group
- Lancashire Teaching Hospitals NHS Foundation Trust
- Lancashire Care NHS Foundation Trust
- Lancashire County Council

Working closely with:

- Central Lancashire district councils

- NHS England (including the specialised commissioning directorate)



Based on the current arrangements and their shared ambitions, there is agreement between these lead partners that transformation of the current models of service delivery for the local populations is required to:

- Ensure that safe, high quality care, is delivered to all patients in a consistent way, and that this meets national clinical, access and other standards.
- Deliver care to patients in the most appropriate and cost-effective setting to meet their healthcare needs, seeking to reduce health inequalities.

The lead partners feel that there is a significant case for changing the current models of delivering services to better meet these two aims, taking an open-minded approach.

The lead partners recognise that whilst some of the key issues faced could be attributed to other health economies and other areas across the NHS, there are some factors that make the local situation more challenging to solve. In particular, this case for change will set out why some of the local workforce features (issue 1), flow (issue 2), and demographics (issue 4), are particularly challenging when benchmarked against the known national position. This emphasises the need for an open-minded approach to reviewing options for transforming care and services.

This document seeks to present a clinical case for change for the acute sustainability workstream of the Our Health Our Care (OHOC) programme. It is designed to deliver our overall ambition: the best possible clinical outcomes for patients.

OHOC programme workstreams

The wider OHOC programme has a total of three workstreams:

- **Acute sustainability** (formerly 'in hospital care'), which this case for change specifically responds to.
- **Locality care** (out of hospital care). This workstream seeks to develop the out of hospital part of the new model of care, considering what services can be provided outside of an acute setting and how we can develop more integrated 'person-centred' services to support people in their own communities.
- **Prevention, early help and self care:** This workstream seeks to develop the prevention, self-care and early help interventions which will be needed to be built into our new model of care considering primary and secondary prevention, self-care, early help and interventions and to keep people well looking after their own health.

Workstream design

The design of each workstream was developed by clinical leaders from within the health economy during extensive clinical engagement events, and solution design workshops. The solution design events held to date have brought together approximately 480 attendees, with representatives from the whole health and social care economy. These include consultants, GPs, nurses, allied health professionals, pharmacists, radiologists, social care workers, and representation from district and county councils and other public services, third sector and patients.

OHOC programme objectives

In line with delivering the overall ambition – the best clinical outcomes for patients, the OHOC programme has a governing objective to develop new models of care that are clinically and financially sustainable, involving the delivery of a more integrated health and care system.

The OHOC programme also seeks to ensure that future models of care are co-designed and involve the provision of high-quality services in the right place and at the right time, focussed on a whole-person centred (or holistic) approach to healthcare.

The OHOC programme recognises that whilst there are three workstreams, there are interdependencies between them in delivering the governing objective, particularly where this relates to the greater collaboration and integrated working approaches

across primary, community, secondary (or acute) and social care sectors. They focus around delivering best quality, patient experience and use of resources.

In total, the OHOC programme has six main objectives:

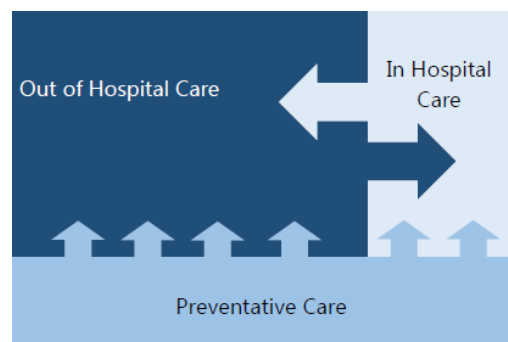
1. To develop a more person-centred approach to health and social care, increasingly delivered within community, locality or home setting where appropriate.
2. To develop new models of health and social care for our local health economy, rebalancing the provision of services to reduce overdependence on acute hospital provision.
3. To encourage and enable people to take responsibility for self-management of their care with support from services to improve their health, wellbeing and quality of life.
4. To develop new models of health and care that are clinically and financially sustainable for the future and able to provide quality services that are safe, accessible, responsive and coordinated.
5. To create models of care that will work within an integrated health and care system, tailored to the needs of our population and delivered in the right place at the right time.
6. To ensure the process is clinically led and that new models of care are co-designed with the public, patients and partner organisations.

The relationships between the workstreams can be shown in terms of the integrated “Future Service Model” on the right-hand side of the figure below, compared with the linear or consecutive “Traditional Service Model” on the left-hand side of the page. MCP refers to multi-speciality community provider.

Traditional Service Model



Future MCP Service Model



Programme Governance

The OHOC programme features a clinically-led design process which has been validated through a robust governance structure and public engagement process in line with NHS England guidance.

In terms of the NHS England guidance, if the case for change were to develop in to a proposal for major service change, arising from an agreed model of care and modelled options, then it would need to meet additional assurance requirements for an NHS England “Stage 2” assessment of such change by the regulator prior to any public consultation on option/s taking place. This process would test any proposed options for clinical, service-based and financial viability.

These assurance statements would be developed in the form of a Pre-Consultation Business Case (PCBC). This more detailed document would include assurance statements relating to the statutory provisions for engagement and “due regard,” and also forming options with an open-mind. Before this point is reached, a separate independent clinical scrutiny process also occurs in the form of an assessment from a Clinical Senate whose opinion informs the contents of and direction included within any PCBC.

To date, the programme has engaged monthly dialogue with the regulators through and following “Stage 1” review of the OHOC programme.

In the Acute Sustainability workstream, the governance structure incorporates three main working groups, namely the Clinical Oversight Group, the Finance, Investment and Activity Group, and the Communications and Engagement working group. The three working groups report in to a Programme Oversight Group, which in turn relates to the Integrated Care Programme Shadow Board for update purposes.

The decision-making forum in the programme is the Joint Committee of the Clinical Commissioning Groups (for Chorley and South Ribble and Greater Preston). All forums in the programme have agreed terms of reference and scope.

The Joint Committee of the Clinical Commissioning Groups for Chorley and South Ribble and Greater Preston is comprised of all members of the respective Governing Bodies for the organisations, including the GP Directors and Lay Members. The Joint Committee is responsible for determining whether or not to accept the case for change and, if it does so, to provide a mandate to develop a model of care (or Clinical Vision) as a first step in response. Only the Joint Committee can provide a mandate for the programme to continue at each developmental stage with regard to the process being properly followed.

Insights and Data Sources

In addition to the formal governance outlined above, this case for change is built from and formalises feedback and insights from a variety of sources. It takes insight from forums attended by clinicians, patients, and other key stakeholders. It is informed by critical analysis of national and local data sources. Data and statistical information are relatively straightforward to obtain from a variety of standard NHS sources, and this information has formed the backbone of this case for change.

However, in this case for change, it is also the conversations with those that work within the system that has provided the compelling narrative that tells the story of why transformational change is required. Conversations with the clinicians directly involved in the care of patients, or those with the responsibility for recruiting and maintaining staff in clinical areas help to “tell us the story behind the data.”

In building this case for change and reviewing why we need such a case for our current urgent and emergency care (including critical care) services provided from our local hospitals, we have sought to triangulate the available data in to a picture of why the existing services are not delivering the requirements that our patients have of them. This has led us to conclude that the current set up just does not work best for patients and because the current set up just does not work best for patients, change is required.

Key Issues

As has been explained in the section entitled “Why We Need to Change,” there are five main issues which are at the face of the problem. They are workforce, flow, lack of alternatives, demographics and effective use of resources. Whilst a number of these issues could be described of other health economies and across the wider NHS, there are three main areas where the current local experience amplifies the case for change. These are the issues of workforce, flow and demographics.

- **Workforce:** Like many trusts, Lancashire Teaching Hospitals faces significant challenges recruiting and retaining staff in key areas, but especially within the Emergency Department. This directly impacts on the ability to provide appropriate care to patients. Traditional recruitment and retention tools, and techniques are not fixing the problem—transformational change is now required to provide a long-term solution. If a long-term solution is not found, then these challenges are likely to get worse.
- **Flow:** Now, more than ever, all NHS organisations need to look at transformational initiatives to deliver greater operational efficiency and improved use of physical, and other resources. As can be seen from the performance of Lancashire Teaching Hospitals NHS Foundation Trust, its issues with improving flow can also be seen in its formal performance reporting against national standards. Across the trust as a whole, NHS Constitution standards for 4-hour Accident and Emergency performance, 18 weeks referral to treatment delivery and 62-day cancer waiting times are not being met and are, in general, on a declining curve

for performance. The trust also experiences issues in reducing delayed transfers of care (DTOCs). This is symptomatic of a system where patients are waiting longer to be seen, having more procedures rescheduled or cancelled, and where the pressures of managing unplanned or emergency activity are hampering the hospitals ability to manage elective (or planned) care flows.

- **Demographics:** As will be explained in later in the case for change, the local populations of Chorley and South Ribble CCG and Greater Preston CCGs are projected to grow in size. In some instances, these rates of change are likely to be higher than regional averages and encouraged by other factors, such as increased house-building. The populations are also expected to move towards an older age demographic. This means that more people, with more chronic (or age-related) conditions are likely to need the support of their local hospitals in the future. The populations also experience significant differences in health status and inequalities. These factors also act to increase the pressure on the urgent and emergency care system.

Structure of the case for change

To help “tell the story” of the problems faced locally, the case for change will be structured in to the following seven sections:

1. The NHS Landscape in 2018:

This section will help to describe how some of the issues faced locally are subject to a national planning, policy, workforce and funding context. It also helps to explain why this case for change has developed over time and is now being put forward.

2. Planning for the needs of the population:

This section highlights some key data points arising from the population healthcare needs, trends and inequalities. In doing so, it provides some more detail as to the types of healthcare problems we are seeking to resolve from the case for change. These are described with particular reference to the design of the urgent and emergency healthcare system, its relationship with other services provided in the hospital, and the linkages with other services provided by the other healthcare sectors. This section will also highlight why change is needed to respond to these expected changes and the current inequalities.

3. Looking at the Problem Inwards:

This section looks at the design and configuration of services from the perspectives of prevention, self-care, community services and social care. These are reviewed with particular relationship as to how transformation in these areas, using a common approach, could help to reduce excess demands being placed on the urgent and emergency care system provided from the local hospitals.

4. Looking at the Problem Outwards:

This section looks at the design and configuration of services within Lancashire Teaching Hospitals NHS Foundation Trust, starting with data relating to activity and performance.

5. A Detailed Look at Clinical Sustainability – Urgent and Emergency Care and Critical Care:

This section provides a detailed review of the challenges faced by its urgent and emergency care system, and its critical care structure in particular from the perspective of clinical sustainability. This section also references existing transformation work already underway at both of the hospital's seeking to improve the problems faced.

6. Benefits:

This section provides more detail as to the benefits available to patients from an improved approach to acute sustainability.

7. Conclusion:

This brief section summarises the case for change and the points made.

The first five sections start with a "blue box" called "Key Drivers for Change." This summarises the content of that particular section of the case for change.

Key Drivers for Change

- **Financial and operational pressure:** The national picture for the NHS is one of financial and operational pressure over the medium to long-term. The healthcare organisations serving the populations of Chorley, South Ribble and Greater Preston are not unique in terms of the challenges they face. This means that if difficult choices are not taken now, then more difficult challenges will be faced in the future. (A1.1)
- **Rising demand:** Nationally, A&E attendances have risen considerably over the past seven years and continue to do so. Emergency admissions are also increasing at a significant rate. Targets around elective care are not being met by most provider organisations and available beds in the NHS continue to decrease in number year on year. This means that without a focus on delivering care in the right place, at the right time, and avoiding the unnecessary use of A&E services, the strains on capacity will only get worse. This would likely mean longer waiting times for patients and worse patient experience. (A1.2)
- **Need to Take Difficult Choices Now:** The financial performance of the NHS is significantly challenged, and healthcare leaders expect it to remain so. This means that there is no real option to park difficult choices in to the future. We must plan with the resources that we know we will have access to now. (A1.3)
- **Recruitment and Retention:** Recruiting and retaining the right staff within the NHS remains a huge challenge for NHS organisations, with political, social and financial factors only set to exacerbate issues. This means that we must accept and together prioritise the need to make the best use of the hard-working, dedicated clinical and support staff that we have now. (A1.4)
- **Need to Collaborate:** The general consensus is that short-term solutions and fixes will not be enough to provide quality care for patients. There is a call for NHS organisations to work together to transform services and focus on improving quality and delivering exceptional care to patients. This means that by collaborating as one system and thinking differently about how primary, secondary, tertiary, social care and voluntary services work together will be vital to finding new answers to the challenges that we face. (A1.5)

To review further information relating to the NHS landscape in 2018 and the key drivers for change, please refer to appendices 1.1 to 1.5.

Section 2: Planning for the Needs of the Population

Area	Key drivers for change
Changing population demographics	<ul style="list-style-type: none">Any planned changes to health services must take account of the particular characteristics of the communities that they serve. This is so as to plan and deliver services which respond to the needs of the current population, and also how to respond to expected population change over time.Increased population size: Chorley and South Ribble CCG is the only Lancashire authority to see a projected population increase higher than the North West or England average, with significantly higher population increase projected for 80+ year olds¹. This means that the expected impacts of an ageing population (in terms of growing use of NHS services) will be particularly significant in this CCG.Increase in over 65 population: The number of people over the age of 65 is forecast to increase by 33,000¹ over the same period. Older people can be more intense users of NHS services. This means that the pressure on local NHS services can be expected to continue to increase over the medium to long-term arising from the ageing population.Reduced number of working age adults: The number of working age in Chorley, South Ribble and Greater Preston is forecast to reduce in the period 2014-2037.¹More hospital contacts required to look after people: During 2017/18 the acute provider in the locality have seen 119,563 more outpatients, 1,520 more emergency admissions and treated 1,053 more patients in a planned care setting than in 2010/11 (Source: NHS Digital, HES data).²Changing demographic of A&E usage: The proportion of A&E attendances for over 65-year olds has been increasing. Between April 2015 and January 2018, the proportion of attendees to the Royal Preston Hospital site being aged 65 or over increased from 21% to 32%. During the same period over 65 population now account for 34% of attendees to Chorley and South Ribble Hospital, up from 23%.³

¹ Office for National Statistics, CCG Population Projections 2016 based (2018):

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/clinicalcommissioninggroupsinenglandtable3>

² .NHS Digital, Hospital Admitted Patient Care Activity: <https://digital.nhs.uk/data-and-information/publications/statistical/hospital-admitted-patient-care-activity/2017-18>

³ Lancashire Teaching Hospitals supplied SUS data.

	<ul style="list-style-type: none"> • Increased re-admissions – patients with more chronic and complex needs: Readmission rates for geriatric medicine are high and generally increasing, reaching a high of over 16% in Q3 2016/17. The number of patients admitted to a geriatric medicine ward is expected to rise as the population ages.
Health Inequalities	<p>The Chorley and South Ribble and Greater Preston CCG areas both contain geographical areas where health inequalities and rates of deprivation are higher than the national average. These health inequalities and deprivation exhibit themselves in worse health outcomes when reviewing factors such as life expectancy, premature mortality, the prevalence of chronic conditions, and health conditions associated with lifestyle choices.</p> <p>Any planned changes to health services must take account of these factors. They must also appreciate that not all areas of both CCGs are the same in terms of health inequalities and rates of deprivation. For instance, 12% of residents in Chorley live in areas which have the highest levels of deprivation (assessed in the top 20% in England). The figure in Greater Preston is 26%, but the figure in South Ribble is just 3.7%.</p> <p>The residents in the most deprived areas are:</p> <ul style="list-style-type: none"> ○ 51% more likely to die from cancer than those in the least deprived. ○ Twice as likely to die prematurely from a stroke as those in the least deprived areas. ○ Six times more likely to experience severe anxiety and depression compared to those in the least deprived areas. <p>Across the wider population, the following health inequalities can be seen:</p> <ul style="list-style-type: none"> • The rate of deaths from cardiovascular disease amongst the under 75s group is worse in Greater Preston than the England average. • Despite dramatic improvement in Chronic Obstructive Pulmonary Disease (COPD) mortality over the past 20 years, Lancashire's rate is still significantly worse than the England average. • The age-standardised suicide rate is 15% higher in Lancashire than the England average. <p>The prevailing health inequalities picture identifies the particularly pressing need to ensure that services are planned and integrated together in an optimal way. Also, that they are designed so as to help “turn the tide,” helping local people to lead longer, healthier lives.</p> <p>The benefit available from this focus will be to help improve measures such as the lower life expectancy and higher levels of premature mortality experienced by the population as a whole, and the most deprived areas in particular.</p>

2.1 Local Population

The county of Lancashire has a diverse population of around 1.20 million people (source: ONS 2016 population estimates).

The populations of Chorley, South Ribble and Greater Preston comprise a GP registered population of 394,589 people (as at November 2018).⁴

2.2 Future Population Trends

Chorley and South Ribble CCG is projected to see a population increase of 11.7% between 2014-2037¹. Chorley is the only Lancashire authority which has a projected population increase higher than the North West or England average.⁵

In contrast the population increase projections in Preston will be below the North West average, being projected at 3.5% in the same period. Part of the projected population increase is expected to be a result of housebuilding under the Preston, South Ribble and Lancashire City Deal plus further housebuilding in Chorley. For the period up to 2019, there is a prediction of over 6,000 new homes within these areas.⁶ However, it should be noted that some of these homes are part of the City Deal to replace some old housing stock that is not fit for purpose.

The projected population increase in Chorley and South Ribble CCG in the 80-89-year old age range is 63.24% versus a national average of 33.15%.¹ For 90+ year olds the figure is 57.66% versus a national average of 30.03%. Populations in the 0-19 age band are projected to reduce slightly in the Greater Preston CCG locality, whilst rising slightly (5%) in Chorley and South Ribble CCG.

Overall, the 65+ age band will increase significantly across both CCG localities between 2014-2037.¹ Chorley and South Ribble CCG will see a rise of 56.2% between 2014-2037 and Greater Preston CCG by 44.1%. This equates to an additional 33,000 people being over the age of 65 in this period compared to now. Older people are more likely to be in poorer health than younger people, and with an ageing population in Lancashire, this will have implications for the provision of health and social care services.

Figure 1 shows the expected population distribution by age band. The orange line (showing over 65s) shows the most significant increase. This contrasts with an expected

⁴ NHS Digital, Patients Registered at a GP Practice – November 2018: <https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/november-2018>

⁵ Office for National Statistics, Local Authority Population Projections 2016 based (2018): <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2>

⁶ Lancashire Enterprise Partnership: <http://www.lancashirelep.co.uk/city-deal.aspx>

decrease in the population aged between 20 and 64. This is a proxy measure for the number of working age adults.

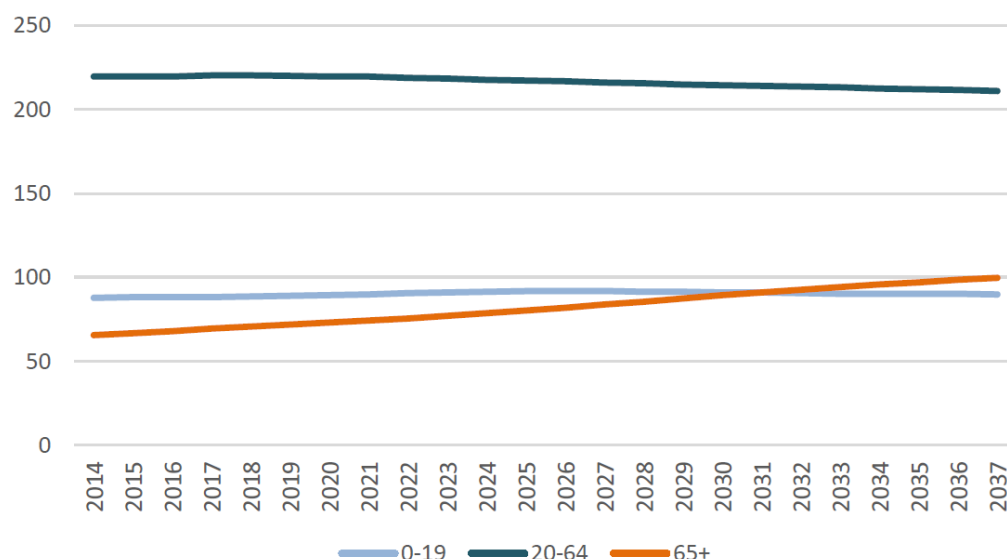


Figure 1: Population Projections – Combined Chorley and South Ribble CCG and Greater Preston CCG in thousands (Source: ONS 2014-based Subnational Population Projections for Clinical Commissioning Groups in England)

2.3 Health Inequalities and Disease Prevalence

Life Expectancy

Life expectancy at birth within the local area varies, as shown at Figure 2. Life expectancy across Preston and Chorley is worse than the average for England for both men and women.⁷ However, it is better than the national average for both genders in South Ribble.

⁷ Office for National Statistics – Life Expectancies at Birth:
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies>

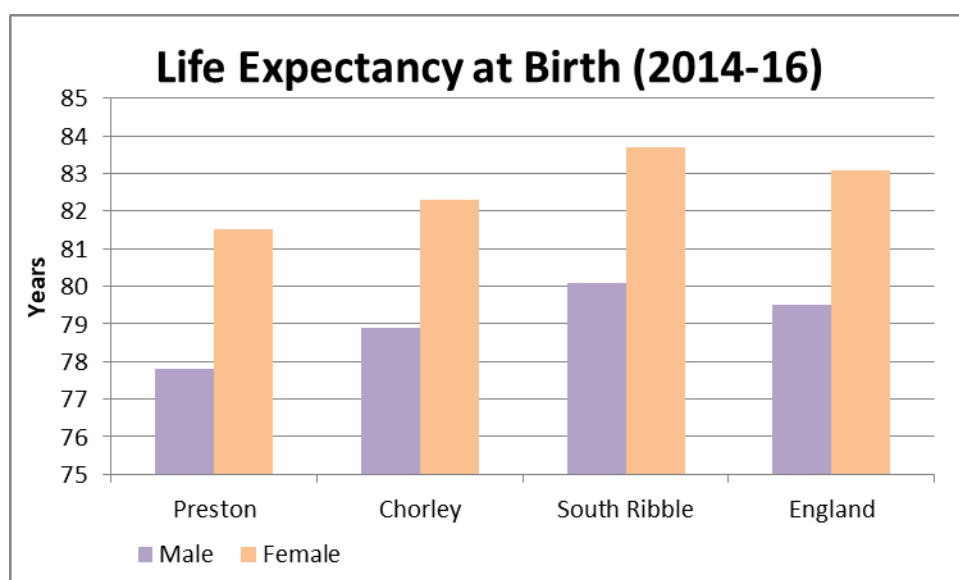


Figure 2: Life Expectancy at Birth (Source: ONS, 2016)

There is variation between and within the geographical areas of Central Lancashire for life expectancy. There is also variation by gender. For example, life expectancy for men in South Ribble is 80.1 years, 78.9 in Chorley, and 77.8 in Preston, compared with the national average of 79.5⁷. For women in South Ribble the life expectancy is 83.7 years, slightly lower in Chorley at 82.3 years, but lower still in Preston at 81.5, against the national average of 83.1⁷.

Premature Mortality

Contributing to the lower life expectancy, premature mortality for cardiovascular disease and cancer can be seen as health issues for both CCGs. A figure of dying before the age of 75s is generally used as a proxy of premature mortality.

Figure 3 below shows the impact of cardiovascular mortality in the under 75 population for the two local CCGs, compared with the national average. The table shows that the directly standardised rate of mortality (DSR) per 100,000 of the population is higher than the national average in Greater Preston, but lower than the national average in Chorley and South Ribble.⁸ When analysing data such as this, it is important to take account of the Confidence Intervals (or CI) to understand the statistical significance. In England, the CI is narrow because more deaths have been observed meaning that the DSR is more definitive. However, locally the CI range is wider because fewer patient deaths (116 and 125 respectively) have been observed from cardiovascular disease amongst the under 75's group.

⁸ NHS Digital, CCG Outcome Indicator Set 2015 – Cardiovascular Mortality

Level description	Gender	DSR (2015)	CI lower	CI upper	Registered patients	Observed
All registered patients in England	Person	64.0	63.3	64.6	52,569,660	33,420
NHS Chorley and South Ribble CCG	Person	61.8	51.1	74.2	163,797	116
NHS Greater Preston CCG	Person	67.2	55.9	80.0	194,488	125

Figure 3: Cardiovascular mortality – Under 75 directly standardised rate (per 100,000) (Source: CCG outcome indicator set, NHS Digital 2015)

Figure 4/5 looks at the mortality rate from cancer for people aged under-75. For cancer, the DSR is higher in Chorley & South Ribble, but lower in Preston, when considered against than the applicable rates across England⁹. The previous comment about CI's also applies to these data. Triangulating this data with mortality in the most deprived areas of Lancashire, it can be seen that people living in these areas are 51% more likely to die from cancer than those in the least deprived.

Level description	Gender	DSR (2015)	CI lower	CI upper	Registered patients	Observed
All registered patients in England	Person	119.5	118.5	120.4	52,569,660	62,077
NHS Chorley and South Ribble CCG	Person	122.2	106.7	139.3	163,797	225
NHS Greater Preston CCG	Person	114.4	99.5	130.9	194,488	211

Figures 4 & 5: Cancer mortality – Under 75 directly standardised rate (per 100,000). (Source: CCG outcome indicator set, NHS Digital 2015)

The same analysis can also be derived for premature mortality from a stroke. People in the most deprived areas of Lancashire are twice as likely to die prematurely from stroke as those in the least deprived areas.

Disease prevalence

Figure 6 shows the burden of disease within the CCG areas, with the left-hand axis showing the percentage of the local population affected by these conditions in 2017/18. Hypertension, obesity and diabetes having the highest prevalence¹⁰.

For the purposes of reading the table AF stands for atrial fibrillation, CHD for coronary heart disease, COPD for chronic obstructive pulmonary disease. For most of these conditions, prevalence is similar to the England average position. The rate of diabetes,

⁹ NHS Digital, CCG Outcome Indicator Set 2015 – Cancer Mortality

¹⁰ NHS Digital, Quality and Outcome Framework, Achievement, prevalence and exceptions data 2017/18: <https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data>

hypertension and diabetes is slightly lower in the Greater Preston than the England average. However, this difference is unlikely to be statistically significant.

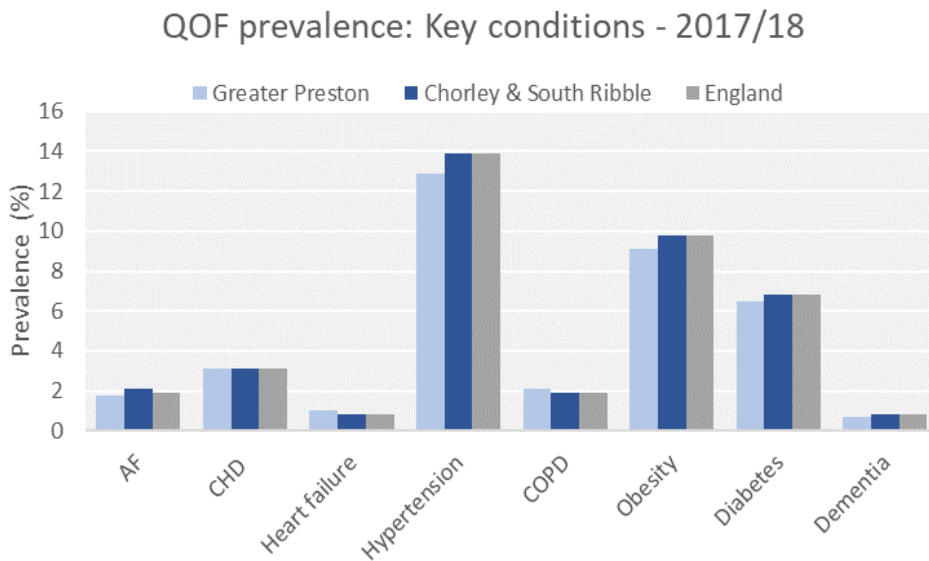


Figure 6: Prevalence of key conditions (Source QOF, 2017/18)

Figure 6 appears to show a relatively small percentage of the population affected by dementia in both CCGs (less than 1%). However, with an ageing population comes with it a projected increase in the number of people living with dementia. There is also a difference between the population believed to have dementia, and those who have been diagnosed with dementia.

The number of people expected to suffer with dementia is likely to increase by 18% over the next three years. Estimates suggest there are almost 15,500 people in Lancashire with dementia, but records show that only 10,347 of these people have a confirmed diagnosis (March 2016). Improvements need to be made in Chorley and South Ribble CCG and Greater Preston CCG to meet the government's 67% diagnosis rate target ¹¹.

Other key conditions - learning disabilities

Figure 7 below compares the number of people predicted to have autism spectrum disorders, by age and by gender, starting from 2017 and modelling forwards to 2035. The figures are shown in percentage change and compared with an all-England position. Figure 7 shows that the number of adults (18+) projected to have autistic spectrum disorders is expected to increase by 4.4% across Preston and 14.4% in

¹¹ Lancashire JSNA annual commentary 2017/18. <https://www.lancashire.gov.uk/media/905111/jsna-annual-commentary-201718.pdf>

Chorley between 2017-2035 ¹². The rate for both 18-64-year olds and those aged 65+ is higher in Chorley than average rate for Lancashire and England.

	2017	2020	2025	2030	2035	% change 2017 to 2035
18-64						
Preston	919	911	900	899	892	-2.9%
Chorley	690	703	712	718	714	3.5%
Lancashire	7,041	6,998	6,925	6,842	6,754	-4.1%
England	337,174	340,725	344,908	348,758	352,112	4.4%
65+						
Preston	195	205	223	249	271	39.0%
Chorley	217	231	259	293	324	49.3%
Lancashire	2,290	2,409	2,642	2,926	3,159	37.9%
England	93,522	99,142	110,376	124,390	136,789	46.3%

Figure 7: People aged 18-64 predicted to have autistic spectrum disorders, by age and gender, projected to 2035 (Source: Projecting Adult Needs and Service Information (PANSI), 2017)

When reviewing the numbers of people with an autistic spectrum disorder locally, it is important to triangulate this data with what is known locally about this population group and broader socio-economic factors. Across Lancashire;

- Nearly half of people experiencing a learning disability live in the most deprived areas. This means that they are over-represented in terms of living in the most deprived areas compared with the wider population.
- People with learning disabilities are much less likely to be in paid employment. Recent changes to benefit and state provided welfare allocations are believed to have affected people with learning disabilities disproportionately.
- People with learning disabilities are over-represented in prison populations.
- Housing needs of people with learning disabilities are considerable and will increase.
- People with learning disabilities experience much poorer health outcomes across a range of conditions.
- Prevalence and need are increasing whilst available budgets have been decreasing and are likely to continue to do so.¹³

¹² Projecting Adult needs and Service Information (PANSI). <http://www.pansi.org.uk/index.php>

¹³ Lancashire JSNA annual commentary 2017/18. <https://www.lancashire.gov.uk/media/905111/jsna-annual-commentary-201718.pdf>

Other key conditions – mental health

Good mental health is the foundation for wellbeing and the effective functioning of individuals and communities. It is fundamental to individual physical health, relationships, education, training, work and the fulfilment of our potential ¹⁴.

Prevalence of depression with Greater Preston and Chorley and South Ribble CCG is 12% and 12.7% respectively. This compares to 9.9% nationally ¹⁵. Those in the most deprived parts of Lancashire are three times more likely as those in the least deprived parts to suffer from extreme anxiety and depression. Over recent years this inequality gap has reduced because prevalence is falling in both groups, but this is quicker in the most deprived group ¹⁶.

Wellbeing is also a strong determinant of health. However, Lancashire residents appear to be less satisfied with their lives compared to the rest of the UK. Estimates of life satisfaction show that Preston is among the worst in the country ¹⁷.

Impact of suicide

The mortality rate from suicide is higher within both Preston (10.7 per 100,000) and Chorley (12.5 per 100,000) compared to England (9.6 per 100,000). In addition, emergency hospital admissions for self-harm are higher in Preston (195.6) than England (185.3).

Consequently, the demand for mental health services in Lancashire is higher than the national average. The mental health teams handle 2.7 times more referrals than the national average (the highest in England) in addition to managing caseloads that are twice the size of the national average ¹⁸.

Achieving Healthy Lifestyles: Supported Lifestyle Choices

The factors of poor life expectancy, premature mortality, and some disease prevalence can be both attributed to lifestyle choices and wider indicators of social deprivation.

¹⁴ Public Health England, Local authority health profiles. Data is for 2016/17.

¹⁵ NHS Digital, Quality and Outcomes Framework, 2017/18.

¹⁶ Lancashire JSNA annual commentary 2017/18.

<https://www.lancashire.gov.uk/media/905111/jsna-annual-commentary-201718.pdf>

¹⁷ Referenced from Lancashire JSNA annual commentary 2017/18. Direct source is the Annual Population Survey, Office for National Statistics.

¹⁸ Mental Health Benchmarking, NHS Benchmarking Network, 2015

This section outlines some of the population health issues faced by the local community arising from lifestyle choices.

Smoking

Smoking is linked to conditions such as heart and lung problems, causing tens of thousands of deaths each year in the UK. Smoking remains England's highest cause of premature death and higher smoking rates are often linked to more deprived areas ¹⁹.

Although smoking prevalence in adults is lower in Chorley (13.7%) compared to the national rate of 14.9%, prevalence of smoking remains high within Preston (20.2%) ²⁰.

Alcohol Consumption

Excessive alcohol consumption is England's second biggest cause of premature mortality after tobacco use. Regular heavy drinking and binge-drinking is associated with a range of physical and mental health issues. ²¹

Alcohol-related harm hospital stays are higher in Preston (690 per 100,000) compared to England (636 per 100,000). However, alcohol-related harm hospital stay is lower in Chorley (600 per 100,000) ²².

Obesity

Figure 6 showed that the diagnosed rate of obesity (in adults) in the local CCGs was around 10% of the population. However, national prevalence of obesity – defined for most adults as having a Body Mass Index (or BMI) of more than 30, is considered to be much higher, affecting around 1 in 4 people in the population ²³.

Health issues associated with obesity prevalence are severe and include type 2 diabetes, coronary heart disease (CHD), some types of cancer, such as breast and bowel cancer, and stroke. Obesity can also affect quality of life and lead to psychological problems such as depression and low self-esteem.

Drug and Substance Misuse

The latest estimates (2014/15) indicate that there are 9.0 opiate and/or crack users (OCU) per 1,000 of the population aged 15-64 living in Lancashire. This is in line with the national (8.6) and North West regional (10.6) estimates. Drug and substance misuse are associated with poorer health status and outcomes.

¹⁹ NHS England: Five Year Forward View <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

²⁰ Public Health England, Local authority health profiles. Data is for 2017.

²¹ Lancashire JSNA annual commentary 2017/18. <https://www.lancashire.gov.uk/media/905111/jsna-annual-commentary-201718.pdf>

²² Public Health England, Local authority health profiles. Data is for 2016/17.

²³ <https://www.nhs.uk/conditions/obesity/>

Figures relating to the treatment of non-opiate drug users (2015/16) show that 50.09% of users accessing services across the Lancashire area overall successfully completed treatment without re-presenting within six months, significantly above the national picture (37.26%).

Analysis of locally held hospital admissions data over the 2012/13 - 2015/16 period found that there was a total of 885 hospital admissions recorded across six Lancashire clinical commissioning groups (CCGs) with a primary diagnosis of drug-related mental health and behavioural disorder. The majority (746) of these admissions were emergency admissions. However, Chorley and South Ribble (16.1) and Greater Preston (18.4) have a lower crude emergency admission rate than the Lancashire region (20.9) and England as a whole as expressed by 100,000 population.

Further analysis of these data shows that 80% (598) of emergency admissions came from persons aged 42 and under, 77% were male and almost half (45%) involved those living in areas classified as being with the most deprived quintile.²⁴

Deprivation

Deprivation varies significantly across the Chorley and South Ribble and Greater Preston conurbations. Deprivation is also commonly associated with health status and population health outcomes.

In the South Ribble area, 3.7% of the population live in the 20% most deprived areas in England, compared to 12% in Chorley and 26% in Greater Preston.²⁵

The deprivation in the Preston district is higher than the England average, with 37% of residents in the Preston District living within the 20% most deprived areas in England (see Figure 8).

²⁴ <https://www.lancashire.gov.uk/lancashire-insight/health-and-care/lifestyle/drugs/>

²⁵ Ministry of Housing, Communities & Local Government, English indices of deprivation 2015: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

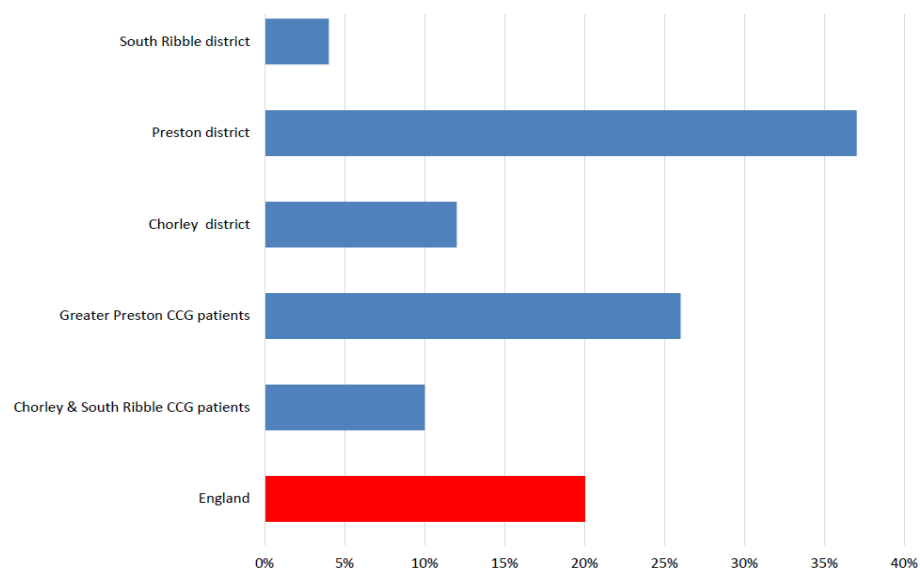


Figure 8: % people in area living in 20% most deprived areas in England (Source: Index of Multiple Deprivation 2015)

Section 3: Looking at the problem inwards

Area	Key Drivers for Change
Prevention and self-care	<ul style="list-style-type: none"> • Data from NHS Right Care would indicate that both Chorley and South Ribble CCG and Greater Preston CCG perform poorly compared to peers in terms of the impact of preventative healthcare measures for a number of long-term conditions, although there are a number of good practice initiatives already embedded in both areas. • For Chorley and South Ribble CCG, performance is worse in a statistically significant sense for five out of 19 long-term conditions (and better in two), whereas in the case of Greater Preston CCG it is worse in twelve (and better in none). • To be most effective, prevention and self-care approaches should be built in to overall care pathway design. This includes a place based and a pathway-based approach. • Evidence from NHS England shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions. All of these benefits would support the improvement of hospital services.
Improving access to primary care and community-based services	<ul style="list-style-type: none"> • Across Chorley, Preston and South Ribble there are 65 GP practices providing services to patients. Extended access models have been developed to increase the number of appointments available in a primary care setting outside of normal working hours. • However, the existing estate in primary care, and workforce constraints are making it difficult to expand the range of services which can be provided in an out of hospital setting. • There continue to be examples of patients being seen in the urgent and emergency care system who could have been seen in primary care were better and more accessible service options be made available for patients to use.
Integrated approach to working with social care and other partners	<ul style="list-style-type: none"> • The ageing population is creating additional requirements for social care services to manage. Delayed Transfers of Care (DTOCs) to home (with a care plan) and to residential or nursing homes continue to create “bed blockages” locally. This feature is replicated nationally. • Where “bed blockages” occur, this impairs the ability of the hospital trust to manage its elective and emergency care activity. As will be shown later in the case for change, this contributes to the problem of “Flow” and drives some of the operational performance issues experienced.

An effective, integrated and sustainable hospital service structure is predicated on a healthy economy which is thinking and acting towards a common goal. Across Chorley,

South Ribble and Greater Preston that goal is crystal clear - to provide the best possible clinical outcomes for patients.

As has been explained in Section 2 relating to demographics and health inequalities, achieving this goal must commence at the very start of the care pathway, and not only at the front door of our local hospitals, as part of an approach to integrated care.²⁶²⁷

Developing sustainable hospital services involves starting with the preventative approaches which can seek to support the local population to lead longer and healthier lives. A population who are supported to make the right lifestyle choices can also help to reduce excess demand on the urgent and emergency care system within our hospitals. This is the start of the integration health services journey.

The next tier is the role of primary care and community services. The British Medical Association, Health and Social Care Information Centre and Royal College of General Practitioners have all estimated that around 90% of patient contacts in the NHS are managed by General Practitioners and the service facilities provided in a primary care environment.²⁸

A properly resourced, effective, and fully integrated primary care system, operating to a neighbourhood care model, is likely to support the reduction of unnecessary healthcare contacts further downstream. This is particularly the case when applied to the management of patients with certain complex and chronic long-term conditions.²⁹ Without an integrated approach to care, patients with complex and chronic long-term conditions and populations residing in areas with high levels of deprivation and inequality are likely to be more intense users of urgent and emergency care services.³⁰

It is commonly accepted that urgent and emergency care services can often be more expensive than equivalent services provided in a less acute, or a community-based setting.

More broadly, an integrated approach between health and social care offers three main benefits; better outcomes for service users and patients; making limited resources go further and improving people's experience of health, care and support.³¹ The same can be described of better working relationships between acute care and mental health services. Linked to hospital performance, as described later in the case for change, improved integration affords the opportunity to reduce Delayed Transfers of Care (or

²⁶<https://www.kingsfund.org.uk/sites/default/files/Evidence-base-integrated-care2.pdf>

²⁷ https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/10PrioritiesFinal2.pdf

²⁸ <https://fullfact.org/health/wanted-source-widely-used-gp-statistic/>

²⁹ <https://www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/integrated-neighbourhood-care-teams>

³⁰ <https://ihub.scot/improvement-programmes/living-well-in-communities/neighbourhood-care/>

³¹ https://www.kingsfund.org.uk/sites/default/files/integrating-health-social-care-where-next-kings-fund-march-2011_0.pdf

DTOCs), improve patient rehabilitation back in to their environment prior to a hospital admission, and also avoid unnecessary use of hospital services.

This helps to explain why the challenge of creating sustainable hospital services really does start at home. This is particularly the case with managing excess demand for hospital services and managing performance issues arising from the interdependencies or linkages between these services. It also explains why it is necessary to provide an overview of the type and configuration of the services currently available for patients in these other health sectors and to consider care models for the future which are based on a whole-person or holistic care concept.

For clarity, as this case for change focusses on delivering acute sustainability and the factors driving this, it does not seek to describe the full remit and role of partners involved in delivering care before the start of the acute pathway. This is the responsibility of the other two workstreams in the OHOC programme. However, this case for change can and must outline the role that these sectors play in avoiding unnecessary use of hospital services.

The remainder of this section goes on to describe the broad configuration of these other health care sectors, their challenges and their contribution to delivering the overall goal of improved clinical outcomes for the patients of Chorley and South Ribble and Greater Preston CCGs.

3.1 Prevention

Demand for health and care services has never been higher. Without promoting prevention and encouraging self-care the local healthcare system will continue to struggle. This extract is taken from NHS England's 5 Year Forward View:

*"The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.... The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks."*³²

There are many forces that affect an individual's wellbeing and resilience, including age, lifestyle, community, housing, socio-economic status, family and support networks. With such a wide range of factors, it is unrealistic to think that any one sector or organisation could transform outcomes without following an integrated approach.

For this reason, prevention is a key priority for the Our Health Our Care programme, including primary and secondary prevention approaches. The aim is to achieve real change through a coherent, whole system, approach. Prevention underpins the out of hospital and acute Sustainability workstreams by helping to shift health care to a more

³² <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

proactive model, thus reducing the pressure on the reactive elements of the system, such as hospital services.

It starts from the point of enabling people to stay well and minimising the risk of people becoming unwell, which applies equally to mental, physical and social states.

The strategy covers both Placed Based Prevention and Pathway Based Prevention.

Placed Based Prevention focusses on aspects of an individual's wellbeing such as culture, community, workforce, and system. An overarching framework has been designed and local district councils (Preston, Chorley, South Ribble) are currently implementing localised solutions.

Pathway Based Prevention is prevention that is embedded within clinical pathways from beginning to end. Prevention is embedded within all pathway redesign work as a core element to ensure full integration of preventative and self-care principles.

Both elements of prevention are overseen by the Health and Wellbeing partnership (HWP) to ensure prevention spans organisational boundaries and is delivered to residents in a co-ordinated way.

Examples of Pathway and Place Based Prevention:

- The **Borough Care Partnership in Chorley** - Lancashire Care NHS Foundation Trust have co-located some of their community teams alongside Chorley council to ensure early identification of residents who may require extra support. For example, housing colleagues at the council may notice that in addition to resident struggling with their housing situation, they could also benefit from some psychological support. In this scenario they refer the resident into the "Minds Matter" programme. This targeted support can help residents avoid accessing acute services either from the mental health trust, or from the general urgent and emergency care hospital system.
- **Diabetes Prevention Programme** - In total, an estimated £14 billion pounds is spent a year on treating diabetes and its complications, with the cost of treating complications representing the much higher cost. The prevalence of diabetes is estimated to rise to 4 million by 2025³³. As section 2 showed, the impact of diabetes is a key condition for the health system to manage. The diabetes prevention programme has recently been piloted in Central Lancashire. This identifies patients with possible diabetes through blood testing. Where these patients are identified they can be offered additional support to prevent them from developing Type 2 diabetes through healthy lifestyle, physical exercise and diet-based interventions. Since its

³³ <https://www.diabetes.co.uk/cost-of-diabetes.html>

inception on 1 October 2017, the National Diabetes Prevention Programme has seen 2,457 people referred across 8 Lancashire CCGs.

- **Falls Prevention** - In 2013, it was estimated that falls cost the NHS more than £2.3 billion per year.³⁴ The Falls Prevention Service is a multidisciplinary specialist service for older people who have fallen or are at risk of falling. Following assessment, a care plan is collaboratively agreed with the individual for intervention and management of further falls. The service provides education to public and staff for raising awareness and prevention of falls and fracture in Central Lancashire. A recent study looking at the costs of providing care for a patient who suffers a fractured neck of femur, and who are admitted as an emergency, as a result, can be more than £14,000 in the first year following the fracture and more than £2,000 in the second year following the fracture.³⁵ These costs include the significant use of hospital bed resources arising from managing patients who suffer a fall.

More widely than this, NHS Right Care³⁶ has produced benchmarking data comparing the performance of Chorley and South CCG and Greater Preston CCG in terms of the effectiveness of prevention and public health measures linked to 19 long term conditions. The Right Care data also examines effectiveness across the other areas of the care pathway. The data are benchmarked with reference to 10 CCGs with similar demographic features. The “peers” are different across Chorley and South Ribble CCG and Greater Preston CCG respectively.

In terms of Chorley and South Ribble CCG, the data indicates that prevention and public health approaches linked to serious mental health conditions, common mental health illnesses, dementia, chronic obstructive pulmonary disease and asthma are statistically worse than the peer group average, performance in terms of diabetes and renal are statistically better, whilst there is no significance to performance relating to prevention and public health activities for the other twelve conditions.

In terms of Greater Preston CCG, the data depicts a more adverse position. Performance in terms of prevention and public health is statistically worse for breast, lung and lower GI cancers, serious mental health conditions and common mental health illnesses, dementia, coronary heart disease, stroke, chronic obstructive pulmonary disease, asthma, frailty, and patients with multiple conditions. Performance for all other conditions is not statistically significant.

³⁴ <https://www.nice.org.uk/guidance/cg161/chapter/introduction>

³⁵ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4740562/>

³⁶ <https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/08/cfv-greater-preston-ltc.pdf>
(see also Chorley and South Ribble CCG data pack from same source).

NHS Right Care has produced examples of best practice to support Clinical Commissioning Groups improve prevention-based activities. They include the Making Every Contact Count initiative in East Sussex (*ibid*).

Right Care has also published pathways which describe the relationship between prevention and early intervention measures with reduced usage of hospital services. These pathways are available for falls prevention and frailty, chronic obstructive pulmonary disease, stroke, diabetes and cardiovascular disease. Without the local application of these types of pathways and the expansion of initiatives already in place, it is likely that avoidable pressure will continue to be put on the hospital services.

3.2 Self care

Self-care means keeping fit and healthy, as well as knowing how to take medicines, treat minor ailments and seek help when you need it. If you have a long-term condition, self-care is about understanding that condition and how to live with it.

Self-care can often be the very best choice for treating very minor illnesses and injuries. Empowering people with the confidence and information to “self-care”, gives people greater control of their own health and encourages healthy behaviours that help prevent ill health in the long-term.

The Urgent and Emergency Care Review (NHSE) has highlighted self-care and self-management area that could have huge benefit on urgent and emergency care. The review has published evidence suggesting that fewer patients would access unscheduled care if they were better supported to self-manage.

For example:

- Schemes to educate and support adults with asthma and chronic obstructive pulmonary disease (COPD) to self-manage have been shown to reduce emergency admissions to hospital
- It is estimated that 80 to 90 per cent of patients with long-term conditions, as well as their carers, can be supported to actively manage their own health.

‘Patient activation’ describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions. Evidence shows that people at higher levels of activation tend to experience better health, have better health outcomes and fewer episodes of emergency care, and engage in healthier behaviours (such as those correlated to smoking and obesity).³⁷

There are a number of local examples of effective self-care initiatives which are seeking to improve patient activation and consequently reduce the demand on hospital services.

³⁷ <https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/>

Specialist Diabetes Service - This service supports people within the Greater Preston, Chorley and South Ribble area who require specialist support in order to look after their diabetes. The team consists of specialist nurses, dietitians, a link worker and administration support staff who work with individuals, their families and carers when specialist care is needed. The service provides a range of interventions such as education programmes for both type 1 and type 2 diabetes (Desmond programme used) to help residents better understand their condition, to make the most appropriate lifestyle choices, and to empower individuals to best manage their care.

Chronic Obstructive Pulmonary Disease: The Respiratory Day therapy programme - This is a collaboration of Lancashire Teaching Hospital and St. Catherine's Hospice. This involves a 10-week programme for patients with advanced lung disease and includes peer support, advanced care planning, complimentary therapies and education ('Know your lungs', nutrition, anxiety, fatigue, breathlessness)

Chronic Obstructive Pulmonary Disease: One Stop Clinic (Pilot) - A one stop clinic was recently trialled within a local GP practice and provided a holistic review of a patient's condition from a health care assistant, respiratory physio, respiratory specialist nurse, and a respiratory consultant. This clinic aimed to ensure that all patients had the correct diagnosis and therefore were on the best management plan possible whilst also educating them in self-management and the supporting services available to them in the community. The pilot identified that 4 out of 22 patients did not have COPD (this is in line with national estimates).

Therapy Services (Pain Team) - Treats patients living with chronic/longstanding pain at Royal Preston and Chorley Hospitals referred from the pain service. Treatment is led by the individual's goals and values in conjunction with their physiotherapist. The aim is to facilitate a patient's understanding of their condition and provide strategies to help with self-management improving their quality of life.

If these types of services, focussed on improving self-reliance and patient activation are not fully developed, integrated, utilised, or accessible across more conditions, then there is a risk that unnecessary pressures will be created on hospital services. Developing these services will require a targeted approach, and the application of a common method for care transformation.

3.3 Social Care and People in Residential Care

Lancashire County Council (LCC) commissions social care services which are provided by a number of providers. The number of local people with social-care needs continues to increase as a by-product of an ageing population. LCC adult social care services are currently provided long-term adult social care services to over 23,000 people each year. This is one of the highest rates in England when calculated per resident. Over 15,000 people receive services enabling them to live at home, over 6,000 are supported in residential care and over 2,000 are supported in nursing care.

At a national level expenditure on adult social care decreased nationally from £18.4 billion to £17 billion between 2009 and 2015. Since 2015, the government has developed the Better Care Fund and an ability for local authorities to add a limited precept to council tax bills to pay for additional costs of providing adult social care. Despite this, data from the King's Fund identifies the issues experienced by the NHS in terms of the changes with adult social care spending over recent years.

One of these issues is the impact of delayed transfers of care (or DTOCs), which are described in more detail later in the case for change. The chart on the next page shows delayed transfers of care, by reason, in the 2016/17 financial year across the NHS.

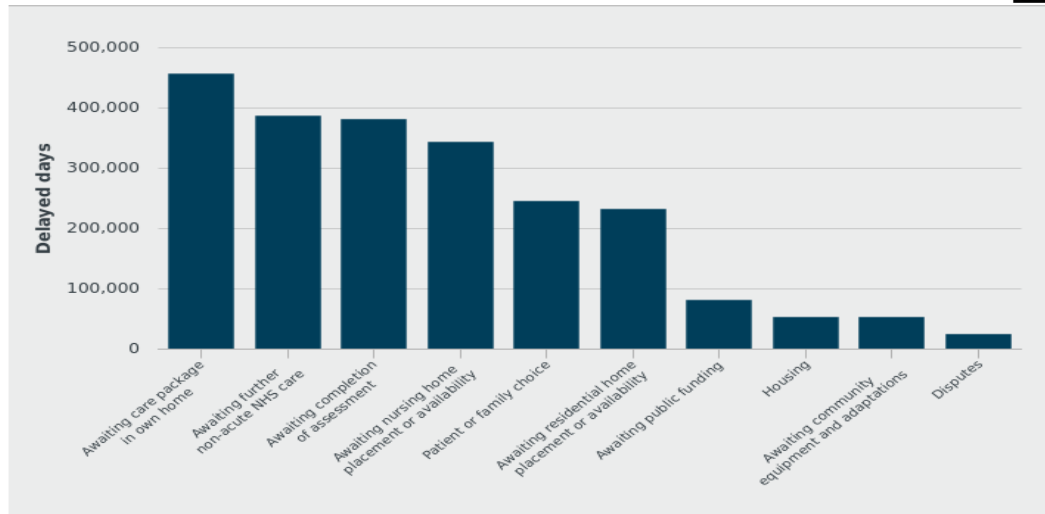
Delayed transfer of care occurs when a medically fit patient is occupying a bed when they are ready and able for discharge. A recent rise in the number of people unnecessarily delayed in hospital is a concern, with data from 2015/16 showing 13.3 people (per 100,000 of the 18+ population) experiencing a delayed transfer of care, which is similar to England (12.1%). Near one million bed days were lost nationally because patients were either waiting for a care package to be provided in their home, or for a place in a nursing or residential care facility to be found.

The data also shows that repatriations (or transfers to another hospital) were also a significant contributory factor to DTOCs. However, both of these issues are key drivers of patient flow, as the hospital cannot admit patients (either electively or as an emergency) if beds are “blocked” with patients whose needs would be best managed in a different care environment or setting.

This national picture is, in broad terms, replicated by the local experience of Lancashire Teaching Hospitals. In August 2018, there was 719 delayed transfers of care at Lancashire Teaching Hospitals due to issues coordinating onward care planning.

Recent surveys conducted with carers and service users in Lancashire reveal overall high levels of satisfaction with the adult social care services received. However, satisfaction levels have shown a slight decrease from prior years.¹

Delayed transfers of care by reason, 2016/17



Source: NHS England, <https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/>

A 2015 study from the Health Foundation and the Nuffield Trust also found that “care home residents had 40 to 50 per cent more emergency admissions and Accident & Emergency (A&E) attendances than the general population aged 75 and over but significantly fewer (about half the number) elective admissions and outpatient appointments.”³⁸

This shows that people in residential care can place higher demands on the urgent and emergency care system.

For these and other reasons, the social care sector must continue to be a valued partner in the delivery system in Central Lancashire. Health and care organisations from across Lancashire and South Cumbria are working together to develop a quality assurance system which will mean health and care intelligence can be reviewed and benchmarked across the region. This will help to learn from best practice and develop more integrated approaches to referral management between social care and the NHS system.

3.4 Primary & Community Care – Service Configuration

The populations of Chorley, South Ribble and Greater Preston have access to both hospital (secondary care) and out of hospital services (primary and community services).

Hospital services are provided (in the main) by Lancashire Teaching NHS Foundation Trust with some secure and inpatient mental health services being provided by

³⁸

https://www.health.org.uk/sites/default/files/QualityWatch_FocusOnHospitalAdmissionsFromCareHomes.pdf

Lancashire Care NHS Foundation Trust. These services are covered in greater detail later in the case for change.

The services provided out of hospital (primary and community services) include all general practices (primary care) and care delivered in community locations by a range of providers. These include the voluntary sector, social care sector, and care provided within an individual's home.

Across Chorley, South Ribble and Greater Preston there are 65 GP practices providing services to patients.

Lancashire Care NHS Foundation Trust provides community nursing, health visiting and a range of therapy services including physiotherapy, podiatry and speech and language provision. Lancashire Care NHS Foundation Trust also provides wellbeing services including smoking cessation and healthy lifestyle, as well as specialising in community mental health services.

Improving Access to Primary Care services

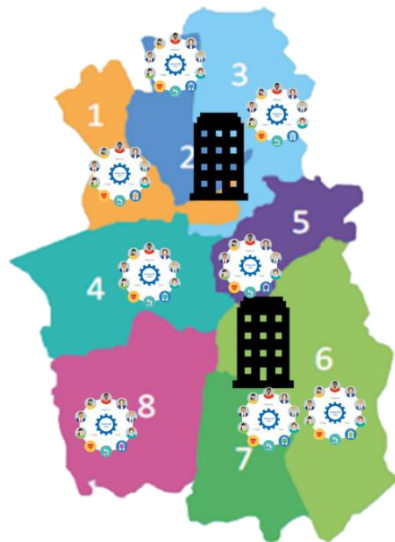
Work has been undertaken to improve access to primary care with GP practices working jointly and together at scale to improve general medical services. The vast majority of GP practices are now working together in collaboratives and joint working has allowed practices to offer weekend, bank holiday and weekday evening appointments for their patients (extended access). Improving access to primary care services helps to provide patients with another option to resolving their healthcare need in an “out of hours” setting than attending either an Urgent Care Centre or an Accident and Emergency Department in one of the local hospitals.

All practices are also working to a GP quality contract which is intended to standardise some practices to reduce variability and improve quality of services provided to patients.

As referred to in the introduction to this section, the principle of a neighbourhood care model is increasingly important in the delivery of effective, and targeted, primary health care services. Eight neighbourhoods have been developed across Central Lancashire representing populations of around 30,000–50,000 with networks being established in each of the eight neighbourhoods.

Networks allow services provided in each area to be tailored to meet local needs. Networks are multidisciplinary community teams with clinical leadership from General Practitioners, which align mental health and social care professionals as well as key links with community and voluntary services. The leadership teams for Networks across Central Lancashire include as a minimum a lead GP, Deputy GP, lead nurse, lead practice manager and community services representative.

GP collaboratives underpin the eight Networks and become capable of holding delegated responsibility for budgets. The diagram below depicts the 8 neighbourhoods that have been developed and the networks that will sit within them.



Several pilots are now utilising this model, including a new Diabetes pathway and a new Care Home Model.

Work is ongoing with Lancashire Care Foundation Trust (LCFT), Lancashire Teaching Hospitals (LTH), GP Practices, Social Care, and the 3rd Sector to further understand the learning from vanguard areas and continue to develop/implement networks.

Despite the above development, it is recognised that further improving access to primary care, and delivering resilience in the primary care workforce, remains some of the most fundamental barriers to delivering effective care with the overall aim of improving patients' clinical outcomes. One of the current adverse impacts of the current primary health care access model is that patients still attend Urgent Care Centres and Accident and Emergency Departments unnecessarily.

The 65 GP surgeries within the health economy unfortunately feature very few with modern clinical and surgical spaces, limiting how far these services can be expanded to deliver more care in an out of hospital setting. In turn, issues with the primary care estate can result in an over-reliance on expensive hospital-based care, as communities utilise the services which are available to them where no practical alternatives exist.

The General Practice Forward View published in 2016, reflected these challenges nationally and sought to set out specific, practical and funded steps. The steps included initiatives such as increasing GP training placements; supporting GPs to return to practice; investing in estates and technology to support better online tools and appointments; and improving record sharing to support teamwork across practices.

In addition, preventative and self-management work with patients is important to progress. Nationally, the treatment of the treatment of minor ailments within primary care accounts for about 20% of total available GP workload and is estimated to cost the NHS about £2bn, an issue which is also felt locally. This impacts on the available capacity within primary care to focus on delivering more care out of hospital and providing better services for the chronic and long-term condition management. In turn, this also contributes to the excess demands being placed on hospital services.

Improving Access to Community Services

In terms of adult community services, Lancashire Care NHS Foundation Trust have experienced a 30% increase, year on year, in referrals for community-based nursing, allied health professional services and psychological services and it is forecasted that the trend will continue over the next five years with an ageing population. This is likely to require a growth in staffing to meet demand and the requirement to redesign pathways and develop new ways of working.

Despite this, progress is being made with the development of an adult community Respiratory Service, Frailty Assessment Service and Moving Well Service (Musculoskeletal service) and a pilot for Integrated diabetes services. The inability to manage increased demand on these services, often results in patients choosing readily accessible services i.e. A&E services, which can often result in appropriate attendances in a secondary care setting.

Conclusion

Central Lancashire has some excellent prevention, self-care, primary and community care and social care offerings for patients. However, if services remain as they are - reactive, complex, and fragmented then it may not be possible to deflect demand from the hospital system. Where alternatives are not accessible for patients, presentation in to the urgent and emergency care system in hospitals can become a default choice. An integrated care approach, using a neighbourhood care system and networked model may help to turn this around.

The focus on prevention, self-care, and patient activation is particularly relevant for vulnerable sections in the community including the elderly, people with mental health problems and those with complex needs and chronic long-term conditions. The Right Care data clearly shows that more can be done to plan and coordinate preventative and early intervention care so that excess prevalence of chronic and long-term conditions can be avoided. In turn, this would reduce the pressure on the hospital services system.

Section 4: Looking at the Problem Outwards

Area	Key Drivers for Change
Using available estate and workforce most effectively	<ul style="list-style-type: none">• At the present time there are a considerable number of services which are provided at both of the two main hospital sites. 30 of the 54 services listed are provided at both of the two sites, 24 services are currently linked to one unique site.• If the available estate space on the two hospital sites is restricted, then it may be necessary to consider different options to best accommodate current services and expected growth rates for some services.• National data used alongside local demographic and population data can reliably translated in to a list of services which will need to grow in size to cope. Achieving this means that it will be important for the available estate be used as effectively as possible.• In some cases - where services are provided at both of the two main hospital sites— this can consequently mean that the workforce is similarly split in to site-specific delivery teams. Where workforce availability and specialist skills are an issue, we need a solution which achieves improved and safe services.
Performance	<ul style="list-style-type: none">• Recently the Trust has worked to improve its access to key services and has paid attention to flow through the organisation by focussing on how it uses its available workforce, space, and also how it manages relationships with its partners (i.e. to promote early and safe discharge planning). The Trust continues to pursue improvement plans linked to these issues.• Achieving effective flow through the organisation will help it to improve performance against the NHS Constitution access standards.• The 4-hour A&E target³⁹, 18-week RTT target⁴⁰, and 62-day Cancer wait target⁴¹ are all being consistently missed by the organisation, with a broadly declining trend when examined as a whole. For patients, waiting longer to be seen, diagnosed and treated means that their experience of local NHS services is not as good as we would want it to be.

³⁹ NHS England, A&E Attendances & Emergency Admissions:

<https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/>

⁴⁰ NHS England, RTT Waiting Times: <https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/>

⁴¹ NHS England, Cancer Waiting Times: <https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/>

	<ul style="list-style-type: none"> • This can be improved by planning services efficiently, by encouraging patients to access their care in the best clinical environment, and by ensuring that clinical pathways reflect best available evidence. • A&E performance at Royal Preston Hospital has been deteriorating significantly since April 2015. In quarter 1 of 2015/16 A&E 4-hour performance was close to 95%, however this has now dropped to 62% in March 2018. Across the Trust as a whole, performance was 75.4% in 2017/18.⁴² • Performance against the Referral to Treatment ('RTT') incomplete pathway standard (of 92% of patients waiting for treatment at the month's end not waiting longer than 18 weeks) has deteriorated.⁴⁰ • The latest performance (September 2018) of the RTT incomplete pathway is only 79.5% for Lancashire Teaching Hospitals, meaning 20.5% of patients have been waiting for 18 weeks or more and are yet to receive their first definitive treatment.⁴⁰ • It is frequently observed that when hospitals are struggling to meet their unplanned or emergency care requirements the capacity available for planned care (such as operations) reduces. This can result in longer waiting times for patients who are on planned care waiting lists. On occasion, it can result in more patients eventually needing to receive their care in an emergency setting. • Lancashire Teaching Hospitals had the second lowest score in England for patient satisfaction with Access and Waiting Domain on the 2016/17 A&E survey⁴³. • Average waiting times until initial assessment in A&E have been slowly increasing at both sites. In April 2015 the average time was 18 minutes at Preston and 17 minutes at Chorley. By January 2018 these had increased to 38 and 32 minutes respectively⁴². • In short, this shows that the pressure on the emergency care service structures across Central Lancashire continues to increase, even with more patients using available Urgent Care services and community-based alternatives from both locations.
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⁴² Lancashire Teaching Hospitals supplied SUS – A&E dataset

⁴³ NHS England, Overall Patient Experience Score: 2016 Emergency Department Survey: <https://www.england.nhs.uk/statistics/2017/10/17/overall-patient-experience-scores-2016-emergency-department-survey-update/>

Decrease in Planned Surgery	<ul style="list-style-type: none"> • There has been a decline in the number of planned elective surgical admissions at both sites. This is from a high of 1,875 admissions at Royal Preston Hospital in July 2015 to 1,506 in January 2018. Over the same period elective admissions reduced from 1,130 to 984 at Chorley and South Ribble Hospital⁴⁴. • Planned elective surgery cancellations for non-clinical reasons are increasing at a higher rate locally than the England average. The rate in increase of cancelled operations has nearly always been higher each quarter than the England rate.⁴⁵ • The number of cancelled operations is generally accepted as a proxy measure for the challenges experienced by a hospital in terms of being able to plan its capacity, workforce and overall flow.
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4.1 Lancashire Teaching Hospitals NHS Foundation Trust

Lancashire Teaching Hospitals NHS Foundation Trust provides healthcare for people in the areas of Preston, Leyland, Chorley, and other surrounding areas in North West England.

The trust operates two main hospital sites:

- Royal Preston Hospital is situated in the north of the city in the Fulwood area (referred to as Preston).
- Chorley and South Ribble District General Hospital in Chorley (referred to as Chorley).

The total land area owned by the Trust is approximately 33 hectares and the accommodation available has a gross internal floor area of approximately 180,000m².

The distance between the two hospitals is 15km as the crow flies. Travel time between the sites varies depending on the mode of transport (either private car or public transport) and the time of day when the journey is taken (either peak or off peak).

Journeys using public transport and taken in peak time often take longer than journeys taken by private car at off peak times (i.e. outside of weekday rush hours). The quickest journey time (by private car in the best-off peak conditions) between the two hospital sites is approximately 25 minutes.

⁴⁴ Lancashire Teaching Hospitals supplied SUS – Admitted Patient Care dataset

⁴⁵ NHS England, Cancelled Elective Operations: <https://www.england.nhs.uk/statistics/statistical-work-areas/cancelled-elective-operations/>

As well as the two hospitals, the trust has a mobility rehabilitation centre plus specialist outreach clinics at peripheral sites across the region including comprehensive renal dialysis services at Blackburn, Accrington, Burnley, Blackpool and Kendal.

4.2 Royal Preston Hospital

Royal Preston Hospital was purpose built as a medium-sized district general hospital in 1981 and allowed rationalisation of services from other acute hospital sites at that time.

Preston provides acute and sub-acute services and hosts the Operational Delivery Network for Lancashire and Cumbria Critical Care and Major Trauma Network with a major trauma centre being based there.

4.3 Chorley and South Ribble District General Hospital

The Chorley and South Ribble Hospital initially opened in 1933 but has been subject to major redevelopment in intervening years. The hospital opened its current form in 1997.

4.4 Services Provided

At the present time there are a considerable number of services provided at both of the two main hospital sites. Elective and non-elective care are currently being provided at both hospitals. The Trust is also a regional specialised centre for:

- Cancer (including radiotherapy, chemotherapy drug therapies, and cancer surgery).
- Disablement services (such as artificial limbs and wheelchairs).
- Major Trauma.
- Neurosurgery and Neurology.
- Renal Services.
- Vascular Services.

The following services are provided at each of the two sites.

Clinical Service	Preston	Chorley
Accident and Emergency	✓	✓
Ambulatory Care (Medical)	✓	✓
Breast		✓
Cardiology	✓	✓
Colorectal	✓	
Dermatology	✓	✓
Diabetes	✓	✓

Clinical Service	Preston	Chorley
Elderly rehabilitation		✓
ENT	✓	✓
General medicine including acute elderly	✓	✓
General surgery – Emergency	✓	
General Surgery – Elective	✓	✓
Genito urinary	✓	
Gynaecology – Benign	✓	✓
Gynaecology – Cancer.	✓	
Haematology	✓	
Hospital Sterilisation and Decontamination Department	✓	✓
Critical care	✓	✓
Investigations	✓	✓
Lower GI (inc endoscopy)	✓	✓
Major Trauma	✓	
Max Fax – Inpatient	✓	
Max Fax – Outpatient	✓	✓
Medical Assessment Unit (MAU)	✓	✓
Nephrology	✓	
Neonates	✓	
Neurology	✓	
Neurosurgery	✓	
Neuro Rehab	✓	
Nutrition	✓	✓
Obstetrics – midwife led unit	✓	✓
Oncology – Inpatient	✓	
Oncology – Outpatient (Chemo. etc.)	✓	✓
Ophthalmology	✓	✓
Oral surgery and orthodontics	✓	
Orthopaedic surgery	✓	✓
Outpatient Parenteral Antimicrobial Therapy (OPAT)	✓	✓
Outpatient services	✓	✓
Paediatrics – medical and surgery	✓	
Palliative Care	✓	✓
Pathology	✓	✓
Plastic surgery	✓	
Radiology	✓	✓
Renal dialysis	✓	✓
Respiratory and cardiovascular	✓	✓
Surgical Assessment Unit (SAU)	✓	
Stroke Rehab – Ward	✓	✓
Stroke Rehab – Outpatients		✓
Theatres	✓	✓
Trauma	✓	
Upper GI (inc endoscopy)	✓	✓
Urgent Care Centre	✓	✓
Urology	✓	✓
Vascular	✓	✓

Figure 9: Services provided by Lancashire Teaching Hospitals

4.5 Lancashire Teaching Hospitals Performance

Recently the Trust has worked to improve its access to key services and has directed significant attention to improving flow through the organisation. As such the Trust uses a range of national (NHS Improvement) and local key performance indicators.

In 16/17 and 17/18 the organisation agreed set improvement trajectories throughout the year for RTT target (RTT target (treatment within 18 weeks from referral), the Emergency Department 4-hour target and Cancer targets. However, performance against these targets has, in the main, consistently failed to meet the relevant NHS Constitution standard.

The next section provides details of quality improvement initiatives relating to the delivery of key performance indicators before describing performance against each of them in more detail.

4.5.1 Quality improvement- seeking to improve performance

The Trust is currently working on a number of internal improvement programmes to help alleviate some of the systemic issues within the Trust.

4.5.2 Delayed transfer of care

In recent years, Central Lancashire has been most challenged with Delayed Transfers of Care (DTOCs). To help identify areas of improvement and possible solutions, the Trust, alongside other providers such as CCGs, Lancashire County Council and Lancashire Care Foundation Trust took part in a value stream analysis (VSA) event, undertaken by Newton Europe. The diagnostic summary identified that 80% of delays were related to processes and decisions within the acute footprint. This helps to show why both the trust and its partners need to focus on improvement to resolve of DTOCs.

The analysis highlighted the four key reasons behind people getting delayed in hospitals as being:

- Patients waiting for ongoing care
- Discharge processes and ward referrals
- Medical review – or the continued testing of patients beyond what was necessary
- Capacity in ongoing services.

The analysis identified a number of opportunities which, if embedded into improvement plans, could result in improved service level governance, patient outcomes and a reduced variation in decision making. The Trust is now working to embed the findings in to overall improvement plans.

4.5.3 Emergency care

The Trust is further participating in the NHS Improvement Emergency Care Intensive Support Team (ECIST) collaborative, who are focussed on enabling clinicians to help

deliver high quality emergency care. The collaborative is delivered by a clinically led national team who are also known as “The Emergency Care Improvement Programme” (ECIP). Working with the Trust, the programme provides deep, intensive support to *“make better use of the resources they have,”* by adopting good practice and applying it. Using this programme, the Trust have implemented a SAFER care bundle. The programme is working with the Trust to systematically create and implement each of the separate areas of the bundle. Recently, the Trust has focussed on the “F” aspect of the bundle. This aspect focusses on improving flow, with wards testing the “pulling” of patients from an assessment area by 10am each morning. From the work of ECIST, divisional nursing directors have helped to achieve the national target of a 25% reduction in length of stay. This work has been recognised nationally.

4.5.4 Theatre Productivity

To address the issues with elective operation cancellations, and the failures to deliver the referral to treatment standard, the Trust has recently undergone a review of its approach to using its theatre capacity productively. The resulting improvement programme, which began in October 2018, is split in to three phases:

1. Improving scheduling and planning
2. Starting theatre lists on time
3. Reducing cancellations

As a product of the programme, the trust aims to deliver an extra 895 cases by the end of the 2018/19 financial year.

4.5.5 4-hour A&E target- current performance

In September 2018 (latest figures available) 84.8% of patients were treated within 4 hours of arrival at A&E³⁹. This compared with a national average of 88.9% and a national target of 95%. The Trust was ranked 90th out of 131 trusts in terms of this target.

4.5.6 18-week Referral to Treatment target- current performance

In August 2018 (latest figures available) 79.5% of patients received planned operations within 18 weeks of referral at the Trust⁴⁰. This compared with a national average of 87.2% and a national target of 92%. The Trust was ranked 114th out of 126 trusts in terms of this target. However, in previous months the Trust have met this target, the last time being May 2018.

4.5.7 62- day cancer target- current performance

In August 2018 (latest figures available) 84% of patients started cancer treatment within 62 days of urgent referral.⁴¹ This compared with a national average 79.4% and a national target of 85%. The Trust was ranked 48th out of 131 trusts. This means that performance against this measure was better than the national standard, but still not meeting the NHS Constitution access threshold.

4.6 Activity trends

This next section describes changes in activity patterns at Lancashire Teaching Hospitals. Activity in the acute provider sector continues to grow year on year, both in elective and non-elective activity. This is a pattern which is replicated nationally.

4.6.1 Activity trends- attendance to urgent care and Emergency Departments

Figure 10 shows A&E attendances at Lancashire Teaching Hospitals between 2015/16 and 2017/18. Since January 2017 there has been a decline in the number of attendances at both Emergency Departments. This appears to be due to patients accessing urgent care services provided by gtd healthcare.⁴²

However, over the past three years there is a growing trend in the demand for urgent and emergency care overall (this is the figure counting both categories together). This can be seen by reviewing Figure 10 and looking at the aggregate of the blue, gold and green stacked bars, across the time series shown from left to right. National A&E attendances also show a growing trajectory.³⁹

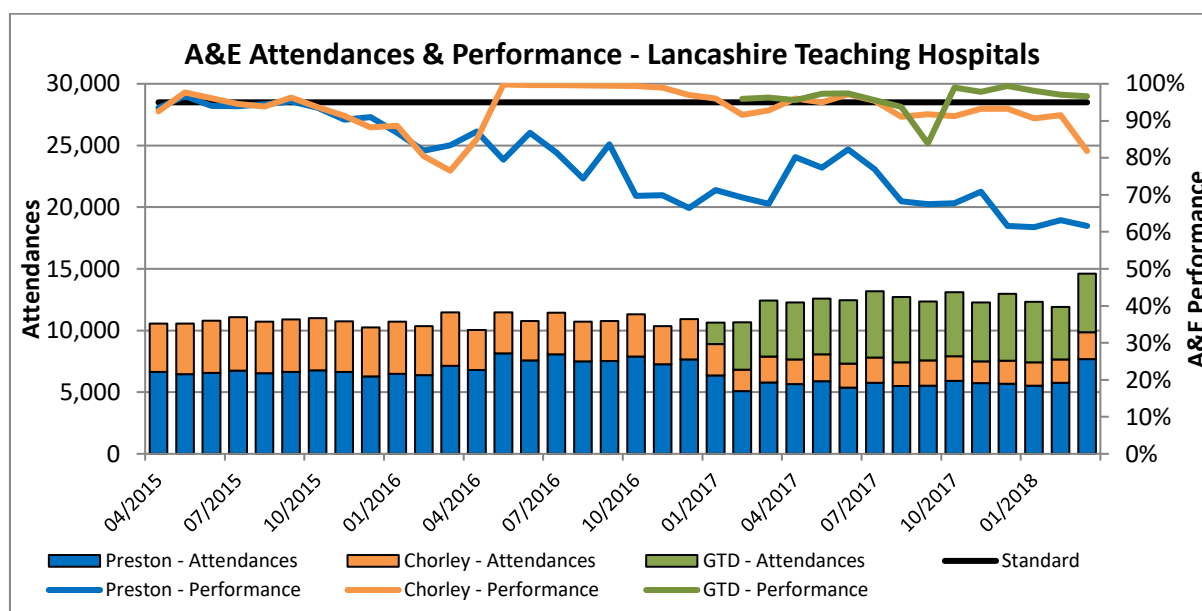


Figure 10: A&E attendances 2015/16 – 2017/18 (Source: Trust SUS data and gtd healthcare data)

4.6.2 Activity trends- age-based trends and repeat attendees to Accident and Emergency Department

Figure 11 shows the age distribution profile of all attenders to the Accident and Emergency Departments at Preston and Chorley.⁴² As can be seen from the blue and the gold line at both sites, the proportion of attenders aged 65 and above has increased from the period from April 2015 to March 2018 overall. In this age category, the number of attendances has also risen. Care should be taken when interpreting the data across the intervening period due to the initial changes to arrangements to Accident and Emergency care at Chorley in April 2016.

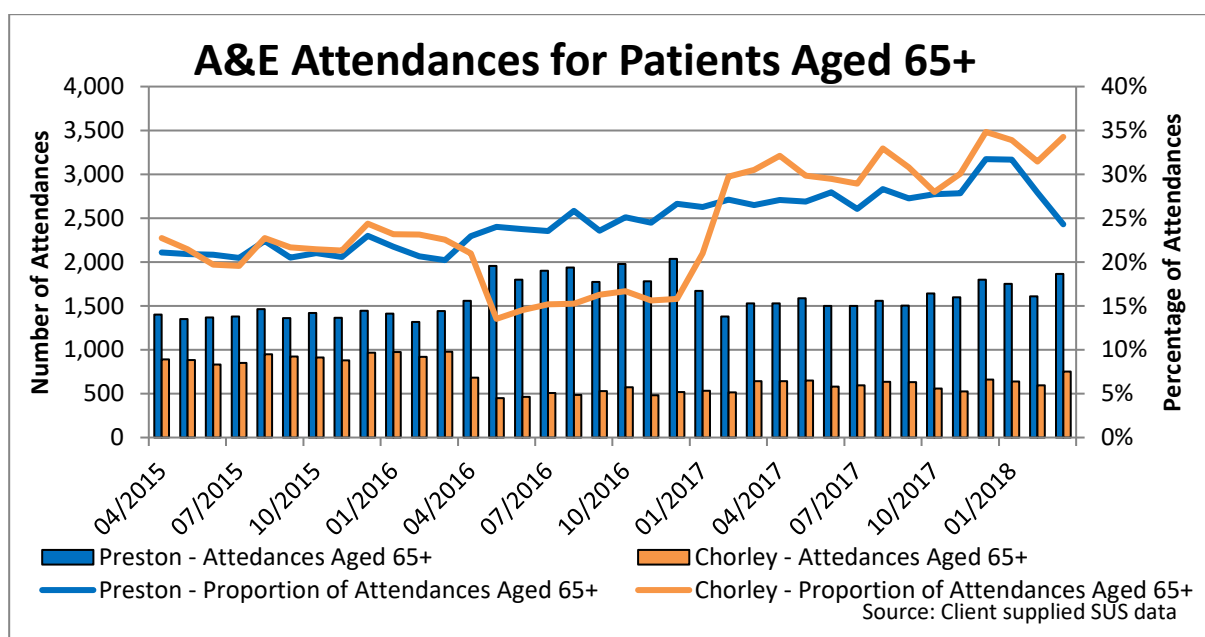


Figure 11: A&E attendances for patients aged 65+ April 2015 to Mar 2018, (Source: Trust SUS data).

During the latest financial year (2017/18) there were 93,774 attendances at the two Emergency Departments made by 66,444 individual patients.⁴² The 2% of patients (6,644 people) with the highest number attendances in the year were responsible for 9,375 attendances. This equates to 10.0% of all A&E attendances.

62.9% of all A&E attendances during 2017/18 were made by just 20% of the individuals accessing A&E services that year.⁴² In short, this unequal relationship shows that some people use A&E services considerably more than others, because the distribution is uneven.

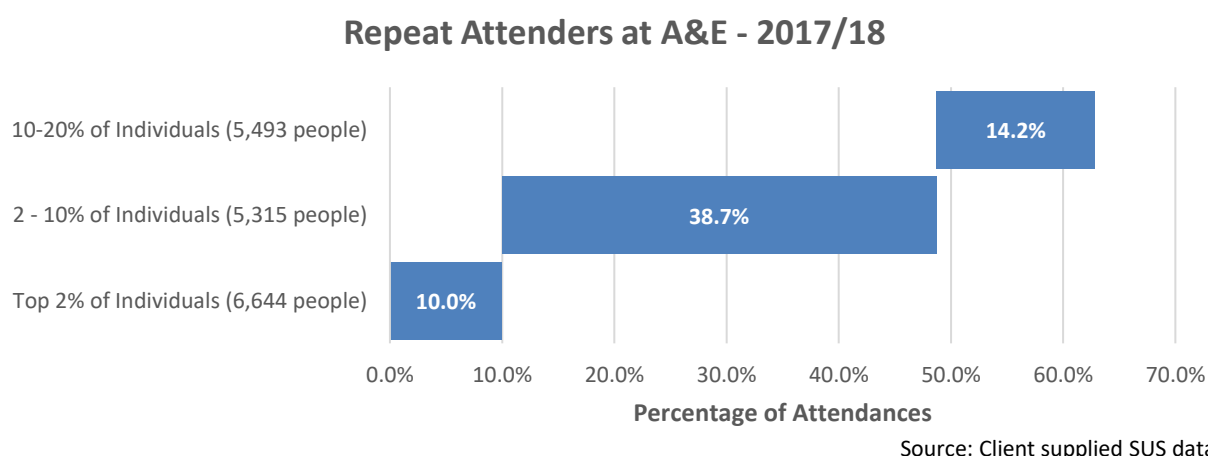


Figure 12: Percentage of people attending Lancashire Teaching A&Es with multiple attendances during the latest financial year (Source: Trust SUS data)

4.6.3 Complexity of spells at Royal Preston and Chorley Hospitals

In 2015/16 and 2016/17, more than a quarter of both Royal Preston and Chorley Hospitals spells for medical specialties were classed as “complex.”

However, across the same period, 15% of Preston’s surgical specialty spells and only 7% of Chorley’s surgical specialty spells were classed as “complex” (*Source: Trusts SUS data*). The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services.

This indicates that medical specialties saw a similar percentage of complex patients (i.e. those Healthcare Resource Groups (HRGs) identified with complications) across both sites whereas for surgical specialties, more complex patients (in both absolute and proportional terms due to higher attendance volumes) were seen at Preston.

For context, HRGs are used to code and classify clinical activities. Based on the presenting complaint and the patient’s history, a clinical activity can often be sub-categorised in to “with no complications,” “with minor complications,” or “with major complications,” and sometimes others. This data looks at the classification within both of the categories linked to “complications,” as opposed to “no complications.”

4.6.4 Admitted bed days

Figures 13 and 14 summarise admitted patient bed days over a three-year period, split by main acute site. These show that the significant majority of activity (inpatient or day case) is undertaken at Preston.⁴⁴ Non-elective and emergency activities comprising the majority of overall admitted activity at Chorley and Preston respectively.

The data labels (including the differences) and admission types arise from the Trust SUS data.

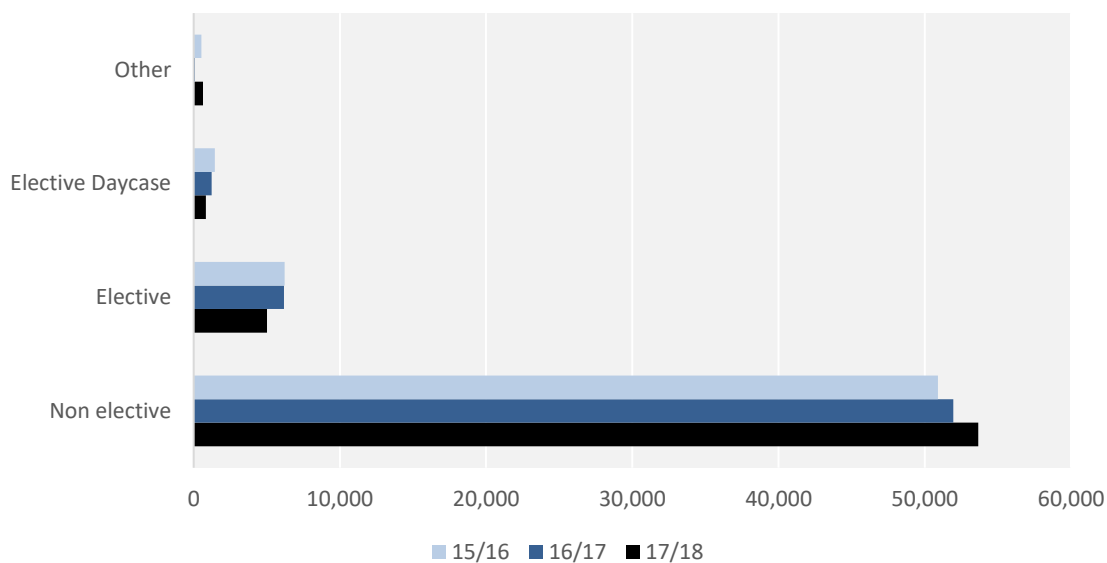


Figure 13: Admitted patient bed days – Chorley and South Ribble Hospital (Source: Trust SUS data)

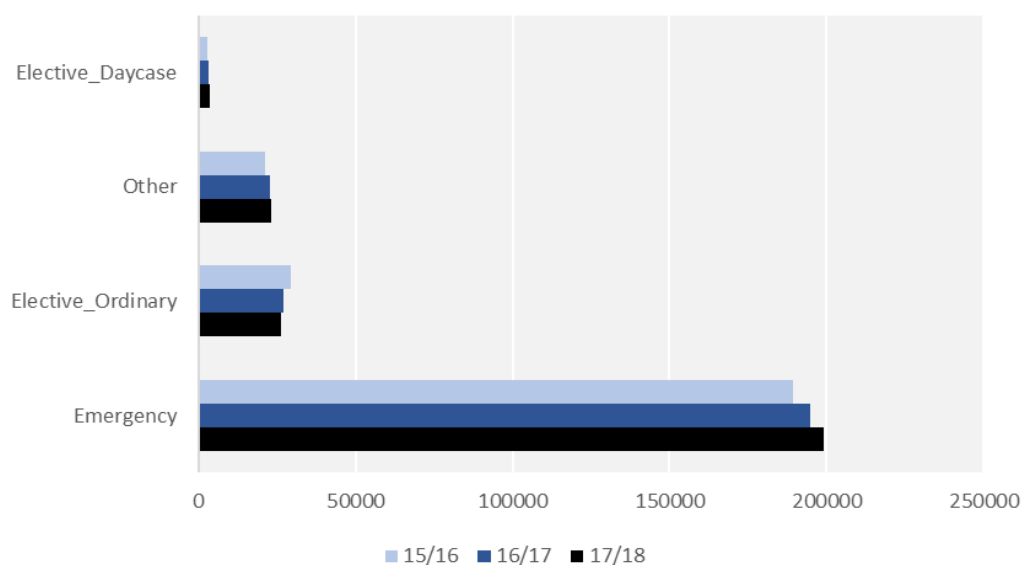


Figure 14: Admitted patient bed days – Royal Preston Hospital (Source: Trust SUS data)

4.6.5 Long-term conditions- bed occupancy

In central Lancashire, the proportion of acute and emergency care beds occupied by patients with long-term conditions is worse than average, when compared to both county and national occupancy rates.⁴⁶ This tends to correlate with some of the information presented in Section 3 relating to NHS Right Care data.

⁴⁶ Long-term conditions in Greater Preston CCG 2016, Lancashire County Council and Long-term conditions in Chorley and South Ribble CCG 2016, Lancashire County Council

Without improvement, the situation may worsen. This is because, as the information in Section 2 demonstrated earlier, older people tend to have more age-related long-term conditions. The population data also suggests that both CCGs will have a higher proportion of their populations aged 65+ in the future. This identifies a probable need to deliver transformational change so that the hospitals have sufficient capacity in terms of beds to care for the patients requiring treatment.

Providing support for people to self-manage their conditions and access alternative community-based recovery services could support the reduction of admission and readmissions into emergency care.⁴⁷⁴⁸ This would both help to improve patient experience and also support the resilience of emergency care services. Resilience would improve because more beds would be available to support the needs of other patients, which would in turn help with the issue of achieving better flow.

4.6.6 Medical Admissions

Figure 15 looks at the age distribution of patients admitted under a medical specialty. The age profile of admissions at Chorley shows more admissions in the over 65 categories than at Preston.

When reviewing this data, it is important to triangulate it with the data relating to the number of admissions. This is because, as shown earlier, the number of admissions across the different admission categories, is higher at Preston than it is as Chorley.

This would mean that the total number of over 65s admitted are higher at Preston than at Chorley.⁴⁴ However, the age distribution of medical admissions is more biased towards an older patient group (i.e. over 65s) at the Chorley site.

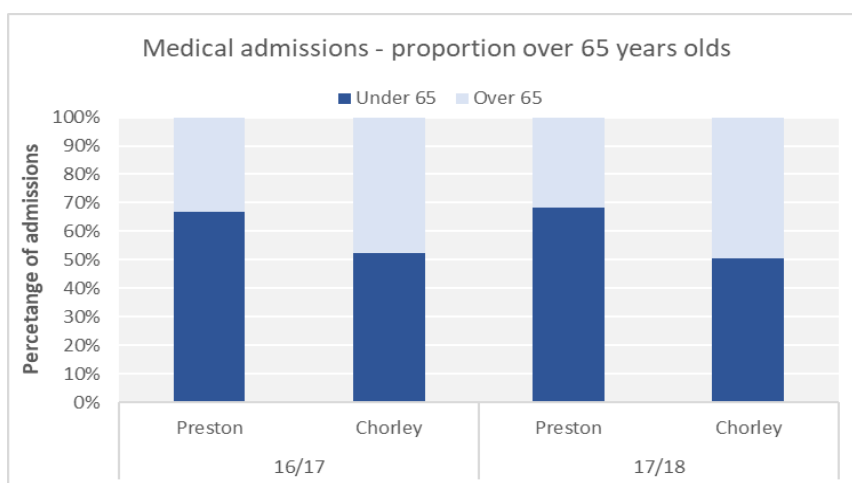


Figure 15: Medical admissions – proportion over 65-year olds (Source: Trust SUS data)

⁴⁷ Long-term conditions in Chorley and South Ribble CCG 2016, Lancashire County Council

⁴⁸ Social Care for Older People, King's Fund

4.6.7 Elective/ emergency medical activity and day case- achieving flow

Figures 16, 17 and 18 look at the activity patterns in elective, emergency and day case admission categories correlated with the number of beds. Each figure shows both the Preston and the Chorley site together. Together, these charts show the impact of clinical activities across Lancashire Teaching Hospitals and give an insight in to some of the issues that it faces in achieving effective flow.⁴⁴

Figure 16 relates to elective medical activity (defined as activity coded to medical specialties). Elective medical activity at Chorley has declined slightly since April 2015 (see the red line in Figure 16), but there are changes in the levels during the time period shown. Elective activity at Preston was on a significant decline towards the end of 2015/16. This decline was reversed in 2016/17 with activity levels returning towards their original level (see the Blue line in Figure 16). However, there has been a significant drop in activity at the end of the 2017/18 financial year. The average beds at Preston largely matched the fluctuations in activity.

Figure 17 shows the same relationships relating to emergency medical activity.

Reading Figure 16 together with Figure 17 - which shows the same relationships relating to medical activities coded as an emergency (or non-elective), it is possible to see how the hospitals aggregate bed usage varies in number and deployment to manage these different admission activities across the year and over time. Figure 18 shows the position for day cases whilst Figures 19 and 20 in the following section express the similar position relating to surgical admissions.

Correlating these trends is complex and can be imperfect. However, they tend to show that the beds accessible to the trust as a whole need to be used dynamically so as to manage variation, including seasonal and other demand-driven factors. The use of and number of beds is not stable at all types of year and allowing for demand-driven variations.

For medical admissions, it is also possible to look at these data alongside bed occupancy and length of stay (including delayed transfer of care (DTOC) data). This helps to provide an insight in to the issues experienced by the trust in seeking to achieve effective flow in to and out of its hospital wards. Also, the challenges it experiences in seeking to maintain elective, or planned delivery capacity, as opposed to needing to accommodate more emergency admissions.

However, as stated above, it should be noted that these relationships and their impacts on bed utilisation and occupancy, as representations of hospital flow, and how effective flow is across the trust, are complex. Other dimensions of these relationships include factors such workforce availability; internal admission and discharge management processes; the planning and delivery of services such as radiology, pharmacy and pathology; and the availability of capacity in other non-hospital locations where patients may be discharged to. These factors will not be readily depicted on these charts.

Further drivers of “flow” include having consistently accessible and effective alternatives to Accident and Emergency. This is because demand surges (impacting on steady flow) can be caused by ineffective streaming and triaging, or not having staffing availability to create the right emergency admission threshold at all times of the day. These alternatives also include those accessible within a primary care environment.

For a system to work well and a dynamic bed model to work, all of the above factors need to be managed effectively. Were this to occur, then this would help to improve operational performance across the Trust.

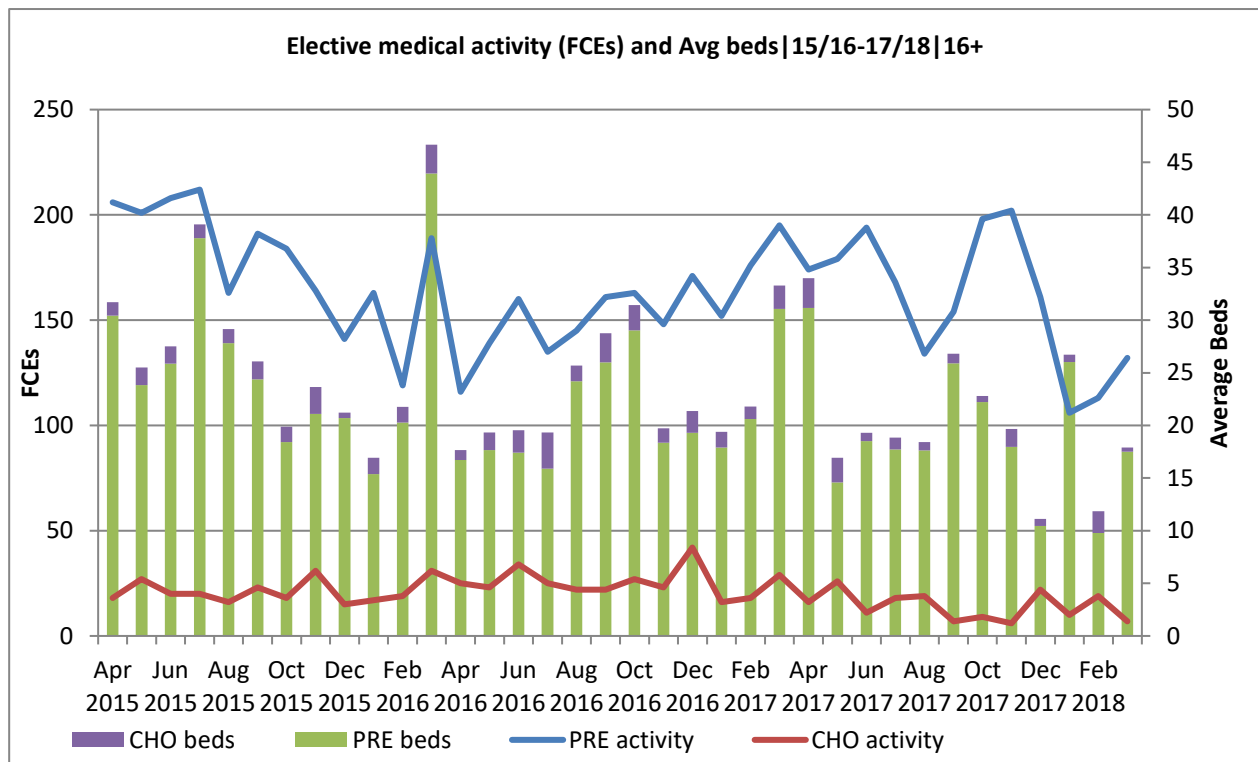


Figure 16: Elective medical activity and average beds 15/16 – 17/18 (Source: Trust SUS data)

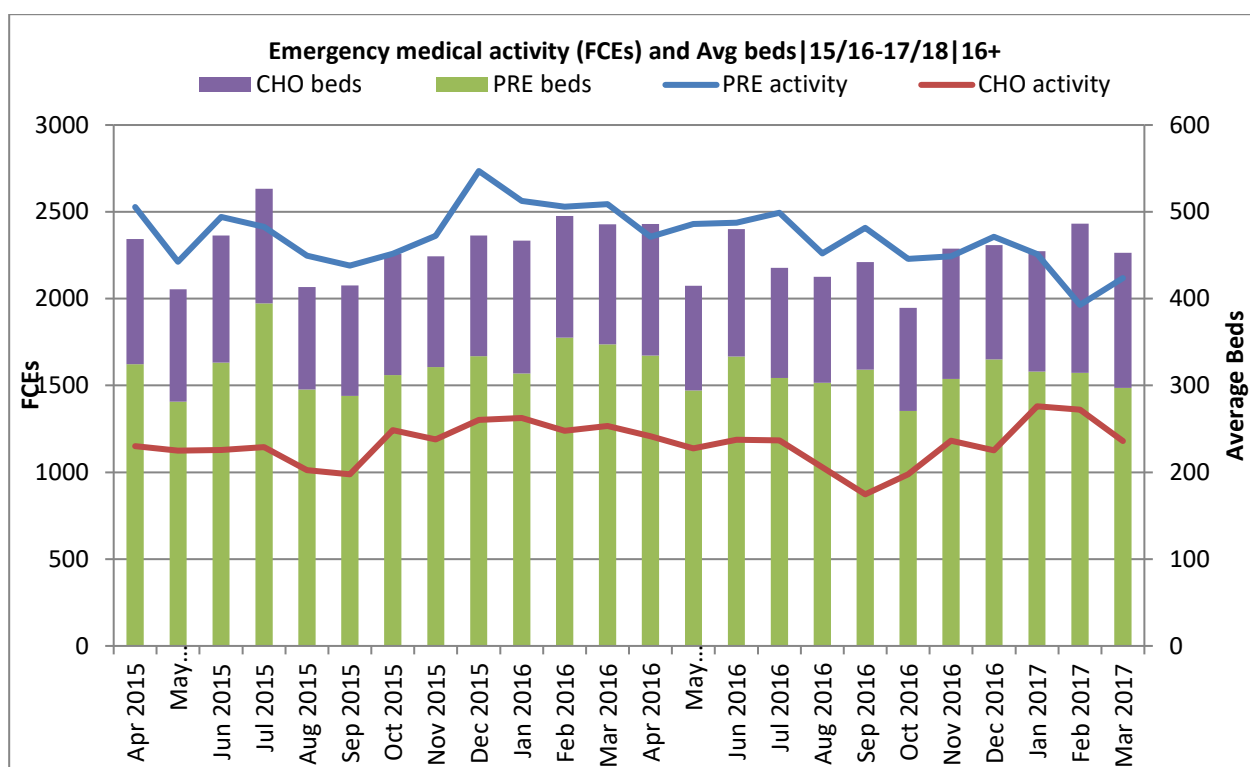


Figure 17: Royal Preston Hospital Emergency medical activity and average beds 15/16 – 16/17 (Source: Trust SUS data)

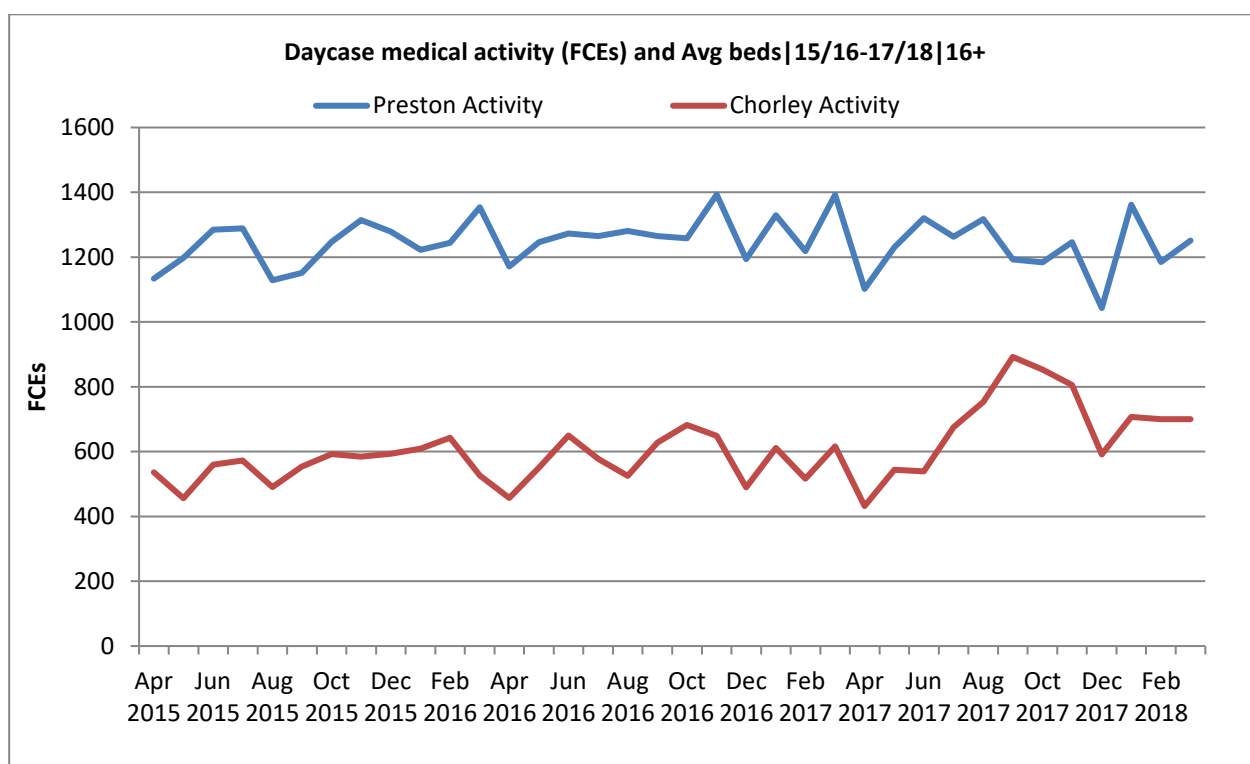


Figure 18: Central Lancashire day case medical activity and average beds 15/16 – 17/18 (Source: Trust SUS data)

4.6.8 Surgical activity

Elective surgical activity at Preston has significantly reduced since June 2015.⁴⁴ In January 2017 activity levels were half of what they had been in January 2016. Activity at Chorley has also reduced over the same period. This reduction mirrors the trend in A&E performance at Preston, which is a significant problem. These figures correlate to the reduced RTT performance.

As with medical activity, the factors causing a reduction in elective surgical activity are complex. Many of the factors influencing this arise from the relationship between emergency and elective admissions, and the need to achieve effective flow are described in the medical activity section. Demand arising from changes to referral volumes are also a factor.

Whilst it is possible to switch capacity between medical and surgical usage, this can make the “bed base” more difficult to manage and coordinate. This concept is known as “bed management,” which the previous section described as needing to be “dynamic.”

Having to make too many beds available for emergency admissions or needing to accommodate patients with delayed discharges subsequently impacts on the capacity available for elective surgical patients. In turn, this impacts on access standards such as 18-week referral to treatment and can lead to increased rates of surgical cancellation. This can create a “cycle” of poor performance which leads to worse patient experience.

In the case of surgical activity, another aspect of the relationship impacting on available capacity is the scheduling and use of theatre capacity, and the performance of a number of clinical adjacencies, including anaesthetics and critical care. In short, if theatre capacity is not used effectively, then surgical activity rates, particularly across elective categories are likely to reduce. This is relevant when considered alongside the quality improvement initiatives being undertaken by the trust in areas such as improving theatre productivity.

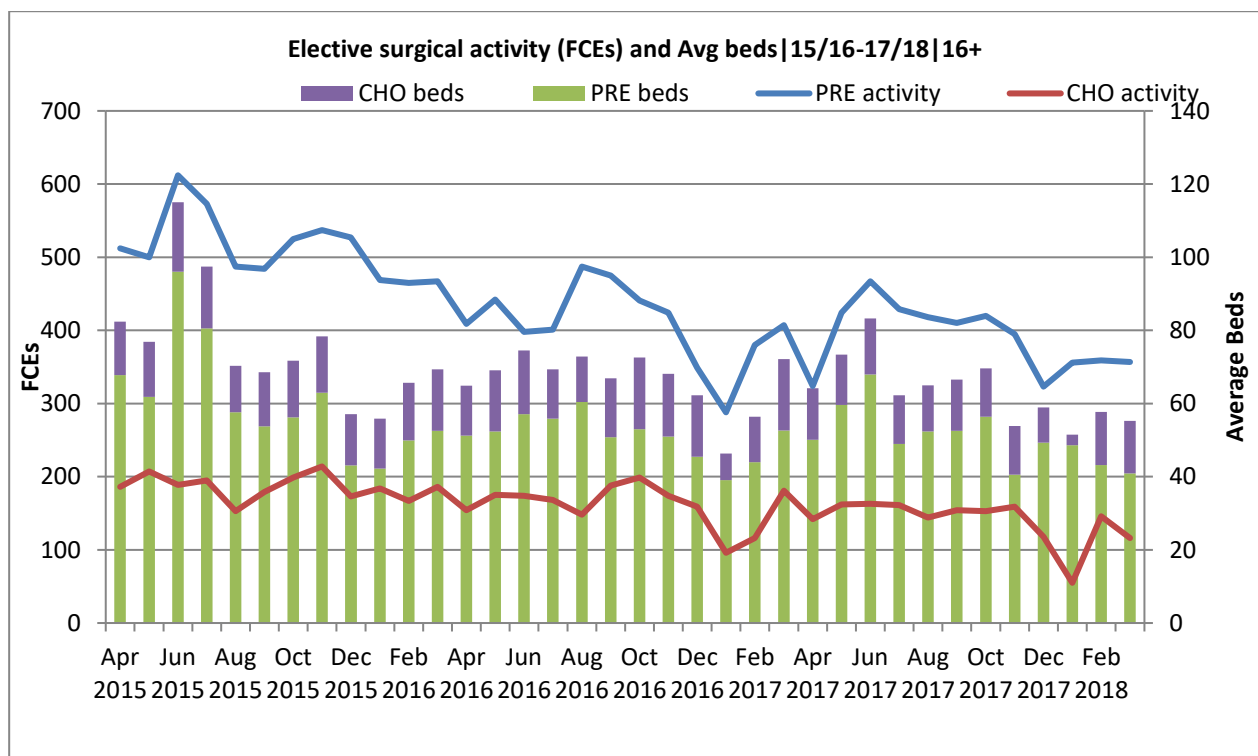


Figure 19: Elective surgical activity 15/16 – 17/18 (Source: Trust SUS data)

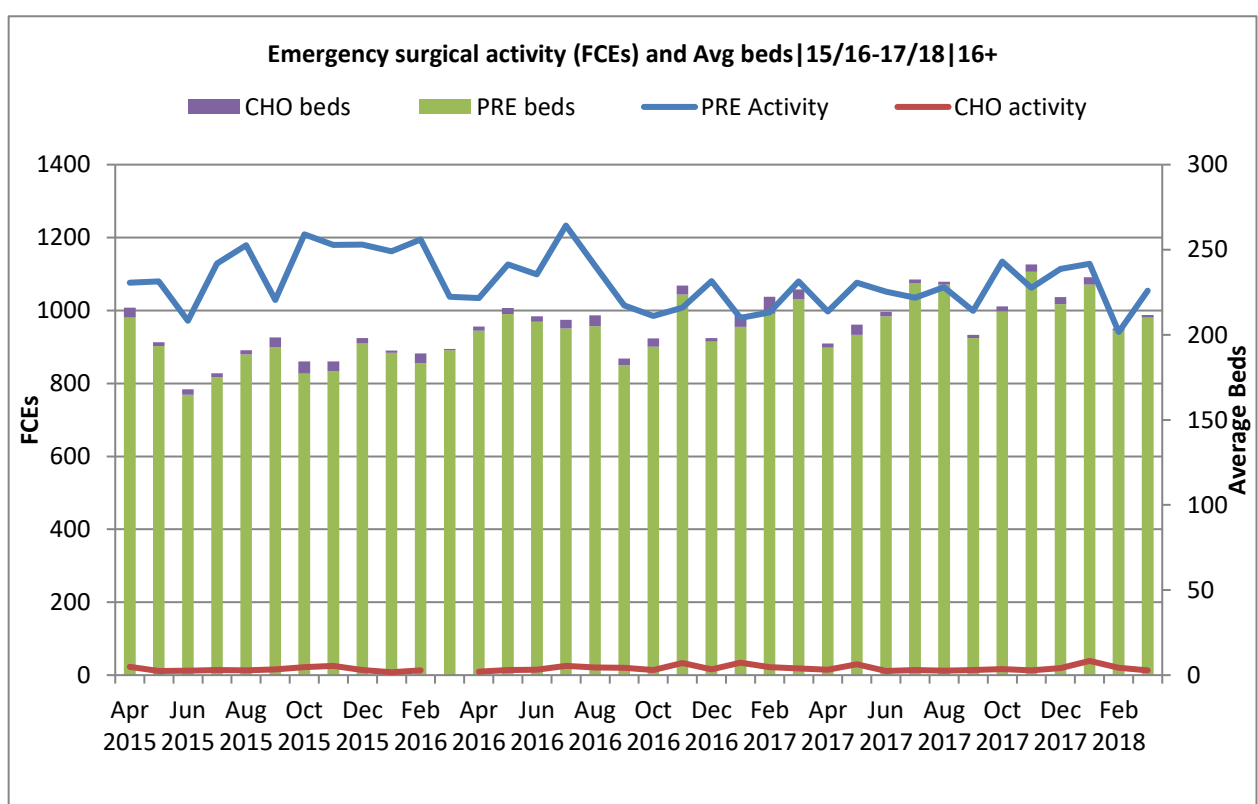


Figure 20: Emergency surgical activity 15/16 – 17/18 (Source: Trust SUS data)

Section 5: Clinical Case for change– Acute Sustainability

This section of the case for change takes a more detailed look at two key clinical areas for acute sustainability at the Lancashire Teaching Hospitals:

- Urgent and emergency care
- Critical care

5.1 Urgent and emergency care

Area	Key Drivers for Change
Workforce and Finance	<ul style="list-style-type: none">• 21 middle grade doctors are required to staff both A&E departments on a 24/7 basis. Despite significant and ongoing recruitment campaigns the Trust has 8.4 whole time equivalent vacancies on the middle grade rota. Currently, the Trust therefore only has around 60% of the middle grades required to safely staff both A&E departments on a 24/7 basis.• 17 middle grade doctors are required to staff both A&E departments according to the current model. The current establishment is also lower than this figure.• 4 locums are currently employed to fill vacancy gaps in the middle grade A&E rota at a cost of c.£0.9m per annum.• All hospitals are set an explicit requirement by NHS Improvement to reduce and closely manage spend on locums. Locums are intended to act as temporary, not full-time staffing solutions, as the cost of these staff is far higher than the equivalent cost of paying substantive staff, meaning less money is available to pay for other staff, equipment and supplies.• It can also be difficult to identify and retain locum staff, particularly in the long-term. For all these reasons, employing locums as a long-term solution is not likely to be a viable one.• The available data would indicate that the workforce availability issue is broader than the issue of middle-grade doctors and consultants. This means that the challenges in providing safe staffing levels, and a hospital system which works best for patients, need to consider both staffing within the department and the areas of the trust (or agencies) which it refers onwards to.
Performance	<ul style="list-style-type: none">• A&E performance at Preston has been deteriorating significantly since April 2015.

	<ul style="list-style-type: none"> • Attendances to the Emergency Departments have been decreasing with more patients receiving treatment via the Urgent Care services provided by gtd healthcare. • In March 2016 there were 4,338 attendances at Chorley which had reduced to 2,191 in March 2018. • This has meant that in addition to the problem of there not being enough middle-grade staff available currently to offer two A&E departments on a 24/7 basis, the emergency teams operating from Chorley are not always fully utilised because of the increased use of Urgent Care services.
Attendance and Arrival	<ul style="list-style-type: none"> • The profile of arrivals at Preston has shifted with evening hours now as busy as mid-morning. This means that making best use of staff outside of traditional working hours is more critical than ever and planning a viable rota is becoming more challenging. • The proportion of attendances for over 65-year olds has slowly been increasing. • Overall, 78% of patients seen in 2017/18 by the Trust (across both sites) could have their care delivered in an Urgent Treatment Centre environment. • This means that, despite the use of alternative service options to A&E currently, there remain opportunities to expand the use of these alternative services.
Emergency Admissions	<ul style="list-style-type: none"> • The proportion of A&E attenders being admitted has been steadily increasing at Preston. There has been an increase from 21% in April 2015 to 33% in January 2018. This comparison reflects the period before and after the entry of the gtd healthcare provided urgent care offer. • Emergency admissions contribute to reduced capacity for elective admissions and is one of the factors impacting on "flow." • Admission rates for Lancashire Teaching Hospitals remain comparable with the England rate of admission from A&E. This means that the Trust is doing as well as others in providing care in the department, only admitting those patients who need either urgent treatment or ongoing investigation/monitoring. • The profile of admissions across the day is changing at Preston with more admissions at night now comparable with admissions in the late afternoon. This helps to show that in

	order to run hospital beds effectively, capacity and services now have to be planned in a very agile manner, right through the day.
Patient Experience	<ul style="list-style-type: none"> • Lancashire Teaching Hospitals had the second lowest score in England for satisfaction with Access and Waiting on the 2016/17 survey. • Average waiting times until initial assessment have been slowly increasing at both sites. In April 2015 the average time was 18 minutes at Preston and 17 minutes at Chorley. By January 2018 these had increased to 38 and 32 minutes respectively.

Urgent and emergency services are provided against the national backdrop of a population that is ageing with higher rates of obesity and a greater number of comorbidities. Locally, the available data indicates that these CCGs also have challenges to manage in these areas. A population with poorer health status will likely trigger an increased demand for NHS provided services across primary and secondary care, including the emergency care system.

However, there remains a significant portion of A&E usage (i.e. those suitable to be seen in an Urgent Care environment) which cannot be attributed to population change and is instead more indicative of:

- Supply induced demand (and/or)
- A failure to treat patients earlier in the urgent and emergency care pathway, including possible gaps in alternative services.

Almost 40% of A&E attendances at Lancashire Teaching Hospitals in 2016/17 were coded as either involving no investigation with no significant treatment or having the lowest level of investigation and treatment.

This is a further data point which suggests that a significant proportion of A&E attendances could have been seen and treated in another care setting.

There are currently 6 A&E Departments, 5 Urgent Care Centre (UCC) and 4 Walk-in/Minor Injuries Units serving a resident population of circa 1.48 million in Lancashire.

5.1.1 Workforce – Emergency Department and the Middle Grade Rota

The challenges around recruiting and retaining staff within the Emergency Department may be the most significant contributing factor to the difficulties faced in operating two 24/7 Emergency Departments at Preston and Chorley.

Recruiting, retaining, and deploying the right staff in the right places to serve patient's needs are all key to improving patient experience.

The main issues relate to the A&E 'middle grade' rota. 'Middle Grade' generally refers to any doctor who has more experience than an FY2 training grade, but less than a consultant. The term can refer to staff grades, clinical fellows, and ST1, ST2, ST3 grades (specialist registrars). Many users of an A&E service will have at least part of their care delivered or supported by a 'middle grade.'

Staffing two Emergency Departments of the size and scope at Lancashire Teaching Hospitals would require 21 middle grade doctors, with a significant proportion of these doctors having the skills and experience commensurate with a Major Trauma Centre.

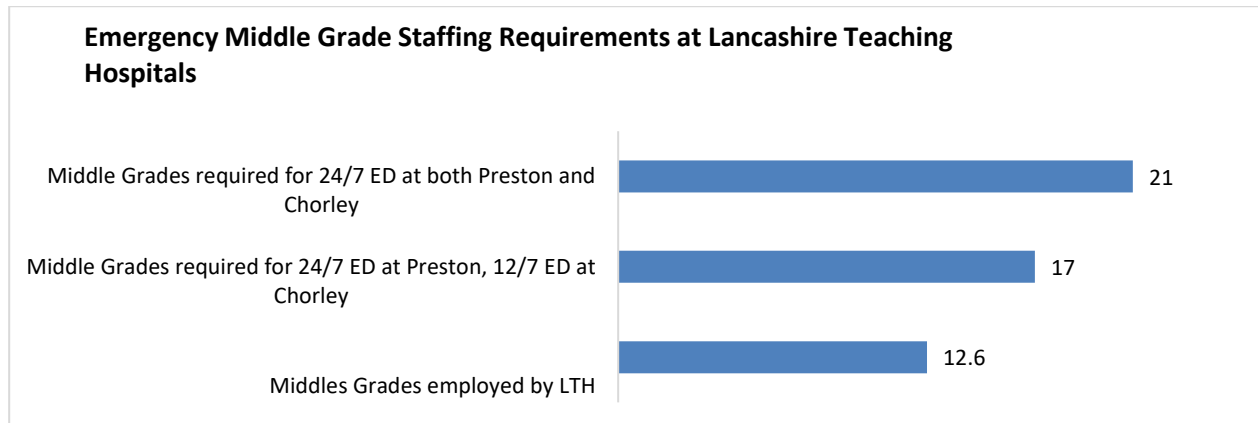


Figure 21: Number of Middle Grade doctors required to staff various permutations within the Emergency Department as at November 2018. Source of the data is client supplied data.

In June 2017 the middle grade rota and staffing numbers for the Emergency Department covering both the Preston and Chorley sites was reviewed in order to determine the number of middle grades immediately required to provide cover for the current opening times (24/7 Preston, 08:00-22:00 (14 hours per day) Chorley). This was largely due to the implementation of the new junior doctor contract that was coming into force that would affect the August 2017 new intake of trainees.

The 17 doctors required to staff this permeation was as follows:

- 3 x CT3 doctors (on rotation via Pennine Acute Hospital Trust (PAHT))
- 5 x ST4-6 doctors (on rotation via PAHT)
- 9 x SAS doctors (Trust employees)

This review took in to account the following:

- New Junior Doctor Contract (2017)
- European Working Time Directive rules
- No increase in weekend frequency
- Increased acuity of patients
- Major Trauma Centre status
- CT3 doctors cannot work full/long night shifts
- ST4-6 cannot work Wed/Thurs night duties (due to attendance at regional training)

- Cover built into rota to accommodate annual/study leave
- Accommodation of SPA time for SAS doctors
- Accommodation of CT3 regional training time
- Administrative sessions for trainees
- Handover times 08:00-08:30 and 23:30-00:00

Clearly vacancies vary over time, but at the time of writing the trust is at 4.4wte short of staffing the current A&E opening times, and 8.8wte short of staffing two 24/7 A&E departments.

As the above review shows, it is not only the number of doctors which is the problem, but also the complex scheduling and rostering patterns needed to service a “compliant” rota. The Trust is using the doctors it has available at its disposal and continues to try very hard to staff the rota optimally within its available resources.

Not being able to deliver a compliant rota can have a number of adverse impacts including impacting on doctors training and development; creating financial issues (due to the excess costs of plugging “gaps” with temporary locum staff). Together, these issues can exacerbate recruitment and retention issues meaning that it can become progressively more difficult for the Trust to manage.

5.1.2 Recruitment and retention initiatives: middle grades

The trust has gone to significant lengths to recruit to the A&E middle grade rota. Since April 2016 the trust has been continually sought out new recruits via:

- Rolling adverts on NHS Jobs and the British Medical Journal
- Sourcing through a variety of international agencies
- Dedicated recruitment campaigns in India
- Introductory fees for new joiners
- An associate specialist role has been re-opened within the organisation and a 3-year specialist registrar CESR post (3-year fixed term contract) has been designed and advertised.

The trust has been unable to recruit suitable doctors; of the 120 applicants to advertised vacancies since April 2016 the Trust was able to make 19 offers of employment were made to international candidates but only 4 have accepted posts or progressed to start, meaning there was a near 80% attrition rate at this late stage of the process.

Two of these four doctors started in August and September 2017 on 3-year contracts but one of these left January 2018 for a post in London. Of the other two, one has recently started but will be supernumerary on the rota until they have been assessed and having developed the full skills and experience to be included on the rota.

Ultimately, this shows that despite the Trust’s continuing attempts to think creatively about recruitment (including its internal processes), and despite its willingness to explore non-traditional employment routes and incentive programmes, there remains a very low conversion rate between the volume and cost of recruitment activity and

eventual improvements rota supply. Many Trusts experience similar issues to LTH and it must be remembered that at the same time as trying to recruit new staff, the trust is trying hard to retain and develop its existing medical workforce.

5.1.3 Locum arrangement and costs: Emergency Department

Agency spend information shows that there has been an increasing trend in the amount spent on Agency fees within the Emergency Department. The broad reduction in A&E attendances (green line) relates to the transfer of this activity to the service provided by gtd healthcare.

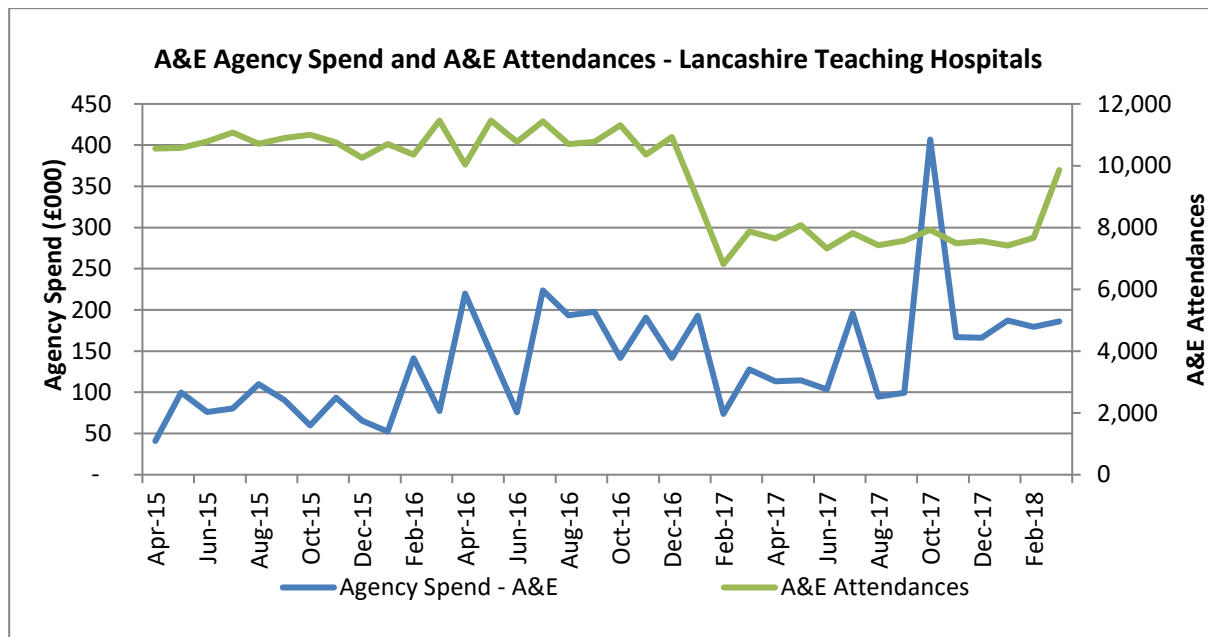


Figure 22: Agency spending in the Emergency Department compared with A&E Attendances between April 2015 and March 2018. Source of the data is client supplied Agency Spend data.

The Trust currently employs 4 Emergency Department middle grade doctors on long-term locum contracts. The cost to the trust of these doctors alone is around £0.9m a year. There has also been a longstanding gap in the number of Whole Time Equivalents (WTE) that are funded with those paid for over the last three financial years for medical positions within A&E.

Gap between Funded WTE & In Month Paid WTE - Emergency Department

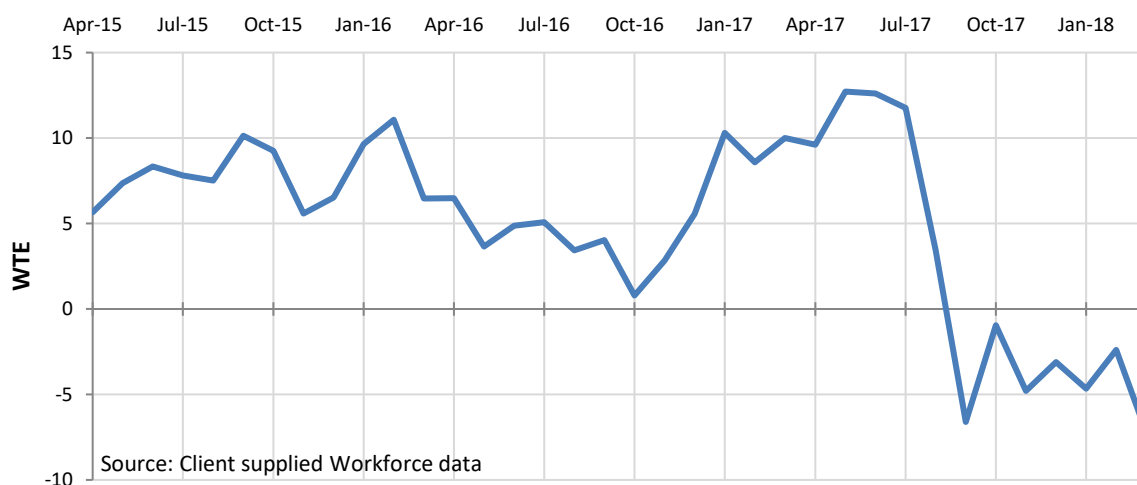


Figure 23: Gap in medical staffing (funded and paid) between April 2015 and March 2018. Source of the data is client supplied workforce data.

Figure 24 also looks at the position in terms of the consultant workforce in the Emergency Department.

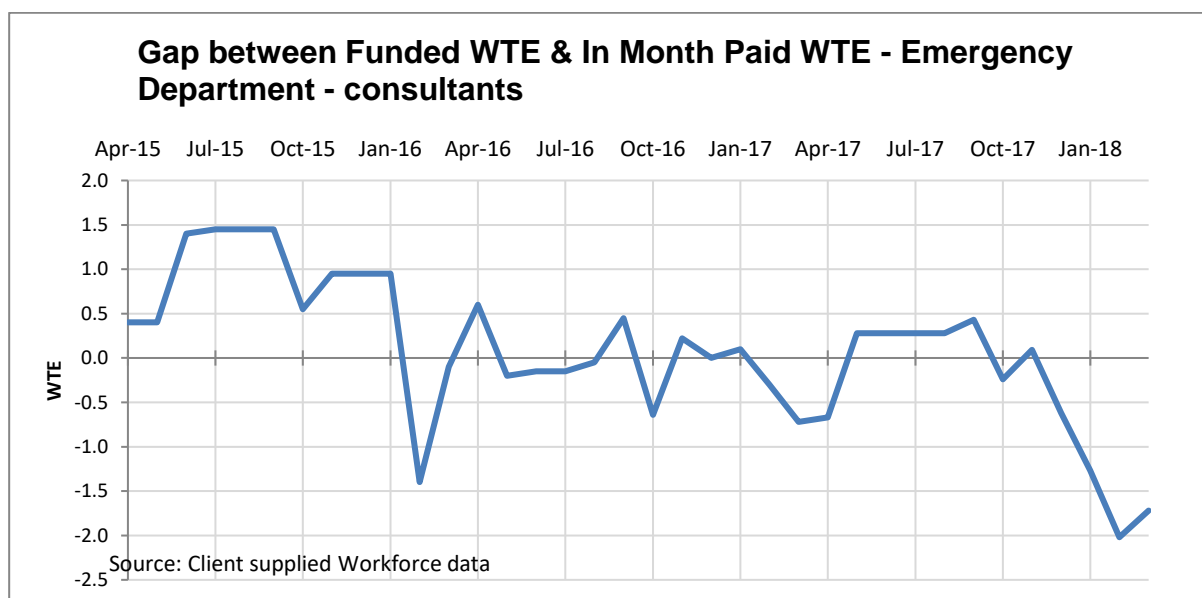


Figure 24: Gap in consultant staffing (funded and paid) between April 2015 and December 2017. Source of the data is client supplied workforce data.

5.1.4 Workforce issues- broader view

This case for change does not seek to provide a comprehensive analysis of all workforce issues faced by the trust.

However, analysis of the reliable data available would suggest as follows:

- As of November 2018, more than one in nine positions in the Trust were vacant. This equates to some 887 vacancies. Trust board papers indicate issues and risks

in securing recruitment of staff across a number of key workforce categories (board papers, November 2018)

- Data from NHS Jobs, one of the leading recruitment vehicles shows that the Trust had 61 separate adverts for roles “live” as of the 30th November 2018. Some of these vacancies had one position available, others more. Near 80% of these vacancies require staff with a clinical qualification to fill them.

The professional groupings of these vacancies were as follows:

- Administrative & Clerical (8)
- Allied Health Professionals (2)
- Additional Clinical Services (5)
- Additional Professional Scientific & Technical (3)
- Estates & Ancillary (3)
- Healthcare Scientists (1)
- Medical & Dental (19)
- Nursing & Midwifery Registered (20)

(Source: Categories of LTH recruitment activity – 30th November 2018. Taken from NHS Jobs candidate homepage. Excludes roles advertised via other media).

Across the two highest categories of workforce vacancies – Medical and Dental and Nursing and Midwifery Registered, the list of roles available gives a “snapshot” insight in to the issues faced by the Trust in delivering safe staffing levels more widely across the hospital sites.

The list also shows that the vacancies are available at a number of levels including consultant, clinical fellow and specialty doctor grades in the medical and dental category and most significantly in the Agenda for Change Band 5 category for nursing.

Pay, terms and conditions are set nationally. This makes it harder for the trust to use financial or other incentives to fill the roles, such as recruitment and retention premiums or (RRP), except where specific conditions are met – as in the case of middle-grade doctors.

Medical & Dental (19)

Locum Consultant in Stroke Medicine
Consultant Obstetrician and Gynaecologist
Consultant Physician in Acute Medicine
Specialty Doctor in Respiratory Medicine
Consultant Gastroenterologist
Locum Consultant Paediatrician
Senior Clinical Fellow Stroke
Senior Clinical Fellow in Palliative Care
Senior Clinical Fellow Orthopaedic Surgeon - Spinal
Consultant in Respiratory Medicine
Consultant Restorative Dentist
Gastroenterology Consultant

Senior Clinical Fellow in Respiratory Medicine
Consultant Neurophysiologist
Stroke Consultant
Junior Clinical Fellow Gastroenterology
Consultant Ophthalmologist Retina (Medical or Surgical)
Specialty Doctor In Paediatrics

Nursing and Midwifery Registered (20)

Staff Nurse - Gastroenterology (CDH)
Staff Nurse - Coronary Care Unit
Staff Nurse - Rookwood B
Staff Nurse - Neurology
Staff Nurse - Respiratory High Care Unit
Staff Nurse - Respiratory (Chorley)
Staff Nurse - Children & Young People's Services
Staff Nurse - Gastroenterology (Ward 24)
Staff Nurse - Respiratory (Ward 23)
Staff Nurse - MAU (Chorley)
Staff Nurse - Nutrition/Colorectal Rotation
Staff Nurse - Renal (Ward 25)
Staff Nurse - Cardiology
Urology Care Co-Ordinator
Staff Nurse
Rotational Staff Nurse - Surgical Acute Admission.
Staff Nurse - Oncology Outpatients
Staff Nurse
Staff Nurse - Endoscopy
Staff Nurse - Ward 10
Pre-Registration Staff Nurse (2019)

5.1.5 Workforce vacancies: alignment with staff survey results

One of the potential issues associated with workforce availability, and recruitment and retention is the experience of staff employed by the trust. Each year the NHS commissions a national survey through Quality Health, which is made available to all members of the NHS workforce. The last completed survey was published in 2017.

This survey asks a series of questions but gauges two important issues – the level of staff engagement at the trust, and also how far staff would recommend the hospitals as a place to work. The data is benchmarked across trusts of a similar type (i.e. acute hospitals). On the staff engagement metric, the trust scores are equivalent to those achieved nationally (3.78 out of 5 versus 3.79 out of 5 nationally).

On the recommended place to work, the trusts score is slightly lower than the national average (3.7 out of 5, versus 3.75 out of 5). Whilst this difference is small, because of the sample size, it is statistically significant.

However, the trust performed better than its peers (in a statistically significant sense) in areas relating to providing flexible working patterns and avoiding bullying, harassment and discrimination in the workplace.⁴⁹ This means that it is hard to analyse that the workforce issues experienced by the trust are solely linked to reputational or employer-driven factors.

5.1.6 Workforce vacancies: regional picture

The analysis in section 4.1.5 is supported by an analysis of the advertised vacancies by Health Education England region. The chart below tracks the number of vacancies by region with the light blue line representing the North West of England. This line is consistently the highest of all regions and the trend line is increasing. The regions include areas with higher population levels than the North West of England. Overall, in the most recent month published, the North West of England had 13% (or more than one in eight) of all vacancies across England.

Graph 2: Advertised vacancy full-time equivalents by HEE Regions and month published

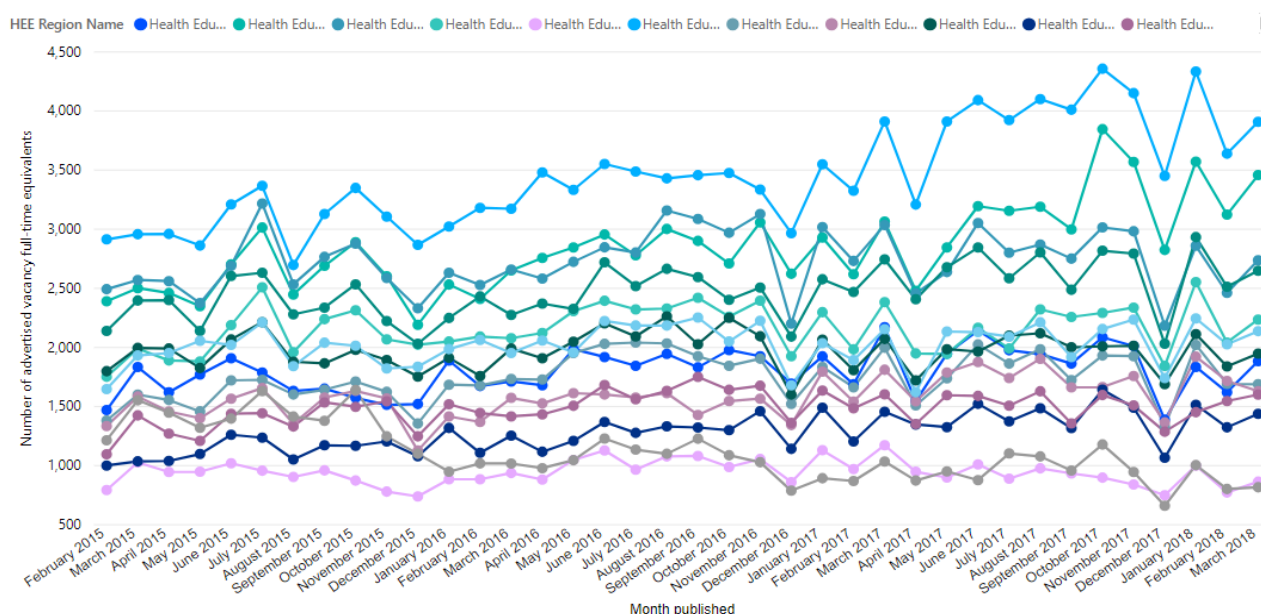


Figure 25: Advertised vacancy Full-Time Equivalents by HEE Region

At a specialty level, the number of vacancies for the two highest categories experienced by the trust are also rising nationally. In the case of vacancies for Medical and Dental, there were 3,330 vacancies in March 2018, compared with 2,611 in February 2015. For Nursing and Midwifery registered professionals there were 8,392 vacancies in February

⁴⁹ http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2017_RXN_full.pdf

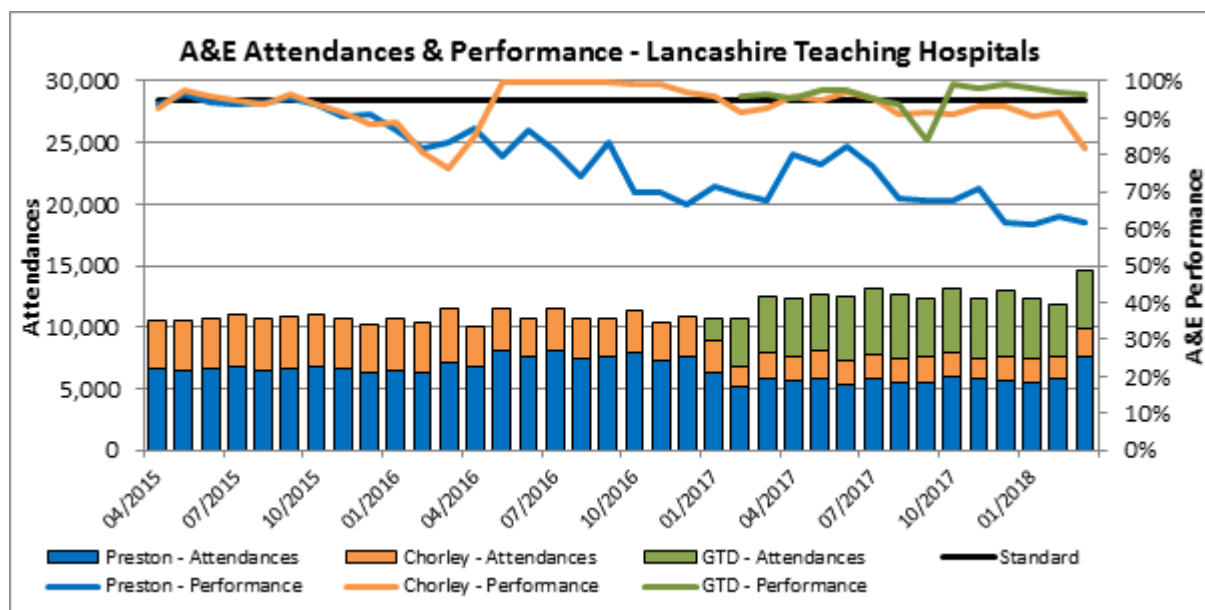
2015, which had risen to 11,483 in March 2018⁵⁰. More broadly, evidence from NHS Employers would indicate that access to workforce in these disciplines is systemic across the NHS and is not perfectly linked to prevailing organisational performance or reputational factors (Source: NHS Employers).

5.2 A&E Performance

A&E performance has been deteriorating significantly at Preston over a sustained period of time. Performance was declining at a similar rate at Chorley until April 2016 when the site became an Urgent Care Centre, before the subsequent NHS England review.

From April 2016 there was an increase in the number of attendances at Preston, most likely due to higher acuity patients who would have previously attended Chorley. Since January 2017 there has been a decline in the number of attendances at both Emergency Departments, due to patients accessing Urgent Care services provided by gtd healthcare.

However, over the past three years there is a growing trend in the demand for urgent and emergency care overall (counting the different categories together).



Overall performance for Lancashire Teaching Hospitals did not meet the NHS Constitution standard of 95% of patients being admitted, transferred or discharged from the department within 4 hours during 2017/18. The trust's performance for the year was 75.4% compared with an England level performance of 85.5%.

Looking at performance alongside the number of admissions (see Figure 27) from A&E shows that there was an increase in the number of admissions from A&E at the Preston site after April 2016 when Chorley was operating as an Urgent Care Centre (similar to the case with A&E attendances). However, this increase in the number of admissions from A&E at Preston has been against a backdrop of deteriorating A&E performance.

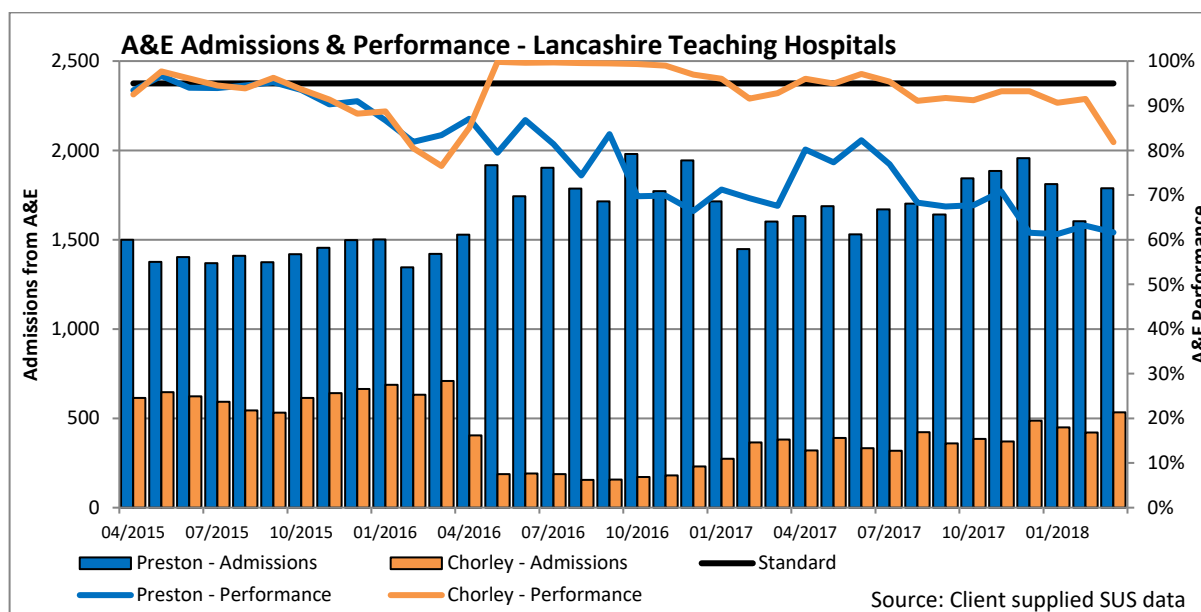


Figure 27: A&E Admissions and Performance split by Royal Preston Hospital and Chorley and South Ribble Hospital (Apr 2015 – Mar 2018). Source of the data is client supplied SUS.

5.3 Attendance and arrival

The profile of patients arriving at A&E at both sites during the 2015/16 financial year was similar to that of most A&E departments across England. At Preston, the busiest hour for arrivals was between 11:00 – 11:59 AM, with an average of 14 arrivals during this hour per day.

Again, the busiest hour at Chorley (when opened as an A&E) was 11:00 – 11:59 AM with an average of 9 arrivals during this hour per day.

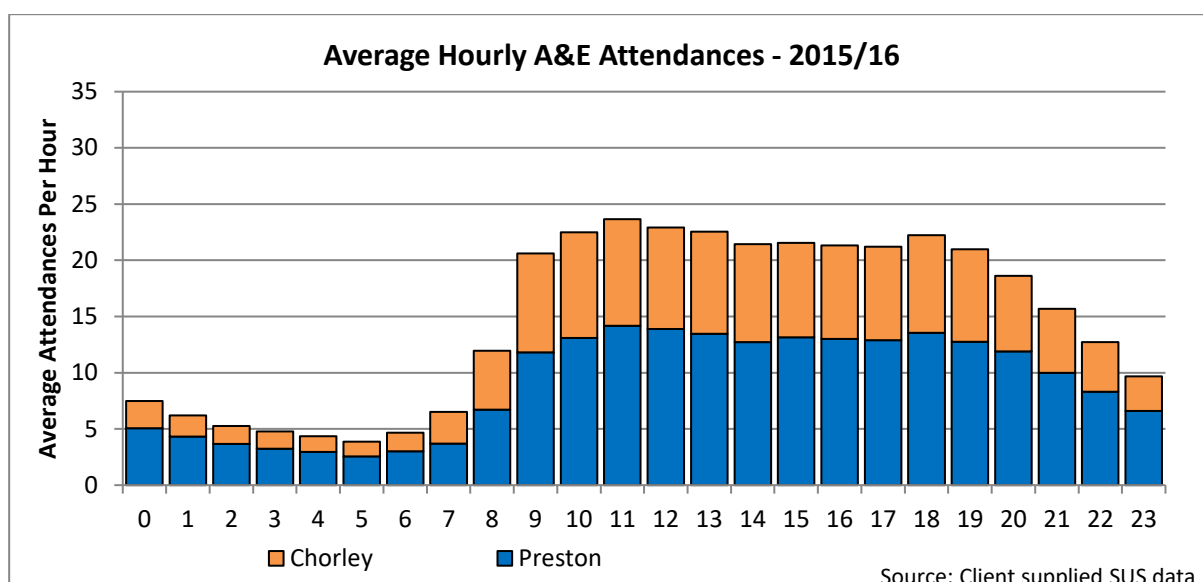


Figure 28: A&E average number of arrivals per day for each hour at both Royal Preston Hospital and Chorley and South Ribble Hospital during 2015/16. Source of the data is client supplied SUS.

Figure 29 shows the time profile of A&E attendances at Preston at the time when the Chorley site acted as a UCC during 2016/17. The 11:00-11:59 time period remained the highest demand time during the day.

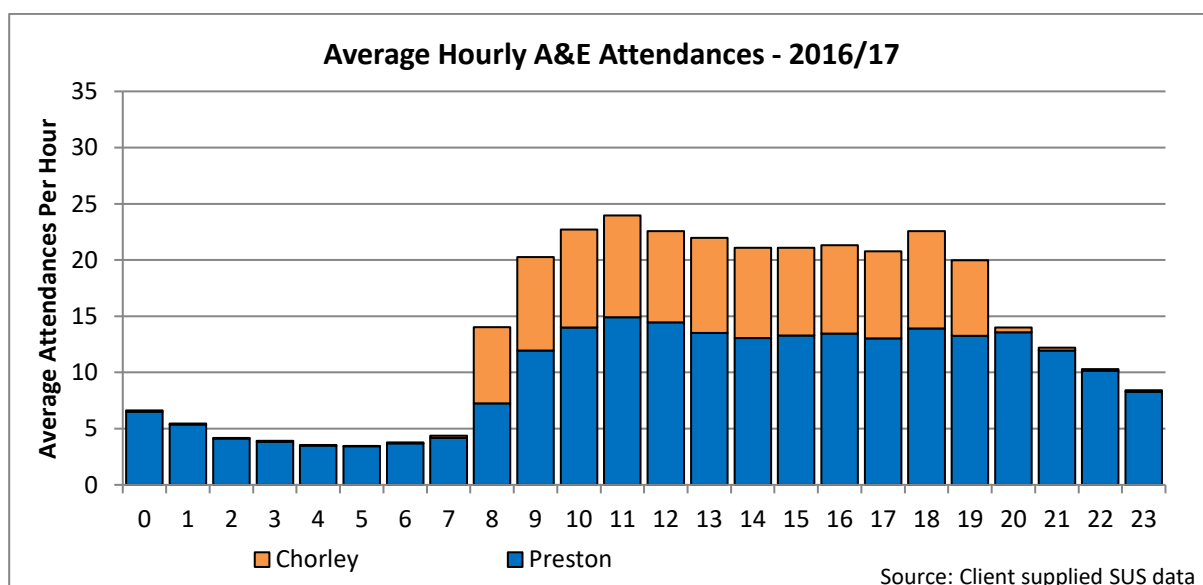


Figure 29: A&E average number of arrivals per day for each hour at both Royal Preston Hospital and Chorley and South Ribble Hospital during 2016/17. Source of the data is client supplied SUS.

The profile of arrivals at the Emergency Departments is very different in the latest financial year where during the hour 11:00 – 11:59 there is only an average of 11 arrivals per hour (down from 14 in the previous year) at Preston. This is due to commissioning of new Urgent Care services from gtd healthcare. The number of attendances per hour at Chorley remains reasonably static across the day whilst its Emergency Department is open with an average of 5 or 6 attendances an hour. This is lower than most of the figures for Chorley on the 2015/16 analysis (Figure 28).

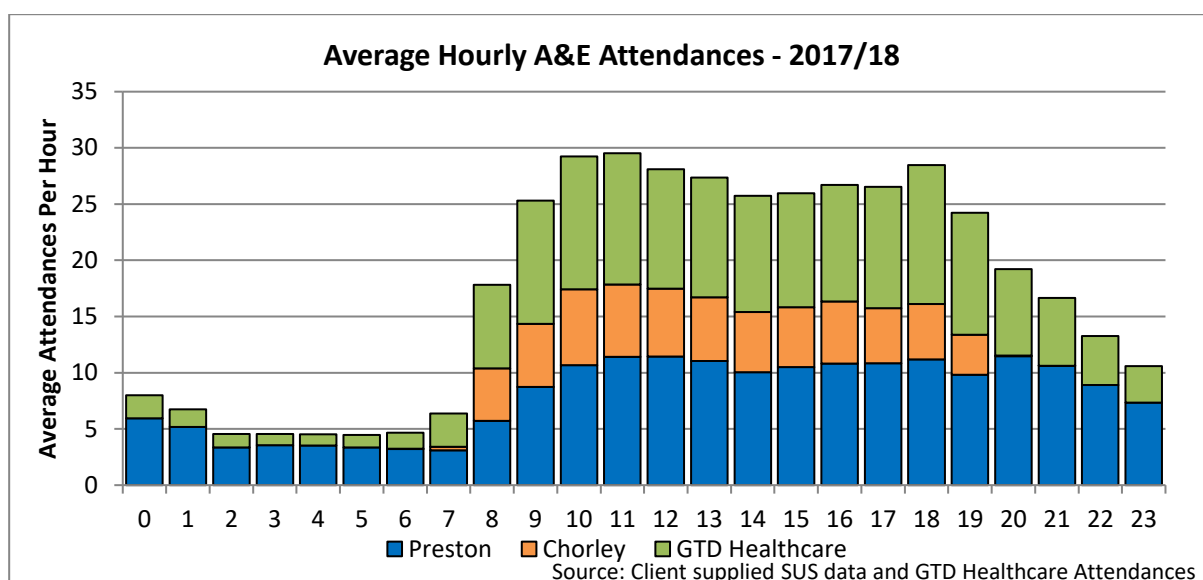


Figure 30: A&E average number of arrivals per day for each hour at Royal Preston Hospital, Chorley and South Ribble Hospital, and gtd healthcare during 2017/18. Source of the data is client supplied SUS.

The proportion of patients arriving via ambulance at Preston has been steadily increasing since April 2015 from approximately 30% of all attendances at A&E to 45% in January 2018. The number of ambulance arrivals at Preston significantly increased in April 2016 when Chorley it became an Urgent Care Centre.

The number of arrivals at Chorley via an ambulance significantly decreased from April 2016 when the site became an Urgent Care Centre. The number of arrivals has increased from January 2017 with a 14-hour service being provided at Chorley however, this is not to the same levels as prior to April 2016.

This indicates that North West Ambulance Service (NWAS) are conveying patients directly to the Preston hospital site.

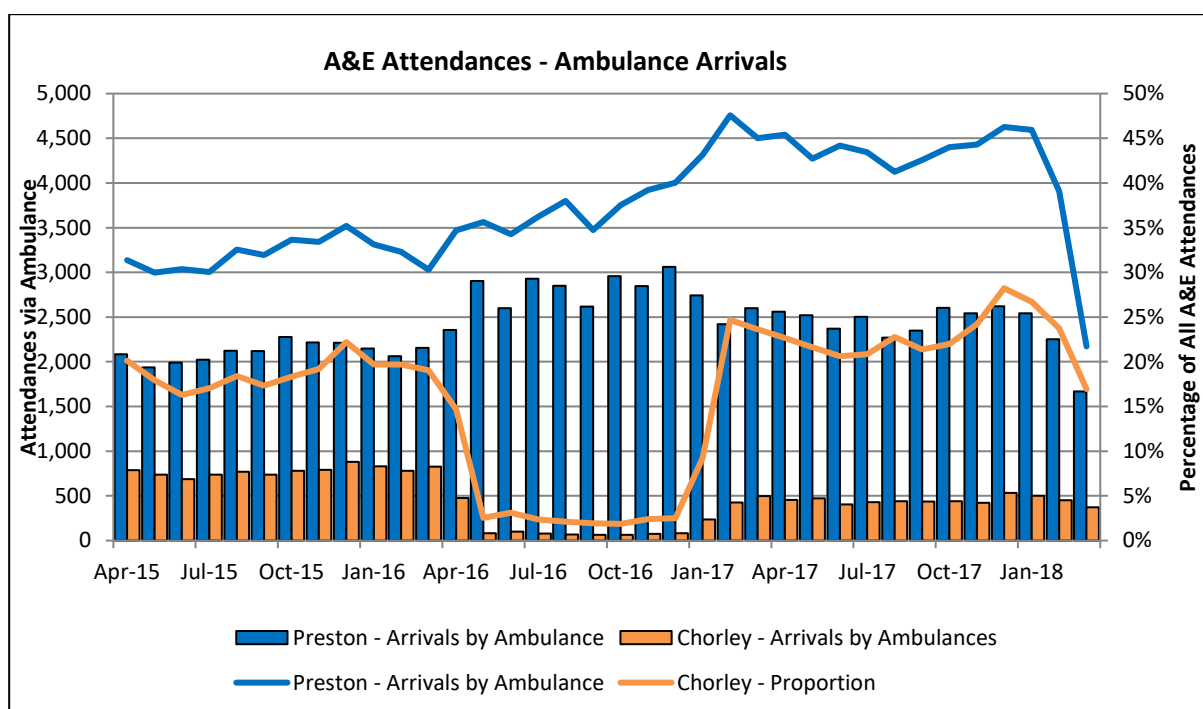


Figure 31: Arrivals at Royal Preston Hospital and Chorley and South Ribble sites via Ambulance between April 2017 and March 2018. Source of the data is client supplied SUS.

In geographic terms there has been little change in the profile of attendances at the Preston or Chorley hospitals since April 2015. Figure 32 shows that the only notable change has been an increased percentage of patients coming to the Royal Preston Hospital whose CCG of registration is Chorley and South Ribble CCG during 2016/17. This corresponds to the period that Chorley was providing an Urgent Care Centre service only. The percentage of attendances at both hospitals from the non-local CCGs has remained static.

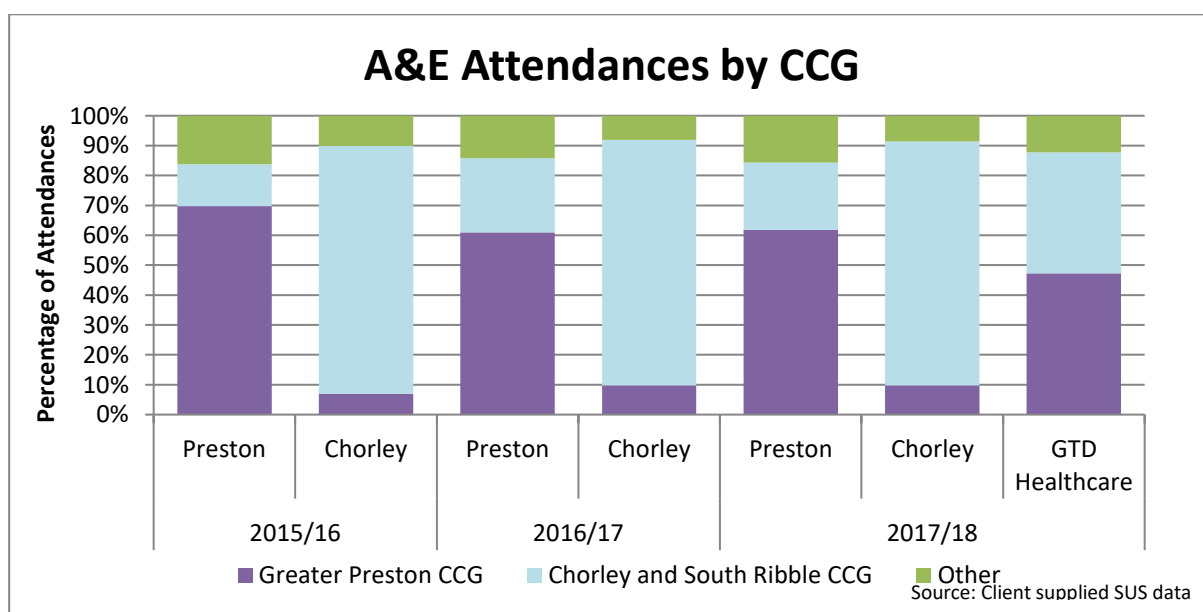


Figure 32: Arrivals at Royal Preston Hospital and Chorley and South Ribble split by CCG of registration April 2015 and March 2018. Source of the data is client supplied SUS and gtd healthcare.

There was little difference in the age profile of those attending the two sites during 2015/16 however; when Chorley became an Urgent Care Centre in April 2016 the hospital saw a lower proportion of more elderly patients. Since Chorley has re-opened as a 14-hour service the proportion of attendances for the over 65-year olds has increased at Chorley and South Ribble Hospital.

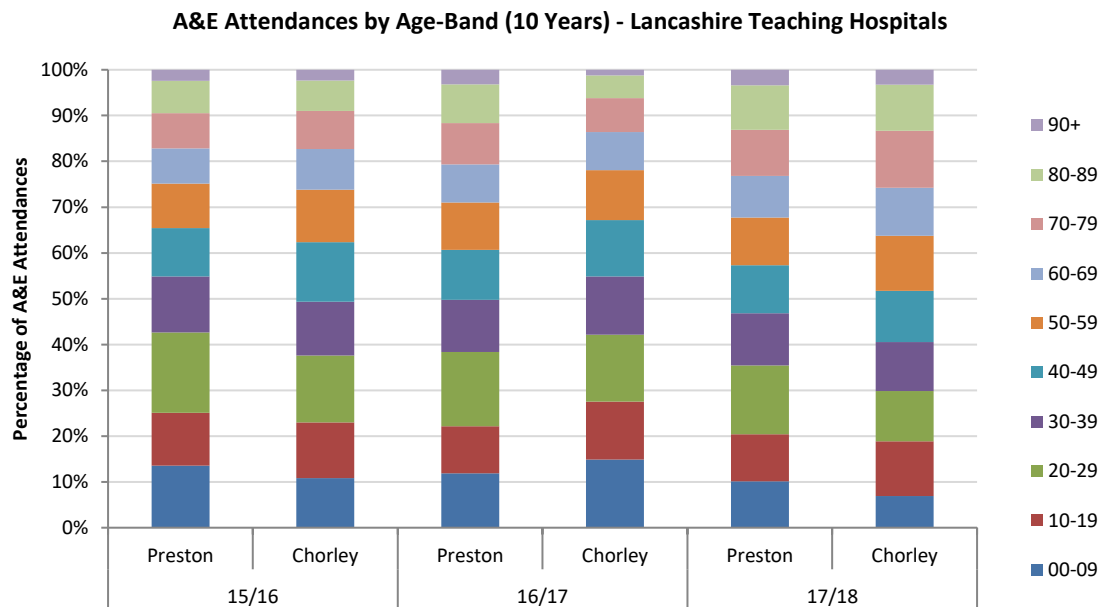


Figure 33: Attendances at Royal Preston Hospital and Chorley and South Ribble hospital between April 2015 and March 2018 split into 10-year age bands. Source of the data is client supplied SUS.

5.4 Emergency Admissions

The number of admissions at Royal Preston Hospital had increased during 2016/17 when Chorley and South Ribble Hospital was functioning as an Urgent Care Centre only. However, the number of admissions from A&E at Preston has reduced during the latest financial year. There has been a long-term trend at Preston in the proportion of attendances being admitted. There has also been an increase in the proportion of attendances being admitted at Chorley and South Ribble Hospital despite the noticeable drop in this proportion between April 2016 and January 2017 when this site was operating as an Urgent Care Centre only.

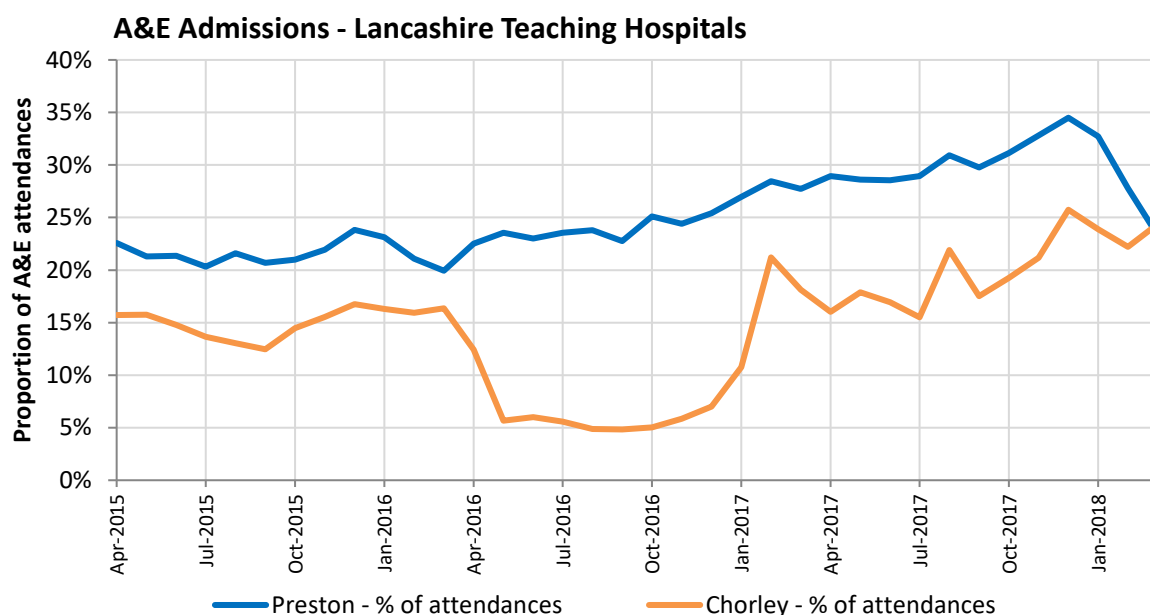


Figure 34: Proportion of A&E Attendances resulting in an admission at Royal Preston Hospital and Chorley and South Ribble hospital for between April 2015 and March 2018. Source of the data is client supplied SUS.

Comparing the trust nationally shows that proportion of attendances resulting in an admission was very similar to the England rate during 2016/17 although this has increased significantly for 2017/18. This is likely to be an artificial increase due to the use of gtd healthcare to provide Urgent Care Services in 2017/18.

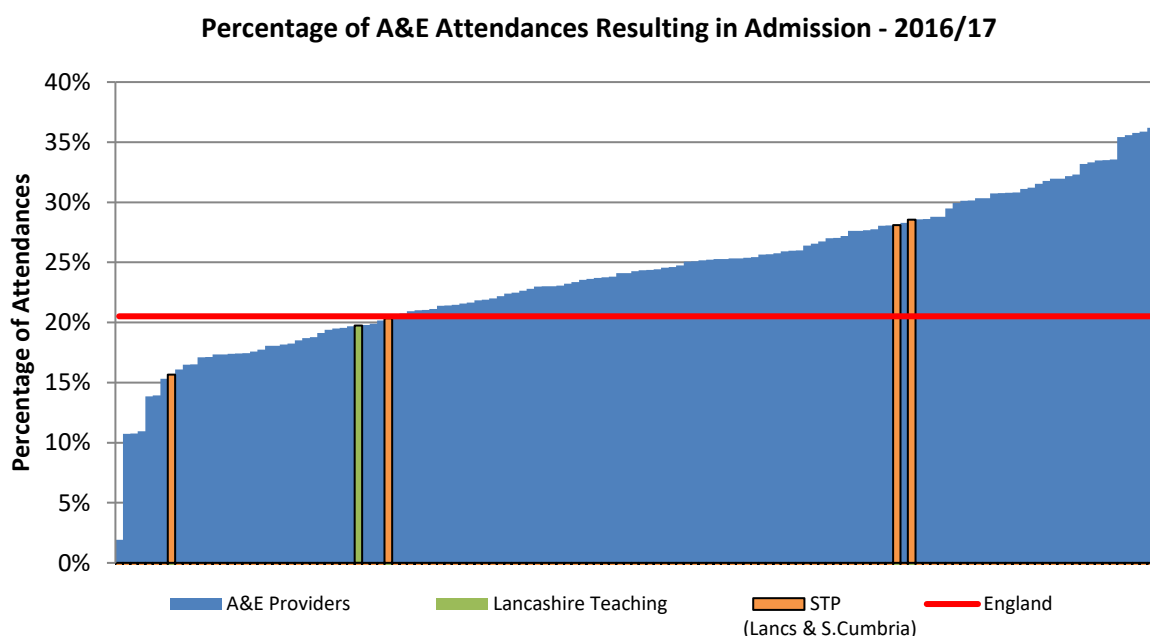


Figure 35: Proportion of A&E Attendances resulting in an admission at Royal Preston Hospital and Chorley and South Ribble hospital for between April 2016 and March 2017. Source of the data is NHS Digital.

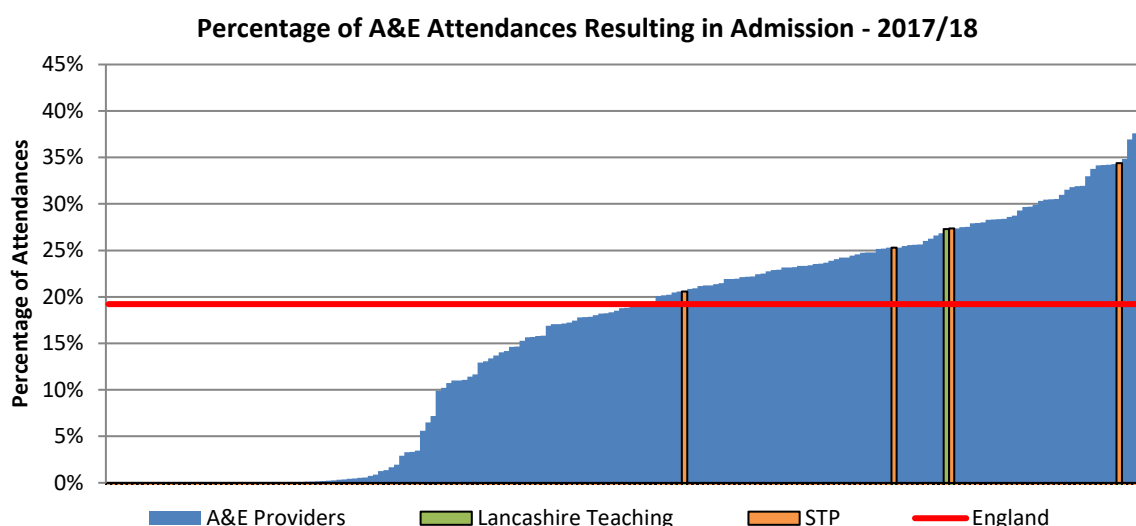


Figure 36: Proportion of A&E Attendances resulting in an admission at Royal Preston Hospital and Chorley and South Ribble hospital for between April 2017 and March 2018. Source of the data is NHS Digital.

During 2015/16 the busiest hour for admissions from A&E is between 16:00 – 16:59 at both of the hospital sites with a daily average of 2.5 admissions within this hour at the Preston and 1.2 admissions at Chorley Hospital.

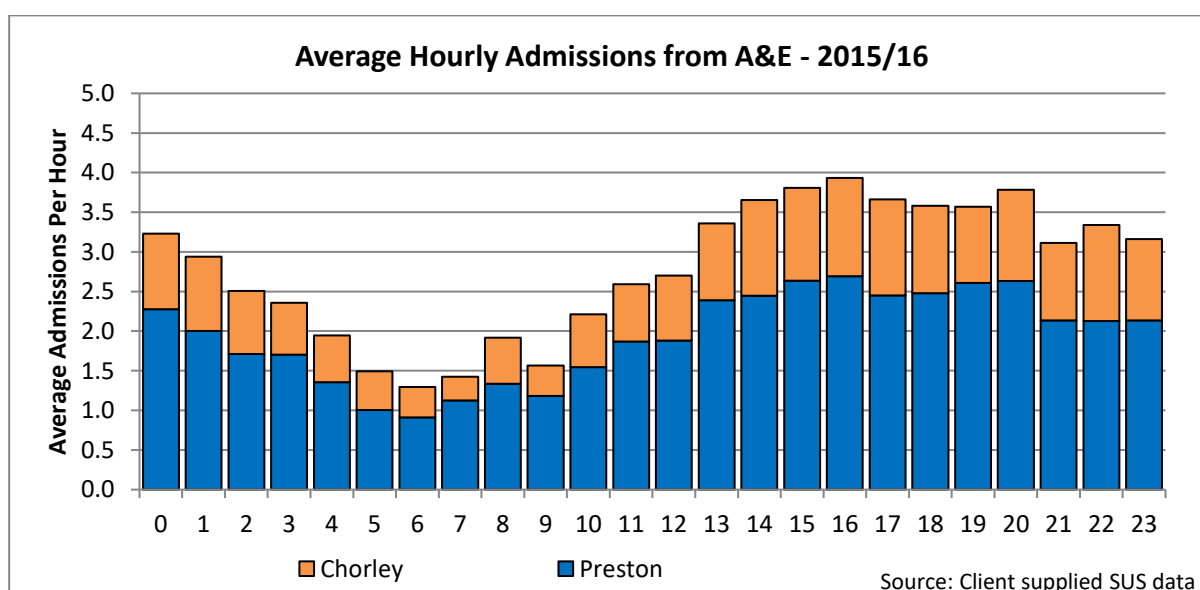


Figure 37: Average daily admissions by hour of admission from A&E for the Royal Preston Hospital and Chorley and South Ribble Hospital in 2015/16. Source of the data is client supplied SUS.

This was a significantly changed picture in 2016/17 with Chorley Hospital then operating as an Urgent Care Centre until January 2017. The average daily admissions at Preston increase with the busiest hour now being between 00:00 – 00:59 with a daily average of 3.3 admissions during this hour. The profile of admissions at Chorley is also significantly altered with fewer admissions however they are now skewed towards much later in the

day with the busiest hour being 20:00 – 20:59 (with a daily average of 0.8 admissions in this hour).

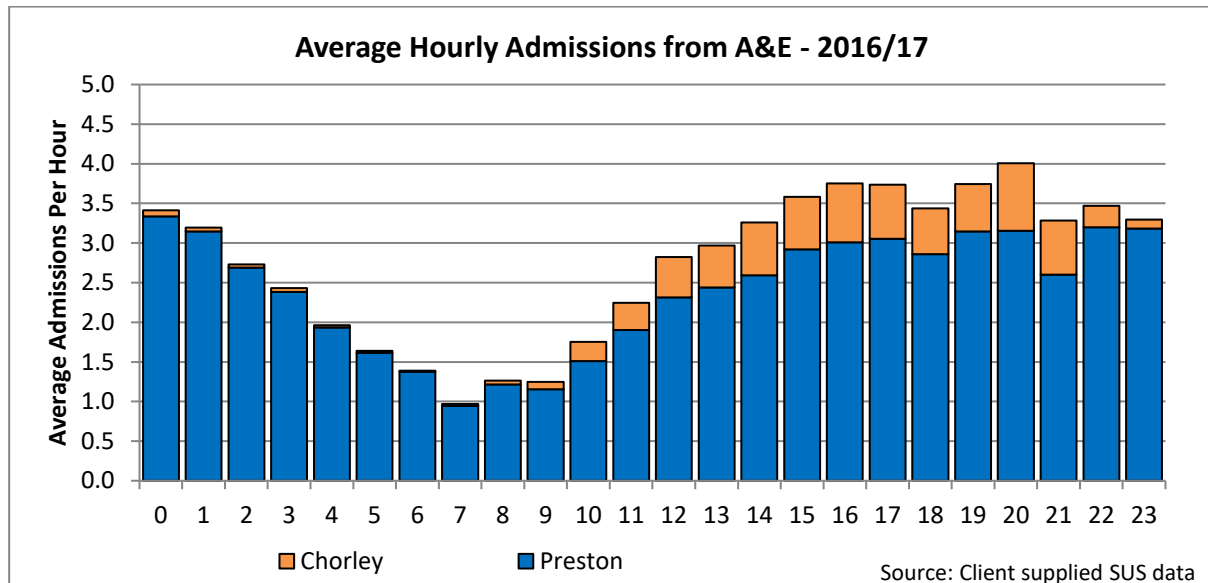


Figure 38: Average daily admissions by hour of admission from A&E for the Royal Preston Hospital and Chorley and South Ribble Hospital in 2016/17. Source of the data is client supplied SUS.

The profile of admissions in the current year is similar to the previous year with the exception during the busiest hour for admissions from A&E at Chorley Hospital (between 21:00 – 21:59) the daily average is now 1.6 in this hour.

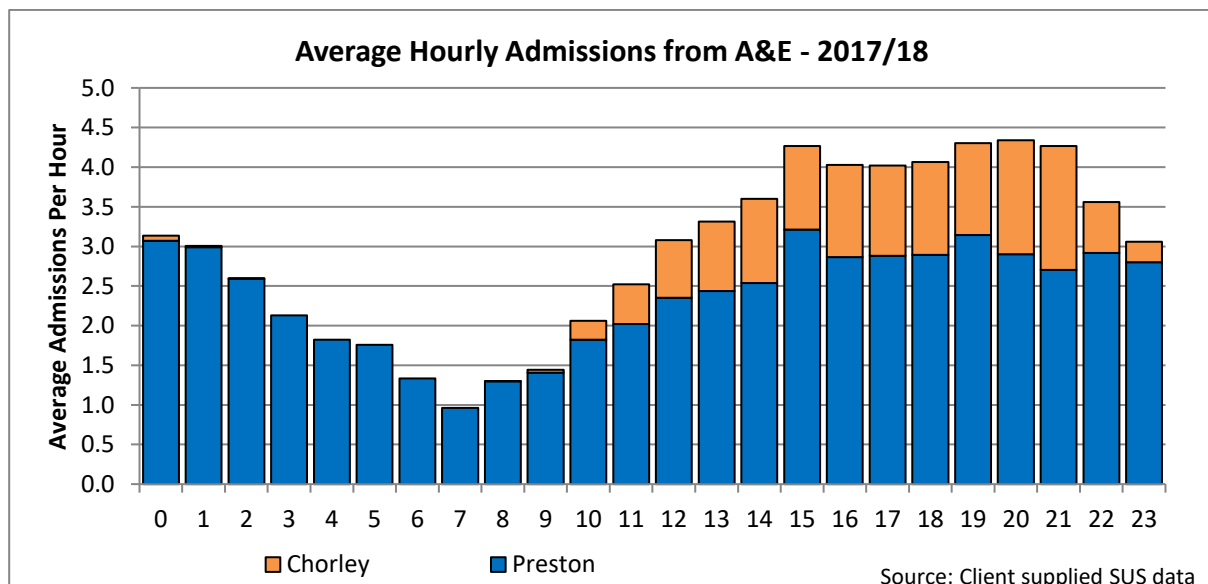


Figure 39: Average daily admissions by hour of admission from A&E for the Royal Preston Hospital and Chorley and South Ribble Hospital in 2017/18. Source of the data is client supplied SUS.

5.5 Patient Experience

The CQC commission the Emergency Department survey to ask people who have accessed A&E services across England their views on a variety of topics such as waiting times, care and treatment and overall experience. The latest survey shows that Lancashire Teaching Hospitals has particularly poor responses to the section Access and Waiting with the second lowest score in England.

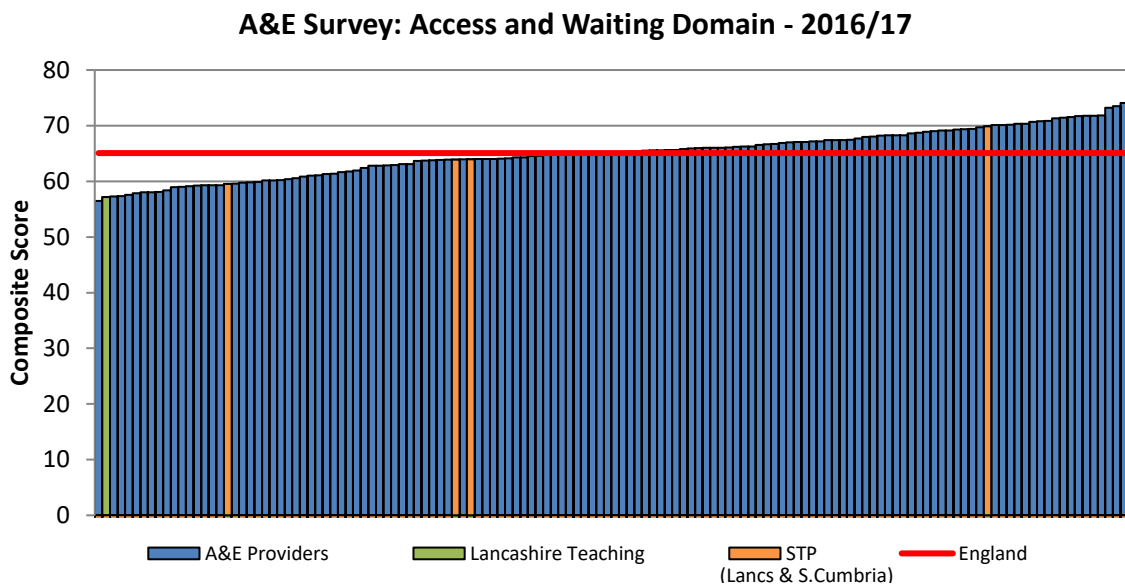


Figure 40: Composite score for Access and Waiting Domain of A&E Patient Survey 2016. Source of the data is NHS England Survey Tool.

A key component of this survey domain was related to how long patients had to wait until they were assessed and saw a nurse or doctor. Using the SUS data provided we can see that the average waiting time until assessment (time from arrival to initial assessment) has been on the increase at both sites. There was a reduction at Chorley whilst it was operating as an Urgent Care Centre. However, this upward trend has commenced once the site operated as a 14-hour service.

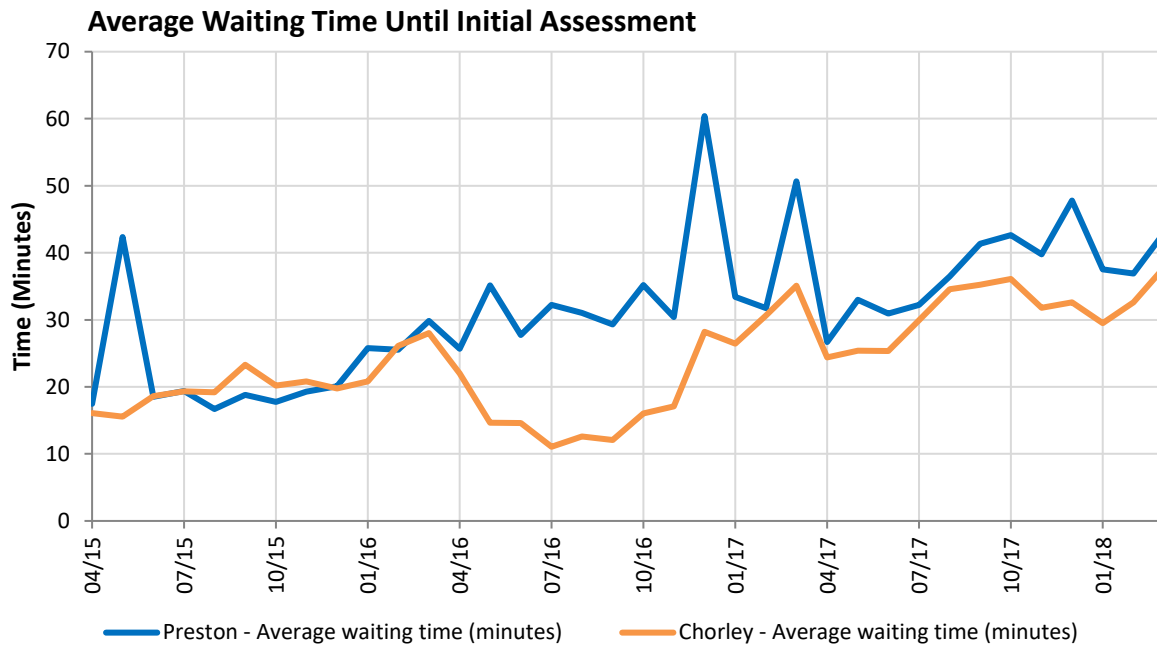
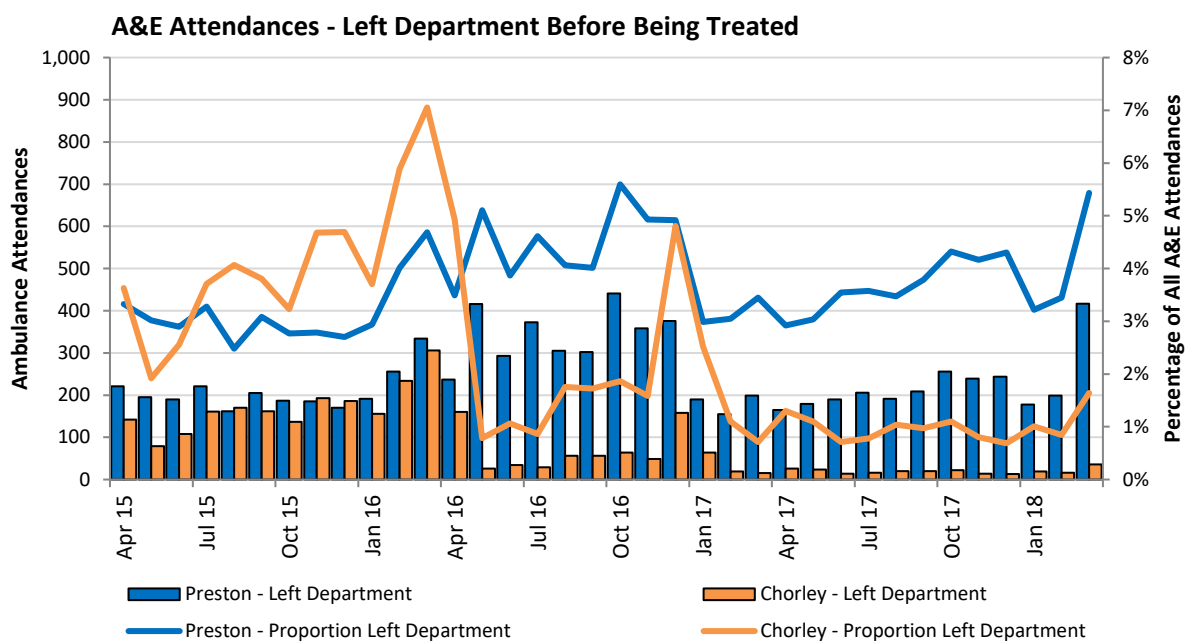


Figure 41: Average waiting time until initial assessment at the Royal Preston Hospital and Chorley and South Ribble Hospital between April 2015 and March 2018. Source of the data is client supplied SUS.

Another key measure in considering patient experience in the A&E departments is to look at the percentage of patients who leave the department before being treated. There had been a significant rise in the percentage of patients leaving at Chorley and South Ribble Hospital from April 2015 up to March 2016 prior to the site operating as an Urgent Care centre. Since this change there has been a significant reduction despite a brief spike in December 2016. At Preston there was an increase in the percentage of patients leaving when Chorley was operating as an Urgent Care Centre however, there has been a reduction to the 2015/16 rates during the last financial year.



Source: Client supplied SUS data

Figure 42: Percentage of patients leaving before being treated at the Royal Preston Hospital and Chorley and South Ribble Hospital between April 2015 and March 2018. Source of the data is client supplied SUS.

5.6 Critical Care

Area	Key Drivers for Change
Utilisation	<ul style="list-style-type: none">The 28 critical care beds at Preston are regularly operating at above 90% occupancy levels. Nationally standards vary, but guidelines suggest a 75-85% maximum utilisation is best to ensure patient safety and quality of service.There are 4 critical care beds at Chorley Hospital with average utilisation of <30%.In 16/17 the 4 critical beds at Chorley were empty for 259 days of the year (equivalent to 8 out of 12 months).
Resource Requirements	<ul style="list-style-type: none">Current utilisation rates result in 0.25 consultants per critical care bed at Chorley Hospital compared to 0.08 consultants at Preston.
Workforce	<ul style="list-style-type: none">The critical care middle grade doctor based at Chorley hospital each day also acts as the bleep holder for the hospital. Therefore, in most instances the most senior middle grade will be assigned to Chorley Hospital to care for the most low-acuity patients, which does not lead to the most appropriate use of the available workforce (or skill mix).The low bed occupancy and maintenance of an effective staff skill base at Chorley has a negative impact on recruitment and retention for the Critical care directorate across medical and nursing staffing groups.
Finance	<ul style="list-style-type: none">Chorley ICU has an annual operating deficit of circa £1.2m per annum.The Critical Care Unit at Chorley Hospital currently pays around £400,000 per annum in locum costs for all out of hours shifts. For the majority of days this unit is not utilised.

5.6.1 Critical Care overview

Lancashire Teaching Hospitals currently has 32 critical care beds across both its sites; 28 beds at Preston Hospital and 4 beds at the Chorley Hospital sites.

The Chorley service supports the onsite elective surgical services and local medical services. It is not configured to care for level 3 patients; therefore, patients requiring a level 3 service are transferred to Preston or admitted as an emergency in the first instance through the Preston Emergency Department.

The Royal Preston Hospital supports the regional services provided by LTHTR; these include the Major Trauma Centre, Cancer Centre, Renal Centre, Vascular Centre as well as the majority of Central Lancashire's District Medical Services.

The Trust has seen a significant growth in the complexity of care it delivers over the last 10 years due to the following:

- The requirement for surgery within Cancer specialty growing steadily.
- Royal Preston hospital became a Major Trauma Centre in 2012.
- Royal Preston hospital became the Regional Vascular Centre in 2015/6.

The demand for critical care services is high, with the Preston site regularly operating at above 90% critical care bed occupancy. Nationally standards vary, but guidelines suggest a 75-85% maximum utilisation is best to ensure patient safety and quality of service. However, the 4 beds on the Chorley site generally operate on c. 30% occupancy, and on occasions the utilisation percentage drops well below this figure.

Poor utilisation rates of critical care can impact on the Trust's ability overall (thinking across both acute sites) to deliver surgical activity within specialities such as neuro, vascular and cancer. This can also lead to cancellations on a regular basis.

The 28 beds at the Royal Preston Hospital site are spread over two locations within the site, which creates an operational staffing pressure. Not all the beds have the relevant medical equipment they need to care for level 3 patients. This in effect means that four of the 28 beds (those located in 'Preston in Area 4') are rarely used due to their equipment and location.

A number of capital scheme proposals have been developed over the last few years to extend the Unit at Preston. These options have not progressed due to cost and complexity.

5.6.2 Drivers for change

Critical care change requirements have formed a crucial part of the discussion with Our Health Our Care stakeholders to date. The following sections document the drivers for change discussed with stakeholders across extensive engagement events.

5.6.3 Variation and 2018 CQC report

Current service provision arrangements and associated staffing requirements mean that there is significant underuse of critical care (and consultant capacity) on the Chorley site and a capacity pressure at the Preston site.

In the October 2018 CQC Report, Chorley critical care received an overall rating of good, with four goods across the board, whereas Preston critical care received an overall rating of requires improvement. The Trust aims to improve its CQC ratings and would want to ensure that the rating of its services is equitable across the different locations where it delivers services.

	Safe	Effective	Caring	Responsive	Well-Led	Overall
Chorley	Good	Requires Improvement	Good	Good	Good	Good
Preston	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement

Information provided by Lancashire and South Cumbria critical care network covering the 12 months March 2017 – March 2018 highlights significant variation in critical care bed occupancy levels and level of medical cover at both consultant and registrar level, with the Preston site at capacity and extremely pressured, compared to the Chorley site which appears significantly underutilised.

Site	No. Beds	Average Bed Occupancy	No. Consultants on Duty	No. Registrars on Duty	No. Consultants per bed	No. Registrars per bed
Preston	24	89.8%	2	2	0.08	0.08
Preston Area 4	4	17.2%				
Chorley	4	27.5%	1	1	0.25	0.25

An internal clinical audit for 2016-17 found that the four-bedded unit in Chorley cared for 106 patients per year. It was empty for 259 days per year (approx. 8 out of 12 months per year).

Of these patients, 95% of admissions were due to medical conditions and 5% required post-operative care from planned (non-emergency) surgery.

Approximately one third of the 106 patients required transfer to the critical care unit at Preston due to requirement for specialised intensive care treatment that cannot be provided on the Chorley site.

The imbalance of patients' numbers between Chorley and Preston, and also the high number of patients transfers, are due to the additional clinical services available on the Preston site. The treatment of high acuity patients

Occupancy rates have been assessed via the critical care dashboards produced internally at Lancashire Teaching Hospitals and via the monthly SitReps submitted to NHS England, and from internal audits carried out by senior clinicians. The monthly SitReps require all NHS providers with a critical care department to submit their occupancy rates on the last Thursday of each month. Comparing the figures for Lancashire Teaching Hospitals to England shows that occupancy levels have been similar to the England rate over the last three years with a slight reduction in the past few months.

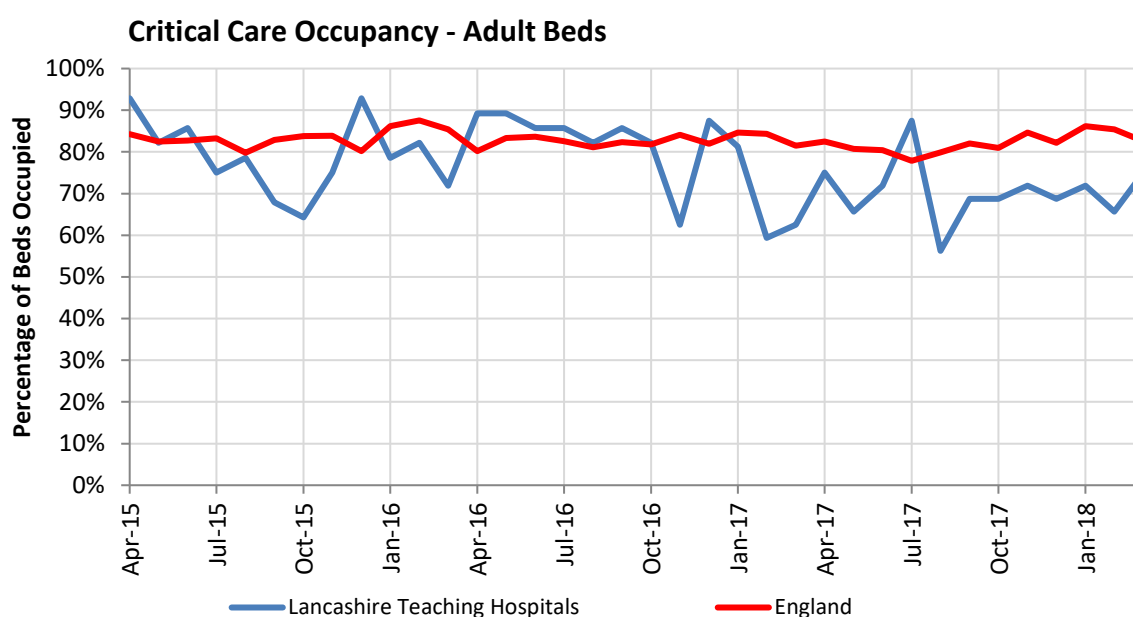


Figure 43: Occupancy rates of critical care Beds at Lancashire Teaching Hospitals compared with England between April 2015 and March 2018. The source of this data is NHS England monthly SitReps.

From the trust's internal reporting we can separate out occupancy rates at the Preston and at Chorley. This shows significant variance in occupancy rates at the different sites, and that critical care occupancy rates at the Royal Preston are very high, with monthly occupancy frequently being over 90% (note that Preston Area 4 only has occupancy rates available from November 2016).

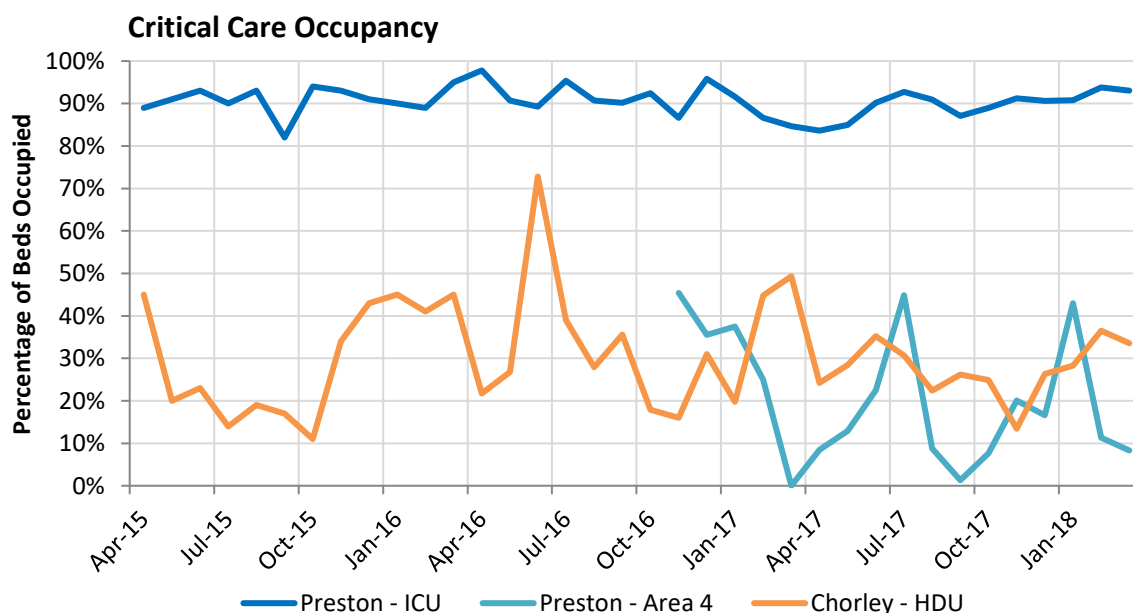


Figure 44: Occupancy rates of critical care Beds at Royal Preston Hospital and Chorley and South Ribble Hospital between April 2015 and March 2018. The source of this data is Lancashire Teaching Hospitals critical care Reports.

5.6.4 Workforce

The variation in care and utilisation rates across the two sites results in difficulties and complexities in allocating staff to clinical areas.

- Both critical care units are designated level 3 units, and the clinical staff deployed all require the requisite high level of competence, experience and seniority to deal with acutely unwell patients. The low utilisation rates do not negate the need for senior members of clinician staff needing to be onsite, so the result is underutilised members of staff.
- The critical care Unit at Chorley needs to be staffed 24/7 by middle grades. At the present time there is only substantive staff available to cover the standard daytime hours from Monday to Thursday. Out of hours Monday to Thursday, and all day / night Friday, Saturday and Sunday are covered with locum shifts.
- The cost of middle grade staffing out of hours at Chorley Hospital is around £7,600 a month, or £0.4m a year.

Review of Trust workforce data has shown that for medical anaesthetics there has been a sustained long-term gap between funded WTE roles and paid WTE roles. This indicates that there are long term vacancies in key staff groups.

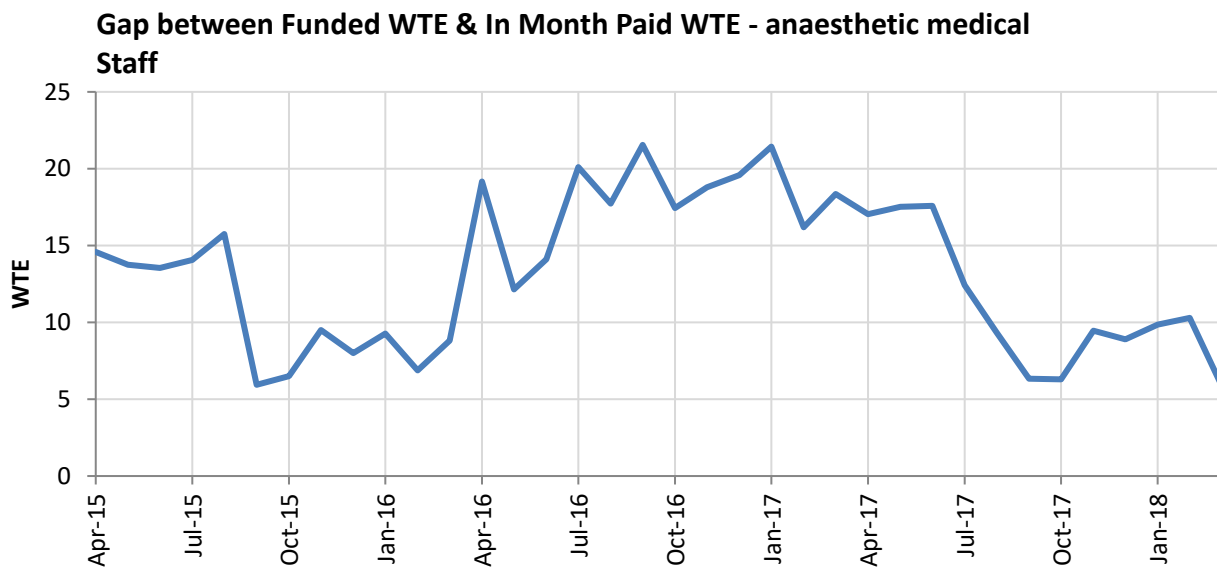


Figure 45: Gap between funded WTE and paid WTE roles at Royal Preston Hospital and Chorley and South Ribble Hospital between April 2015 and March 2018. The source of this data is Workforce data supplied by the acute trust.

5.6.5 Mortality Rates

The Intensive Care National Audit & Research Centre (ICNARC) produces a risk-adjusted mortality metric to assess mortality across critical care units in England. This

model adjusts for the case-mix of patients admitted to each unit and adjusts for factors such as age, physiological markers and past medical history. Both of the critical care units at the Royal Preston Hospital and Chorley and South Ribble are within the expected mortality range for the patients they treated during 2016/17. Chorley's low mortality rate will be partly due to the high proportion of transferred patients.

This shows that one of the main issues to solve is the planning and configuration of the critical care service as opposed to being concerned with clinical outcomes

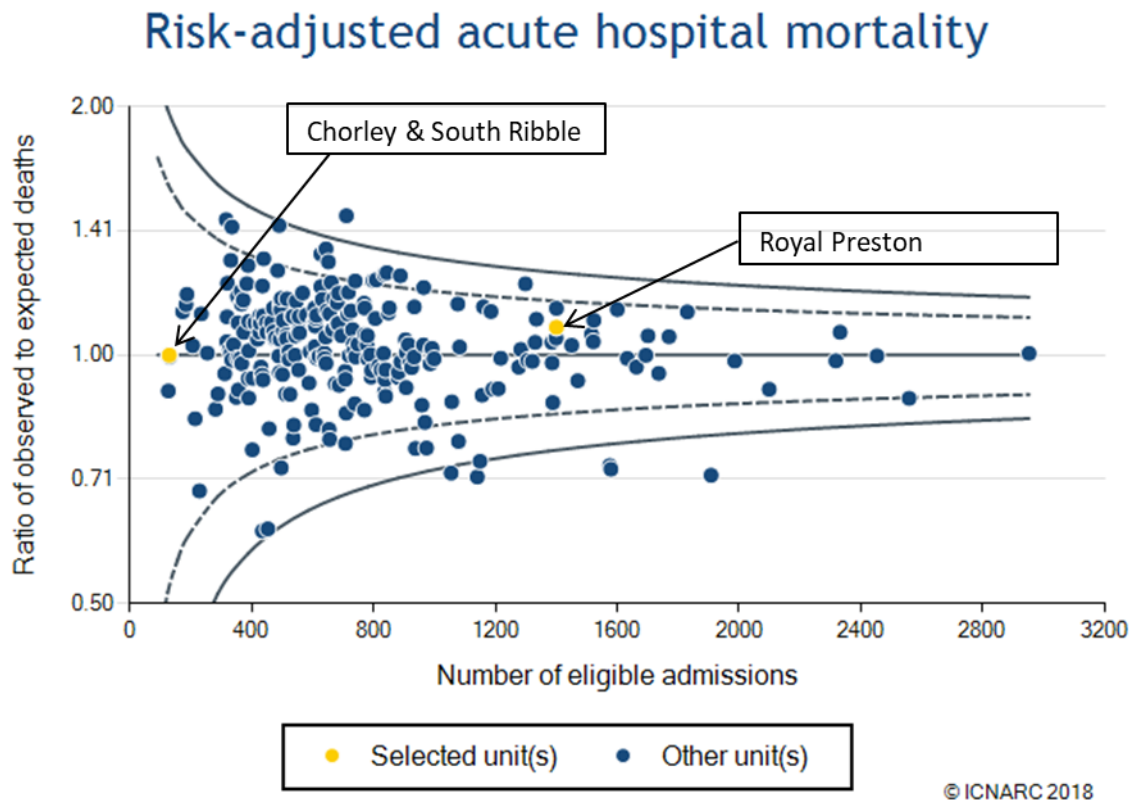


Figure 46: Funnel plot showing risk-adjusted mortality rate for Royal Preston Hospital compared to England for 2016/17. The source of this data is ICNARC.

5.6.5 Out-of-hours discharges

Both Royal Preston Hospital's and Chorley and South Ribble Hospital's critical care units are within the expected range for out-of-hour discharges.

The same audit provides information on the proportion (and number) of patients who are discharged from the critical care unit between 22:00 – 06:59 for patients who were not delayed. The proportion of patients discharged out of hours for both the Royal Preston Hospital and Chorley and South Ribble is within the expected ranges. However, the number of these discharges is far higher at the Royal Preston Hospital site.

Out-of-hours discharges to the ward (not delayed)

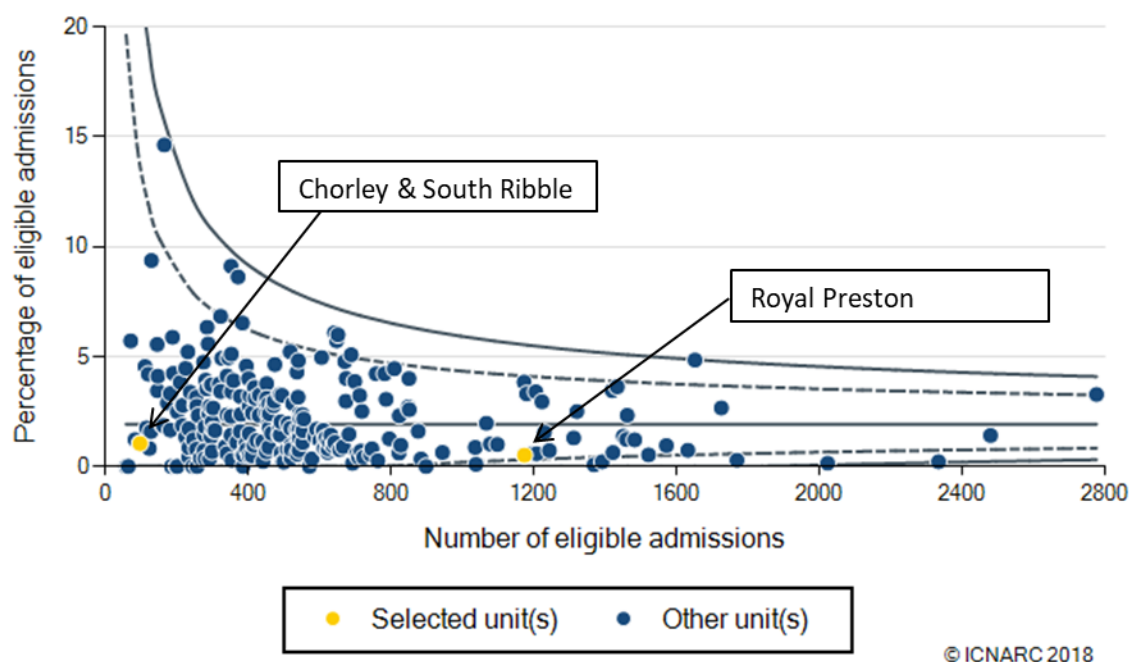


Figure 47: Funnel plot showing percentage of out-of-hours discharges for Royal Preston Hospital compared to England for 2016/17. The source of this data is ICNARC.

5.6.7 Delayed discharges

In 2017/18 there were 1,270 patients having a delay in their discharge from critical care of more than four hours (1,187 at Royal Preston Hospital and 83 at Chorley and South Ribble Hospital). The delays for these patients have totalled over 19,000 hours (equivalent over 800 bed days) with 18,009 at the Royal Preston Hospital and 1,226 at Chorley and South Ribble Hospital. The Trust is working to reduce these delayed discharges through organisational efficiency work, but there is more work to do to make best use of available resources.

The number of patients delayed has increased slightly at the Royal Preston Hospital; however, the number of hours these delays account for has reduced slightly over the past year.

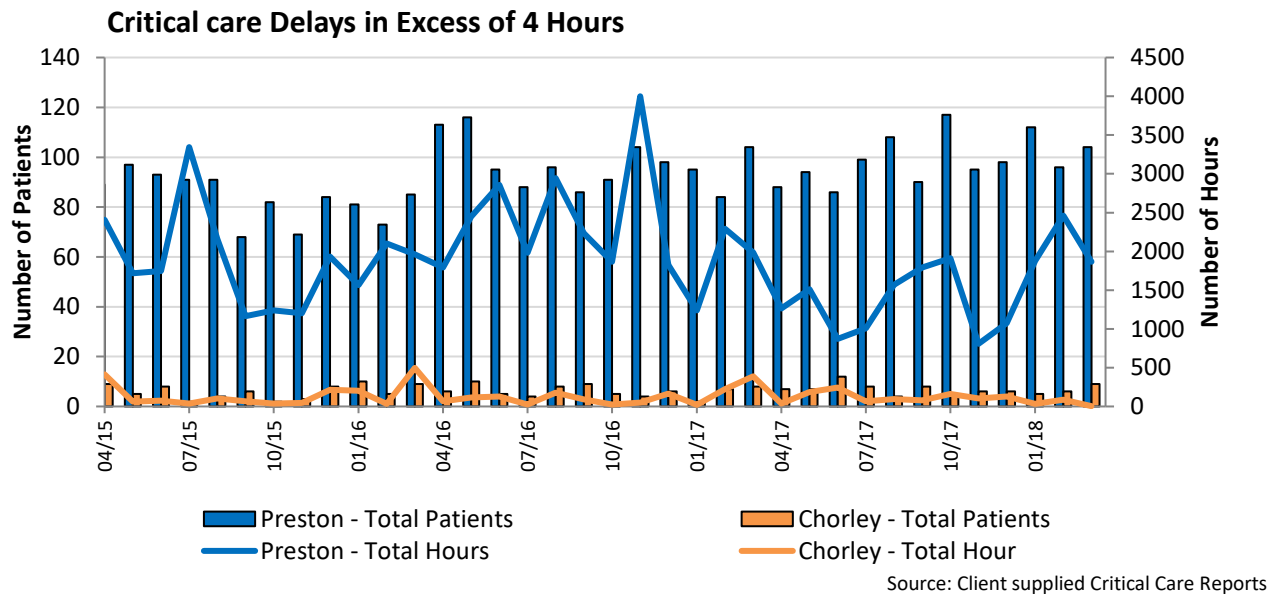


Figure 48: Delayed Discharges of more than 4 hours at Royal Preston Hospital and Chorley and South Ribble Hospital between April 2015 and March 2018. The source of this data is Lancashire Teaching Hospitals critical care reports

Section 6. Opportunities for change

Benefits of change

We are proud to serve the people of Central Lancashire and want to provide the best possible care for our population, meeting national standards which result in better outcomes and more personalised care for everyone across the system. This is in pursuit of our overall ambition – to deliver the best clinical outcomes for patients. To do so, effective and swift change is needed to create a sustainable and high-quality healthcare system which will deliver the needs for this generation and for future generations.

Learning from our challenges and working to improve our healthcare system, we strive for a future where the following happens every day:

- The healthcare system is easy to understand and is accessible for the whole population so that when patients need care, they are easily able to find out what services are available to serve their healthcare needs;
- The healthcare system will consider long term planning and prevention to account for future changes in the demographic. Planning in advance will help to prepare for future problems which the healthcare system will need to address;
- Traditional organisational barriers of healthcare systems will be broken down to allow for organisations to work closely together, to ensure patients receive continuous care which is joint up and end-to-end;
- As organisations work more closely together, patients will experience a seamless journey, with no unnecessary delays, handoffs in services or issues when moving from one organisation to another;
- Care will be delivered where possible as locally and as close to home as possible;
- Patients will receive personalised care, designed around their needs. People will be supported to make empowered decisions about how and where they receive their care;
- More services will be delivered in the community, ensuring that only when acutely unwell will patients need to access emergency services. No one will be admitted to hospital unless necessary and no one will stay in hospital longer than needed;
- Services will consider a patient's whole life: including their mental and physical health equally, rather than just their conditions or presenting needs. Patients will be treated by the most appropriate healthcare system, able to meet their needs;

- Primary care services will work collaboratively delivering local services with multidisciplinary services as close to home as possible. This will keep patients receiving the best possible care without the needs to be seen in hospital, unless necessary. It will further allow opportunities for services to work differently in terms of the planning and the delivery of services;
- Our increasingly ageing population with complex needs will receive care by equipped teams who are prepared to meet those needs. This will ensure that older patients will receive the most suitable care, in the most appropriate environment. No longer will elderly patients receive fragmented care. Frail patients will receive supported care in their homes and not kept in hospital beds;
- Urgent and emergency care services will be able to meet national standards for all clinical areas. This will ensure that patients receive the best possible care, by the correct workforce using the correct equipment. This will ensure that patient have better clinical outcomes and a better patient experience;
- Hospitals will be sufficiently resourced, with the correct workforce, so that all patients have the same access care. The workforce will no longer be stretched, contributing to poor access to standards and performance;
- Patients will experience senior decision making up front and timely interventions into their care, to ensure the best possible outcomes;
- Patients will be seen quickly and not made to wait for increased length of stays. Alternatively, patients will not experience high levels of cancellations for routine and planned procedures;
- Patients will have the opportunity to receive routine procedures closer to home and in the community;
- NHS Constitutional standards will be met, particularly relating to the 4-hour A&E waiting time, 18 weeks Referral to treatment standards and the 62 Cancer waiting targets;
- Central Lancashire will be a positive place to work, increasing in recruitment and the retention of staff. The workforce will feel supported and empowered, given the skills and knowledge they need to deliver high quality services. They are utilised in the right ways to support patients. There will further be a reduction in the use of agency staff and locums. This will help to create a more financial sustainable service;
- Organisations will maximise the use of technology to assist with continuity of care, including data sharing to support the workforce in delivering services as efficiently as possible, working together to make the best use of resources;

- In essence, we hope that all patients across Central Lancashire will experience the right care, at the right time, at the right place to meet their healthcare needs.

We hope that in the future by achieving this and more, patients within the Central Lancashire will receive the best quality of care delivered by experienced and appropriate clinical staff, tailored to the needs of patients, ultimately resulting in better clinical outcomes. This will not only create a service which is fit for the population of Central Lancashire, but it will future proof the service, to create a provision which is sustainable, efficient and accessible for all for many years to come.

Section 7. Conclusion

This case for change has identified five key issues, which are:

1. **Workforce:** We do not have the workforce we need in critical staffing areas: Our urgent and emergency care system workforce is stretched - a symptom of the issues with recruitment and retention being experienced right across our health system and more widely in the NHS.
2. **Flow:** We are not delivering effective patient flow in our hospitals. In short, this means that too many patients are waiting too long for their care, whether their care is either planned or unplanned. Too many patients are experiencing delays to be discharged. Our hospitals are struggling to balance the needs of patients with urgent and emergency care need (including critical care) with those receiving planned care, including day cases and outpatients. They are not running as efficiently as they could do.
3. **Lack of alternatives:** We do not have a comprehensive range of alternative options available to using the urgent and emergency care system at all times. This means that too many patients are using urgent and emergency care services because they either do not know the best alternative to use, or because that alternative is not available to them at a time and place to best meet their needs. This is a problem right across our health system – we recognise that the problem does not start at the front door of our hospitals Emergency Departments.
4. **Demographics:** We are serving a growing and ageing population which continues to experience inequalities in health status, reflected in different clinical outcomes. In short, this means some local people have worse life expectancy than others; some people are more likely to have chronic and complex long-term conditions than others; and some people are making additional use of urgent and emergency care services because they do not know the best alternative to use. This includes community-based and self-care alternatives.
5. **Effective use of Resources:** To build a sustainable healthcare model, we must use the resources as an integrated health and social care system. We are not currently doing this well enough. This is because we have yet to fully develop an asset-based approach to healthcare, particularly where this impacts on the best use of our urgent and emergency care system. We can also do more in terms of delivering a neighbourhood care model, and we will need to deliver more care closer to home where this is safe and practical.

The lead partners involved in Our Health Our Care are all focussed on delivering the best possible outcomes for patients, which meets their expectations as taxpayers and as citizens.

Whilst we recognise that some of these issues prevail across the wider NHS, the issues relating to workforce, flow and demographics in particular all have contributory factors which are subject to local determination, and therefore influence. This means that we can do better for our patient by thinking differently about the services and assets that we have as a health system and how they can be best utilised to provide effective healthcare, including high quality urgent and emergency care services.

In terms of acute care, put simply, we do not have the workforce we need to run services as they are currently designed. There is a high vacancy rate for health and care roles, which is managed through the employment of agency or temporary workers, but this is costly and can affect the quality of care. The current workforce model is not sustainable for the future. This is reflected in the issues surrounding flow and, without change, will get worse arising from demographic changes in the future.

Therefore, there is a compelling case to think differently about how to address these challenges, in order to meet the expectations that patients rightly have for their health care services. Thinking differently, with an open mind now about how we plan and deliver services, in particular urgent and emergency care services will help us resolve these themes, enabling future generations to continue to benefit from safe and sustainable NHS care in Central Lancashire.

1.1 Financial and Operational Pressure

The NHS is facing significant financial and operational pressures, with services struggling to maintain standards of care. The majority of NHS provider organisations are failing to meet the core NHS performance targets. Financial pressures on the NHS are severe and show no sign of easing.

Local and national NHS leaders are therefore focussing on improving quality and delivering efficient world-class healthcare for patients

Clinicians and system leaders from strategic organisations, commissioning organisations and provider organisations are coming together to look at how quality improvement methods can be the heart of local plans for redesigning NHS services. NHS leaders in management and clinician roles play a vital role in making this happen.

To deliver the changes that are needed to sustain and improve care, the NHS needs to move from pockets of innovation and isolated examples of good practice to system-wide improvement.

Financial Performance

The NHS Provider Sector was initially expected to balance financially in 2017/18,⁵¹ but this was revised to a planned deficit of £496m once financial plans had been submitted.⁵² By the end of 2017/18 the actual deficit stood at £960m⁵³, despite the £1.8bn sustainability and transformation support monies and significant emphasis on substation cost savings across the system.

The most recent performance data shows a £814m deficit for Q1 alone within the Provider Sector, £78m worse than the same quarter last year.⁵⁴

2017/18 was also a challenging year for CCG finances with a national overspend of £250m. 75 out of 211 CCGs overspent their budgets during this period.

In a King's Fund survey nearly two-fifths of CCGs were expecting to overspend their budgets in 2018/19. 42% of NHS Provider Trust Directors of Finance were expecting to end 2018/19 in deficit.⁵⁵

⁵¹ <https://www.england.nhs.uk/deliver-forward-view/>

⁵² <https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-1-201718/>

⁵³ <https://improvement.nhs.uk/resources/quarterly-performance-nhs-provider-sector-quarter-4-201718/>

⁵⁴ <https://improvement.nhs.uk/news-alerts/provider-bulletin-12-september-2018/>

⁵⁵ <https://www.kingsfund.org.uk/publications/how-nhs-performing-june-2018>

Operational Performance

National targets are becoming increasingly challenging for the vast majority of NHS organisations. The latest performance data for the NHS (Q2 2018/19) paints a picture of continuing pressure and challenge for NHS staff and services as a whole.

A&E Performance against 4 Hour Target

The most recent planning guidance from NHS England⁵⁶ in February 2018 set out an expectation that national performance would rise so that 90 per cent of patients are seen within four hours in A&E during September 2018 and beyond. Second, that by March 2019 the majority of providers will see 95 per cent of patients within four hours. Finally, the NHS overall returns to 95 per cent performance 'within the course of 2019'.

In terms of the 4-hour target, NHS organizations in England have come very close in the past three months to achieving the 90% target (89.3%, 89.7%, 88.9% in the period August 2018 to September 2018 inclusive).

However, other data underlines the pressure faced by NHS organisations. A King's Fund report⁵⁷ in June 2018 found that in March 2018 only 9 of 137 trusts with major consultant-led A&E departments met the 95% standard. Indeed, the overall 95% standard has not been achieved nationally since July 2015. It seems unlikely that 95% performance will return to the NHS by March 2019 when the current performance is considered.

The same King's Fund report found that only 23% of trust finance directors were confident they would achieve 95 per cent performance by March 2019 – and this was bolstered by finance directors from community trusts that operate walk-in centres and minor-injury units, where achievement of the 95 per cent standard has largely been maintained.

Of the 32 CCG finance leads surveyed, only one was confident their local providers would achieve the standard.

In summary, the demand on A&E departments in England is increasing year on year and there is a broad consensus that this challenging landscape is likely to continue.

Elective Care – 18-week Referral to Treatment Performance

The NHS aims to start planned consultant-led treatment within a maximum 18-weeks of patient referral. A national target states that 92% of patients are expected to be seen within this timeframe.

2018/19 planning guidance from NHS England states that Trusts should aim to keep waiting lists for planned care in March 2019 at the same level as those in March 2018, when 4.1 million people were waiting.⁵⁸ It also instructs the NHS to halve the number of

⁵⁶ <https://www.england.nhs.uk/publication/refreshing-nhs-plans-for-2018-19/>

⁵⁷ <https://www.kingsfund.org.uk/publications/how-nhs-performing-june-2018>

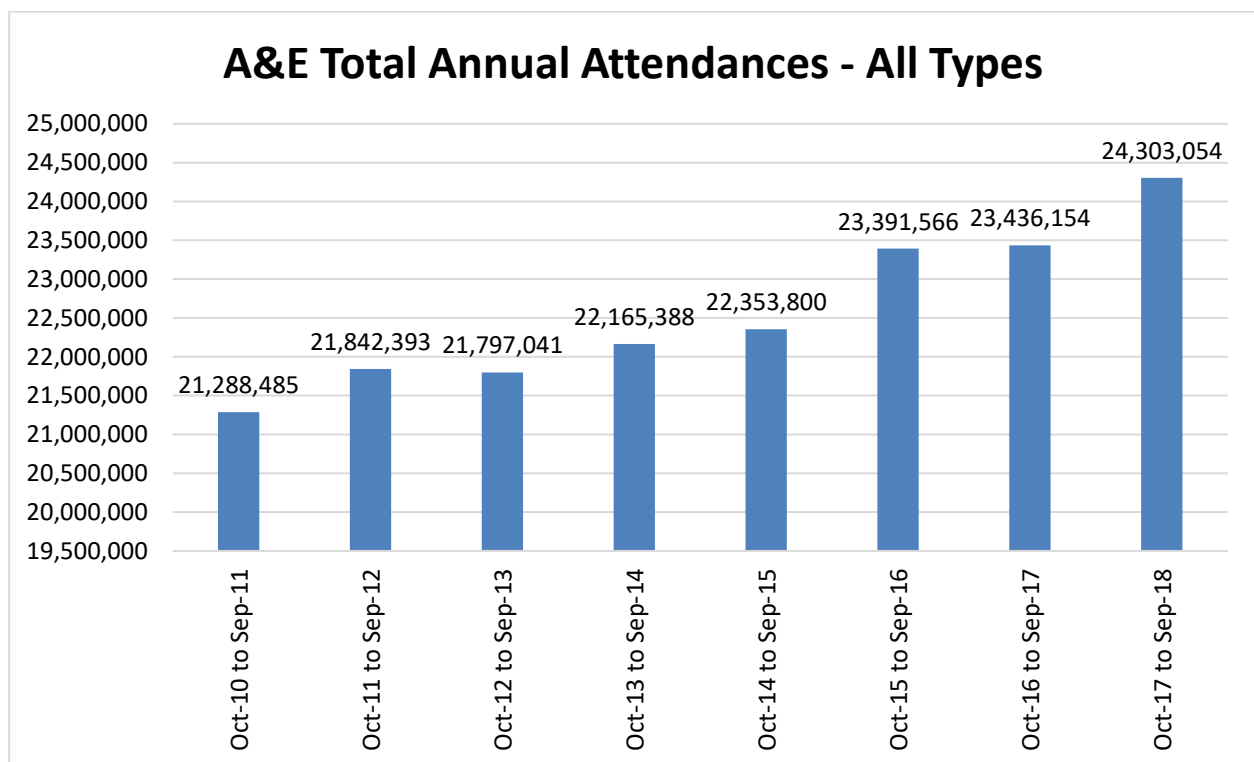
⁵⁸ <https://www.england.nhs.uk/publication/refreshing-nhs-plans-for-2018-19/>

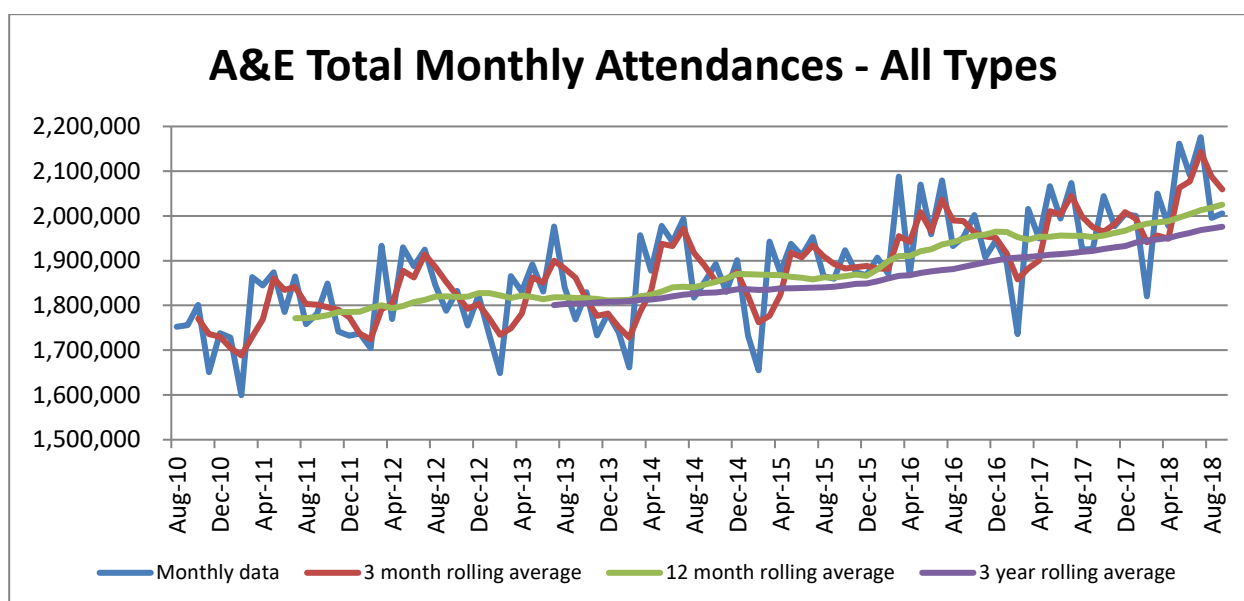
patients waiting more than one year for treatment. By March 2018, 2,755 people had been waiting more than a year for treatment – the highest number since 2012/13.

The time 92 per cent of patients are seen in the NHS had risen to 22 weeks by March 2018 – its highest level since March 2009 and far above the 18-week target.

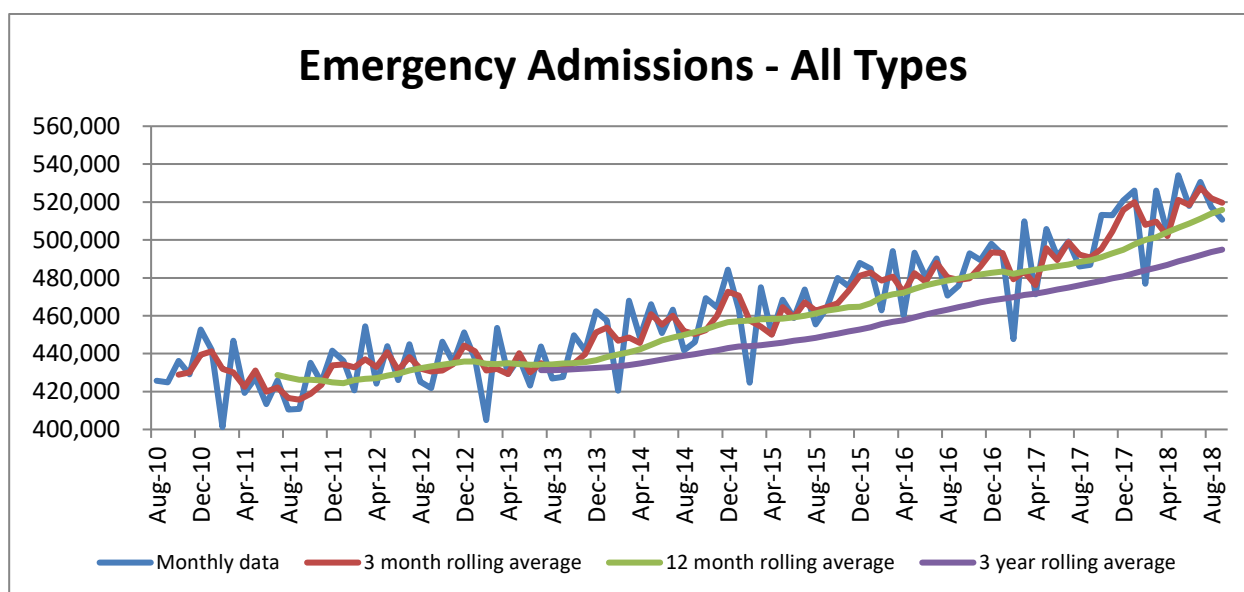
1.2 Rising Demand

Nationally, attendances at A&E continue to rise year on year. In the period October 2017 to September 2018 a total of 24.3m people attended A&E departments in England, compared to 21.3m people in the same period in 2010/11. This represents a national increase of around 14% over a seven-year period.



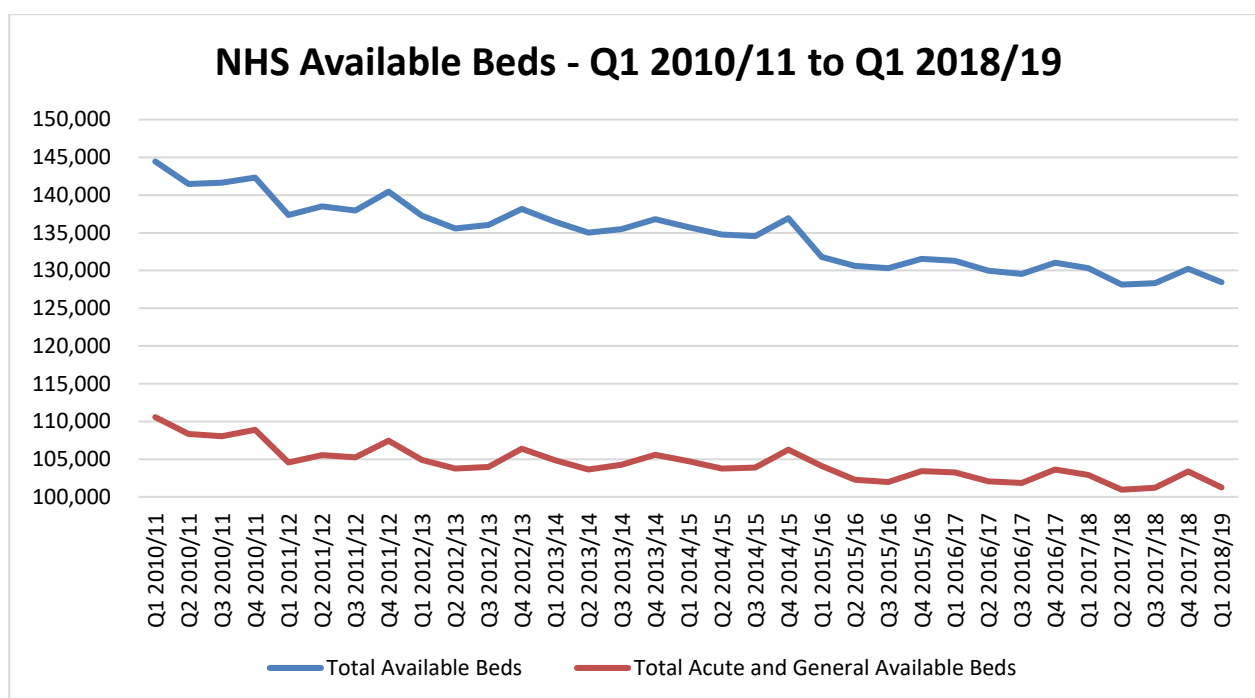


Perhaps even more challenging for NHS hospitals is the admission rate following a visit to A&E. In the period October 2017 to September 2018 a total of 6.2m people were admitted to hospital following a visit to A&E in England, compared to 4.7m people in the same period 2010/11. This represents a national increase of around 32% over a seven-year period.



More people are attending Accident and Emergency Department and more patients are being admitted following their visit.

There is a clear picture of increasing demand on both A&E services and the variety of clinical interventions required following admission from A&E.



GP referrals for hospital treatment are growing a slower rate than in previous years but are still growing⁵⁹.

Hospital bed availability is at its lowest level in 8 years. Since Q1 2010 there are 12.5% less beds available across the NHS as a whole, with 9.2% less beds available within the acute and general sector.

In summary, there simply isn't enough capacity within hospitals to cope with rising demands for planned and emergency care.

1.3 Need to Take Difficult Choices Now

The financial performance of the NHS is significantly challenged, and, as explained in Appendices 1.1 and 1.2, healthcare leaders expect it to remain so. This means that there is no real option to park difficult choices in to the future. We must plan with the resources that we know we will have access to now.

On the 19th June 2018, the Government announced details of a long-term funding settlement for the NHS. The NHS will receive an average of 3.4% a year⁶⁰ real-terms increase in funding over the next five years (3.6% over the first two years), whilst a new 10-year long-term plan for the NHS will be developed to support strategic planning across the health service. This will mean that the NHS will receive increased funding of £20.5bn in real terms per year by the end of the five years compared to today.

⁵⁹ <https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/>

⁶⁰ <https://www.gov.uk/government/news/prime-minister-sets-out-5-year-nhs-funding-plan>

Whilst news of this increased funding has been broadly welcomed, independent commentators such as the King's Fund have identified that a “run-rate” increase of 4 per cent per annum will be needed to allow the NHS to keep track of the additional pressures placed up on it. There may be additional increased needed to pay for the costs of new research, treatments and technologies to benefit patients in the NHS⁶¹.

The Government have determined the strategic priorities for use of the new funding including:

- Getting back on the path to delivering agreed performance standards – locking in and further building on the recent progress made in the safety and quality of care;
- Transforming cancer care so that patient outcomes move towards the very best in Europe;
- Better access to mental health services, to help achieve the government's commitment to parity of esteem between mental and physical health;
- Better integration of health and social care, so that care does not suffer when patients are moved between systems;
- Focusing on the prevention of ill-health, so people live longer, healthier lives.

The government has also set the NHS five financial tests as part of its commitment to put the service on to a more sustainable funding:

- Improving productivity and efficiency;
- Eliminating provider deficit;
- Reducing unwarranted variation in the system so people get the consistently high standards of care wherever they live;
- Getting much better at managing demand effectively;
- Making better use of capital investment.

In summary, this means that whilst more money will be available to the NHS over the next five to ten years, it faces both the pressure to manage the demands placed upon it now, and the pressure expected to be placed upon it in the future.

The challenges set by the government to improve productivity and efficiency, reduce unwarranted variation, and getting better of managing demand effectively are all directly relevant to this case for change. It is important that local clinicians, leaders, and broader stakeholders think differently about how they can best use current resources and the limited additional funding that can be expected to be provided in the future. This explains why there is a need to take difficult choices now.

⁶¹ <https://www.kingsfund.org.uk/publications/pm-letter-funding-settlement-nhs>

1.4 Recruitment and Retention

An October 2018 report from NHS Providers found that at the end of June 2018 there were over 107,000 vacancies across the NHS, including nearly 42,000 nursing posts and 11,500 doctors.⁶² They stated that workforce challenges remained the biggest concern for trust Chief Executives. Key issues raised were as follows:

- Workforce shortages are resulting in trusts having to resource services differently or change how and where they are provided;
- The vast majority of NHS organisations, alone or collectively, are trying to recruit health care staff from overseas. However, these costly international recruitment drives, both within and outside the EU, are not providing the number of staff required;
- Trusts have found that a combination of the decision to leave the EU and more stringent requirements of the international English language testing system (ILETS) has requested in a significant cut to the supply line of EU workers;
- The uncertainty of Brexit is also hampering trusts' ability to attract and retain workers.

The workforce challenges seen in the NHS clearly have considerable implications on existing staff.

To fill rota gaps many staff work additional hours, work paid (or in some cases unpaid) overtime, or extra bank shifts.

Agency and locum staff are also being used more widely. All these measures are coming at an additional cost and administrative burden to trusts.

1.5 Need to Collaborate

The general consensus is that short-term solutions and fixes will not be enough to provide quality care for patients. There is a call for NHS organisations to work together to transform services and focus on improving quality and delivering exceptional care to patients. This means that by collaborating as one system and thinking differently about how primary, secondary, tertiary, social care and voluntary services work together will be vital to finding new answers to the challenges that we face.

One of the opportunities developed to enable this collaboration is the Integrated Care System. Locally, the programme is called Healthier Lancashire and South Cumbria.

⁶² <http://nhsproviders.org/steeling-ourselves-for-winter-201819/5-what-does-winter-mean-for-the-nhs-workforce>

The Lancashire and South Cumbria system covers a region made up of five local areas (Central Lancashire, West Lancashire, Pennine Lancashire, Fylde Coast, and Morecambe Bay). These areas provide a way for organisations and groups involved in health and care to join up locally. The partners include:

- **CCGs:** Greater Preston, Chorley and South Ribble, East Lancashire, West Lancashire, Blackpool, Fylde and Wyre, Morecambe Bay, Blackburn with Darwen;
- **Five acute and community trusts:** Lancashire Teaching Hospitals NHS Foundation Trust, University Hospitals of Morecambe Bay NHS; Foundation Trust, East Lancashire Hospitals Trust, Blackpool Teaching Hospitals NHS Foundation Trust and Lancashire Care NHS Foundation Trust;
- **Two upper tier councils** (Lancashire and Cumbria) and **two unitary councils** (Blackpool and Blackburn with Darwen).

The system covers a population of around 1.7 million and the region is diverse, with areas of differing geographies and local challenges. Some people experience ill health from an early age and die younger, especially where there are higher levels of deprivation. For most of the area, the quality of life for people with long term health conditions is worse than the average across England.

Through effective partnerships in Lancashire and South Cumbria, the system is working to invest in health and deliver high quality healthcare within the resources that all the partners have at their disposal. This will drive the health, wellbeing and cohesiveness of all its towns and communities, so that all of the diverse populations have the fairest access to good care and the best possible chance to have healthy fulfilling lives. It seeks to deliver the following:

- A strong focus on improving health and wellbeing outcomes will enable people to stay well for longer and have greater control over their health and wellbeing;
- Utilising new technologies will help reduce the demand on services and support both self-care and prevention of ill health;
- Making the best use of resources will ensure the best quality outcomes and value for money;
- The extension and improvement of community and primary care services will improve access for local people.¹

Appendix 2: Timeline of provision of A&E services

Chorley A&E Closure

This appendix presents a timeline of activity at Chorley A&E from early 2016 to September 2018. The summary timeline is as follows:

- April 2016 – Initial closure, staffing model and reaction
- August 2016 – Independent Review by NHS England commissioned by the Trust
- September 2016 – Report published by Lancashire County Council's Health Scrutiny Committee: makes 10 recommendations to the Trust
- October 2016 – NHS England Report published and recommends A&E is re-opened on a part-time basis
- January 2017 – Chorley A&E re-opens on a part-time basis
- November 2018 – Chorley A&E continues to operate on a part-time basis

April 2016 - Initial Closure

In early 2016 it became increasingly difficult to staff the middle grade doctor rotas across the two Emergency Departments across Lancashire Teaching Hospitals NHS Trust. At an emergency system resilience group (SRG) meeting in April 2016 the Trust shared an option appraisal of potential interim solutions.

The supported option, agreed jointly by the trust and both CCGs, was to temporarily downgrade the Emergency Department at Chorley Hospital to an urgent care centre (UCC) service operating between the hours of 08:00- 20:00hrs. The decision was made on **13th April 2016** and the ED was temporarily downgraded on **18th April 2016**.

At the time it was stated that 14 doctors were needed to staff the department, but only eight were available. Consultants were working additional shifts to staff the rota, but the trust felt that "this was not sustainable, and this approach was beginning to affect our ability to cover the consultant rota."

Although not referenced by the Trust at the time, it was felt that the locum cap, announced in November 2015, will have had an impact on trying to staff the A&E department at Chorley. The nationwide initiative, which aimed to save £1bn over three years, came into effect in April 2016 and stated that NHS trusts would not be able to pay agency staff more than 55% additional payment for a shift compared to a permanent member of staff.

Staffing Model Post-Closure

Following emergency closure of Chorley Emergency Department, all ambulance and ED attends were transferred to Royal Preston Hospital and the urgent care service at Chorley Hospital. In order to staff this, all ENPs (10.21 WTE) were transferred from RPH to deliver an urgent care service at Chorley Hospital.

The service at Chorley Hospital was open 08:00hrs -22:00 hrs. (last attendance 20:00hrs) and was staffed with ENPs (minimum of 2 throughout core opening hours) GPs (2), one junior doctor and one consultant (one shift 9 hours Monday - Friday). The consultant, associate specialist and junior were left in place following introduction of the new UC service.

August 2016

Chorley A&E was due to reopen in August 2016. However, on **3rd August 2016** the Trust announced that the department would remain closed until “at least next year” (likely April 2017) due to “unacceptable safety risks”.

On **5th August 2016** the Trust called for an independent review of its decision not to reopen the Emergency Department. This independent review was commissioned by NHS England. Site visits were made by NHS England on **22nd and 23rd August 2016**.

September 2016

In September 2016 Lancashire County Council’s Health Scrutiny Committee published a report which made ten recommendations regarding the closure of Chorley Hospital A&E.

October 2016

On **4th October 2016** NHS England published the independent report, which stated that Chorley A&E should reopen on a part-time basis (8am to 8pm) in January 2017.

January 2017

On **18th January 2017** Chorley Hospital A&E department was reopened as an Emergency Department on a temporary basis, opening for 14 hours a day (08:00 – 22:00hrs) and running alongside a 24-Hour urgent care centre(s) located at both Chorley Hospital and Royal Preston Hospital.

November 2018

The service and staffing model implemented at Chorley Hospital in January 2017 is currently still in place.
