Improving Hospital Services and Clinical Outcomes in Central Lancashire

Our Model of Care

Title	Improving Hospital Services and Clinical Outcomes in Central Lancashire: Our Model of Care
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Foreword

It's time to make a change

It has been accepted by all partners in Central Lancashire that local health and care services need to change. Changes are needed to deliver our local communities the best possible patient experience that they deserve as local citizens and taxpayers.

Building these changes will require us to think in truly transformational and radical terms. Being truly transformational means establishing a culture which both seeks to prevent ill health as well as manage complex conditions - responding at pace and scale to the significant shortages of workforce we experience across primary, community, and hospital care settings.

Thinking radically will mean changing our approach to and our philosophy of providing care. We will need to develop joined-up care, built around the individual needs of people. We need to move us away from responding reactively to the growing needs of our population and thinking which is only based in terms of existing organizational set ups and budgets, to one which is proactive and formed on the belief that the system must act as one to deliver truly integrated care. Only this approach will help us deliver care which is the best care possible within the resources that we have available.

Clinicians, with input from local communities, and guided by national quality standards, have developed our Model of Care – a compelling clinical vision which responds to the issues identified in the Case for Change. It reflects our continuing ambition to deliver the best clinical outcomes possible, building care around the needs of the patient and local communities, and is in full alignment with the NHS 10 Year Plan and the direction set within our Integrated Care Partnership. At its heart is the view that the best way of delivering change is to be united and unfaltering in working together and being prepared to be honest and transparent at all times with clinicians, patients and the broader public.

Faced with such a complex challenge, delivering success will take time and it will be difficult. When our people can live longer, healthier lives, and when we are successfully tackling the prevailing inequalities between access to care and care outcomes in our population, we will know that we are moving in the right direction.

Where care is needed, success will mean that it is provided closer to home, wherever this is safe and practical. The best care will always need to be delivered in accordance with the standards set out in the NHS Constitution, the best practice evidence available, and the best approach – viewing the patient as a person who has a range of healthcare needs which need to be managed and understood as a whole.

1. Executive Summary

It's time to make a change

The Case for Change explained the central problem that we are trying to solve. Our health system is currently failing to deliver the best possible patient experience and clinical outcomes available to the citizens and taxpayers of Central Lancashire, including the services that are provided by our local hospitals.

We want to do better for our patients. This means delivering this Model of Care at pace and at scale with their best interests at the heart of our thinking at all times.

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

When we described this problem in our Case for Change, we cited **five issues:**

- **Demographics:** We are serving a growing and ageing population which continues to experience inequalities in health status. This is reflected in different clinical outcomes. Our wider system, including the services provided by **our local hospitals, are not set up to best respond to the changing needs that the local population is making of them**. Improvements can also be made by challenging health inequalities and by creating a culture of wellbeing which encourages people to make **healthier lifestyle choices**, taking **more supported responsibility** for their healthcare and understanding the wider determinants of **health status**.

- **Lack of alternatives:** We do not have a comprehensive range of alternative options available to patients, instead of using the urgent and emergency care services provided by our local hospitals at all times. This means that too many patients are using both these services because they **either do not know the best alternatives to use**, or because those alternatives are **not available to them at a time and place to best meet their needs**. This includes making more of these alternatives available in a **community setting**. This lack of effective alternatives for patients to use contributes to the issues of poor patient experience, access, clinical outcomes, and is also creating **additional costs** for healthcare services to be provided.

- **Flow:** We are not delivering effective patient flow in our local hospitals. **Too many people are waiting too long** for their care and too many people are experiencing **delays** in being discharged, either back home or to another place where they will receive further care. Our local hospitals are struggling to balance the requirements of providing urgent and emergency care (including critical care) with the other types of care that they provide, such as day cases and outpatient care.

- **Workforce:** Across our health system, including our local hospitals, we do not have the workforce that we need in **critical staffing areas** and there are **significant shortages**. This problem stretches in to primary care and in other sectors, and more widely in the

NHS. We recognise that we will need an effective workforce strategy which covers the breadth of our health economy.

- **Effective Use of Resources:** As a health system, we are not using the combined resources that we have at our disposal as **efficiently as is possible**. Linked to the new NHS 10-year plan, we can use a neighbourhood care model and the principle of networks to help us deliver more **care closer to home, where this is safe and practical**.

This case for change, which answered the '**why change**' question, was formally approved by Central Lancashire's local NHS clinical commissioning groups' (CCGs') Joint Committee in January 2019. It provided the mandate for the Our Health Our Care programme to start to describe what a local 'model of care' could look like.

This model of care starts to answer the question **"what needs to change,"** based around a central concept which is referred to throughout this document – an integrated health and social care system for Central Lancashire. This means joining up care and services. This concept, and what it means, has been developed clinically and has been informed and improved through the ongoing engagement work with clinicians, patients and the broader public.

Joined up care and services will be provided around needs of the person, at the times they are required, and in the settings where they should be accessed. The concept of joined up care spans the whole health system, including the services provided by our local hospitals. It spans the whole journey of care – from a **culture of health and wellbeing, self-responsibility** and effective preventative healthcare, right through to the specialist interventions provided in our hospitals. Joined up care needs to be a **shared decision** between patient and professional. Joined up care is **tailored** and **personalised,** more **accessible** and **coordinated**, and delivered **closer to home** wherever safe and practical.

As part of the overall approach to delivering better **joined up care**, and as part of our broader opportunity to create an integrated health and social care system which responds to the issues outlined in the Case for Change, this Model of Care describes how services provided by our local hospitals could be better delivered in the future. Improvements to the services provide by our local hospitals will be delivered both by changes that they can make, and how the excess demands placed on them can be reduced by other changes across the health system.

Therefore, the **joined up care** concept is a constant in each of the seven areas of improvement which this Model of Care outlines. All of these areas are integrated with the proposals set out in the NHS Long Term Plan.

1. Creating a **single point of access** and urgent care advice hub.
2. Providing **more responsive urgent care** services.
3. Delivering **better emergency care**.
4. **Optimising** the efficiency of **critical care**.
5. **Separating planned and emergency surgery**.
6. Modernising **outpatient** services.
7. **Improving discharge planning**.

As explained above, the Model of Care applies each of these improvements in to their broader health system context, including the wider possibilities to radically transform care for the better. Each is also explained referring to **"best practice" clinical standards** and what outcomes could be achieved including **improved patient experience**; **reduced waiting times** and **improved access**; and using **new technologies** and **ways of working** to deliver

more and better care closer to home. It uses the end-to-end pathway examples of frailty and chronic obstructive pulmonary disease to show these relationships, also providing the common approach to change which can be used to transform primary care and community services more widely for the benefit of the people who use them. This means that these pathways show how the additional demands placed on the services provided by our local hospitals could be reduced by better prevention and supported self-care, along with the development of alternative service models and options in primary care and community services.

This means that the approach to transforming care outcomes will have significant and far reaching benefits for the people of Central Lancashire. In particular, the proposals set out in his Model of Care will transform service delivery, access, and outcomes for a number of patients' groups, including the **more than 93,000** attenders to our **emergency care** departments each year. Many of these patients could be signposted and supported to receive the same care in a **better, less acute** place.

These and other patient groups will be right to expect the following outcomes by implementing this Model of Care:

- ✓ Their services will be delivered closer to home where this is both safe and practical.
- ✓ They can expect to experience the benefits of new technologies, research, learning and ways of working in the NHS.
- ✓ They will continue to be able to access cost-effective care as taxpayers in line with the standards set out in the NHS Constitution.
- ✓ They will continue to be supported to make the right choices about the best places to receive care and advice, helping them to lead better, more independent lives.
- ✓ They will continue to be supported to make practical choices and lifestyle decisions which will help them use NHS services in a sustainable way.
- ✓ They will continue to have their healthcare services commissioned in ways which are decisively focussed on seeking to reduce health inequalities and improve care outcomes.

Delivering these improvements and these broad-ranging outcomes will be challenging. It will require both the commitment of the individual to lead a healthy lifestyle and the continued support of all of the NHS, local authority and voluntary sector organisations who are working closely together in the Integrated Care Partnership, who are also delivering an ambitious and aligned programme of work, linked to the seven main areas (called strategic platforms). All of these partners remain unmoved and entirely focussed on their overarching ambition of doing what we can to ensure that people in Central Lancashire can **live longer, healthier lives**. Also, that we deliver this ambition with **pace**, at **scale**, and with **urgency**.

The mandate sought from this Model of Care is for the Our Health Our Care programme to develop an **open-minded range of options** which can compare how these improvements could be best delivered for patients and their individual needs as taxpayers and local people. In making this statement, we are clear that some of these options could require the programme to progress from the ongoing listening and engagement work that has taken place with patients and the broader public to a more formal **consultation process**. This is particularly relevant to changes which could be proposed to the services provided by local hospitals amongst the overall improvements to the health system in Central Lancashire.

As described in the Case for Change, any consultation process could only take place once any options had been **rigorously** and **objectively modelled**; subjected to the review of an **independent** Clinical Senate; and also brought together in a **pre-consultation business case.** This would be reviewed by NHS England as the regulator in relation to specific tests which are applied to proposals for what is called "major service change". The right amount of time will be taken to do this work **properly, thoroughly** and **well**. It would also depend on if any option/s determined to be viable would require a consultation process.

The Clinical Senate, as an independent panel of expert clinicians and others drawn from beyond the Central Lancashire health economy would help test the options both against the programme objectives and also how far they would help us to transform care and outcomes, resolving the issues described in the Case for Change.

The Model of Care marks the first step in outlining what can be done. If it accepted by Central Lancashire's local NHS clinical commissioning groups' (CCGs') Joint Committee and the mandate is provided to develop a range of open-minded options, then the next stage will be to try and answer **"how the change can be delivered."**

As this process develops, all of the partners in the Our Health Our Care programme continue to commit to being honest and transparent with patients, staff and clinicians, presenting a true picture of what is happening now, and what changes may need to happen as a result.

In order to tackle the issues described in the Case for Change and provide the best opportunity to implement the improvements shown in this Model of Care, our options will be developed around our programme objectives and guiding principles: being **clinically-led**, **patient-centred** and planning around delivering **sustainable** healthcare in **an integrated health and social care system**.

Using these principles will help us ensure that our options and proposals stand the best chance of success for our people. It's time to resolve the issues in the Case for Change – **it's time for change**.

Document Approach:

This document is structured into different sections, as described on the contents' pages. This navigation section seeks to explain the skeleton of the document and how it fits together into an overall Model of Care.

As a summary, the Model of Care seeks to deliver three main requirements.

1. A clinically-led vision for the future, which responds to the issues raised in the Case for Change.
2. Clear evidence of how the involvement and engagement of clinicians, patients and the broader public have helped to inform, refine and improve the Model of Care developed.
3. Linked to the proposals and clinical standards around the Model of Care, how will it be possible to develop and test a range of options or care scenarios to which it could be applied.

Introduction Section:

Linked to the above three points, Section 2 (Introduction) starts with a description around what is a Model of Care, how this Model of Care links to the vision and ethos of the broader Our Health Our Care programme, and how it relates to the plans of the Integrated Care Partnership and the local response to the NHS Long-Term Plan. In this sense, the opening section of the document seeks to place the document into its strategic context.

This means that this Model of Care does not sit in isolation, but instead sits within a constantly changing health and social care landscape, where all providers of health and social care services are trying to respond in an agile way to the changing demands of the people who use their services.

After making these points, the document begins to explain why the issues identified in the Case for Change, and therefore the starting point for the Model of Care, do not commence at the front door of local hospitals. Instead, they are a symptom of a wider health service which is struggling to cope with the demands placed upon it, including the wider determinants of health status including health behaviours, socio-economic factors, and built environment factors. This is important because if a Model of Care does not recognise the wider context within which it operates, then the clinically-led ideas it identifies are unlikely to be cognizant of the broader opportunities to transform health outcomes across the whole health economy, by thinking as one in the provision of joined up (or integrated) care.

Following on from this point Section 2 continues to describe the different parts of our current health system, how they are set up and organised, and builds on the information presented in the Case for Change. It also describes how the concept of "joined up care," as part of an integrated health and social care system, may start to support a rounded and coherent strategic framework within which the specific improvements to the services provided by local hospitals and a common transformation methodology could be applied. This allows the document to describe what breadth of impact could be achieved from the Model of Care, looking right across the care spectrum and the range of conditions (chronic, long-term, specialist and others) which patients can often seek support for.

Engagement Section:

The engagement section starts Section 3. This section precedes the discussion of the main proposals for the Model of Care because it seeks to set out how the vision for the

programme, the principles and objectives have all been influenced, refined and improved through a process of co-design with patients and the public. It also proceeds to describe the approach and methodology for seeking the clinical engagement in to the design principles for the Model of Care and the improvement areas identified.

This section describes the methods by which public engagement has taken place, how this work will continue in concurrence with the design of the programme and the development of options and equivalent narrative relating to clinical design.

In terms of what is important to patients and others in terms of the Model of Care, it summarises the learning and feedback described in Appendix A at both a strategic and a more operational level. Strategic issues include patients seeking better access, coordination and equity of care. Operational issues include improvements to the design, set up and configuration of facilities where patients use services provided by the hospital – these include points such as waiting environments, information provided, and how patients want to be treated by those who care for them. A similar overview commentary is provided relating to clinicians and workforce.

The other side of engagement is the interface with key influential documents and reference points of best practice. For this reason, the engagement section concludes with details of which documents have been reviewed and consulted in detail to frame and support the clinical development of the improvements suggested.

Model of Care section:

The Model of Care section commences in section 4. It starts from the “building blocks” set up from the introduction and engagement sections and is established within the context, flow and key messaging set out in the Executive Summary of the document. The section commences with a brief section outlining some of the key challenges established from the Case for Change and how this longer section is set out.

This is achieved by first setting out the seven key ideas within the Model of Care and how they relate to the broader operational and delivery context within which the services provided by hospitals operate. An infographic diagram helps to show the relationship between each idea; the enablers; the care settings to which they directly apply; the broader health goals and reference points in the Case for Change which they influence; and, in total, how they contribute to the vision of delivering an integrated health and social care system for Central Lancashire. Or in short, how individual steps towards delivering more joined up care, each contribute towards our ambition for improvement and transforming care outcomes.

Each of the seven ideas is then explained in turn, with reference to what is included, why it is included, and the relevant clinical evidence base. This includes, where relevant, the service design features, and how the service would best manage the types of patient care which it would be responsible for. Each idea has a specific summary of what outcomes and benefits would be sought after by implementing it.

After each of the seven ideas has been described and the broader operational context and whole system transformation opportunity has been outlined, they are applied to the frailty and chronic obstructive pulmonary disease (COPD) pathways. These pathways have been chosen as examples of how the ideas, when applied in the broader service redesign context,

could transform the care and care outcomes for people affected by specific medical, chronic and long-term conditions. These pathways also provide evidence around how existing pilots can be refined, improved and expanded to deliver a more substantive impact for patient care. In summary, the pathways represent “blueprints.”

These “blueprint” pathways show how changes to the services provided by local hospitals can both be enabled and can indeed trigger wider improvements on a whole pathway basis with greater impact on patient outcomes beyond the care solely provided in a local hospital setting. Whole-pathway improvements, based on the principle of delivering more and better joined up care, can start to address and resolve the issues identified in the Case for Change. They can also set the framework for understanding which care scenarios, as developed in the options generation stage, provide the best chance of realizing these improvements at pace and at scale for these pathways and others which will be developed according to similar operating principles. These blueprint pathways also show the concept of partnership working coming to life – how each constituent partner in the Our Health Our Care programme can work and collaborate to magnify the benefits for people using these health services, including the preventative component.

Conclusion and Appendices:

The conclusion section briefly draws the Model of Care to a close, re-emphasising the central points made both in the Executive Summary and evidenced in the other sections. The document concludes with four technical appendices linked to the main purposes of the Model of Care.

Firstly, Appendix A – which is a detailed engagement log of contacts, demonstrating the stakeholder interfaces in more detail. Second – Appendix B which is called “Clinical standards that will underpin the redesign of services. Appendix C – Service Co-Dependency framework which describes which clinical services need to be co-located together or in close adjacency on a hospital site. Appendix D gives details of existing improvement initiatives underway at Lancashire Teaching Hospitals. These four appendices are more technically orientated and should be read in conjunction with the constituent sections of the main Model of Care document.

2. Introduction

This Model of Care focusses on how we can deliver sustainable hospital services in the future and what enabling changes will be required across the whole care pathway in Central Lancashire to deliver this. They are based around the principle of delivering joined up or integrated care with partners coming together to deliver better care for the benefit of patients.

This Model of Care will be used to develop open-minded options for change which are clinically-led, patient-centred and focus on dealing with the issues addressed in the Case for Change.

2.1: Our Model of Care

The Model of Care sets out a clear, clinically-led vision to protect and improve the NHS services which our patients rightly care about in Central Lancashire. It is based around the principle of delivering better, joined up (or integrated) care which will provide the best opportunity for the services provided by our local hospitals to improve for the benefit of the people who use them.

The Model of Care has been developed in relation to the acute sustainability ('in hospital care') element of the Our Health Our Care (OHOC) programme. It is based on the rich learning and engagement that the programme has undertaken with the public, clinicians and wider stakeholders and creates an exciting and compelling agenda for action, which seeks to resolve the issues identified in the Case for Change.

Our aim for the population of Chorley, South Ribble and Greater Preston is for them to be supported to stay healthy, but where care is needed, for them to receive this joined up care. By this we mean where a person's care needs are co-ordinated, their support and interventions are connected, and their pathways of care are seamless. For the professionals delivering this care, their contributions are co-ordinated, regulated for quality, and measured against performance and quality standards.

The aim of providing joined up or Integrated Care is to put patients at the heart of what we do and in doing so, avoid duplication and unwarranted clinical variation.

2.2: Our Vision and OHOC Ethos

The OHOC programme has a central delivery ethos – our number one priority always remains simple and crystal-clear – taking the right actions now which will transform patient experience and clinical outcomes. All of the lead partners in the Our Health Our Care programme are united in delivering this common purpose for the future. The lead partners are Chorley and South Ribble and Greater Preston Clinical Commissioning Groups, Lancashire Teaching Hospitals NHS Foundation Trust; Lancashire Care NHS Foundation

Trust; Lancashire County Council, working closely with the district councils in Central Lancashire; and the specialised commissioning directorate in NHS England.

2.3: What is a Model of Care?

The Model of Care is a clinical vision. It does not attempt to describe specifically where services should be provided in the future, beyond the setting, such as in primary care (or out of hospital) as opposed to secondary care (or in hospital). This work is the mandate which the Model of Care seeks – the ability to develop an open-minded, wide range of possible options for how the clinical vision could be delivered with pace, energy and urgency for patient benefit. Were these options to propose radical (or major) service change, then this document would be used to support a formal consultation process.

This would only occur after regulator approval of a pre-consultation business case and a review from an independent clinical body, the Clinical Senate.

2.4: Where does this Model of Care sit in relation to the other changes taking place in terms of local health services?

It is important to signal that the Model of Care in the OHOC programme does not sit in isolation or within a health system which is standing still. Health and care services are subject to often constant, complex changes, linked to the availability of new technologies, treatments and more effective ways of delivering services over time. Health and care services will always seek to respond to the requirements of individuals, families and population groups as they change, constantly becoming more effective, personalised and responsive to the needs of the people who use them. It is important that where possible patients are aware of these changes and their role in being involved and engaged around how these changes can take place with their views in mind.

Often these changes take place informally, but where the changes could trigger what is called “major service change,” a more formal consultation process could be required. For the OHOC acute sustainability programme we will not know whether consultation is required until options are developed (how may we deliver the changes we need to). Before options can be developed this process starts with a Case for Change (or the reasons why changes are needed), and then creates a Model of Care which is a clinical vision (what are we aiming to achieve). In this light it is different from the requirements of out of hospital and prevention workstreams in OHOC.

2.5: What is the Model of Care part of – is there a “master plan?”

In this constantly changing landscape, it can be difficult for people to understand and interact with the “master plan,” or, in other words, how do all of these different plans come together in to a central strategy or set of ideas which seek to deliver large-scale change for patient benefit.

In Central Lancashire, the Integrated Care Partnership (or ICP) has been developed to oversee the bigger changes needed to deliver health service reform and locally interpret key policy documents, such as the NHS 10 Year Plan. The ICP is part of the Integrated Care System for the Lancashire and South Cumbria geographical region. Regionally, the

Lancashire and South Cumbria Integrated Care System, covers five local areas and a population of 1.7 million. The partner organisations working together to achieve integration include eight CCGs, five Acute and Community Trusts and four upper tier Councils.

The ICP has a transformational change programme of which there are seven strategic platforms, know together as the OHOC Programme. The acute sustainability programme is one of what is called the "seven big strategic platforms." This is shown in Figure 1 below.

Figure 1: Seven Strategic Platforms

2.6: What does the Master Plan mean for our Model of Care – how does it fit in?

What does this mean for patients and what does it specifically mean for the Model of Care developed by the acute sustainability platform in the OHOC programme?

In short, this means that whilst the acute sustainability programme in OHOC focusses on the changes needed to deliver better hospital services for patients, it is only one part of a bigger and brighter aim. This bigger and brighter aim looks at transforming services and clinical outcomes for local people. All of the programmes within OHOC will come together with a coherent plan - this will help us to develop our contribution to the integrated health and social care system that sits in the heart of this Model of Care.

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

WHINs for short. These come together under the broader Integrated Care Strategy and the development of the Integrated Care Partnership. Before the establishment of the ICP in 2018, we had three workstreams within OHOC: Early Intervention and Prevention; Locality based care; and Hospital care. All the thinking, design and engagement from this work has continued as part of the WHINs platform or the Acute sustainability platform.

Therefore, this Model of Care refers to the changes to be considered across the wider health economy. In addition to the changes to how the hospital system works for patients, to deliver the clinical vision, these changes will also be required to help hospital services providing specialist care to deliver successfully. Together, this will help us to achieve what is called "end to end" transformation across the whole health economy.

Taking this approach and way of thinking towards the development of the integrated health and social care system will be an essential part of solving the issues raised in our Case for Change.

2.7: Why does this Model of Care not start off by talking about Lancashire Teaching Hospitals?

As the Case for Change stressed and the previous section discussed, the issues faced by our hospitals do not start at their front door. They are a symptom of a wider health service which is struggling to cope with the demands placed upon it, and one which is not set up in the best way to meet need based on the limited resource available to use.

When we are thinking about health services in their widest sense, it is also important to remember that only 20% of a populations' health can be attributed to the clinical care they receive. Therefore, in order to improve health status and reduce health inequalities the wider factors that influence health also need to be addressed. This is outlined in Figure 2 below.

Figure 2: Determinants of health status

Health Behaviours 30%	Socio-economic Factors 40%	Clinical Care 20%	Built environment 10%
Smoking 10%	Education 10%	Access to Care 10%	Environmental Quality 5%
Diet/Exercise 10%	Employment 10%	Quality of care 10%	Built Environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/Social Support 5%		
	Community Safety 5%		

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

This means two key things. Firstly, we need to develop an integrated health and care service locally with a culture which promotes personal responsibility for health and wellness, integration and joined-up thinking in the right way. This will create the best possible environment in which patients can receive the best care from our hospitals relating to the 20% (access to care and quality of care components).

The lack of an integrated health and care system which promotes a culture of personal responsibility and wellness, integration and joined up thinking, leads to the following detrimental effects:

- Patients do not always have the information and support to make the optimal choice for them, including where to seek support and knowing what options are available, closer to home.
- This can lead to too many patients attending hospital when they do not need to. This contributes to the issues in terms of poor patient experience, access and clinical outcomes.
- As the alternative options to using hospital services are not sufficiently available, accessible and comprehensive, the settings where patients do access care can create excess costs of providing that support.

Each of the above detrimental effects mean that, when patients do use hospital services, and in particular unplanned (or urgent and emergency care) services, local hospitals struggle to deliver effective "flow" and make available the workforce and support services needed to cater for the patient needs that they need to.

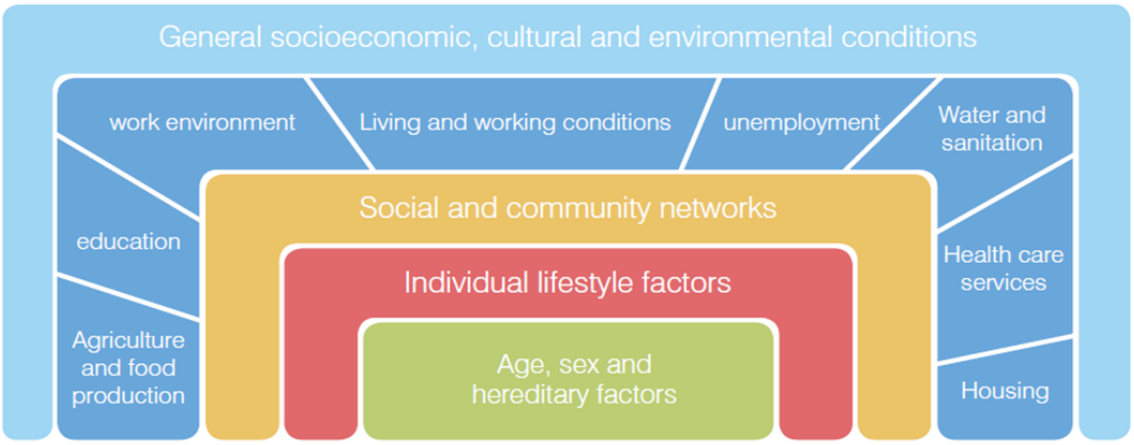
This means that whilst the focus of this Model of Care is on improving hospital services and making them work better for patients, in terms of realising all of the benefits, it will be necessary for changes across the care pathway to also take place, working towards the common aim of an integrated health and social care system for Central Lancashire.

This is what the vision outlined in this Model of Care seeks to achieve. By setting up and redesigning services which place the patient at the heart of what is done, and how care is delivered we can help deliver the contribution necessary from our hospital services to our wider system aim.

When thinking about how the contribution of transformed hospital services will sit alongside and support the transformation of other sectors, working to the common aim, an effective approach will consider the determinants of health (Figure 3) – see next page.

All of these determinants of health impact on the lives of people within Central Lancashire neighbourhoods and communities. This will require an approach of "health in all policies." It also requires effective partnership working so that organisations work collaboratively for the benefit of communities and are not restricted by organisational barriers.

Figure 3: The Determinants of Health (1991) Dahlgren and Whitehead1

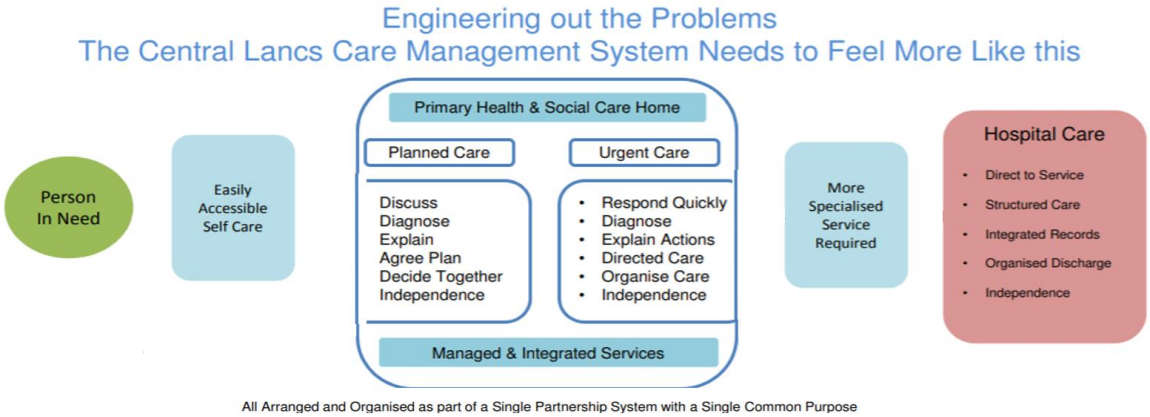


2.8: The big idea in our Model of Care – an integrated health and social care system

Linked to an understanding of the determinants of health and health status, the aim for an integrated health and social care system spans prevention and place-based care right through to the specialist care provided in hospitals. This will be explained more in terms of the conical diagram in this section. It includes the services, within the health structures, from those which are delivered in localities and neighbourhoods to those which are planned on behalf of the integrated care system.

We are trying to be part of a change programme which fundamentally rethinks how care is provided, coordinated, focussed and ultimately delivered to deliver the best possible clinical outcomes for the benefits of patients. Figure 4 shows what we mean by this:

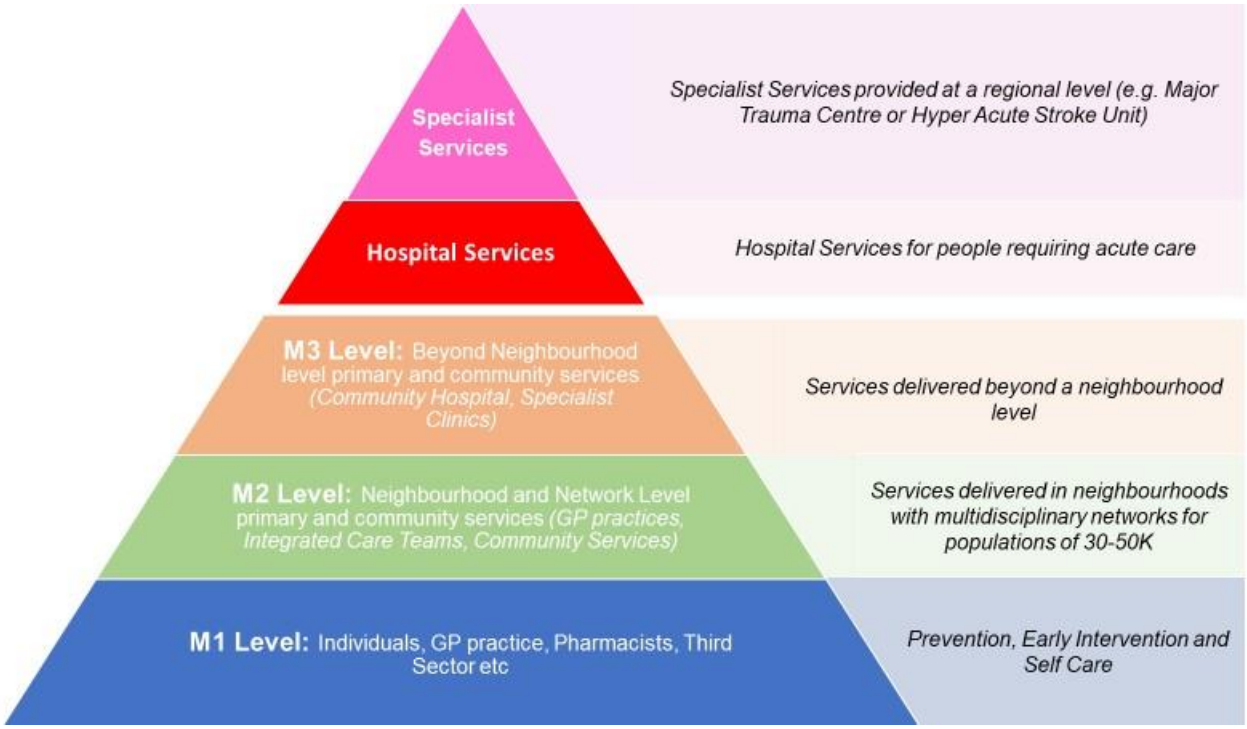
Figure 4: Central Lancashire Care Management System



[1] Dahlgren G, Whitehead M. 1991. Policies and Strategies to Promote Social Equity in Health. Stockholm, Sweden: Institute for Futures Studies.

To start to understand how services can move to the model described above, we must understand how services are currently provided now. Figure 5 helps to show the relationship between the care provided in different parts of our health system – it is called a "conical" diagram.

Figure 5: Care conical: Different parts of our health system



The conical diagram shows how care is provided at different levels, based on how many patients the service looks after. It shows how the health services "start" close to home. The conical represents how fewer, but more specialist services and episodes of care are provided as you rise up the diagram from the lowest (M1) level in the blue area, to the highest "hospital" in the red and pink colours. In general terms, more complex care is delivered higher up the conical, which tends to be costlier and use more of the CCGs available financial resources. Also, in general terms, the higher up the conical the care is provided, the further away the service is provided from the patient's home.

This short section now seeks to explain what the conical means, and its importance to setting the plan and wider context for the "in hospital" Model of Care. A more detailed explanation of this approach to modelling and delivering care can be found within the CCGs Out of Hospital Strategy.

M1 Micro Level

The first level is "M1" which stands for micro. This is how the most "upstream" care is provided to patients – in short, services and infrastructure which focus on keeping patients well, encouraging people to make health lifestyle choices and to take supported personal responsibility for their own health. Examples of these types of choices include eating well; taking part in regular physical exercise; avoiding harmful behaviours such as smoking, drinking too much alcohol and using illegal substances; and engaging in community and family life to support positive physical, mental and social wellbeing.

This level includes core GP services provided by individual practices to keep patients well and healthy; but also includes the care that patients can provide for themselves, when they fall unwell, through the advice and information available to them through the trusted sources of information that they can use, such as NHS choices and the NHS 111 service. A simple example of this may be where a patient visits a local pharmacy to purchase medicine for a heavy and persistent cough and they feel comfortable in knowing how to take and use the medicine and know what to do if their symptoms do not improve over time.

This level also includes the facilities, environmental and other services that the partners of the OHOC programme contribute to and lead on to deliver healthy communities. We understand that good health starts at an early age, that the experiences of our young influence our resilience and outcomes in future life. Simple examples of this type of service include the role that local authorities play in creating green spaces and safe community environments, effective schooling, and also how they make space for local businesses and voluntary organisations to thrive who promote healthy lifestyles and behaviours.

The local NHS in Central Lancashire will be able to make a significant contribution to the development of healthy and sustainable built and natural environments by adopting an approach of healthy place making. This is outlined in *Putting Health into Place Introducing NHS England's Healthy New Towns programme*[2](NHS England). The local NHS will be able to engage with planners and public health to influence planning policy so that the built and natural environment developed across Central Lancashire improve health and wellbeing and reduces health inequalities (E.G Whnydyke Garden Village NHS Healthy New Town, Fylde).

This level also includes the role of public health who, for instance, provide screening programmes to protect local populations from serious conditions to which they would otherwise be vulnerable.

Many of these services and the impact that they have on supporting healthy lives go on in the background. They are not always immediately obvious to patients, or what people will describe as being the start of the health service. However, if any of these services were not to be in place, then they could ultimately be the cause of ill health and require intervention and treatment at higher levels of the conical.

M2 Meso Level

The second level – M2 (meso) of the conical diagram refers to neighbourhood and network level care.

Networks of GPs will work together on a locality basis to support populations of 30-50,000 people. These networks will often relate to a group of smaller areas (such as wards, small villages, or groups of practices) and they provide a sensible unit size for planning and delivering health services. Individual practices work together to provide and manage these types of care on a scale which makes sense in terms of the demands placed on staff and services but always make sure that as many of these services are accessible to patients as close as possible to their home.

Neighbourhoods may contain a number of these networks and other providers of care. Working in this manner, patients will have access to a wide range of services which seek to keep patients well and supported to live healthy lives. They are provided in a community environment and aim to avoid patients being referred to hospital unnecessarily. Most of this

[2] https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/

care is planned, as opposed to unplanned. This means that patients can be referred or self-refer to the service, usually with an appointment being made.

In terms of mental health 1 in 4 people in the UK will experience a mental health problem each year. Self-referral to a wellbeing service offering a range of free psychological therapies to people aged 16 and over (Improving Access to Psychological Therapies service (IAPT) enables patients to easily access a range of brief therapeutic interventions, including courses & workshops, online programmes and face to face therapy, across our localities to support people's differing emotional needs.

Examples of other types of services and the professionals included in neighbourhoods include nursing teams (those who visit patients in their own homes), Allied Health Professionals, such as Occupational Therapists who seek to maintain patients' independence, and Physiotherapists who seek to support patients to keep active and mobile. Other members of neighbourhoods will include community mental health provision, Dieticians, and health advisors.

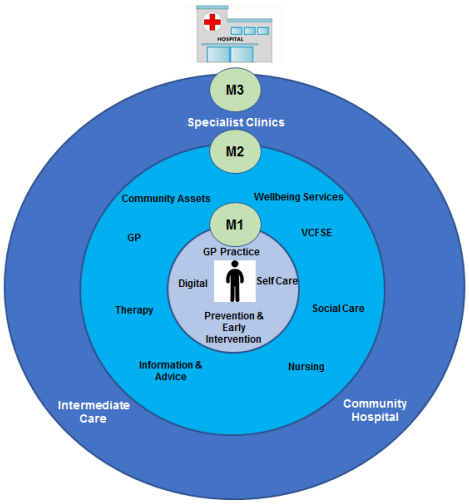
M3 – Macro Level

Where it is not practical or cost effective to provide care at the M1 or M2 level, then the third level of the conical comes in to play. This is known as M3 or macro. It describes the same types of community services which are planned to be delivered outside of hospital, but not always in each neighbourhood team. This can include, for instance, specialist nursing and can also include sub-acute services such as minor injury units or walk-in centres. This can mean that either one service is available to the entire local community, or in some instances more than one, but not one per integrated care team. The hospital services themselves sit outside of the M1, M2, M3 structure.

The neighbourhood care model

Figure 6 shows this differently in terms of the constituent parts and services provided at each of the three levels of care, M1, M2 and M3 and how they come together as part of an overall care model. Some of this is provided now, more is needed for the future.

Figure 6: The Wellbeing and Health in Integrated Neighbourhoods vision



This diagram shows how services in higher levels are provided further away from the patient.

The patient is in the centre of the diagram because all care is planned, coordinated, and ultimately delivered in response to their current, future and projected health needs.

This diagram also starts to show some of the enablers to delivering care closer to home, such as better information and advice, digital services/access, and better community services structures.

2.9: What does the clinical vision in this Model of Care need to help us to do?

We can understand the following simple facts from looking at these diagrams and the current set up around what we need to change through implementing this Model of Care, with respect to improving hospital services and patient care.

The changes will need to start at the front-end of the patient pathway. As described above, these are the parts of the pathway which are involved before the patient needs to attend hospital.

Each of these changes will be necessary because they will help us to create the space needed to deliver better care in hospitals in the future.

- **A Culture of Prevention and Early Intervention:** This will be enabled by improving what can be done to prevent the unnecessary use of expensive hospital services – including improved access to information and support for patients, the role of health advisors through Social Prescribing, which enables vulnerable and high intensity user patients to make the right choices in terms of when and how to seek care, and creating a culture and community atmosphere in Central Lancashire which promotes a sense of wellbeing and supported self-responsibility.

- **Primary Care Transformation:** We will achieve this by taking a close look at how care closer to home can happen, in tandem with the changes proposed to hospital services, using the other parts of the OHOC programme as described earlier in this section. This includes developing the workforce available in primary care; ensuring the best use of technology and digital integration; making the most effective use of the estate or assets available in primary care; being realistic as to what can safely and practically be delivered out of hospital; respecting patient choice and preference as is safe and practical; and using the planning concepts of networks to best effect.

- **More Care Closer to Home:** For our patients to receive care in the right space, with the right facilities and the most appropriate workforce available, more service provision will need to be offered at the M1, M2 and M3 levels. This will also allow better access to hospital services to deal when patients really need them.

Taken together, this means that as we start to look at the detailed clinical vision for how our hospital services will look in the future, we will need to contextualise this thinking in terms of how specific pathways will be transformed on an “end to end” basis (i.e. right from prevention and M1 to through the specialist, complex care provided in hospitals) ultimately improving patient care.

2.10: How can we show what this means in reality?

By way of example, the plans shown in this Model of Care will be described fully by using two pathways (Frailty pathway and the management of patients with Chronic Obstructive Pulmonary Disease - COPD), a serious respiratory illness) in some detail. They will show how our clinical vision will be developed in reality, based on this “end to end” transformation approach.

However, the impact of this Model of Care will be much wider than these two pathways. It will impact and transform the outcomes of all the following (and other) patient groups:

In 2017/2018:

- **Patients requiring emergency care: There were 93,774 attendances across the two Emergency Departments** (Royal Preston Hospital and Chorley District Hospital), made by 66,444 individual patients.

Each of these attendances (and the patients care they reflect) would benefit from improved access to Emergency and Urgent Care, improved environment, input from senior decision makers and improved patient flow from the proposals outlined in this Model of Care.

- **Patients requiring emergency hospital admission due to a fall: There were 5,146 Emergency hospital admissions due to falls in people aged 65 and over in Central Lancashire.[3]**

Patients would benefit from integrated working between primary care, community care, social care and hospital-based teams. It is more likely that patients at risk of falling are identified and supported appropriately at home or in community settings.

- **Patients with COPD: 8,810 people in Greater Preston, Chorley & South Ribble were living with COPD**, which equates to more than 2% of our local population.[4]

All of these patients would benefit from integrated working between primary care, community care, social care and hospital-based teams. Greater use of technology could also improve patient experience with for example mobile apps for COPD empowering individuals to take the right steps to help increase their wellbeing and reduce exacerbations.

- **Patients suffering from depression and other mental health conditions: 12% of all over 18-year olds are recorded to have suffered with Depression. This is more than 39,000 people across Central Lancashire.[5]**

These patients would benefit from a more integrated workforce who can recognise when someone is struggling with the mental health, even if enquiring about a physical health condition. Additionally, by providing more care closer to home, patients who need support will not always have to wait until crisis point to access urgent or emergency care but could instead access community facilities when they need them most. Access to IAPT services and lower intensity mental health approaches will support patients during difficult times manage their conditions without escalation to crisis.

For these and other types of mental health conditions, the set-up of Mental Health Decision Units (MHDU) provide the appropriate environment and expertise for the patient's need. There are multiple benefits of the patient accessing this environment rather than an acute service which can often further exacerbate the mental health condition and can result in very

[3] https://fingertips.phe.org.uk/search/falls#page/0/gid/1/pat/6/par/E12000002/ati/101/are/E07000123/iid/22401/age/27/sex/4

[4] https://fingertips.phe.org.uk/search/COPD#page/3/gid/1/pat/46/par/E39000040/ati/152/are/E38000034/iid/253/age/1/sex/4

[5] https://fingertips.phe.org.uk/search/depression#page/3/gid/1/pat/46/par/E39000040/ati/152/are/E38000034/iid/848/age/168/sex/4

poor patient experience. Patients suffering an acute mental health episode can often suffer from spending too long waiting in the wrong environments. Our proposed partnership working approach can help to change this for the better.

Mental health presentations can also account for at least 20% of primary care attendances. For patients requiring support but not in crisis the Urgent Care Service will have 24/7 direct access to the psychiatric liaison team. Local psychiatric liaison teams called Rapid Assessment, Interface and Discharge teams (RAID) will be responsible for ensuring consistent levels of cover for the Urgent Care Service described in the Model of Care.

- **Patients with Diabetes: More than 21,000 people living across Central Lancashire are living with Type 2 Diabetes[6]**.

These patients in particular, alongside those affected by long-term conditions would benefit from the greater focus indicated around prevention and early intervention, also our concept of wrapping care around a patient's needs, and how we can support our populations to make the right lifestyle choices and lead healthier lives.

- **Patients with Cancer: 11,474 people in Central Lancashire were affected by Cancer[7]**.

These patients would benefit from integrated working between primary care, community care, social care and hospital-based teams, ensuring that the patient accesses the appropriate service when required. People suffering with cancer should be able to access the right skills and experience in their local communities, and only need to access acute services in an emergency. We can make sure that we look after the whole person, not just the person's cancer care.

- **Patients with Musculoskeletal (MSK) conditions: More than one in six of our adult population suffer with a Musculoskeletal (MSK) condition.[8]**

Patients would benefit from integrated working between primary care, community care, social care and hospital-based teams, ensuring that the patient accesses the appropriate service when required. People suffering with an MSK condition should be able to access the right skills and experience in their local communities, and only need to access acute services in an emergency.

- **Patients affected by Stroke: 7,641[9] people in Central Lancashire have been affected by Stroke.**

Patients would benefit by resources being used in the right way across the locality. By reducing unnecessary demand on hospital services, people requiring specialist support at a time of need should be able to access highly specialised acute care, whilst then being able

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[6] https://fingertips.phe.org.uk/profile/diabetes-ft/data#page/0/gid/1938133138/pat/46/par/E39000040/ati/152/are/E38000014/iid/241/age/187/sex/4

[7] https://fingertips.phe.org.uk/search/cancer#page/3/gid/1/pat/46/par/E39000040/ati/152/are/E38000034/iid/276/age/1/sex/4

[8] https://fingertips.phe.org.uk/profile/msk/data#page/3/gid/1938133186/pat/6/par/E12000002/ati/101/are/E07000123/iid/93377/age/168/sex/4

[9] https://fingertips.phe.org.uk/search/stroke#page/3/gid/1/pat/46/par/E39000040/ati/152/are/E38000034/iid/212/age/1/sex/4

to manage their follow up care in the community with the support of multidisciplinary networks.

2.11: How can we enable these changes across the health economy?

Throughout the end to end pathway examples (COPD & Frailty), you will the principle of delivering better joined up shine through and also how this relates to the issues described in the Case for Change. Alongside developing a culture of prevention and wellbeing, primary care transformation and more care closer to home, these principles set the right strategic framework for how we will work together to redesign care, both helping and requiring our hospitals to work better for the people they serve.

These principles also apply to each of the different types of care which hospitals provide, specifically and including:

- Outpatient care.
- Planned (or elective) care.
- Non-elective care (including urgent and emergency care).

Our Model of Care is based around the central governing idea of creating an integrated health and social care system, will also apply to how we will enable these changes to happen. This includes looking at themes such as:

- Workforce transformation (for instance new roles and ways of delivering services through integrated teams and multi-disciplinary working approaches).
- Digital transformation and integration (for instance the seamless sharing of records across care boundaries and the role of tele-health, telephone or app-based care as an alternative/support to traditional service models).
- Estate transformation (using the buildings, assets and facilities we have to best effect, right across the health economy.
- Use of new service models, strategies, the ability to move resources to the right place, and what can be achieved through the continued engagement and involvement of patients in service planning, design and improvement.

For clarity, the clinical vision outlined in this Model of Care aligns with:

- The relevant clinical standards and co-dependencies set out in the technical documents attached to this Model of Care.
- The principles outlined in the CCG out of hospital and broader primary care. transformation strategies.
- The intentions and direction being developed through the integrated care programme.
- The policy mandate set out in the NHS 10 Year Plan.

Beyond these “end to end” pathways, the Model of Care sets out the ideas and proposals which will be used to transform all services provided via the planned and urgent and emergency care system in our hospital to better improve care for patients. The impact of this change will be significant and vast, enabled by the plans and principles outlined above.

2.12: How will these enabling changes help us to improve the services provided by our local hospitals?

In all, the CCGs Out of Hospital Strategy[10] describes six main supporting areas which are being developed, using the common transformation methodology, to support the principles described in the Model of Care and provide the opportunities to improve the services provided by our hospitals with the best chances of success.

Each of these areas refers to the "Out of Hospital" strategy. As specified earlier in this section, this recognises that to deliver transformational change across a health economy, a whole pathway approach is required. This section describes the work in these areas, and the outcomes expected to be achieved. The creation of a more sustainable health economy, where care is joined up and integrated towards the common purpose of transforming patient outcomes will provide use with the best opportunity to respond to the issues highlighted in the Case for Change.

New Models of Care: Many practices are now starting to work together and are seeing the benefits for themselves, patients and the wider health and care system. Working at scale is not about merging or relinquishing contracts, but about working collaboratively to maximise the benefits of economies of scale, workforce development, resilience and service delivery opportunities.

Expected outcomes:

- Practices working collaboratively on population footprints of 30,000+ in order to maximise the benefits of operating at scale.
- A multidisciplinary workforce encompassing new roles and best practice.
- Delivery of a greater range of services to all patients.
- Services delivered closer to home.
- Maximum utilisation of non-clinical staff to free up clinical time.
- Efficient management of workload through the implementation of the "10 high impact actions."
- Workforce planning across general practice collaboratives.
- Clinical leadership in the collaboratives.
- Rationalisation of back office functions.

Access: The current care system across the two CCGs is unsustainable in its current form. Therefore, fundamental change is required. There is a clear willingness across the central Lancashire health economy to address the challenges outlined below in a proactive way.

Expected outcomes:

- Safe and accessible services for all patients with a focus on: - Children - Population groups - Long term conditions - Frail elderly - Care home and house bound.
- New models of care that offer patients access to GP services seven days a week.
- Services provided in a timely way.
- Patients can easily access the most appropriate care professional for their needs.
- Access to all general practice additional and enhanced services for all patients.
- Provision of support and resources to enable patients to self-care.
- New ways of accessing services through the increased use of technology.
- Co-located general practice, community, social, third sector and some hospital services.

[10] https://www.chorleysouthribbleccg.nhs.uk/download.cfm?doc=docm93jijm4n5999.pdf&ver=11599 (Accessed February 2019)

Integration: Integration of health and care services underpins all future models of service delivery. Recognising the importance of breaking down organisational and professional barriers; to enable a joint focus on patient need, the removal of duplication and delays in patient care.

Expected outcomes:

- Integrated care teams delivering services to populations of approximately 30,000 to 50,000.
- General practice collaborations working alongside acute, community and local authority colleagues to maximise the pivotal role they play in the coordination and continuity of care for patients.
- The removal of organisational barriers, which prevent a joint focus on patient need.
- Co-ordinated care and services for patients who need health and/or social care support in the community.
- Co-ordinated care wrapped around the person and their family/carer.
- Health and care professionals working within multidisciplinary teams to create personalised solutions.
- Rapid intervention to prevent unnecessary hospital admissions.
- Integrated support to ensure safe and timely discharge back in to the community following a hospital stay.
- Focus on 'home first' to enable people to live as independently as possible.

Technology: The CCG is working to deliver a Lancashire wide digital strategy which aims to maximise the use and benefit of technology to support efficient and seamless patient care.

Expected outcomes:

- All of our population will be 'digitally enabled citizens' in relation to their health and care.
- All patients will have the same level of access to online primary care services, such as electronic prescribing, 'real time' appointment books and viewing of their patient records.
- No barriers to patients accessing technologies that will better enable them to manage their own health, care, conditions and treatment.
- Fully interoperable IT systems to allow seamless information sharing between organisations.

Members of the public participating in a range of engagement activity have cited technology as a key issue for them. People said IT and technology are particularly important for:

- Patients to be able to access information about themselves.
- To link the third sector into health and care information systems.

Estates: It is critical that all public sector organisations locally work together to make the most efficient and effective use of their estate and ensure there is sufficient fit for purpose infrastructure to support service delivery in the required locations.

Expected outcomes:

- All public sector estate will be fully utilised to support integrated working.
- The estates will be fit for purpose now and in the future.
- Primary care estates will be 'future proofed' to accommodate population expansion as a result of initiatives such as the Preston City Deal.

All potential avenues of capital and revenue will be exploited to their fullest to help develop the estates – for example:

- Estates, Technology Transformation Programme.
- Community Infrastructure Levy.
- Section 106.
- Public Private Partnership.
- NHS Property Services investment.

Workforce: As we develop new ways of working, we need to maximise the existing workforce and embrace new roles, and ensure working environments are flexible and motivating enough to help recruit and retain staff.

Expected outcomes:

- Locality workforce plans will be in place.
- Primary care careers will be prioritised.
- Training placements within primary care will be increased
- Opportunities will be in place, such as work shadowing, secondments, flexible working to provide career development opportunities for all.
- Clinical skill mix, and the use of new roles will be maximised.
- The use of non-clinical staff will be maximised with the aim of freeing up clinical time.

2.13: How will we be able to secure the workforce changes necessary to deliver this Model of Care – a high level approach

The CCG Out of Hospital strategy and other sections of this document have emphasised the role of enablers. Enablers are key supporting changes or building blocks which will give the opportunity to improve the care delivered by our hospitals the best chance of success. The importance of developing a shared approach to workforce planning, retention and innovation will be one of those key building blocks – this will come together through a workforce strategy.

The reason why this is a key building block is because the NHS nationally spends almost 65% of its operational budget on this most valuable asset and the local picture is not significantly different. Arising from growing demands for healthcare, as described in the Case for Change, almost all clinical professions in the NHS have grown in the last five years; the NHS has over 40,000 more clinicians substantively employed than in 2012, a 7.3% increase[11]. To be successful overall, health and care needs to be organised around

individuals, rather than service or professional silos. We will need to think innovatively, work differently and transform the way healthcare is delivered including how we utilise the available workforce.

Therefore, this section describes how the workforce strategy, linked to the national framework and the local approach being adopted within the clinical commissioning groups will provide the Model of Care with the best chance of being implemented.

In order to deliver more care out of hospital and more joined up care, more workforce resources are required in primary care locations where staff will be supported, trained and developed to make a continuing and vital contribution to the delivery of safe, effective and responsive care. This means more community services staff and general practice staff available to support the concept of care delivered as part of networks, responding to the national policy and funding intent set out in the NHS 10 Year Plan.

[11] Health Education England, *Facing the Facts, Shaping the Future*.

A local workforce strategy will also need to recognise the shortfalls and issues in the some of the specialist staffing areas within the services provided by our local hospitals. As identified in the Case for Change, these shortfalls and issues are, in some respect, a demonstration of the regional picture of supply and vacancies from new training places. They also demonstrate opportunities to improve role design, innovation and staff experience. New professional workforce comes from only three places; new graduates; returning practitioners, or recruitment from elsewhere. This means that the focus of a strategy must centre around each of these, but also making the best use of the existing resources and staffing accessible.

At a national level, the Health Education England publication - *Facing the Facts, Shaping the Future - A draft health and care workforce strategy for England to 2027*[12], identified that there are six main principles associated with the delivery of a successful long-term plan for the recruitment, retention and sustainable supply of key workforce posts in England.

The six principles are:

1. **Securing the supply of staff that the health and care system needs to deliver high quality care in the future.**

Since the NHS began patients have been well served by staff from around the world. However, maximising the self-supply of our workforce is critical. It cannot be right for the NHS to draw staff from other countries in large numbers just because we have failed to plan and invest.

2. **Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff.**

Individual NHS professions have distinct roles but there is scope for more blending of clinical responsibilities between professions. This flexibility is rewarding for staff and can provide the NHS with more choice in how we organise our services.

3. **Providing broad pathways for careers in the NHS, and the opportunity for staff to contribute more, and earn more, by developing their skills and experience.**

Structured career opportunities which enable staff to progress both within and between professions will enhance retention and make the health and care system more resilient and attractive in the face of changing demands from staff.

4. **Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare.**

This enshrines the public duty to provide equal opportunity for all and will ensure the NHS workforce of the future more closely reflects the populations it serves. If delivered successfully it will increase the pool of people available to be recruited into the NHS.

[12] https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts,%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf

5. **Ensuring the NHS and other employers in the system are inclusive modern model employers with flexible working patterns, career structures and rewards.**

These need to support staff and reflect the way people live now and the changing expectations of all the generations who work in the NHS. To retain dedicated staff now and in the future requires employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home life.

6. **Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested.**

This will help ensure the NHS gets the best for patients from all its resources. Aligning service and workforce planning fosters realism alongside creativity in considering what the workforce in all the relevant groups can best contribute to a new or changing service. This will also increase the resilience of workforce planning and ensure the NHS workforce is rightly seen as an enabler of improved services, not as a constraint.

The local interpretation of this national workforce strategy is aligned with a strategy report published earlier in 2015 identifying the opportunities to develop, deliver and oversee an effective healthcare workforce as one of the supporting strands to the Our Health Our Care programme. That report simplified the ideas in to six main ideas for the local health economy workforce strategy, with research in to the strategy picking up the main themes around how this could be achieved, as described in Figures 7 and 8.

Figure 7: Our health economy workforce strategy

Alongside the other enablers to delivering the Model of Care set out in this document, the other important aspect will be around demonstrating how success can be identified, measured and tracked. In this context and linked to the local workforce strategy the success of a collaborative workforce strategy in the longer-term will be measured by:

- Increased recruitment and retention rates across the health economy clinical workforce,

- A reduction in clinical vacancies, and an increase in staff and patient satisfaction across the local health economy,
- Successful implementation of newer models of care (including the one described in this document and the pathways relating to frailty and chronic obstructive pulmonary disease),
- Financial efficiencies within the health economy and,
- Quality improvements across delivered services.

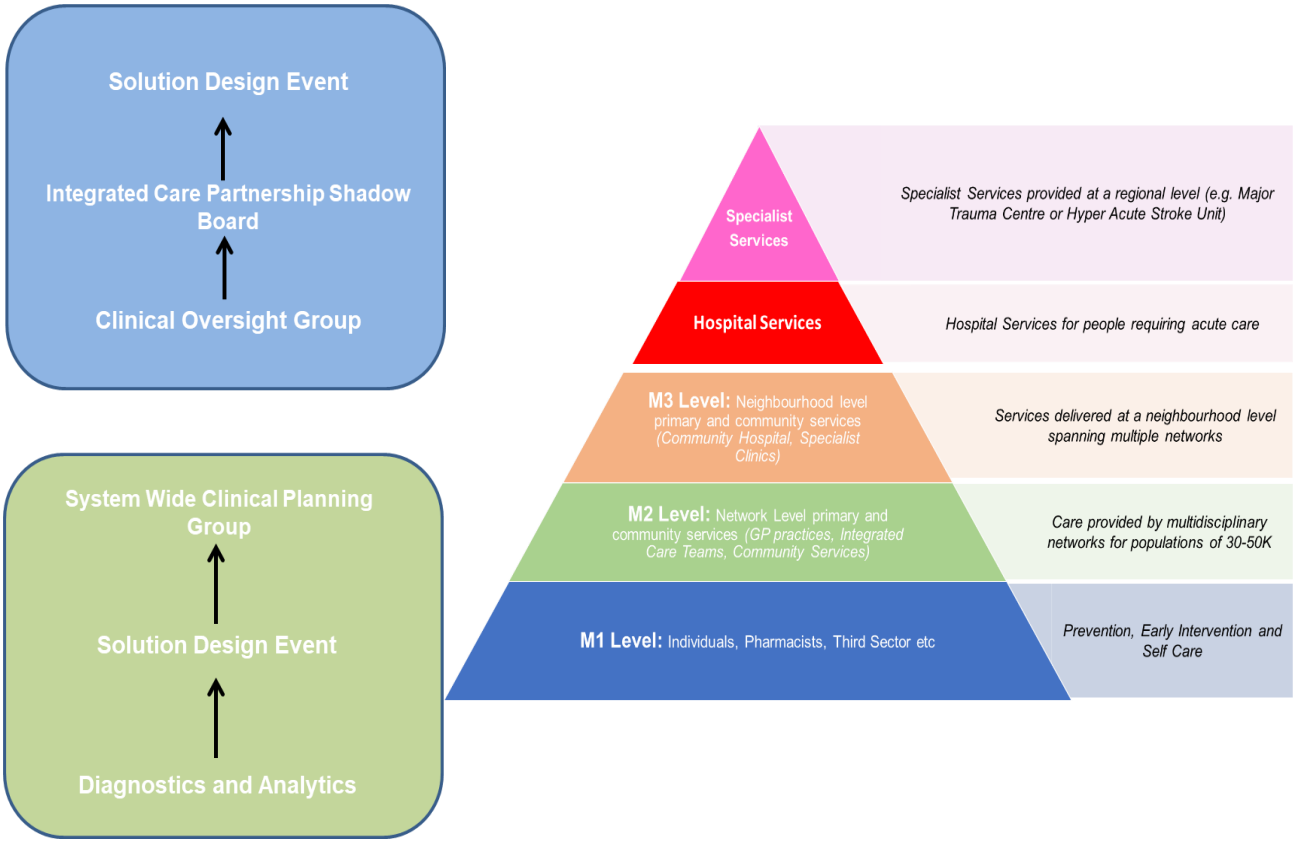
2.14: Our transformation methodology and approach

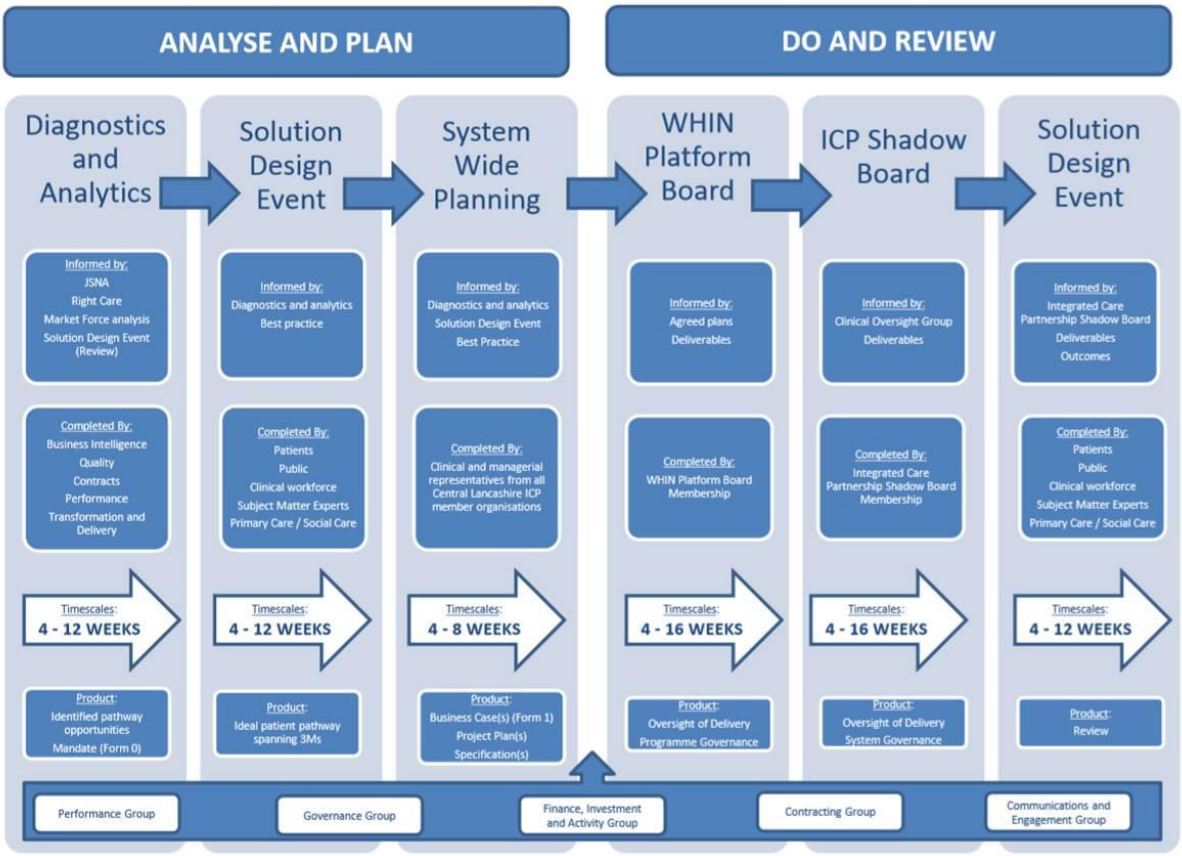
To inform the wider development of Integrated Care, the Wellbeing and Health in Integrated Neighbourhoods (WHINs) platform will follow a methodology of transformation. The process follows a commissioning cycle and identifies the actions required to redesign pathways to include timescales, products, process, governance and resources required.

By systematically approaching pathway development this way, the programme builds up an evidence basis focussing on prevention, early intervention and community-based services.

We will use this as our common approach to change, helping us to implement the Model of Care and the enabling changes which it requires. This will be developed through the options generated at the next stage of the process. The pathway redesign process is shown in Figure 8, on the next page.

Figure 8: Our Methodology and Process of Transformation: Pathway Redesign





As with any methodology of transformation, a clear understanding of outcomes and measurement, as well as the procedural and methodological steps is also important. When it comes to delivering the main outcomes from the Model of Care, it is important to be clear what the main measures are, and how they will be developed, monitored and evaluated.

In terms of this Model of Care, the starting point is the expectations that people make, as taxpayers, citizens and front-line service users of our health services.

Outcomes for patients:

- ✓ Their services will be delivered closer to home where this is both safe and practical.
- ✓ They can expect to experience the benefits of new technologies, research, learning and ways of working in the NHS.
- ✓ They will continue to be able to access cost-effective care as taxpayers in line with the standards set out in the NHS Constitution.
- ✓ They will continue to be supported to make the right choices about the best places to receive care and advice, helping them to lead better, more independent lives.
- ✓ They will continue to be supported to make practical choices and lifestyle decisions which will help them use NHS services in a sustainable way.
- ✓ They will continue to have their healthcare services commissioned in ways which are decisively focussed on seeking to reduce health inequalities and improve care outcomes.

This Model of Care describes a series of clinical standards, which will proscribe detailed means of demonstrating if the right care is being delivered, as well as the practical issues of how this care is being delivered and in what setting.

For each of the care pathways described, in addition to their being examples of these outcomes for patients in action, a further measure would be to develop an analysis between the current state of what is already available, what is available to some patients through local pilots and initiatives and what could be achieved through implementing each of the specific proposals, with a sufficient implementation period.

Each of these measures would be assessable against one or more of quality, access, sustainability, patient experience and/or financial criteria and how they in turn relate to the improved usage and performance of services provided by our local hospitals. In these ways, the means of evaluating the pathways would directly refer back to the issues identified in the Case for Change and more broadly the vision for the programme and its specific objectives. This theme would be expanded in a Pre-Consultation Business Case.

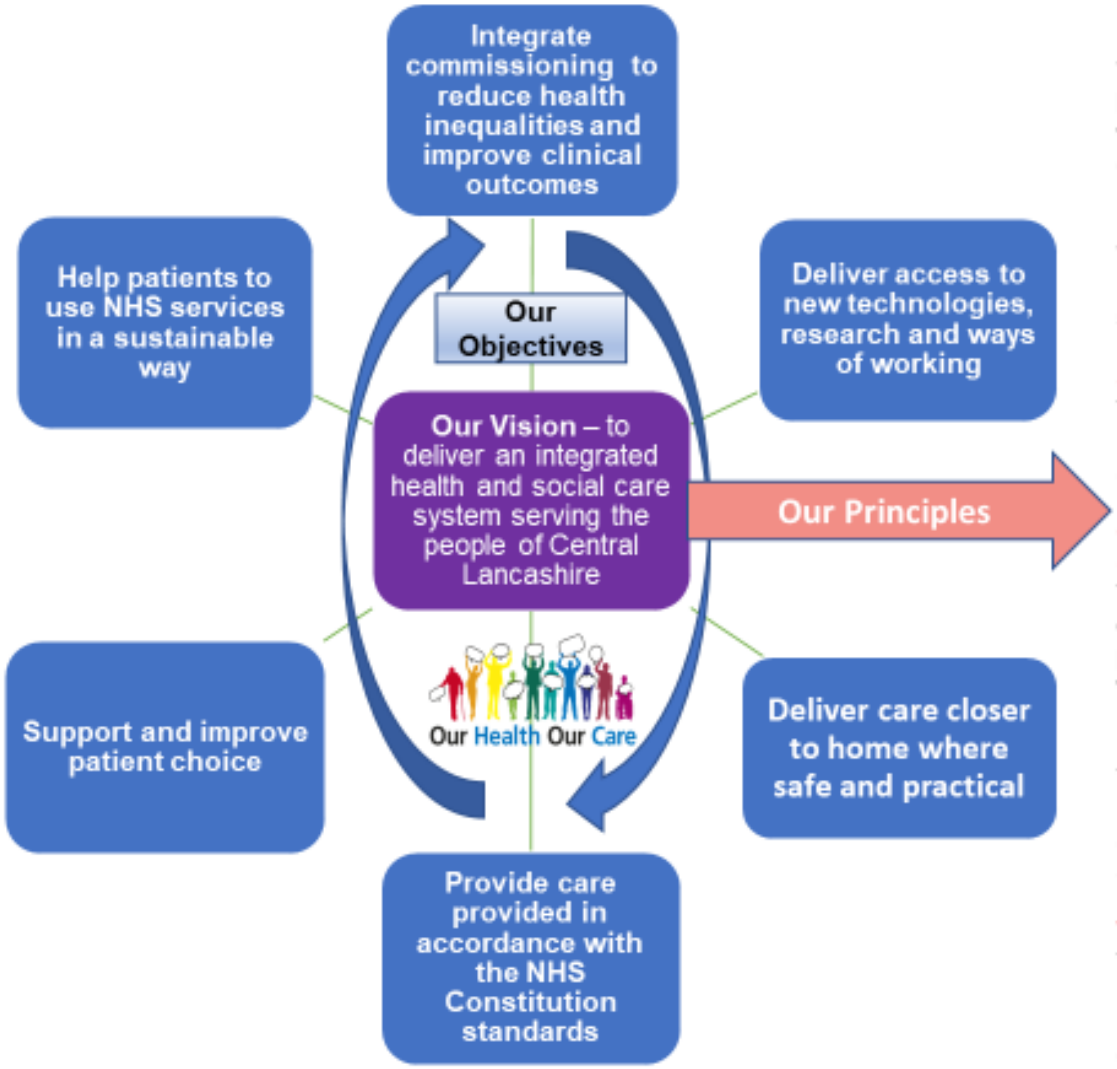
3. How we have engaged on this Model of Care…developing our principles?

Since March 2016 significant work has been undertaken to design the proposed Model of Care based on the feedback of clinicians, patients and the public as well as the wider workforce that delivers this important care every day.

Our learning and listening has been iterative, making sure that we test proposals, ideas and new concepts at an early stage. This has helped us to ensure that they can continue to be refined and improved as we continue our journey of engagement. This section describes the activities that have taken place to ensure the public and staff voice has informed this Model of Care.

Figure 9 on the next page shows how our vision and principles for the Model of Care are in line for the vision for an integrated health and social care system in Central Lancashire.

Figure 9: How our Vision and Principles are in line with those for delivering Integrated Health and Social Care



Promoting population health and wellbeing:
We will use all opportunities to support patients to make better lifestyle choices and lead healthier lives, creating a culture of wellness and supported self-responsibility to reduce the pressure on our hospital services.

Best care, right place, most appropriate time:
We will make sure that patients receive high-quality care in the right place, even if they make the wrong choice as to where to seek care.

Supporting our hospital to help it work better:
We will work together as one system to avoid unnecessary hospital admissions, keeping patients healthier for longer at home and in the community.

Commissioning better, as one integrated health and social care system:
We will commission and deliver care which is safe, effective, delivered in accordance with NHS constitutional standards - providing access to new technologies, research and ways of working wherever possible.

Using our resources as wisely as possible:
We will use the resources that we have available to best effect by using a data-led approach to transformation, planning for delivery at the right scale across all of our care pathways, using a common approach to transformation.

You said, we listened:
We will treat patients as the experts. They are best placed help us redesign services through their knowledge, experiences and insights. We will make sure that our plans reflect our diverse communities and the personalised needs of people.

3.1. How we have engaged with the public

We have used numerous methods to engage with the public such as open public meetings, workshops, focus groups and digital methods including social media, emails and surveys.

A full engagement log is provided in Appendix A. This also provides continuing reference to the engagement journey, including an overview of the purpose and methods of engagement carried out.

The engagement activities also include the specific approaches used relating to the Frailty and Chronic Obstructive Pulmonary Disease (COPD) pathways, used as examples later in the document.

- **Public Engagement Events.** We have held 28 public events since March 2016 across Chorley and South Ribble and Greater Preston. Through these events we have sought to understand what's important to the public and what our services should deliver. We have listened to varied experiences and feedback on the developing Model of Care, complementing the significant other work which has taken place with focus groups, listening events, and our local governance groups.

- **Targeted Engagement.** We understand that many communities are not able to or want to access public events and therefore we have worked to have conversations with targeted groups. Informed by an Equality Impact Analysis and with support of organisations such as Chorley Equality Forum, Galloway's Society for the Blind, Preston and District Carers Support Group, Preston College, Ingleton Congregational Church and the Preston Health Mela we have sought to understand what matters.

  These conversations have been focussed on going beyond the protected characteristic groups explicitly described the Equality Act in to a wider, deeper conversation with seldom heard groups in our local communities. These conversations have focussed more on understanding what matters to people, at a time, place and in settings which is most comfortable to the group concerned. This has been complimented by market research activities to ensure that is representative of the communities we represent.

- **Digital Engagement.** Alongside our newsletter we have used virtual mechanisms such as our website, emails, Twitter and Facebook. Two online surveys were developed to seek patient experience, Model of Care understanding and feedback.

Alongside the above we have established a Stakeholder Panel for advice and input on communications and engagement activities. We also have a Patient Voice Committee and a Patient Advisory Group.

The feedback from these groups has helped us inform the programme vision:

"Our vision is that the people of Greater Preston, Chorley and South Ribble are enabled to lead healthy independent lives, and when required, their health and care services, they are safe and effective, accessible, responsive and co-ordinated."

What this means in reality is the delivery of an integrated health and social care system serving the people in Central Lancashire, providing more joined up care.

As we have spoken to people throughout our engagement journey, we have been able to develop a rich picture of what the Model of Care means for people.

Our engagement work has also helped us to understand that:

- Often, when it comes to the “big things” clinicians and patients often want the same thing – high quality, personalised, effective care.
- When discussing the “big things” it is important not to forget the “small things.” These often matter just as much to patients, as do how the hospital services work with community services and primary care.

Figures 10 and 11 show how the engagement has informed the clinical vision and what matters to patients helps to demonstrate this.

Figure 10: How feedback has informed our clinical vision

Figure 11: Extracts from patient feedback

The involvement and engagement with patients and clinicians also help us when referencing the statements made in the Case for Change around what should happen to transform care and service delivery across Central Lancashire.

- Services can be delivered closer to home where this both safe and practical.
- Patients can experience the benefits of new technologies, research, learning, and ways of working in the NHS.
- Patients can access cost-effective care as taxpayers in line with the standards set out in the NHS Constitution.
- Patients can be supported to make the right choices about the best places to receive care and advice.
- Patients 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.

We recognise that some of the people we have spoken to have strong views around where, how, and by whom, some hospital services in the future should be provided.

Looking at this in a more detailed way, we have sought to triangulate the ongoing themes generated from the public engagement events, targeted engagement, similar work undertaken by partners and other sources of information such as friends and family test and complaints data.

When describing “the voice of the patient” it is important to demonstrate not only that you have spoken to and engaged with services users, but how you have then sought to help these insights improve and influence the proposals – in this case explained in the Model of Care for improving hospital services.

At a high level in the OHOC programme, there are three main lessons which we have taken from the “patient voice.”

- **Improved access:** Patients will expect to have better access to services. Where services are delivered are important to patients and that they are as geographically accessible and close to home as possible. With longer operating hours, and greater access to services seven days per week, as opposed to the traditional five-day week operating model.
- **Better coordination of care:** Patients will expect there to be better coordination between services. This will mean that patients will not have to tell their story more than once necessarily – they can expect service providers to work together, with joined up thinking, to help them interact with care more seamlessly

- **Equity:** Patients expect to receive the best care possible irrespective of they need the support of services for physical health, mental health or social care. They expect the system to work as one around their needs.

Looking specifically at hospital services and in particular the unplanned (or urgent and emergency care system) we are clear that it is not just the big things and the overarching principles that matter to patients, the smaller things count too. The voice of the patient has helped to improve this Model of Care in the following ways, a process which will continue as options are developed and the next steps of the programme continue.

- **Waiting:** That if they have to wait, then they always have access to comfortable and appropriate waiting areas, with refreshments and clean facilities.

  We will be making clear commitments in this area in terms of how this care is provided in the future.

- **Discharge:** When they are discharged then there is more follow up support provided to them at home, so they can avoid being re-admitted to hospital.

  We are committed to helping the service to work as one, using the M1-3 concept, to help improve in this area.

- **Information provision:** That information, however provided, is specific, clear, and easy to understand.

  We will focus on using our existing patient involvement forums to use their expertise to help review and improve the information provided by hospitals, particularly in the written format.

- **Kindness:** They and their families, carers, visitors and others will be treated with kindness, respect and compassion at all times.

  All of the constituent partners in OHOC have organisational values which put this commitment at the heart. They are also committed to training and developing all staff to focus on providing an improved patient experience. The CCGs will also follow this internally and hold providers to account as required.

- **Personal treatment:** They will be spoken to as people, be greeted personally, and not spoken of in the third person as clinical presentations. They will be given the time and space to ask the questions which are important to them about their care. This will mean that they will be able to give informed consent to decisions taken about their care and make the right choices when more than one option is available.

  Feedback on these points are regularly reviewed from the ongoing work of teams such as the Patient Advice and Liaison Service, the complaints team and also the customer care and equality and diversity teams from within the CCG. Local organisations have championed national initiatives in this area, such the highly successful “Hello, my name is” campaign.

- **Personalised:** Their specific needs will be taken in to account when planning and delivering care so that, as far as is possible, their care is personalised to their needs and preferences.

  All partners in the OHOC programme have approaches and commitments to ensure that patients are involved in their care planning, can provide informed consent, and can explain their needs and preferences with respect to how they receive their care.

- **Learning Culture:** Their doctors, nurses and other staff will be always be keen to understand what can be done to improve care, always seeking to co-design improvements with patients.

  The approach of working with service users through solution design events and using a transformation methodology which places both the patient voice and the perspective of the patient at the heart of improvement efforts have been used in the programme to date and will also be utilised as the principles in this Model of Care are used for other care pathways.

- **Honesty:** If a mistake is made, or there are delays or problems in coordinating their care, then an honest explanation is given.

  All partners in the OHOC programme have approaches in place to ensure that where there delays or problems then an honest explanation is given. Examples of this include the Duty of Candour provided for in the NHS Constitution and approaches such as “Root Cause Analysis” which are ways that issues can be investigated and trends identified, so that issues can be identified, and appropriate lessons learned.

3.2 How we have engaged with the workforce across the system

Alongside the views of the public we have gained the input and ideas of the people who deliver this essential care across Central Lancashire. Through the bringing together of their collective leadership, experiences and best practice, they have worked together to develop this proposed Model of Care.

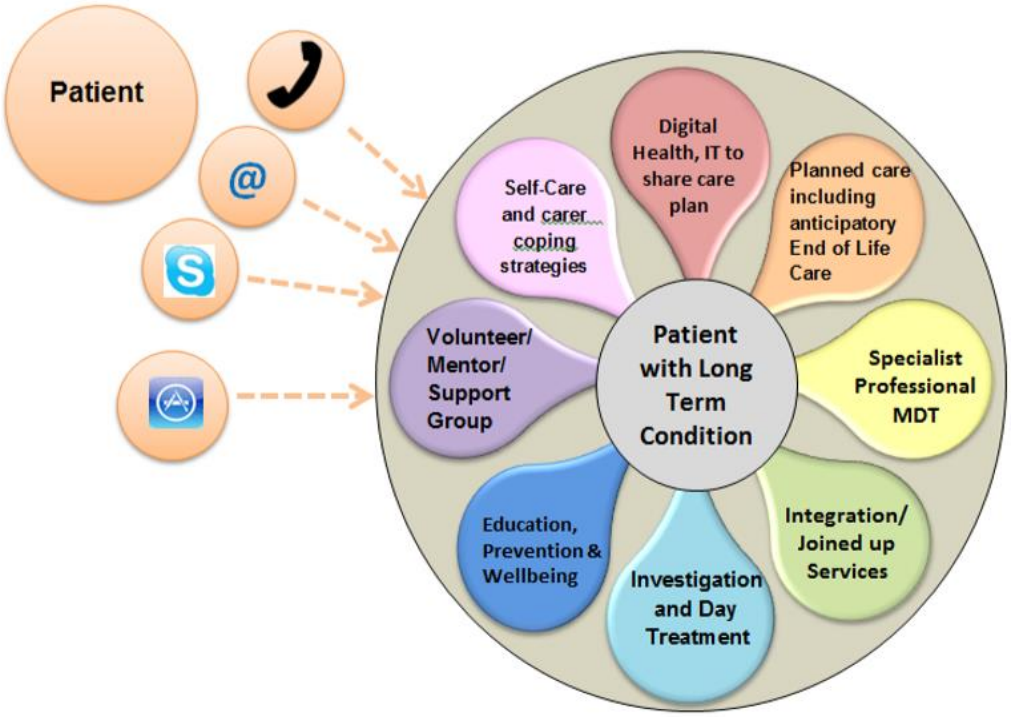
- **7 multi-sector engagement events** have taken place. These events have involved a multitude of professionals from primary care, social care, community care and the hospitals. We have heard from experts who have led initiatives outside of Central Lancashire and sought input from wider agencies such as the Faith Sector, the Police and MIND. Over the events a number of detailed debates and focus groups have taken place to inform the proposed Model of Care including its underlying principles, the benefits it must achieve, future clinical pathways and what needs to take place to make change happen.

  These changes (or enablers) include improved and shared information technology systems and digital integration, a developing workforce across the health economy, embracing innovation, and making changes to the way in which our services are purchased and managed (commissioned).

- **A focus on supporting Long Term Conditions**: During these events we have thought carefully about not only the care which patients need to receive from the urgent and emergency care system when they become seriously unwell, but also how they manage the long-term conditions which affect them in their everyday lives. We know that the broader determinants of health stretch further than the actual clinical care patients seek to receive. Care professionals across Central Lancashire have thought about what the high-level framework which the approach to long-term condition management should operate within.

  They have worked hard to develop end to end clinical pathways that would support those who access their service the most, that is those patients with long term conditions – the example of chronic obstructive pulmonary disease is referenced in Chapter 4 of this Model of Care as an example. This engagement and the rich, clinical conversations contained therein have helped developed the following framework.

Figure 12: Framework for patients with long term conditions



Linked also to the voice of the patient and what matters to them, our care professional workforce who have been engaged with throughout programme have also made pledges to how they would personally support the changes required to provide better care for their patients.

Figure 13: Workforce pledges

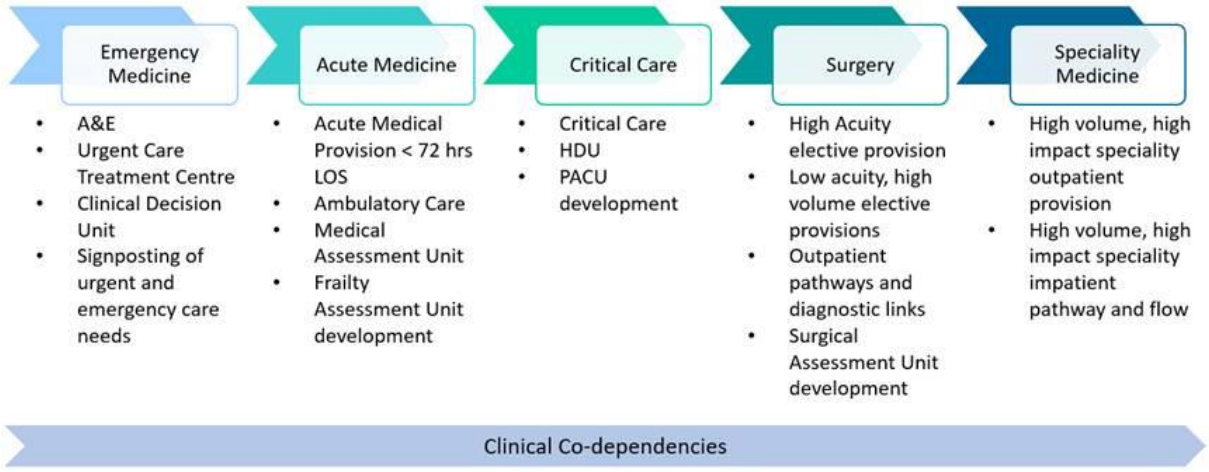
Care professionals across the system have collectively agreed the benefits that they would want to see any future changes achieve. As discussed above, the ambitions from care professionals are similar from patients and service users. They also seek to ensure that this Model of Care will improve the quality of care, service delivery and outcomes, alongside the flexible and sustainable services that an integrated health and social care model for Central Lancashire will help to achieve.

3.3 How our clinicians have led this process

The development of this document has been led by senior clinicians, representing the Central Lancashire health economy and the partners involved in the development and delivery of the OHOC programme. They have ensured that the proposals encapsulated within this Model of Care, and as linked to the relevant clinical standards and co-dependencies framework, are evidence based, have considered best practice, and are linked to the learnings taken from engagement exercise.

For the specific elements of the acute sustainability platform Clinical Leads were appointed to facilitate workstreams and a further lead to develop a framework to capture the clinical co-dependencies for each specialty (including consideration for support services such as Diagnostics). Further targeted support has been sought from Primary Care colleagues through their various membership council and peer group meetings. The remit and scope for each workstream is depicted in Figure 14.

Figure 14: Scope and remit of clinical subgroups



3.4 Key Documents and Best Practice

There have been numerous best practice documents and strategies released over the past 5 years that have drawn on clear evidence, learning and best practice from across England. This Model of Care has drawn from the learning provided within these key documents and the clinical teams have worked to ensure these concepts are adapted to local need and local circumstances.

<u>These key influential documents are:</u>

- NHS Confederation (2012) *Making integrated out-of-hospital care a reality*
- NHSE (2014) 5 year forward view
- NHSE (2016) *GP 5 year forward view*
- Lancashire County Council (2018) *Lancashire Health and Wellbeing Strategy*
- Lancashire County Council (2018) *Care Support and Wellbeing of Adults in Lancashire*
- The Kings Fund (2018) *A vision for population health*
- The Kings Fund (2018) *Reimagining Community Health*
- NHSE (2019) *10 Year Plan*

<u>With specific reference to the acute services:</u>

- Department of Health (2011) - No Health without Mental Health
- NHSE (2013) - *Transforming Urgent and Emergency Care in England; Urgent and Emergency Care Review: High Quality care for all, now and in the future*
- Royal College of Physicians (2013) - *Future Hospital: Caring for Medical Patients*
- NHSE (2015) - *Transforming Urgent and Emergency Care in England. Safer, faster, better: good practice in delivering urgent and emergency care*
- Nuffield Trust (2018) - *Rethinking Acute Medical care in Smaller Hospitals*
- Royal College of Physicians (2018) – Outpatients: The future – Adding value through sustainability

Clinical standards

The clinical leads have also reviewed and agreed the national specifications and standards which the programme will adhere to and that our public have a right to expect. These are detailed within Appendix B.

Co-Dependencies

The Co-Dependency Framework (see Appendix C) sets out the services the Our Health Our Care programme relies upon in order to provide high quality care for patients. It is recognised that co-dependent services do not always need to be co-located on the same hospital site.

The framework differentiates between those co-dependent services that may be required immediately (and therefore must be on the same site); those which can be accessed within a given timescale; those accessed through an emergency/elective protocol, or through planned arrangements.

4. Proposed Model of Care

So far, this Model of Care document has described how the issues identified in the Case for Change will need the clinical vision for the programme to be centred towards the development of an integrated health and social care system for Central Lancashire. Work to transform hospital services, alongside this broader work seeking to join up and coordinate care will support the delivery of improved patient experience, use of resources, health status and care outcomes.

In terms of the issues faced by patients accessing the hospital services system, this document has identified the impacts arising from gaps in the delivery of an integrated health and care system, specifically:

- Because patients do not always have the information and support to make the optimal choice for them, where to seek support and what options are available, closer to home.

- Because the system is complex, difficult to navigate and needs to evolve more around the individual, patients feel they need to attend hospital when they do not. This contributes to the issues in terms of poor patient experience, access and clinical outcomes.

- Because the alternative options to using hospital services are not sufficiently available, accessible and comprehensive, the settings where patients do access care create excess costs of providing that support.

Patients wait longer than they should for treatment as local hospitals struggle to deliver effective “flow” and make available the workforce and support services needed to cater for the patient needs that they need to.

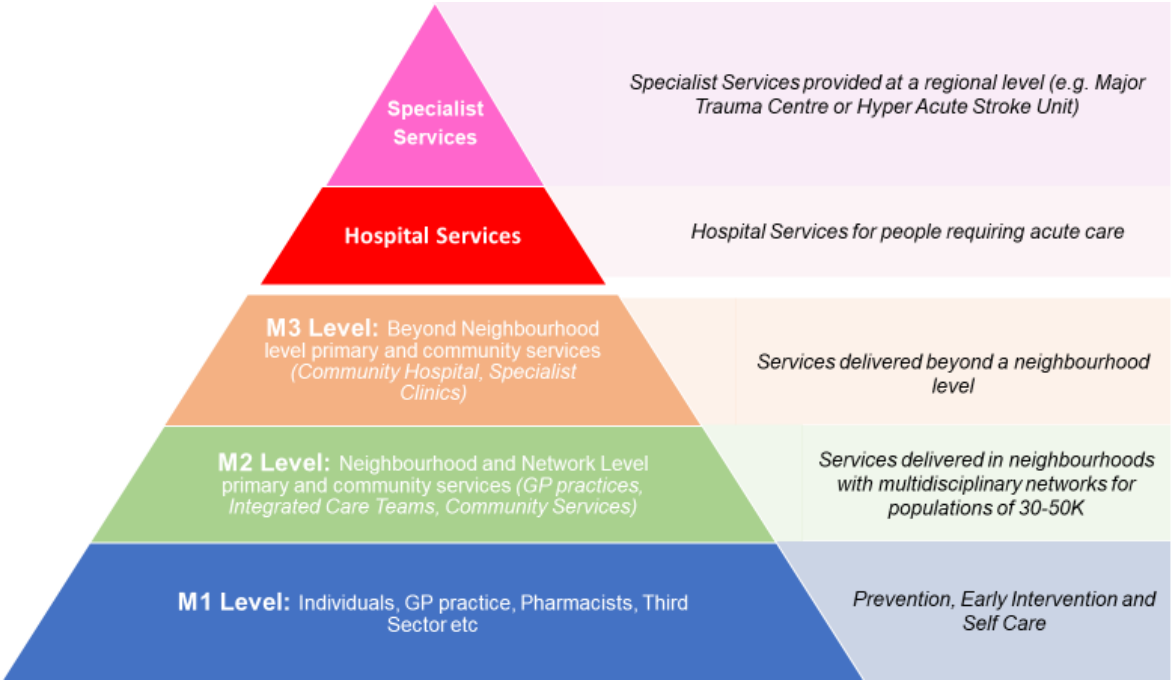
This section now describes the proposed Model of Care for Central Lancashire relating to the hospital services system in particular. It then proceeds to provide examples of how end-to-end pathway transformation will be delivered relating to the frailty and Chronic Obstructive Pulmonary Disease (COPD) pathways in particular. This section provides a description of the proposed services, how they will be accessed and how they will link together to deliver the aim of Integrated Care for the patients of Central Lancashire.

It is important to note that this chapter of the Model of Care focusses on the hospital-based elements of our health system. This is because it is the potential changes to this part of the care pathway that could require the programme to develop a formal consultation. This will depend on the options generated, and how these options are considered to be viable (or not) linked to the NHS England tests for major or significant service change. Therefore, this section provides a detailed description of the proposed Model of Care for hospital-based services. However, they remain set in to the context of the preventative and out of hospital services available to the population of Central Lancashire and the provision of Integrated Care.

Two diagrams on the next two pages help to explain what this means. The first, Figure 15, shows what is called a “care conical” and how the different parts of our health system interact together. This section is now looking at the top of the conical – those specialist and hospital services which need to be provided in that setting because of the clinical need of the patient. These are patient care needs which cannot be managed at levels

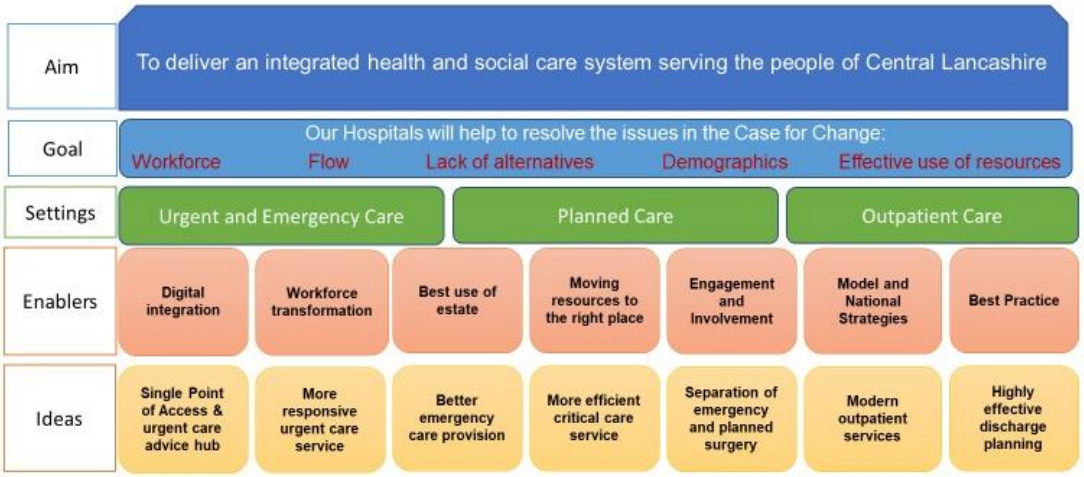
M1, M2 and M3, and represent the patient journeys, as explained in the Case for Change which are associated with poor "flow" and patient experience.

Figure 15: Care conical: Different parts of our health system



The second diagram, Figure 16, shows the relationship between the vision for the Model of Care, which is based on the engagement activities, our principles and the high-level strategic plans, and the particular operational proposals which will be necessary to help the hospital services system deliver its contribution to an integrated health and social care system for Central Lancashire. Each of these operational proposals arises from the clinical engagement and leadership bound within the programme and the learning and listening undertaken with patients, the public, and other stakeholders to date.

Figure 16: Our vision, principles, strategic plans and operational proposals



The figure is based on several levels.

The **first-level** shows what each of the proposals are. The next section of the Model of Care will describe the clinical requirements for each of these.

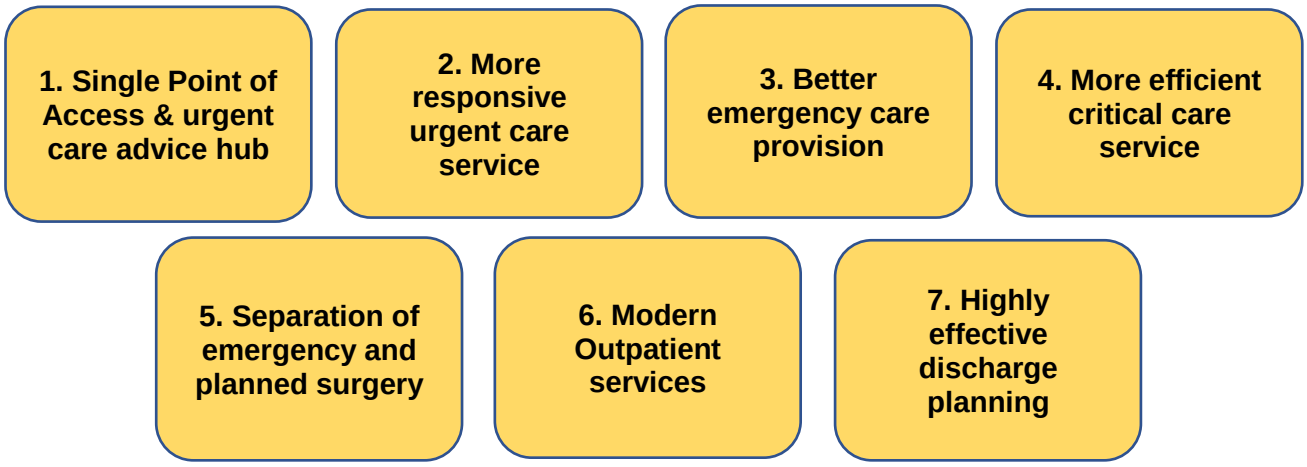
The **second level** shows the enablers. This means, what are the concepts and approaches which will help these changes to happen.

The **third level** shows the settings where these changes will apply to – specifically urgent and emergency care, planned and elective care, and outpatient care.

The **fourth level** shows what these changes are seeking to deliver and how they relate to the **top-level** aim; the development of an integrated health and social care system for Central Lancashire.

The purpose of this diagram is help show, visually and straightforwardly how the vision in the Model of Care relates to operational reality.

4.1 Proposed Model of Care for our Acute Services



This section describes the proposed acute Model of Care for Central Lancashire patients. It provides a description of the above seven concepts in turn. The Model of Care describes a vision which is built upon existing best practice, service models and/or concepts which have been demonstrated to be effective and/or referenced in national policy documents. Parts of this Model of Care are already in place, others need to be developed to provide the overall coherence to and support from the hospital services system to the principle of an integrated health and social care system.

Beyond those aspects of the Model of Care which are not clinically sustainable, the Model of Care does not intend to be restrictive or overly prescriptive. We have provided a realistic and positive strategic framework around how services could work better for patients in the future, built around the known clinical standards which are relevant to the transformation of care and able to be enhanced and applied as a detailed service specification is developed. It will build a base from which a wide-ranging, open-minded series of options can be generated and subsequently analysed and assessed.

4.1.1 Single Point of access and urgent care advice hub

1. Single Point of Access & urgent care advice hub

In order to ensure our patients and workforce are aware of and able to access a range of alternative services appropriate to their needs we will simplify the navigation and access of acute services. To do this we will establish an urgent care clinical advice hub for professionals (hub) which will directly link into the already available Central Allocation Team for Care and Health (CATCH) service.

The hub is not a physical clinical environment, but a virtual space staffed by an experienced urgent care clinician with good knowledge of optimal clinical pathways and appropriate and available services. Through the hub, colleagues from primary and community care will be able to discuss a patient's needs directly and personally with another senior clinician from within the hospital services. Typically, a senior clinician, with good local knowledge of available services, can handle 10-15% of GP referrals over the phone without the need for the patient to attend hospital[13].

The clinical conversation with the referrer from primary care can be used to pre-plan the patient's care with the patient through shared decision making. This may include discussion about appropriate care in an outpatient setting; having investigations before arrival; or planning their transfer back to primary care.

Responsibility for care will thus be shared between the patient, the practitioners in hospital and primary and community care, and continuously supported by live dialogue. Patient experience, need and outcomes will be continually audited and monitored to ensure that pathways evolve and expand to the patient needs and benefit from medical/technological advances.

For patients that do need to physically access the urgent or emergency care at a hospital there will be one front door. This one door can be accessed via multiple routes, by ambulances, via primary care, the integrated teams, or by the patient self-presenting. Upon arrival, the point of first contact is important in giving patients reassurance and confidence around how their care will be coordinated and delivered. This means that the provision of a highly-skilled reception function is essential. It is also important that the logistical factors associated with arrival are properly considered including access to the service from local bus routes and other transport, "drop off" facilities, accessible car parking, and any other measures which are practical in relation to local road set ups and configurations.

The benefits this would achieve:

- Ensuring that the urgent and emergency care system is used by patients who most need it.
- Avoiding unnecessary patient travel and providing more care closer to home.
- Reducing variations in clinical practice.
- Reduce delays when patients do need to present to hospital
- Improved care coordination and planning.
- Contribution to improved hospital flow.

4.1.2: More responsive urgent care service

2. More responsive urgent care service

What should we be delivering?

With growing demographics, demands of our urgent and emergency care services and increasing workforce challenges we shall deliver a more responsive and integrated urgent care service. Advice on the provision of urgent care from NHSE (2015)[14] is clear:

- For those people with urgent care needs we need to provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- For those people with more serious or life-threatening emergency care needs, we need to ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

NHS England (2017)[15] have also defined very clear standards for what an urgent treatment centre should offer. However, by using advancing care professional roles and pooling the skills of our existing workforce, we can provide an urgent care service (including ambulatory care) that goes beyond NHSE expectations. We think that this is the right clinical vision for Central Lancashire.

Whilst the standards for an urgent treatment centre state that urgent treatment centres will usually be a GP-led service, this model proposes a shared leadership model between acute care physicians and GPs. This will further enhance the ability to care for patients closer to home avoiding the need for unnecessary transfer to an Emergency Department.

One of the reasons why we are proposing a model which goes further than the national guidance is an analysis of existing local practices, and how they are working for patients. For example, in 2017/18, up to 78% of patients seen in 2017/18 by the Trust (across both sites) could have their care delivered in an Urgent Treatment Centre environment.

Doing things differently provides a real opportunity for a greater number of people to receive the care they need in a more appropriate location. Delivering care in this way would avoid unnecessary travel, reduce delays, improve hospital flow, and improve patient experience.

How the urgent care service will work - effective and timely triage:

Patients who have already received clinical assessment via their GP, nurse or paramedic will be reassessed to ensure they have not deteriorated, then directed to a waiting area or to be seen by an appropriate clinician. Self-presenters (i.e. those who have not had prior

[14] https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf
[15] https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

clinical assessment before attending) will undergo triage within 15 minutes of arrival and be directed as appropriate. An accepted system-wide trusted clinical triage such as the Manchester Triage System will be used and recorded within the shared electronic record.

How the urgent care service will work – waiting environment:

The intention of the waiting environment is to provide a facility which is suitable for a wide range of patient's needs, including those whereby aesthetic and design factors influence the experience of care received. The other important feature of a reassuring waiting environment is that is that it needs to adequately appointed for the needs of patients, their carers and families, who may need to wait in that setting for a number of hours. These two factors are particularly important because they signify the patient's first experience of the hospital environment.

For these reasons, the reception area will need to be designed to have dedicated adult and children's waiting areas. These areas will need to be co-designed with service users affected by dementia, autism and mental health conditions. Live information and general health advice will need to be displayed on an electronic board and the environment set up to provide access to hot refreshments and snacks, and clean sanitation facilities. This will include the ability to provide and relay information in formats based on the particular communication needs of the individual patient.

How the urgent care service will work - direct referral

Patients accessing our current ambulatory care (same day medical) services are receiving a variation of access with patients living in Preston having to attend Chorley Hospital for same day medical care if they have been referred by their GP. It is important to provide local hospital access for these patients, wherever practical.

In addition to the design factors set out above, it is important that patients referred by their GP for urgent care, have this facility accessible locally. This takes particular account of the fact that journeys may be unplanned. They may need to take during peak hours, where local traffic conditions could cause a longer than normal journey time. This means that providing local access, wherever possible, is important.

Direct entry into the hospital will also be possible through services such as the surgical assessment unit (SAU) and medical assessment unit (MAU). This removes the possibility of unnecessary movement through an emergency department or urgent care service.

Effective streaming means that the specialists in Emergency Medicine can focus their efforts on those patients with highly complex and very serious care needs. Examples include those patients who require resuscitation, have undifferentiated conditions (i.e. are difficult to diagnose) and those with serious musculoskeletal injuries.[16]

What will the urgent care service be able to offer to make the emergency care department accessible to the patients who need it the most?

The principles of the urgent care service are that it needs to be accessible at the times where patients need it, be responsive to patients needs and be locally provided wherever possible. For these reasons, the urgent care service in the future will focus on offering a wider range of services delivered by a combined workforce that will work closely with Primary and Community Care to ensure clinical skills are maximised whatever the

[16] https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

location. This will ensure that the Emergency Department is accessed only by those who need it, reducing waiting times and improving patient experience overall.

Principle 1: It will be accessible 24/7 via direct booking, GP, ambulances, booked appointments and walk-in:

With clearly agreed communication and pathways between North West Ambulance Service (NWAS) and primary care colleagues, patients will be referred/transferred to the urgent care service where appropriate. For patients wishing to self-refer they would be able to make an appointment to attend at their convenience or by attending at the direct time of need.

Principle 2: It will specialise in the assessment and treatment of minor injuries:

Advanced care professionals such as emergency nurse practitioners, advanced paramedics and physiotherapists are the best people to treat minor injuries. These professionals are experts in their field with highly specialist training and skills used every day and are therefore able to diagnose and treat the majority of minor injuries. Supported by video conferencing links to an emergency centre for specialist advice when required, the urgent care service will effectively treat a full range of minor injuries.

Principle 3: It will provide direct and timely access to non-specialist diagnostics:

There will be access to the required diagnostics such as plain film for minor injuries and illness, CT scans for ambulatory care processes and a range on point of care (on the spot) testing to ensure that the clinical team and the patients get the assessment required without delay.

Principle 4: It will help care professionals to work flexibly, using the principles of multi-disciplinary team working.

Through the hub, the urgent care service is able to provide advice to care teams outside of the hospital. Paramedics, nurses, GPs and care homes will all be able to benefit from one to one clinical discussion and advice to enable patients to be cared for in their own home or the most appropriate environment for their needs.

Principle 5: It will aim to reduce delays caused to patient journeys arising from the need to wait for prescriptions from the hospital pharmacy:

Prescriptions will be sent electronically to a pharmacy of the patient's choice and *patients* will be able to choose which pharmacy they wish to collect their medications from. Their prescription would be sent electronically from the urgent care service to the pharmacy of choice where it would be prepared ready for collection.

Principle 6: Access to summary care records so information is shared between health care professionals to improve the coordination of care:

Full shared care records between all health and care organisations are a key enabler of true integration work. A two-way feed would enable care providers to have full access to care professional assessments, advice and treatments delivered.

Principle 7: Better management of patients with conditions treated by ambulatory care:

Ambulatory Care is medical care provided on an outpatient basis including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services. Extending

and enhancing how we provide ambulatory care provides an opportunity to change how we manage patients currently who present to emergency care and enables many patients to be treated in the same day avoiding admission to hospital. Patients can access services quickly will have more choice of treatment options and therefore experience less of the anxiety associated with admission. Patients may be transferred direct for ambulatory care on attendance and if appropriate brought back the next day.

The proposed model will ensure a standardised ambulatory care is provided. Ambulatory care will be integrated into the urgent care service and not a separate department. The pathways will be enhanced by continual audit of success and need. Acute Physicians within the urgent care services will liaise with primary and community care and their patients to provide advice, guidance and ensure shared decisions are made.

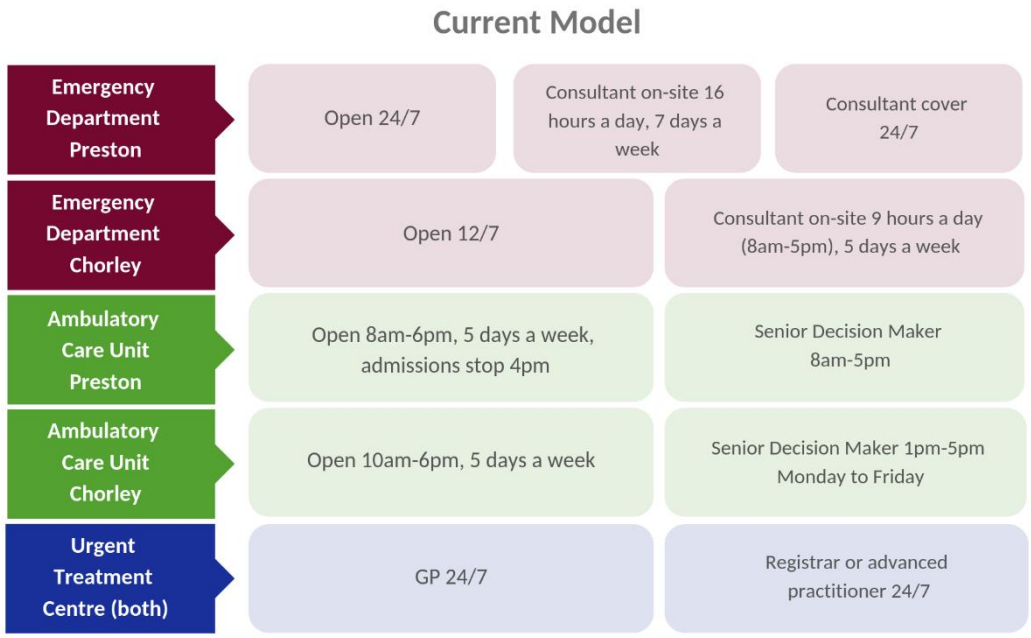
Principle 8: Management of patients with mental health needs

Urgent and emergency mental health care is a response that health and care service providers deliver 24 hours a day, 7 days a week (24/7) to people who are experiencing a mental health crisis. Mental health liaison services will provide an urgent care pathway, with a full assessment taking place within 24 hours of referral.

The existing staffing model for acute based urgent and emergency services

The figure below shows the current operating models for the emergency department, urgent treatment centre and ambulatory care at the Royal Preston Hospital and Chorley and South Ribble District General Hospital sites. Figure 17 shows the hours of operation for each service, and how the clinical leadership for the service currently operates.

Figure 17: Workforce summary



Potential benefits of thinking differently in terms of service and workforce models:

Currently patients presenting to the emergency department at Chorley District Hospital will only have on-site access to a consultant Monday to Friday 9-5. Our Urgent and

Emergency Care services are currently provided by three groups of clinicians: emergency physicians, acute physicians and general practitioners.

The Nuffield Report (2018)[17] - in their report relating to smaller hospitals - describes the possible benefits for patient care of combining the skills of clinicians that provide patient assessments in several units or places. This means that the services provided by these clinicians should not be run as separate services in distinct clinical areas but should work as one combined team, as one integrated urgent care service. The clinical vision is to improve patient experience by providing timely, accessible care that responds to need, provided by the right care professional at the right time, it is envisaged that the issues arising from poor "flow" in the hospitals could be improved, for the benefit of patients.

As an example of what this could mean for patients, it is possible to look at the proposals for the management of frail patients. A fuller service model is provided later in the Model of Care, but in this context, setting up the service so that it facilitates the in-reach of community care professionals and having the acute frailty service supported by the geriatricians could both support the reduction in avoidable admissions. In such a service, frail patients would be assessed, treated and supported by skilled multidisciplinary teams delivering comprehensive geriatric assessments in the urgent care service and acute receiving units.[18]

Redesigning the workforce and service delivery structure to deliver this, and reducing avoidable admissions as a result, would enable inpatient capacity to be focussed more on those patients who need it. It could also improve hospital flow, allow the service to be sustainable for the future demands placed upon arising from demographic pressures, and support the improved use of resources. In this way, such a proposal could respond to the specific problems identified in the Case for Change.

Minimum potential future workforce model for the urgent care service

As described earlier in this section, the urgent care service must be staffed and otherwise resourced so that it maximises the level of care that can be safely, effectively, and locally provided in that setting. If achieved, excess demands on the emergency care service would be reduced. It is also important that when considering the future service model for urgent care, close attention is paid to the types of clinical needs which patients will present with now, and in the forecastable future.

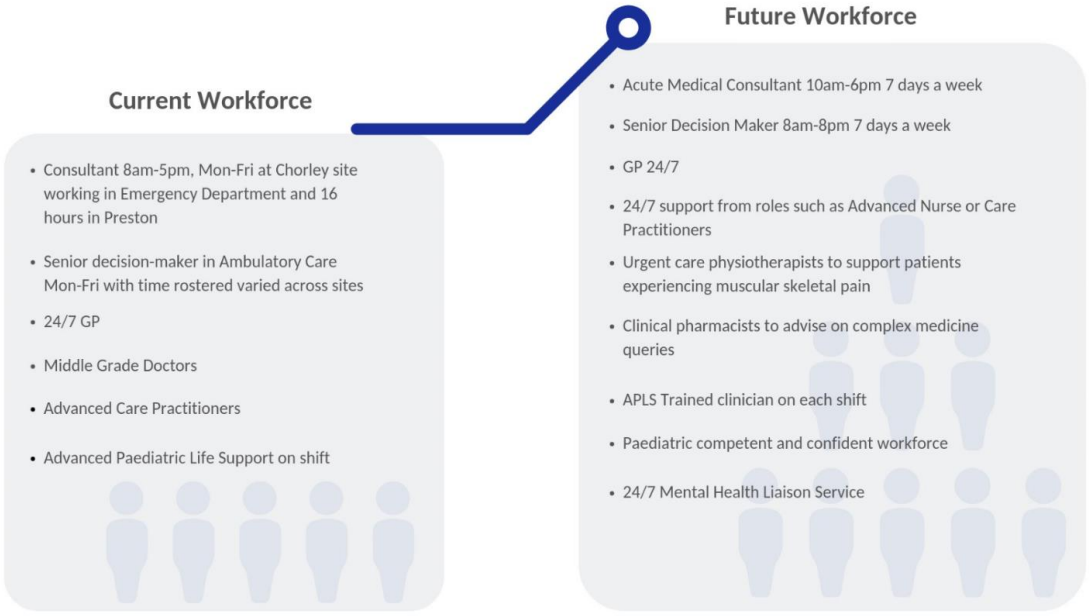
Based on the current clinical assessment of the existing service, a consideration of sustainability, and the principles outlined earlier in this section, it is forecast that, as a minimum, the urgent care service will need to staffed by at least by an acute senior decision maker at least 12 hours a day. An acute medical consultant would need to be present at least 8 hours a day, 7 days a week. A GP will need to be in attendance 24 hours a day, 7 days a week, to ensure patients have access to urgent care at all times.

For clarity, this summary possibility does not preclude alternatives which could lead to a more significantly staffed and accessible service model for patients. It does not prevent a different proposal from being further considered once a fuller, more detailed analysis of patient flow and access requirements is developed in the next options generation phase. What it does say is that the minimum proposed future workforce model must be safe, sustainable, and effective. It must also be linked to the ability of the hospital trust to work

[17] https://www.nuffieldtrust.org.uk/files/2018-10/nuffield-trust-rethinking-acute-medical-care-in-smaller-hospitals-web-new.pdf
[18] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf

with its partners to create these service structures, and to create and nurture the new types of workforce roles and service delivery patterns described.

Figure 18: Summary of current actual and minimum potential future workforce



The benefits this would achieve:

- Seamless 'front door' for urgent care and minor injuries service
- Pooled skills and resource from the acute clinical teams to provide urgent care that delivers to patient need and not traditional concepts
- Support Primary Care
- Reduce unnecessary hospital admissions
- Give patients confidence to manage conditions at home
- Improved quality of life

4.1.3: Better emergency care provision

3. Better emergency care provision

Introduction

This section describes the proposed clinical model for those patients who would require a high level of acute care either via an emergency department, major or emergency surgery, and/or specialist medical care. The patient journeys described in this section represent those which could not be best managed in another, less acute, care setting.

Patients with high risk conditions often present with challenging medical or surgical conditions that have significant, unpredictable needs. In response, services for these high-risk patients must provide senior care that is both prompt and supported by the relevant specialist teams. These patients are at risk of deterioration and are our most vulnerable.

Clear and effective communication with the wider system and the population will ensure that patients are directed or taken to the most appropriate service, that is, high quality acute care delivered by senior clinicians for those that need it most.

Set up of any Emergency Department in Central Lancashire - Arrival

Acutely unwell patients must have fast access to the expertise and infrastructure of an emergency centre, in accordance with all of the relevant clinical standards applicable to the delivery of safe and effective care in such a setting. In principle, patients should access care in this setting directly wherever possible, avoiding secondary transfer of care from another hospital, except where this is clinically necessary.

This will impact on the way in which the emergency department is configured to work with services such as North West Ambulance Service (NWAS). Clear pathways will be agreed and communicated to ensure that acutely unwell patients do not have to leave the safety of one hospital site to be transferred to another site unnecessarily. Instead patients will, through a trusted assessment, be conveyed directly to the appropriate service for their needs that is they will go to the right place, at the right time to be seen by the right person.

Delivery of care in any Emergency Department in Central Lancashire

The delivery of care for patients in an emergency department setting will be subject to a rigorous and highly structured approach of delivering care based on acute clinical need. This will mean, in practice, that patients presenting with life threatening illnesses and major trauma will be clinically prioritised over the care of other patients with sub-acute, or less acute need. Care standards and delivery approaches will also be aligned to the advice of relevant professional bodies, such as the Royal College of Emergency Medicine.

The intention of the delivery of care in such a system is to optimise clinical outcomes. It also involves taking all necessary, practical, and available steps to ensure that care is provided in accordance with the access standards set out in the NHS Constitution, including the onward transfer to other care settings in the hospital. It also intends to manage these transfers in a way which does not impair the ability of the hospital to deliver the other requirements of its planned/elective and outpatient caseloads.

In some instances, this will mean that care will need to be provided and coordinated immediately upon arrival, or within a much shorter time window than the traditional “4 hour” waiting standard. A good example of this is a patient presenting with symptoms indicative of potential sepsis.

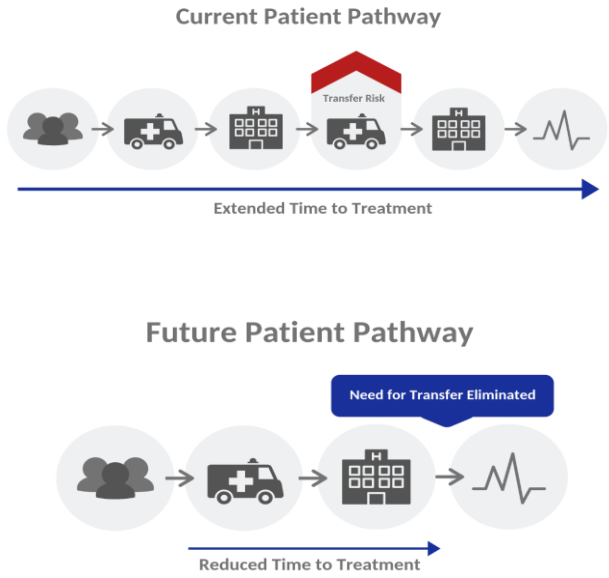
Care of patients with highly acute requirements needs to be seamless. This includes, where necessary, starting resuscitation and other life-saving care in the Emergency Department, which overlaps with definitive care and care planning provided by specialties. It also involves providing some care pathways in Centres of Excellence, or regional centres. Centres of Excellence, through Major Trauma Centres, have been demonstrated to deliver improved clinical outcomes[19].

A good example is the management of patients experiencing a Heart Attack. Delivering resuscitation in the ambulance and coordinating the care plan immediately before presentation in the appropriate Emergency Department is now done by about half the hospitals in England. Patients experiencing a Heart Attack currently bypass Chorley and Preston Hospitals to go to Blackpool for specialist care, while Trauma patients bypass Blackpool Hospital for Preston Hospital.

These acutely unwell patients have good outcomes by international standards because the diagnosis can be made in the ambulance and the right patients are taken to the right hospitals for the most advanced treatment.[20] This means that for paramedics to get patients to the best and most appropriate services, they will sometimes drive past the nearest Emergency Department to get the patient to the right place.

They spend more time in the care of high-trained ambulance staff initially, but access the right treatment earlier, and spend less time travelling overall.

Figure 19: Current and future patient pathway (for those requiring transfer)



[19] https://www.england.nhs.uk/2018/08/more-than-1600-extra-trauma-victims-alive-today-says-major-new-study/
[20] https://www.bl.uk/collection-items/transforming-urgent-and-emergency-care-services-in-england-urgent-and-emergency-care-review-end-of-phase-1-report

The diagrams above show how the experience of patients that attended ED could be improved by **reducing the need for transfer** to another service, **if clinically required**. In 17/18 there were 4,844 patients who attended Chorley A&E and were admitted. Of these 739 were admitted from Chorley A&E to a bed at Preston.

The emergency department will deliver to the national standards as detailed within Appendix B. The separation of emergency and urgent patients by quality clinical triage will ensure that all patients that need emergency care receive it from a senior clinician without delay.

Medical Care

We do not have the workforce we need in critical staffing areas. Our system is stretched due to issues with recruitment and retention felt locally, but also more widely across the NHS. Therefore, we need innovative solutions, which also supports the delivery of effective flow.

Medical specialists describe how they feel unable to spend the quality time they need with a patient. The conflict of treating patients within the urgent care pathway against not taking their time away from those patients needing scheduled interventions means that often lists are overbooked and the time the clinician has with the individual patients reduced.

Separation of planned and acute activity enables predictability. Predictability improves patient experience through timeliness of intervention, more time with the clinician and less internal bed movements.

Dependent on the specialty, many medical procedures can be needed to support those patients admitted to hospital as an emergency specialty. These are also needed for patients who are booked in as a planned admission. This means that there is a clear co-dependency of speciality medicine procedures with the speciality and acute medical wards.

Figure 20 illustrates the four components of care that will be the focus for our specialist medical services. As some Consultants are trained as both a general and a specialist consultant and others purely as a specialist consultant detailed work will take place with the medical teams to redesign optimised rotas utilising individual skills and experience in the most effective and flexible way. The outpatient Model of Care is described later in this document.

Figure 20: Four components of care in specialist medical services

An Opportunity to improve care - Hot Clinics

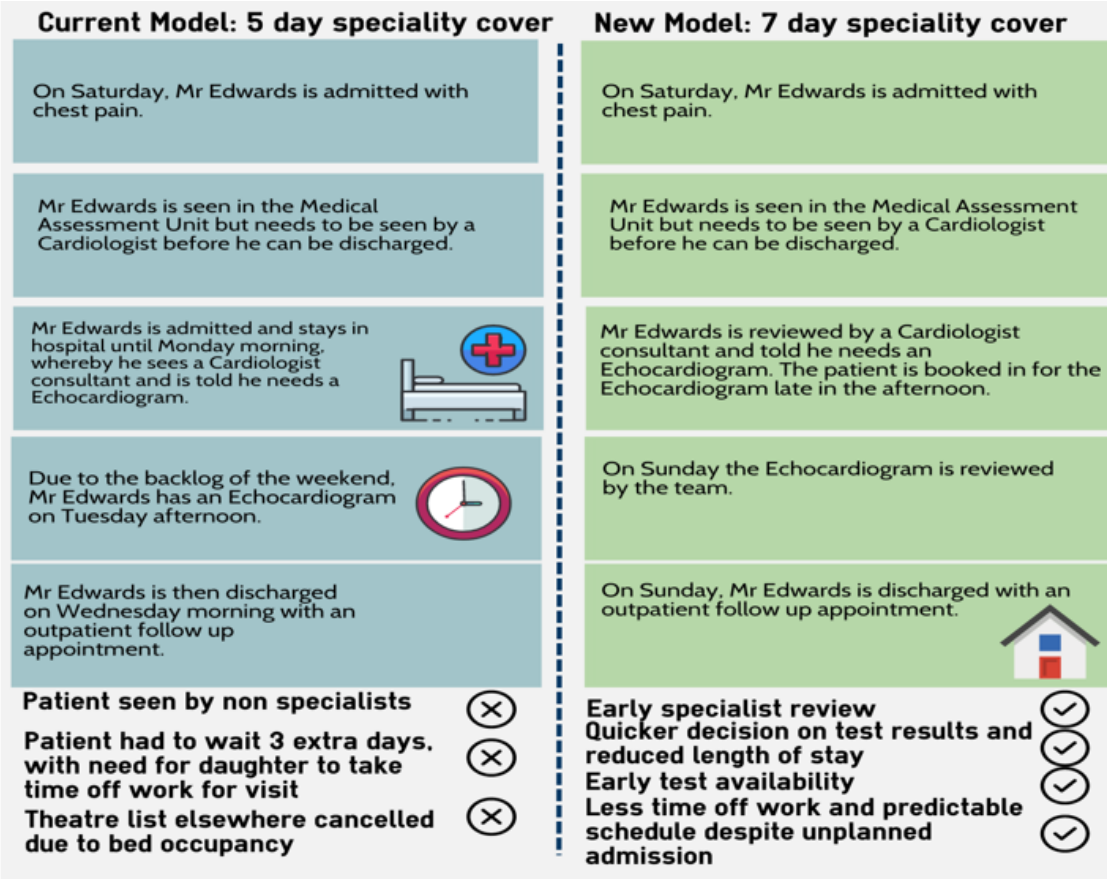
Hot clinics are same day or next day clinics with a specialist that a GP or other Health Care Practitioner can refer into. The purpose of hot clinics is to prevent the admission of patients with acute problems and is suitable for referral of patients that would likely require admission if not reviewed promptly. Patients are discharged from the clinic with a management plan drawn up by a Specialist Consultant.

Specialised Medicine

Our specialist consultants will work proactively with primary care to reduce the need to be admitted to hospital. Beds will be configured to provide the most efficient service and diagnostics available 7 days a week so the specialist medicine Model of Care will support the timely review treatment of the patient presenting with an acute medical need. This will in term reduce weekend mortality, length of stay and improve patient experience.

Specialities will work with the community and voluntary sector organisations to develop programmes that will improve the quality of life for patients accessing their services such as specialist singing groups for lung health that can improve quality of life, remove social isolation, improve respiratory function and reduce healthcare utilisation.

Figure 21: Current and Future Model for Speciality Medicine



The benefits this would achieve:

- No need to transfer patients who are very ill to another hospital = less risk to the patient's health
- Quicker decisions on whether patients can be safely discharged from hospital
- Delivered to National Standards
- More coordinated in and out-of-hospital care for physical and mental health patients

4.1.4: More efficient critical care service

4. More efficient critical care service

As a health system, we need to use the combined resources that we have at our disposal as efficiently as is possible. Emergency Departments are required to have a full critical care unit co-located on site. This is because they must be able to care for any patient that presents to them and some of these will be very poorly. Patients need a clear and safe pathway for escalation of care from Level 2 care (HDU) to Level 3 (ICU) For patients requiring access to critical care facilities the transition from the different levels of critical care will be seamless without needing to move the patient to different ward environments and to unfamiliar staff.

'It is not acceptable or logical to provide a ceiling of Level 2 critical care in isolated sites, as this may result in harm to patients[21]*.'*

National standards for adult critical care are already in existence (Appendix C). Patients must be cared for under the leadership of a Consultant in Critical Care Medicine who is dedicated to providing that care free from any other commitments 24/7.

It is essential that the standards for adult critical care are part of the Model of Care, as it is that the principles of working described elsewhere in this document are applied to care provided in this setting.

21 https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

4.1.5: A focus on emergency surgery and planned surgery

5. A focus on emergency surgery & planned surgery

Best Model of Care for Emergency and Higher Risk Surgery

Our hospitals are struggling to balance the requirements of balancing urgent and emergency care and directing patients to the right expertise first time will support effective flow through our hospitals and unnecessary waits in emergency departments. Patients that require emergency or urgent surgical assessment will be directed to a dedicated Surgical Assessment Unit (SAU). A SAU is a facility that provides comprehensive, patient-centred care by a dedicated hospital team. It provides access to specialist surgical assessment in a timely manner, avoiding unnecessary waits in the Emergency and Urgent Care Service. This service also helps to improve patient flow, avoid unnecessary care transfers, and improve patient experience.

Admissions to the SAU can be organised either directly from GP referral, from the Emergency Department, Urgent Care Service, or a hospital outpatient clinic. When referred to the SAU, all patients undergo senior review by a decision-maker before leaving the SAU to be taken to theatre, a ward or discharged home.

'Dedicated surgical assessment units can provide a centralised area where acutely ill surgical patients can be assessed and monitored prior to being admitted and/or receiving treatment. Well-resourced and designed units can provide speedy access to assessment, diagnosis and treatment and avoid unnecessary delays and admissions.'[22]

Complex surgery can be defined as those operations with an increased predictability of complication from their surgery that may require a return to theatre or critical care support. The increased probability of complications for these types of patient requires to a Consultant Surgeon 24/7, to be able to return to theatre, and to access full critical care support if required. For these reasons higher risk planned surgery will be co-located with emergency surgery.

Planned surgery – a summary of the problems we are trying to fix:
In the current service model, pressures with emergency admissions (unplanned) impact upon surgical planned care activity. This ultimately affects the quality of the service offered to patients. These pressures also have adverse impacts on delivering effective flow, patient experience and care according to the other access standards set out in the NHS Constitution, for instance the 18-week referral to treatment waiting standard.

In practical terms, if the hospital is unable to provide enough elective (or planned) surgical capacity because of excess demand for unplanned admissions, operations such as hip replacements may be cancelled. If not cancelled, those planned patients that do have a

[22] https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/emergency-surgery-standards-for-unscheduled-care/

bed may be allocated to a bed on a ward that is not staffed by nurses specifically trained in the relevant surgical speciality care.

Reorganising existing services and improving performance – what can be achieved?

Best practice scheduling and capacity management approaches can result in performance improvement. NHS Improvement (formerly Monitor, Oct 2015) indicated[23] that if every NHS provider followed the good operational practices adopted by the highest performers at each stage of their elective ophthalmology and orthopaedic care pathways, they could save between 13% to 20% of today's spending on planned care in these two specialties. These best practices are already being progressed within Lancashire Teaching Hospitals through existing service transformation work.

However, a significant and growing body of evidence supports the separation of emergency and planned care. To achieve this a more transformational approach would be required, taking the learnings and policy directions set out in the NHS 10 Year Plan. This states,

'Planned services are provided from a 'cold site' where capacity can be protected to reduce the risk of operations being postponed at the last minute if more urgent cases come in. Managing complex, urgent care on a separate 'hot' site allows trusts to provide improved trauma assessment and better assess to specialist care, so that patients have better access to the right expertise at the right time.'[24]

Transforming Surgical Care practice – ERAS+[25] - a summary

Transformations in surgical care practice and clinical case management can also contribute to improved patient flow and patient experience. Enhanced Recovery After Surgery Plus (ERAS+) is the first surgical pathway in the UK to focus on reducing post-operative complications to the lungs. This is the most common significant complication after major surgery, which affects up to 30% of patients. ERAS+ is a patient and family facing pathway that has been designed with patients for patients and aims to puts people at the centre of their own recovery.

In lung surgery, post-surgical complications are associated with increased length of stay in hospital of 5-8 days and a 10% greater risk of death.[26] In addition to the obvious clinical benefits for patients of such an approach, the resource benefits of implementing a clinically more effective approach which reduces length of stay are considerable. In sites where this has been implemented post-surgery lung complications have reduced by and the length of hospital stay reduced by 3 days. ERAS+ is supported to be successful by following the two care principles outlined below, linked to a wider clinical model and approach to delivering care led by the multi-professional team:

[23] https://www.rcophth.ac.uk/wp-content/uploads/2015/10/Elective-care-report-FINAL-Monitor-edit-v11.pdf

[24] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf
[25] https://www.erasplus.co.uk/
[26] https://www.health.org.uk/improvement-projects/improving-surgical-care-for-patients-and-their-families-in-greater-manchester-–?gclid=EAIaIQobChMI4pH1sce44AI

Principle 1 Support patients to be as healthy as possible before surgery

For a patient using the ERAS+ pathways they would be supported to be as healthy as possible before their surgery including attending a "Surgery School." Surgery School is an opportunity for the individual, their family and friends to understand what to expect after major surgery. They are shown how to prepare your body for your operation to make sure you have they successful and healthy recovery.

Principle 2: Support the patient to become functionally independent as soon as possible after surgery

During and on recovering from surgery, the patient is supported by a team of skills professionals to return to normal as soon as possible. Professionals that will support recovery in the patient home as the default and not in the hospital.

How can ERAS+ be used more to transform surgical care?

For planned surgery ERAS+ approaches will be implemented more widely by building further on locally successful pilot work and local care transformation. A good example is orthopaedic pathway where ERAS and rehabilitation already takes place. Support will be provided in the community by pre-op clinics and pre-habilitation provided to ensure that patients are at optimum fitness before undergoing their surgery. There are a number of other opportunities to use similar principles and approaches to innovation to deliver better care outcomes and experience for patients.

How could the principle of separating planned and emergency surgery transform patient care and outcomes?

For surgery that is non-complex and does not require a long hospital stay, carrying out this care in a specialist unit for planned care could lead to better throughput, lower surgical cancellation rates, and improved patient experience. The effective management of such care in a planned unit setting would also be anticipated to have reciprocal positive benefits for other elements of the care system. The full opportunities and pros and cons, of taking advantage of such an approach will be analysed in the options generation phase.

For this approach to work, the Royal College of Surgeons recommendations[27] around care streaming will need to be closely considered. Clinicians will need to stream elective care into minor, intermediate and complex and consider post-operative arrangements for recovery depending on the 'level' of elective surgery provided.

How could this approach improve surgery delivered as a day case?

It is commonly accepted that maximising the volume of low-risk, planned surgical care which can be safely and effectively delivered in a day case, as opposed to overnight admitted care setting are sound ideas in terms of making best use of finite surgical capacity and resources. With this in mind, the clinical vision would to be ensure that, wherever safe and possible, the use of day case surgical approaches are maximised and expanded. Also, that where such a surgical management approach is taken, all day cases are delivered via a dedicated day care unit.

[27] https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/seperating-emergency-and-elective/

Making the planned / emergency surgery split work – the role of PACU:

The planned care service would be supported by a dedicated Post Anaesthetic Care Unit (PACU). The PACU would be a protocol led unit led by experienced Advanced Nurse Practitioners. The unit would ensure that patients receive an increased intensity of pain relief, monitoring and nursing care when they require it.

Digital technology would connect the PACU to a full Critical Care Unit to provide remote intensive medical input supported by daily wards rounds by an intensive care consultant. For patients that have an unexpected deterioration a team would attend from the critical care unit to support urgent transfer. The PACU would have an equipped transfer room and rotation of staff across the PACU and critical care unit would ensure competent and confident care is immediately available regardless of location.

The benefits this would achieve:

- Fewer cancelled operations
- Operations scheduled and completed more quickly
- More comprehensive care for patients
- Care delivered in more convenient settings
- Patients will recover from surgery more quickly
- Timely consultant surgeon review and intervention available 24/7
- If you need to return to theatre overnight there will be someone to review you and take you straight there
- Any complications will be dealt with quickly and by an expert
- No need to move patients to another hospital or move them to different ward environments with unfamiliar staff.

4.1.6: Modern outpatient services

6. Modern Outpatient Services

Summary of the problem:

Nationally, just over 50% of outpatient referrals are received from general practice with 27% from other consultants, including the Emergency Department. Trends have shown a faster growth in outpatient referrals from other consultants, negating any reduction in GP referrals and the benefits of community-based triage approaches. Numerous interventions to reduce referral volume and increase appropriateness have been trialled in an attempt to manage demand with minimal success [28].

The cost of outpatient appointments is not just isolated to the NHS and to commissioners (those who pay for care) but is also incurred by the patient with wider economic effects such as missed work, childcare, car parking charges and travel time. As the volume of outpatient activity undertaken by the hospital is higher than the care provided through other modes (such as emergency, elective and urgent care), the issues caused from excessive outpatient department referrals impact adversely on patient experience at a significant scale.

Examples of the issues linked to patient experience caused by significant excess demands for outpatient appointments in the acute sector include:

- Longer referral waiting times;
- Longer waiting times to be seen in the hospital environment;
- Shorter median appointment times (as capacity is finite and split across more patient slots);
- Significant rates of appointment rearrangement or cancellation;
- More patients sent to the LTH site furthest away from their home, and more difficulties in providing patients with choice of appointment dates, times and place;
- Logistical issues such as more frequent patient travel to hospital and challenges in accessing the hospital site.

Hospital staff working in such facilities, such as outpatient clinic staff and administrative personnel involved in the coordination, planning and booking of activities can often have higher workloads to manage than is either planned, or ideal.

In addition to the problem of excessive demand for hospital-based outpatient appointments, the hospital loses access to appointments and sometimes has to duplicate outpatient activity. This arises from either appointments being missed (for instance where the patient does not attend an agreed or notified appointment), or those rescheduled at short notice by the patient, where the slot cannot be provided to someone else on the

[28] https://www.kingsfund.org.uk/sites/default/files/Referral-management-lessons-for-success-Candace-Imison-Chris-Naylor-Kings-Fund-August2010.pdf

waiting list for the specialty concerned. The mains reasons for missed appointments have been identified[29] and are summarised in Figure 22.

Figure 22: Main reasons for missed appointments (taken from national work)

Administrative factors	Convenience Factors
Clerical errors or communication failures	Distance needed to travel or cost of travel prohibitive
No longer needing to attend	Getting time off work or childcare issues
Difficulty in cancelling appointments	Organisation of clinics
Poor appointment notification design	Time or day of appointment may be inconvenient
Lack of notification or short notification	Transport/parking
The appointment booking process	

The new model for outpatient services will aims to address these challenges, based on the following principles

Principle 1 Providing care post discharge at home, wherever possible to avoid unnecessary hospital appointments

By supporting the patient at home following hospital discharge and looking to restore the patient's recovery and functional independence wherever possible, unnecessary contacts in the hospital can be avoided. With resources and workforce being in the right place, we can use the teams in community settings to do this, such as district nurses and practice nurses. This can complement the practice-based review that general practitioners are often responsible for when patients are discharged from hospitals.

Building on the theme of working together, as part of one integrated health and social care system, this care will be enhanced where required by Specialist Nurses, based in the hospital, but providing both in-reach and outreach services will provide initial support, and be available as an ongoing source of expertise to the community teams.

Principle 2 Using technology to best effect

Wherever possible, and always considering patient choice and preference, the use of technology will be incorporated into outpatient pathways. Alternative methods to face to face consultations can have a significant impact on population health by reducing NHS related travel. These appointments reduce disruption to patients' lives and the need for hospital infrastructure.

[29] https://www.rcplondon.ac.uk/projects/outputs/outpatients-future-adding-value-through-sustainability

Patients are being reporting as '*embracing new technology and increasingly expect there care to be supported by it'*. Our model for outpatient services will include a number of forms as an alternative to face to face consultations.

Principle 3 Improving referral practices

Training and feedback on referrals given to all referrers, not just GPs so that all health professionals continue to adapt and learn so that patients get sent to the right person first time.

Alternative to face to face consultations

Virtual Follow up:

The orthopaedic service at LTH run a virtual follow up clinic (VC). Under a VC within an orthopaedic pathway, patients can opt to have X-rays done closer to home, and complete hip and knee scores at home on a web-based system. The X-ray films and scores are then assessed by a surgeon in a virtual clinic, and they can then report back to the patient and their GP.

The Royal College of Physicians Future Hospitals programme[30] describes a consultant-led virtual clinic model for chronic obstructive pulmonary disease. Patients are identified through targeted searches and their primary care record reviewed in a joint primary/secondary care education session. These sessions aim to educate and up-skill primary care staff, promote non-pharmacological interventions such as pulmonary rehabilitation and smoking cessation, and promote safe prescribing practices. There are opportunities to expand this method of virtual follow up.

Telephone and Video Consultations:

These are not designed to totally replace face to face consultations but are able to deliver some of their functions via a video link or telephone. Telephone follow up appointments are now common place and this success will be rolled out further using video links where able. It is also possible to use this method for professional discussions about care and advice. By making more use of video calls both in the community and across provider sites, it may also be possible to reduce unnecessary staffing travel time, thereby releasing more time to care.

Remote monitoring:

Remote monitoring is a term used to describe any technology that allows patients to submit personalised data which can be used to reassure and support their health goals through self-management and allow data transfer back to the health care team. Portals used for data sharing can alert clinical teams to potential problems triggering more formal review. Care delivered in this manner can replace face to face follow up appointments with ones triggered by patient need.

Wherever possible appropriate observations will be delivered remotely allowing the patient as little disruption as possible to their day-to-day life, improving outcomes and wellbeing by creating reassurance without anxiety. Results will be monitored by specialist nursing staff, escalating to consultants only when required.

[30] https://www.rcplondon.ac.uk/projects/outputs/future-hospital-programme-delivering-future-hospital

Telephone/ tablet applications:

Apps will be increasingly used to remind clinicians of investigations, referral methods or other pathway criteria both during implementation. They will also be used by patients to monitor or manage their condition on discharge, to commence and participate in interventions such as cardiac rehabilitation, or to receive requests or instructions from the clinicians.

Risk stratification:

For cancer services the traditional model of follow up has been to offer screening and outpatient reviews over a period of three to five years. Lancashire Teaching Hospitals has already implemented a risk stratification approach within Breast and Head and Neck Services to inform the most suitable outpatient pathway.

Use of Risk Stratification in the Head and Neck Cancer Service at Lancashire Teaching Hospitals:

Thyroid cancer has a lifelong risk of recurrence so patients must be followed up for life and patients treated are risk stratified at two key points of their recovery journey. Since this stratification commenced in 2012 over 993 outpatient episodes have been seen by the Clinical Nurse Specialist (CNS) and removed from consultant clinics and freeing their time for more complex and urgent patients. Patient feedback over successive audits is excellent, with emphasis on the therapeutic relationship between CNS and patient, and management of treatment side-effects.

For other types of Head and Neck Cancer clinicians at Lancashire Teaching Hospitals have developed a local risk stratification model based on available data locally and nationally. The clinic commenced in January 2019 and is removing these patients from consultant led follow up into CNS follow up. Complex psychosocial issues are not uncommon due to the lifelong nature of treatment side effects – these are addressed in the clinic if required. Head and neck patients are currently followed up for 5 years after completion of treatment – using this model it is anticipated 60% of patients will be in CNS, rather than consultant, follow-up by the end of 2019.

The benefits this would achieve:

- Recognise the public as individuals with varying health needs, personal pressures and ability to manage their own treatment.
- The public will have more control over when and how they receive care.
- Self-management supported by the availability of an appropriately trained member of staff to educate and support them.
- Work alongside the community and voluntary sector organisations to develop programmes that will improve the quality of life for patients and the wider population.
- Use technology such as digital dictation, telemedicine, digital recording of consultations and remote monitoring to support delivery of care that is convenient for the patient.

4.1.7: Effective planned care and discharge planning

7. Effective planned care and discharge planning

This section complements the others in so far as it describes how the best use of inpatient capacity can be delivered from utilising best practice linked to discharge planning. Timely support and review of patients will ensure they remain in hospital for only as long as they medically need to be and that they feel supported and well informed when they go home.

The approach below has a general application which has the opportunity to bring significant benefits in terms of delivering improved hospital flow, better patient experience and a more effective use of resources.

Effective Discharge Planning:

The 10 steps of discharge planning were highlighted as a continuing High Impact Action to support trusts make the best use of finite inpatient bed capacity and associated resources. The principles of these steps have been developed to work alongside the existing systems, process and transformation programmes developed by a hospital. They are also based on the principle that effective triage, whether in the emergency department, in the CATCH service or other settings has taken place to ensure that if a patient needs to be admitted, that this decision is a necessary response to the presenting complaint and the scope of the patient's needs at that stage.

In this way, they are complementary to the other ideas described in this Model of Care for the management of inpatients, linked to each of the other aspects/areas of the care pathway described.

1. **Start planning before or on admission:**

In elective care, planning can commence before admission and may take the form of a screening tool, risk assessment or care pathway. The principle is to anticipate potential delays and manage those in a proactive manner.

2. **Identify whether the patient has simple or complex needs:**

Identifying the likely patient pathway from admission and undertaking a holistic care plan will enable the admitting department to understand to what extent the patient's needs are either simple or complex. This will then help to understand whether or not the likely clinical management plan or length of stay projection for the patient is likely to be accurate, given the patient's wider needs.

3. **Develop a clinical management plan within 24 hours of admission:**

Most patients admitted by junior medical staff will have an outline management plan. Developing this plan quickly helps prevent unnecessary waiting for patients in a complex inpatient facility, which in turn contributes to issues of poor "flow" throughout the hospital.

4. **Coordinate the discharge or transfer process**:

Communication, multi-disciplinary working and assessment are three key roles for discharge coordinators. These roles are particularly vital where transfers of care to other centres of settings where onward care will be provided will be complex, or where capacity to receive the patient will be limited. Examples may include transfers to residential care homes, specialist rehabilitation facilities or supra-regional centres for highly specialist conditions where care is not fully provided by Lancashire Teaching Hospitals.

5. **Set an expected date of discharge within 48 hours of admission:**

The patient's discharge date should be estimated as early as possible to guide the discharge-planning process. Estimated dates of discharge have three main purposes; helping to predict overall capacity, assessing the progress in terms of the delivery of clinical care plans, and also for patients to help understand their current and likely care plan and expected outcomes.

6. **Review clinical management plan daily.**

A three-step approach is generally employed; Review, action, progress (RAP) to take account of changes in the patient's condition and progress in implementing the agreed clinical management plan.

7. **Involve patients and carers.**

This is aimed at managing patient/carer expectations and understanding potential complexities or challenges; it mainly involves therapy and social care partners, who should be guided by the clinical referrals and actions in the clinical management plan. This type of involvement is key to helping the patient and their support structure around them prepare for the next step in their care and ongoing treatment.

8. **Plan discharges and transfer to take place over seven days.**

This relies on engagement from services that support discharge, such as therapy, X-ray, transport, district nursing and intermediate care, as have been described through this section of the Model of Care. Seven-day service working are a key principle as described in the Keogh recommendations and more recently the NHS 10 Year Plan.

9. **Use a discharge checklist 48 hours before transfer.**

The use of a discharge checklist is to ensure that in the planning stage and pre-discharge stages, vital aspects of the planning are not missed.

10. **Make decisions to discharge and transfer patients each day.**

Nurse-led discharge will never replace the role of the multi-disciplinary team working and the role, coordination and support of senior decision makers, such as consultants, but it is vital that this role and working concept is fully utilised to inform and deliver effective hospital flow[31].

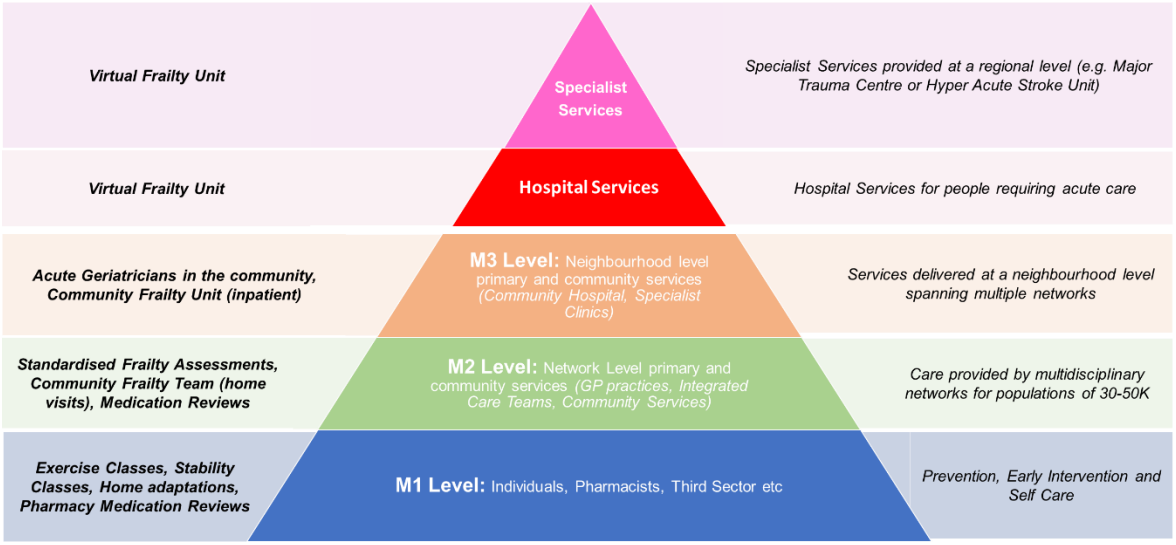
[31] https://www.nursingtimes.net/Journals/2013/01/17/x/l/m/130122-Effective-discharge-planning.pdf - accessed 16th February 2019 (amended from).

4.2 Delivering whole system care: An end to end approach for patients

This section of the Model of Care outlines how end to end care could look in reality for our patients. Two end-to-end pathways, Frailty and COPD, have been identified to provide this overview. These pathways were chosen after reviewing the priorities outlined in the NHS 10 Year Plan, analysing of local CCG data and reviewing ongoing local pilots to ensure we can describe pathways that can be provided at scale to deliver real impact to local patients across our health economy.

4.2.1 The Frailty pathway

This section describes the 'end to end' pathway for frail patients. It describes the proposed Model of Care to deliver care in an integrated way across the whole health economy. Some of the services described are already in place and others are an aspiration for the future. Each of the segments in the figure below, relevant to frail patients, are described.



The British Geriatrics Society describe Frailty as "a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves[32]"

Often, tools such as the Rockwood Frailty Scale are used to determine the severity of an individual's frailty. The Rockwood scale uses a scoring system (1-9) to determine how frail an individual may be, irrespective of age. This tool (Figure 23) will be used locally across all services to ensure patients receive standardised assessments and clinicians are able to develop care plans that are individual to the patient's needs.

[32] https://www.bgs.org.uk/resources/introduction-to-frailty

Figure 23: Clinical Frailty Scale

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

Our Vision for Frailty

We want our patients to have easy, local access to a range of preventative service to help them stay fit and well for longer, with specialist support available to them both in the community, and in hospital.

Our frail population deserve to receive their care in the most appropriate location. Often, for our patients, this is in their own homes. Our vision for the future is that health, care, and third sector services will work collaboratively to identify patients at risk of becoming frail and ensure that they have the knowledge and ability to signpost to appropriate community services. For example, patients should be offered classes to improve fitness and stability, as well as receiving home assessment to minimise their risk of injury whilst feeling like they are receiving support from "one service".

When patients do require additional support, we want to ensure speciality knowledge is available to them in the community to reduce unnecessary hospital visits, and when patient do require acute care, they receive specialist frailty support on a daily basis to ensure their hospital stay is as short as possible.

Our system needs to act as one for the benefit of our frail population. This Model of Care outlines how.

4.2.2 Preventative services

To identify people at risk of becoming frail (*generally over 65-year olds but younger people can also be frail)* we will work with non-NHS and third sector organisations who through their work regularly come into contact with people in the community or their own homes; to empower them to actively recognise and signpost people to services which may help them maintain their independence and remain healthy (for example maintaining adequate nutrition).

Integrated Working

GPs practices will work together to review the populations they serve, to identify those people who are likely to be at risk of greater heath and care use, using tools designed to categorise frailty (such as the Electronic Frailty Index and the Rockwood Assessment Tool).

Prevention and Early Intervention

The GP practice will play a key role in keeping those at risk of being frail, well. Multi-disciplinary teams within practices will signpost to local support groups, suggest opportunities to maintain health (such as participation in exercise[33]) and provide information on living a healthy lifestyle to enable patients to look after themselves. They will also provide more routine care such as ensuring patients are offered yearly Flu vaccinations and that minor illness and injuries are promptly treated. Community pharmacists will support the management of patient's medication by undertaking frailty assessments.

Enhanced Self-Care

[33] This is often described as Social Prescribing which is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services.

It is important that mental health support is considered at each element of the patient's journey. Frail patients will be offered psychological support through the Improving Access to Psychological Therapies (IAPT) service. People with long-term conditions can often suffer with their mental health as a result, and additionally, this can often then exacerbate the comorbid physical health problem. IAPT provides patients with access to therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimize outcomes. Practitioners use routine outcome monitoring to ensure shared ownership of goals and progress with the patient.[34] Patients can either self-refer to this service or be referred by clinicians within the network.

Integrated Working

Prevention and Early Intervention

For those at greater risk of becoming frail GP practices working together will offer targeted support for both physical and mental health needs. For example, patients could be directed to a range of classes to improve their condition e.g. postural stability classes.

Additionally, patients will be signposted to fall prevention services. The falls prevention service works with community residents and care homes using an individual multifactorial risk assessment and person-centred group education model, together with direct links to psychological support, clinical falls services and third sector organisations. Additionally, they have access to other services that support falls prevention i.e. a functioning medicines use review service, accessible falls prevention exercise sessions, access to service that deliver on minor household adaptations, good supply of local opticians and chiropodists, appropriate opportunity for exercise, brief intervention and support for alcohol use.

Preventative and Early Intervention

4.2.3 Patient treatment and management provided out of hospital

4.2.3.1 For patients who are deemed to be mildly frail, primary care and community teams will undertake a clinical review. This will be in the form of a geriatric assessment to allow a personalised care plan to be developed with the patient where necessary, detailing how their frailty will be managed in the context of the other conditions the patient may have and their individual circumstances. The care plan should be managed by an identified key worker within the neighbourhood.

Personalised Care

Care planning could involve referring patients for occupational therapy home assessments, physiotherapy exercise programmes, voluntary sector or social care support. They should also involve undertaking a falls assessment, reviewing medication and putting a plan in place with the ambulance service to avoid hospital admissions where appropriate. It should also consider the role and needs of the patient's carers where appropriate.

Integrated Working

4.2.3.2 For patients who are deemed to be moderately to severely frail, networks and practices will be able to refer to a number of community services through a single point of access called the CATCH service (*Central Allocation Team for Care and Health).* This service has one telephone number and is available 8am-8pm, 7 days per week, for GPs and other health professionals to utilise.

Seamless Service Delivery

For patients who are at the end of their life, palliative care pathways will be followed[35].

[34] https://www.england.nhs.uk/mental-health/adults/iapt/

[35] Gold Standards Framework use for patients requiring End of Life care

Community services available will include:

Services designed to keep patients well in the community or home environment to prevent an unnecessary hospital admission due to loss of independence (step-up services):

- **Community Frailty Service**: A *community team consisting of advanced nurse practitioners, physiotherapists, occupational therapists and support workers. The wider team will include social workers*, *mental health liaison*, *and Peer Support Workers*[36]*.* **Care Closer to Home**
    - This service will undertake comprehensive geriatric assessments for these patients, through either attendance at the service (currently based at Longridge Community Hospital) or through a home visit from a specialist practitioner, in order to develop an advanced personalised care plan; **Integrated Working**
    - For those patients who require it, this service will be able to admit patients for a 72-hour stay (intermediate care provision - for those patients who require treatment and support but who don't necessarily require the services provided in a hospital setting for acutely ill patients); and
    - Alternatively, this service will be able to provide care in patient's own home for up to a 6-week period to improve their condition.

- **Acute Geriatricians to work in the community** to support Integrated health and social care teams who will work at a neighbourhood level to support frail patients. Geriatricians will provide leadership in shifting the balance of the clinical care of frailer older people into the community where that is appropriate. This includes leadership in the development of appropriate community services, and participation as specialist medical staff in those services.[37] This integrated team will include social workers, district nurses and community matrons, with strong links to general practice. The geriatricians will lead the integrated teams in providing targeted support to care homes. **Care Closer to Home**

- **Central Lancashire District nursing team:** A community team providing a responsive service for housebound patients with complex nursing needs, including patients with palliative care needs. **Integrated Working**

- **Social services** who provide specific services for patients who are frail including e.g. Integrated Home Improvement service in Lancashire funded by Lancashire County Council which provides Home Improvement Services and Minor Aids and Adaptations.

Services designed to support patients who have been in hospital with an acute illness or injury who require support to facilitate their discharge from hospital (step-down services):

- **Acute Geriatricians to work in the community** (as described above)**.** This team and the geriatrician will operate a 'virtual ward' managing patients who have been

[36] Peer support involves an individual with lived experience of a condition using their own knowledge and understanding to help support those who are going through a similar experience. Peer support can be introduced in either a voluntary capacity or as part of a paid job role. PSWs use their own lived experience and knowledge to help service users who are receiving treatment, undergoing recovery or learning new skills. They share the story of their experiences to help inspire others.

[37] https://www.bgs.org.uk/resources/geriatricians-in-medicine

discharged home or to intermediate care. The geriatricians will also provide targeted support to care homes.

- **Central Lancashire District Nursing team** as described above.
- **Social services** as described above.
- **Voluntary sector** services should be available to provide a 'welcome home' service for frail older people who live alone 7 days a week. For example, Age UK Lancashire works with the hospitals to assist in the safe and timely discharge of patients through the provision of a 'Take Home and Settle' service.[38]

Integrated Working

In addition, primary and community care clinicians as well as paramedics will have access to advice from acute hospital clinicians via an *'urgent care clinical advice hub'* available 7 days per week which will further support the management of patients in the community or own homes, where appropriate.

In support of managing patients out of hospital, there is broad recognition of technology's potential for improving the safety and independence of frail elderly persons, giving people the ability to remain in their own homes for longer, improving their quality of life by improving their independence; and to allow patient monitoring which enables appropriate escalation instead of waiting for signs of deterioration resulting in emergency admissions. Several options are being reviewed to enable technology to be integral to the patient pathway described above.

Enhanced Use of Technology

4.2.4 Patient treatment and management provided in hospital

Patients who are frail often require acute hospital care due to acute illness caused by other conditions or acute injury such as a fall. Their frailty is a factor to manage in order to improve their outcome and quality of life, however, it is not usually the primary reason for their hospital visit.

Patients who require acute care:

4.2.4.1: Could be referred to the hospital by primary or community care clinicians through a single point of access **'urgent care clinical advice hub'**. This hub will facilitate a discussion about the patients' needs directly and personally with a senior clinician from the acute hospital. The hub will be available 7 days a week to facilitate primary and community clinicians to utilise advice and ensure the right acute service is accessed. This service will be run in partnership with the CATCH service to ensure routes to community services (as described above) are also available.

Integrated Working

Following live dialogue with an acute care senior clinician via the urgent care clinical advice hub patients could be managed in the community. They could also be referred directly into any of the following, thus reducing pressure on the emergency department:

[38] This can be: Going ahead to ensure the home is accessible and at a suitable temperature; Going ahead to meet a friend or relative to ensure a safe and settled return home; Travelling home with a service user when hospital transport or friend/family collection would delay the discharge of the older person; Purchasing a crisis shop on behalf of the older person to get them through their immediate return home until additional support is put in place.

- the patient is booked into a **hot clinic** under the speciality from which they require care. This is a rapid access clinic which is consultant-led and allows diagnostics to be undertaken quickly to start the process of getting to a diagnosis for the patient; or
- the patient may be referred into **Ambulatory Care** (same day medical or surgical services) which allows patients to be treated on the day, without being admitted to the hospital; or
- the patient is referred into **a short stay assessment unit** Surgical Assessment (SAU) or Medical Assessment (MAU)) which provide timely and effective evaluation and initiates a patient's treatment, patients could be discharged home from this facility to complete their treatment or from here be admitted to a hospital ward.

Improved Access

4.2.4.2: Alternatively, the patient may not go via primary or community care and instead go to the hospital directly. Here the patient will access the 'front door' of the hospital, via ambulance or by presenting themselves.

Those patients who self-present will undergo triage within 15 minutes of arrival and be directed as appropriate. The triage process will be a wide assessment of the patient's health and wellbeing with clinicians signposting to voluntary sector services and support groups as appropriate.

Improved Flow

The triage process will result in the patient being directed or transferred to one of the following services:

- Urgent Care treatment centre/ Local accident and emergency department: where they will be reviewed and treated by acute physicians and GPs; or
- Major emergency department: where they will be reviewed and treated by emergency department doctors.

Alternatively, the patient may be sent home or asked to see their local GP if they are not deemed to be acutely unwell.

Those patients who are conveyed by ambulance will be taken to:

- Urgent Care treatment centre/ Local accident and emergency department: where they will be reviewed and treated by acute physicians and GPs; or
- Major emergency department: where they will be reviewed and treated by emergency department doctors.

Better Use of Resources

Some patients who ring for an ambulance, may be re-directed to community frailty services (via the CATCH service described above). Agreements are in place with the North West Ambulance Service to allow this direct referral into community services to avoid unnecessary hospital attendances.

To ensure the effective management of frail patients it is important that all patients over the age of 65 are taken through a frailty screening process; the Rockwood assessment tool will be used at the front door to facilitate this.

4.2.4.3 A proportion of these patients will then be admitted to hospital.

All older people being admitted should have an expected discharge date set within two hours. A proactive approach to discharge planning will be undertaken, using a standard discharge planning document. A Central Lancashire Discharge Charter has been

Improved Flow

developed which local organisations have agreed to use to standardise the process from when a decision to admit a patient is made.

Those patients assessed as frail will then receive a comprehensive geriatric assessment undertaken by the Lancashire Integrated Frailty Team (LIFT) made up of specialist therapists, nurses and geriatricians, within 24 hours of their admission. They may then be admitted onto a 'Virtual frailty unit' which means they will receive daily patient reviews from this specialist team, whilst being cared for on the ward to which they have been admitted.

In addition, patients who may require surgery will be provided targeted support by the Elderly Medicine clinicians within the hospital.

Each ward will have a discharge facilitator, who will ensure the patient has both an Expected Discharge Date and summary of clinical criteria for discharge in place. Senior clinicians who can make discharge decisions will review patients before midday in order for their decisions to be enacted upon, furthermore there will be emphasise placed on enabling early discharge (before 12pm midday) for patients where possible.

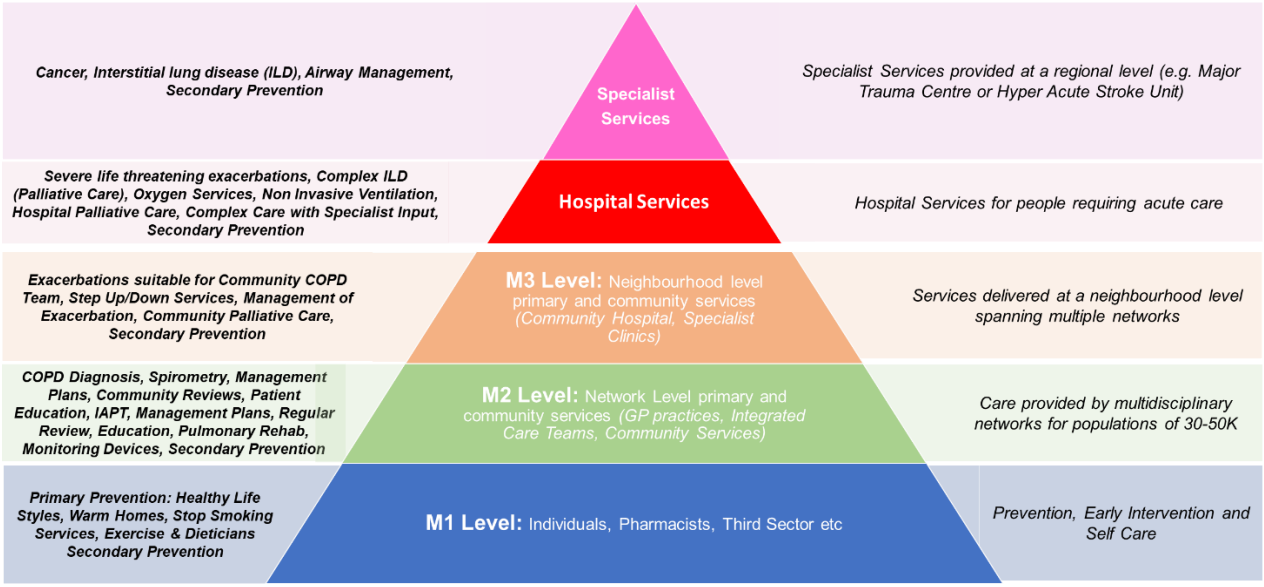
Where patients do have a longer stay than expected, a multi-disciplinary team will assess the patient with a clear 'home first' mind set.

When preparing for discharge, the patient and their carers will be offered details of local voluntary sector organisations and practical and emotional support including information on accessing financial support and reablement services.

On discharge from hospital a number of 'step-down' community services will be available to support the patient, as described earlier.

4.3 Chronic Obstructive Pulmonary Disease (COPD) pathway

This section describes the 'end to end' pathway for patients with COPD. It describes the proposed Model of Care to deliver care in an integrated way across the whole health economy. Some of the services described are already in place and others are an aspiration for the future. Each of the segments in the figure below, relevant to patients with COPD, are described.



Our Vision for COPD:

We want to empower our patients to be able to better self-manage their COPD and provide them with integrated, quality care when they need it most.

Our patients should have improved access to a greater range of preventative services across the region and be supported by specialist COPD clinicians in their own communities. Staff will have greater control over their records and be able to confidently share "what is normal for me" with clinical staff to avoid telling their story multiple times.
Service provision will be standardised, and staff across the system will work as one team, with patients receiving seamless care from "one service".
This is what our patients deserve.

4.3.1 Preventative services

Primary prevention initiatives help our local population avoid developing COPD. There are a number of primary prevention initiatives for respiratory conditions which will be available in Central Lancashire, these are summarised below:

Prevention and Early Intervention

- **Warm Homes:** Living in a cold home can can have a serious impact on health. Those particularly at risk include the very young, the old and people with long-term illness or disability that, for instance, stops people moving around to keep warm or makes them more likely to develop chest infections. Cold weather and in particular cold homes is believed to be a main factor in causing the winter increase

of respiratory and circulatory disease.[39] Cold homes can also suffer from damp and mould issues which can cause respiratory infections, allergies and asthma. Interventions would typically include physical measures such as heating repairs, replacement, insulation and draught proofing which can be accessed via government programmes and grant schemes, together with support such as income maximisation advice on energy bills and tariff switching and general energy efficiency advice.[40]

- **Air Quality:** Air pollution is the top environmental risk to human health in the UK.[41] Long-term exposure reduces life expectancy, mainly due to cardiovascular and respiratory diseases and lung cancer. Short-term exposure to elevated levels of air pollution can also cause a range of health impacts, including effects on lung function, exacerbation of asthma, increases in respiratory and cardiovascular hospital admissions.[42] These are nine areas in Central Lancashire where the local authority identifies statutory air quality limits are exceeded and there is relevant public exposure. Local authorities have put together action plans detailing remedial measures to address these problems.

Integrated Working

- **Smoking:** Smoking remains the single largest preventable cause of ill health, premature death and health inequalities. In Lancashire there are over 140,000 smokers and we are committed to reducing the prevalence of smoking through developing partnerships and de-normalising smoking. The stop smoking service will be offered at a network level, with GPs working together on a locality basis to provide access to the stop smoking service in surgeries where smoking prevalence is high, in order to target smokers providing brief advice and support to quit smoking. In addition, community pharmacists will also signpost people to smoking cessation. The stop smoking service would offer intensive psychological support for COPD patients to quit smoking and also provide targeted support to those with mental health conditions, pregnant women, patients with long-term conditions and patients undergoing surgery.

Prevention and Early Intervention

4.3.2 Patient treatment and management provided out of hospital

A standardised process will be put in place for patients suspected of having a respiratory condition to ensure a clear diagnosis, this will include the standard use of Spirometry.

4.3.2.1 Patients who are diagnosed with COPD will have a quality assured diagnosis that includes standardised spirometry to reduce variation (by 2021 spirometry should be performed and interpreted by an ARTP accredited individual). This will reduce variation amongst practices and make better use of resources in the community. Standardised spirometry will also save valuable clinical time by reducing the need for repeat investigations.

Standardised Care

COPD patients will be entered onto a disease register by GP practices to allow their care to be effectively managed. GP practices will undertake an annual care planning process for all these patients to ensure individual patient management plans are relevant to their

[39] The Health Impacts of Cold Homes and Fuel Poverty: the Marmot Review Team. 2011 (p24)
[40] Excess winter deaths and illness and the health risks associated with cold homes, NICE Guideline, 2015 (recommendation 3)
[41] Clean Air Strategy 2019, DEFRA
[42] Public Health England

stage of disease and to ensure patients are able to access **secondary prevention** initiatives. Secondary prevention initiatives aim to help patients with COPD have less disease progression and fewer exacerbations. For example, care planning could involve referring patients for Pulmonary Rehabilitation (where patients are functionally disabled by COPD). These sessions would be provided at the network level to ensure patients are able to access close to their homes.

Greater Self-Management

Promoting Patient Empowerment and Responsibility: Our local population will be enabled to have a better quality of life by taking a more active role in their own care. In order to achieve this, patients require access to information on how to best self-manage their condition and to truly understand what is "normal" for them. Our vision is that all COPD patients across Central Lancashire will be issued with a patient passport. This passport will enable patients to access information on how to manage their condition in different situations and how to lead their condition. This passport will also be updated after any clinical interaction and their baseline constantly updated to ensure that they are clinicians are able to understand what is that patients normal. Patient passports will enhance data sharing across Central Lancashire whilst also enhancing the ability for patients to take control of their condition.

Prevention and Early Intervention

Promoting Patient Education and Self-Management: A proactive approach to education will be taken with GP practices working together in networks to provide structured education sessions for patients and their carers. These education sessions will allow patients access to respiratory specialists such as specialist nurses, physiotherapists, pharmacists, expert patients, and stop smoking services, with overarching support provided by respiratory specialists. They will provide detailed information about their condition and how patients can help themselves manage COPD through for example education on the use of equipment and what to do if their condition is exacerbated.

Integrated Working

Additionally, GP practices will also apply a risk stratification process target their patients with COPD most likely to attend or be admitted to hospital to allow interventions and to maximise their alternative treatment options. GPs will also provide more routine care such as ensuring patients are offered routine inhaler checks and yearly Flu and Pneumonia vaccinations

Prevention and Early Intervention

We aspire to offer more patients the use of remote monitoring devices which will allow patients to manually upload a daily questionnaire and regular readings of oxygen saturation/blood pressure to a tablet so that healthcare professionals are able to monitor any changes in patients' conditions. This will enable early intervention and prevent unnecessary hospital admissions. A local pilot is currently in development that will allow more than 30 patients to trial the technology for 6 months. There is a significant opportunity to expand the use of this technology based on the outcome of the pilot and feedback from clinicians, patients and others.

Enhanced Use of Technology

It is important that mental health support is considered at each element of the patient's journey. Patients diagnosed with COPD who co-present with Anxiety and/or Depression should be offered psychological support through the Improving Access to Psychological Therapies (IAPT) service. People with long-term conditions can often suffer with their mental health as a result, and additionally, this can often then exacerbate the comorbid physical health problem. IAPT provides patients with access to therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimize outcomes. Practitioners use routine outcome

Integrated Working

monitoring to ensure shared ownership of goals and progress with the patient.[43] Patients can either self-refer to this service or be referred by clinicians within the network.

GPs and other primary care professionals will be able to refer to a number of community services through a single point of access called the CATCH service (*Central Allocation Team for Care and Health).* This service has one telephone number and is available 8am-8pm during the week.

Services designed to keep patients well in the community or home environment to prevent an unnecessary hospital admission (step-up services):

- **'One-stop shop' multidisciplinary integrated clinic**
  - Patients to see specialist respiratory clinicians (with access to Pharmacy and Stop Smoking services if required).
  - Where possible this clinic will be used to review the treatment plans of patients confirmed to have COPD: optimising their medicines management and directing patients to other services e.g. Pulmonary Rehabilitation, stop smoking services, vaccination services, dietician or speech and language therapy etc.
  - This clinic helps support complex patients avoid the need for patients to attend hospital.

Integrated Working

- **Community COPD Team**: A community team consisting of Specialist Respiratory Nurses, Respiratory Physiotherapists, Rehabilitation assistants.

Care Closer to Home

This service will offer personalised care and provides advice and education to help patients to manage their own condition, recognise the early signs of an infection and know when to seek medical advice. The services support people with COPD to stay healthy and remain in their own home wherever possible. The service includes:

  - Intensive Home Support available for patients with an infective or non-infective exacerbation of COPD
  - Diagnostic spirometry for more difficult diagnoses
  - Pulmonary Rehabilitation
  - Specialist COPD review (nurse or physio)
  - Breathlessness Management
  - Palliative Care

- **Central Lancashire District nursing team:** A community team providing a responsive service for housebound patients with complex nursing needs, including patients with palliative care needs.

Care Close to Home

Services designed to support patients who have been in hospital with an acute illness or injury who require support to facilitate their discharge from hospital (step-down services):

- **'One-stop shop' multidisciplinary integrated clinic** (as described above)

- **Community COPD Team**: (as described above) but focused on the provision of Intensive Home Support available for patients with an infective or non-infective exacerbation of COPD support patients after a hospital admission.

Care Close to Home

[43] https://www.england.nhs.uk/mental-health/adults/iapt/

- **Central Lancashire District Nursing team** as described above.

- Clinicians will be able to refer patients directly into **Pulmonary Rehabilitation** provided across networks in the region.

- **Oxygen Assessment Services:** A team of specialists provide services to support patients on oxygen at home. The team provide initial assessment in a clinic (following referral) to ensure oxygen is needed and assess the type of oxygen equipment which will best meet the patient's needs. They then provide on-going monitoring of oxygen needs and advice on medication, fire safety and equipment related to oxygen use

In addition, primary and community care clinicians as well as paramedics will have access to advice from acute hospital clinicians via an *'urgent care clinical advice hub'* available 7 days per week which will further support the management of patients in the community or own homes, where appropriate.

4.3.3 Patient treatment and management provided in hospital

Patients who have COPD often require acute care in a hospital setting however the development in how the clinical and nursing teams work across the system, along with the widening of their skill set allowing patients to be treated at home, creating improved outcomes and mental health and wellbeing, along with a reduction in time spent in hospital.

An increased use of specialist respiratory nurses, along with a possible increased access to radiology services will improve accessibility.

4.3.3.1: Patients could be referred to the hospital by primary or community care clinicians through a single point of access **'urgent care clinical advice hub'**. This hub will facilitate a discussion about the patients' needs directly and personally with a senior clinician from the acute hospital. The hub will be available 7 days a week to facilitate primary and community clinicians to utilise advice and ensure the right acute service is accessed. Clinicians are also able to use the CATCH service to ensure routes to community services (as described above) are also available.

Integrated Working

Following live dialog with an acute care senior clinician via the urgent care clinical advice hub, patients could be managed in the community. They could also be referred directly into any of the following, thus reducing pressure on the emergency department.

- the patient is booked into a **Respiratory hot clinic**. This is a rapid access clinic which is consultant-led and allows diagnostics to be undertaken quickly to start the process of getting to a diagnosis for the patient; or
- the patient may be referred into the urgent care service for **Ambulatory Care** (same day medical services) which allows patients to be treated on the day, without being admitted to the hospital; or
- the patient is referred into **the Medical Assessment Unit** (MAU) which provides timely and effective evaluation and initiates a patient's treatment, patients could be discharged home from this facility to complete their treatment or from here be admitted to a hospital ward; or
- The patient is booked directly into the **Respiratory Speciality Ward** where they will receive timely review 7 days a week.

Improved Access

- For patients requiring specialist support for their breathing they would be cared for within the **Critical Care Service**

4.3.3.2: Alternatively, the patient may not go via primary or community care and instead go to the hospital directly. Here the patient will access the 'front door' of the hospital, via ambulance or by presenting themselves. These patients (through an initial clinical assessment) would be directed as above.

Alternatively, the patient may be sent home or asked to see their local GP if they are not deemed to be acutely unwell supported by the community teams.

4.3.3.3: For patients admitted to hospital, the aim for patients will be for them to see the respiratory specialists as quickly as possible, to ensure their care is provided by a multi-disciplinary team.

A proactive approach to discharge planning will be undertaken, using a COPD discharge bundle. The content of this bundle is being monitored through the national COPD audit.

Each ward will have a discharge facilitator, who will ensure the patient has both an Expected Discharge Date and summary of clinical criteria for discharge in place. Senior clinicians who can make discharge decisions will review patients before midday, 7 days a week in order for their decisions to be enacted upon, furthermore there will be emphasise placed on enabling early discharge (before 12pm midday) for patients where possible.

Improved Flow

Where patients do have a longer stay than expected, a multi-disciplinary team will assess the patient with a clear 'home first' mind set.

On discharge from hospital a number of 'step-down' community services will be available to support the patient, as described earlier.

5. Conclusion

This Model of Care has set out a clear, clinically-led vision to address how we will improve our hospital services to ensure patients receive the best possible patient experience and clinical outcomes. It has demonstrated that the central opportunity is to deliver more joined up care, so as to provide the best opportunity to resolve the issues stated within the Case for Change. These relate in particular to demographics (and the associated issues of health inequalities, the broader determinants of health and a supported culture of prevention, self-responsibility and early intervention); patient experience; flow; workforce; and delivering an effective use of resources.

We recognise that to achieve this goal and to deliver on our vision of an integrated health and social care system serving the people of Central Lancashire, we will need think and act as one. We will need to see our plans to improve hospital services for patients within the broader context of whole system transformation. This recognises that all parts of the OHOC programme will continue to need to work together towards this goal, whilst maintaining a close focus on the urgent and pressing needs to improve our hospital services system for patients, based on the five challenges identified in the programme case for change and using our common transformation methodology.

Taking this approach will deliver important, health-economy wide transformation, stretching beyond the care provided by our local hospitals and patients suffering from chronic obstructive pulmonary disease and from frailty. The approach to transforming care outcomes will have significant and far reaching benefits for the people of Central Lancashire. In particular, the proposals set out in his Model of Care will transform service delivery, access, and outcomes for a number of patients' groups, including the **more than 93,000** attenders to our **emergency care** departments each year. Many of these patients could be signposted and supported to receive the same care in a **better, less acute** place.

These and other patient groups will be right to expect the following outcomes by implementing this Model of Care:

- ✓ Their services will be delivered closer to home where this is both safe and practical.
- ✓ They can expect to experience the benefits of new technologies, research, learning and ways of working in the NHS.
- ✓ They will continue to be able to access cost-effective care as taxpayers in line with the standards set out in the NHS Constitution.
- ✓ They will continue to be supported to make the right choices about the best places to receive care and advice, helping them to lead better, more independent lives.
- ✓ They will continue to be supported to make practical choices and lifestyle decisions which will help them use NHS services in a sustainable way.
- ✓ They will continue to have their healthcare services commissioned in ways which are decisively focussed on seeking to reduce health inequalities and improve care outcomes.

This is the right Model of Care for Central Lancashire. It's time to change.

Appendix A – Engagement logs

The engagement logs can be accessed on page 145

Clinical standards that will underpin the redesign of services

Title	Clinical Standards
Workstream Lead	Dr Geraldine Skailes, Medical Director, Lancashire Teaching Hospitals
Authors	Clinical Leads
Audience	JCCCG
Version	1.0
Date Created	26th July 2018
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Document History:

Date	Version	Author	Details
26.07.2018	0.1	Hayley Michell, John Boileau and Charlotte Griffiths	Initial draft
06.08.2018	0.2	Charlotte Griffiths	Integration of feedback from Clinical Lead Design Workshop
29.08.2018	0.3	Hayley Michell	Amends following further feedback from Dr Lee Helliwell
04.09.2018	0.4	Hayley Michell	Formatting
05.09.2018	0.5	Mellanie Patterson	Final amends
05.09.2018	0.6	Dr Geraldine Skailes	Review
09.09.2018	0.7	Hayley Michell	"Status" column added
25.10.2018	0.8	Charlotte Griffiths	Additions to 'status' column
20.12.2018	0.9	Gemma Batchelor	Removal of status column following feedback from OHOC JC members
01.02.2019	1.0	Kelly Bishop	Amendment to standard 3.5 and 9.5 following feedback from JC member. Then developed for circulation to JC with view to formal approval.
Approved by Dr Geraldine Skailes			

Distribution			
Version	Group	Date	Purpose
0.6	Clinical Oversight Group	12.09.2018	Endorsement and Recommendation
0.6	ICP Board	20.09.2018	Endorsement and Recommendation
0.8	OHOC JC	21.11.2018	Development Session – Review
0.9	OHOC JC	17.01.2019	Development Session – Review
1.0	Clinical Senate	01.02.2019	External Assurance
1.0	OHOC Joint Committee	13.03.2019	Approved by OHOC Joint Committee

Where there is potential for a service to be redesigned it is important to understand the mandatory NHS England standards and national guidance (e.g. provided by NICE and the Royal colleges) that should underpin that design.

Following a workshop with Lancashire Teaching Hospitals Clinical Leads (2nd August 2018) the following list of standards has been developed and agreed with the Trust Medical Director. The list relates only to services that may be redesigned under the OHOC proposals (i.e. not all services delivered by the Trust). It also includes standards only once where they are repeated in multiple sources.

Figure 1: Clinical Standards and Source

ID	Standard Description	Reference
1. Generic Standards		
1.1	Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them. This should happen consistently, seven days a week.	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.2	All emergency admissions must be seen and have a thorough clinical assessment by an Acute Physician as soon as possible but at the latest within 14 hours from the time of admission to hospital.	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.3	All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.4	Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant in-coming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.5	Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology.	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf

1.6	Consultant-directed diagnostic tests and completed reporting will be available seven days a week • Within 1 hour for critical patients • Within 12 hours for urgent patients • Within 24 hours for non-urgent patients	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.6	Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols. These interventions would typically be: • Critical care • Interventional radiology • Interventional endoscopy • Emergency general surgery • Emergency renal replacement therapy • Urgent radiotherapy • Stroke thrombolysis • Percutaneous Coronary Intervention • Cardiac pacing (either temporary via internal wire or permanent)	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.7	Support services in the hospital must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.8	All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.	https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf
1.9	Any consultant-supervised interventions and investigations along with reports should be provided seven days a week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day. This should include	http://www.aomrc.org.uk/wp-content/uploads/2016/05/Seven_Day_Consultant_Present_Care_1212.pdf

	interventions which will enable immediate discharge or a shortened length of hospital stay.	
1.10	7 day working for all specialties ensuring, consultant assessment and review, diagnostic tests and consultant-led intervention.	https://www.england.nhs.uk/seven-day-hospital-services/our-ambition/
1.11	A comprehensive set of standards for clinical patient records are needed to ensure that information can be recorded and integrated in electronic patient care records across professions, disciplines and specialities, while properly reflecting best practice. The records help to generate data that can be used for service delivery and performance management, commissioning, audit and research from data recorded for patient care at the point of care.	https://www.rcplondon.ac.uk/projects/outputs/standards-clinical-structure-and-content-patient-records
2. Critical Care (In addition to Section 1)		
2.1	Care must be led by a Consultant in Intensive Care Medicine.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.2	Consultant work patterns should deliver continuity of care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.3	In general, the Consultant/ Patient ratio should not exceed a range between 1:8 – 1:15 and the ICU resident/Patient ratio should not exceed 1:8.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.4	There must be a designated Clinical Director and/or Lead Consultant for Intensive Care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.5	A Consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes and must undertake twice daily ward rounds.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

2.6	Consultant Intensivist led multi-disciplinary clinical ward rounds within Intensive Care must occur every day (including weekends and national holidays). The ward round must have daily input from nursing, microbiology, pharmacy and physiotherapy.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.7	All treatment plans should have clear objective outcomes identified within a specific time frame and discussed with the patient where appropriate, or relatives/carers if appropriate.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.8	Intensive Care trainees must comply with the requirements set by the Faculty of Intensive Care Medicine.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.9	Intensive Care Units that receive trainees for training in Intensive Care Medicine must comply with the requirements for training set them by the Faculty of Intensive Care Medicine.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.10	Level 3 patients (level guided by ICS levels of care) require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.11	Level 2 patients (level guided by ICS levels of care) require a registered nurse/ patient ratio of a minimum 1:2 to deliver direct care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.12	Each designated Critical Care Unit will have an identified Lead Nurse who is formally recognised with overall responsibility for the nursing elements of the service e.g. Band 8a Matron.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.13	There will be a supernumerary clinical coordinator (sister/ charge nurse bands 6/7) on duty 24/7 in critical care units with < 6 beds may consider having a supernumerary clinical coordinator to cover peak activity periods, i.e. early shifts.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.14	Units with greater than 10 beds will require additional supernumerary (this person is not rostered to deliver direct patient care to a specific patient) registered nursing staff over and above the clinical coordinator to enable the delivery of safe care. The number of additional staff per shift will be incremental depending on the size and layout of the	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

	unit (e.g. multiple single rooms). Consideration needs also be given during events such as infection outbreaks.	
2.15	Each Critical Care Unit will have a dedicated Clinical Nurse Educator responsible for coordinating the education, training and CPD framework for critical care nursing staff and pre-registration student allocation.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.16	All nursing staff appointed to Critical Care will be allocated a period of supernumerary practice.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.17	A minimum of 50% of registered nursing staff will be in possession of a post registration award in Critical care Nursing.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.18	Where direct care is augmented using non-registered support staff, appropriate training and competence assessment is required.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.19	There must be a critical care pharmacist for every critical care unit.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.20	Clinical pharmacists providing a service to critical care must be competent to provide the service.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.21	Clinical pharmacists who provide a service to critical care areas and have the minimum competencies (Foundation Level) must have access to a more senior specialist critical care pharmacist (for advice and referrals).	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.22	There must be a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

2.23	There must be documentation in the patient record of the time and decision to admit to Intensive Care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.24	Admission to Intensive Care should occur within 4 hours of making the decision to admit.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.25	Patients should not be transferred to other Intensive Care Units for non-clinical reasons.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.26	On admission to Intensive Care all patients must have a treatment plan discussed with a Consultant in Intensive Care Medicine.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.27	Patients should be reviewed in person by a Consultant in Intensive Care Medicine within 12 hours of admission to Intensive Care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.28	Each patient must have an assessment of their rehabilitation needs within 24 hours of admission to Critical Care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.29	There should be a standardised handover procedure for medical, nursing and AHP staff for patients discharged from critical care units.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.30	Patients need a clear and safe pathway for escalation of care from Level 2 care to Level 3.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.31	Transfer from Critical Care to a ward must be formalised.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

2.32	Discharge from Intensive Care to a general ward should occur within 4 hours of the decision.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.33	Discharge from Critical Care should occur between 07:00hrs and 21:59hrs.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.34	Unplanned readmission rate to ICU within 48hrs of discharge, to a ward, should be minimal.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.35	The Intensive Care team must engage, contribute and participate in a Critical Care Operational Delivery Network (ODN), including audit activity and regular peer review.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.36	Level 3 units should have access to a Regional Home Ventilation and weaning unit. Arrangements should be in place to collaboratively manage patients with weaning difficulties and failure, including the transfer of some patients with complex weaning problems to the Regional centre.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.37	Patients discharged from ICU should have access to an ICU follow-up clinic.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.38	Intensive Care facilities should comply with national standards.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.39	All equipment must conform to the relevant safety standards and be regularly serviced.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

2.40	All staff must be appropriately trained, competent and familiar with the use of equipment.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.41	Units must hold multiprofessional clinical governance meetings, including analysis of mortality and morbidity.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.42	The ICU should participate in a National database for Adult Critical Care.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.43	Presence of a risk register and associated audit calendar.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.44	The intensive care service is consultant led.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.45	There is 24-hour cover of the ICU by a named consultant with appropriate experience and competences.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.46	A consultant in intensive care medicine reviews all emergency surgical admissions to the ICU within 12 hours.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.47	Critical care input is available either directly or through an outreach team to advise and support the management of emergency surgical patients on the wards. Agreed escalation protocols result in appropriate and timely critical care referral.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.48	Clear defined parameters for monitoring and detecting deterioration in surgical ward patients are in place, with guidelines and defined responsibilities for escalation of care and involvement of senior staff from critical care and surgery.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

2.49	M&M reviews of surgical patients admitted to intensive care facilities are undertaken with surgical teams with post mortem data available where appropriate. Critical care teams are also involved in review of surgical patients who died on the ward for lack of active management.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.50	Regular multidisciplinary reviews of patient outcome.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.51	Intensive care requirements are considered for all patients needing emergency surgery. There is close liaison and communication between the surgical, anaesthetic and intensive care teams peri-operatively with the common goal of ensuring optimal safe care in the best interests of the patient.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.52	Level 2 and level 3 bed provision is sufficient to support the anticipated emergency surgical workload.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.53	Units providing level 2 and level 3 support to emergency surgical patients are staffed and equipped to agreed standards.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.54	Critical care facilities are available at all times for emergency surgery. If this is not the case, agreed protocols for transfer are in place.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.55	Specialist intensive care services are matched to specialist surgical requirements, e.g. neurosurgery and cardiothoracic surgery. Specialist surgery that is likely to require specialist ICU support is not undertaken without appropriate intensive care support unless the patient's life is endangered by transfer prior to surgery. When specialist critical care services are not available following emergency surgery, or when the patient requires transfer to another facility for emergency surgery, the critical care team supports patient transfer in line with agreed transfer protocols. Where appropriate and available, specialist retrieval services, e.g. PICU, are used.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

2.56	All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf
2.57	All patients who undergo anaesthesia are at risk of postoperative complications including compromise to the airway, breathing and circulation. Therefore, management and transport of patients immediately after anaesthesia can potentially be hazardous. When considering the provision of anaesthesia, the Royal College of Anaesthetists recommends that specific areas should be addressed to reduce these complications and harm, improve outcomes and promote patient wellbeing	https://www.rcoa.ac.uk/system/files/GPAS-2018-04-POSTOP.pdf
3. Emergency Department (In addition to Section 1)		
3.1	In all hospitals receiving undifferentiated patients to their EDs, a patient for whom an emergency surgical assessment is required will receive the same within 30 minutes of referral being made in the case of a life- or limb threatening emergency, and within 60 minutes for a routine emergency referral.	https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/emergency-surgery-standards-for-unscheduled-care/
3.2	The member of the on-call surgical team responding to the request is at ST3 level or above, or a trust doctor with equivalent ability (i.e. MRCS with ATLS® provider status).	https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/emergency-surgery-standards-for-unscheduled-care/
3.3	Should the designated first on-call surgeon be unable to attend due to other emergency duties (e.g. emergency theatre or dealing with a separate life-threatening emergency elsewhere in the hospital), protocols are in place for another member of the surgical team, of similar or a greater level of competence, to be available to attend the ED, within the above time scale.	https://www.rcseng.ac.uk/library-and-publications/rcs-publications/docs/emergency-surgery-standards-for-unscheduled-care/
3.4	When considering the care of children within ED, a number of standards must be considered.	https://www.rcpch.ac.uk/sites/default/files/2018-06/FTFEC%20Digital%20updated%20final.pdf

3.5	A minimum of twelve (wte) Tier 5 clinicians are needed to provide sustainable combined evening and weekend working if late shifts routinely go beyond 2200. This figure is increased in larger departments to sixteen+	https://www.rcem.ac.uk/docs/Workforce/RCEM%20Medical%20and%20Practitioner%20Staffing%20in%20EDs.pdf
3.6	All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.7	A trained and experienced doctor (ST4 and above or doctor of equivalent competencies) in emergency medicine to be present in the emergency department 24 hours a day, seven days a week.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.8	A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours a day (matched to peak activity), seven days a week. Outside of these 16 hours, a consultant will be on-call and available to attend the hospital for the purposes of senior clinical decision making and patient safety within 30 minutes.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.9	24/7 access to the minimum key diagnostics: • X-ray: immediate access with formal report received by the ED within 24 hours of examination • CT: immediate access with formal report received by the ED within one hour of examination • Ultrasound: immediate access within agreed indications/ 12 hours with definitive report received by the ED within one hour of examination • Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken • Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken • When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf

3.10	Emergency department patients who have undergone an initial assessment and management by a clinician in the emergency department and who are referred to another team, to have a management plan (including the decision to admit or discharge) within one hour from referral to that team. When the decision is taken to admit a patient to a ward/ unit, actual admission to a ward/ unit to take place within one hour of the decision to admit. If admission is to an alternative facility the decision maker is to ensure the transfer takes place within timeframes specified by the London inter-hospital transfer standards.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.11	A clinical decision/ observation area is to be available to the emergency department for patients under the care of the emergency medicine consultant that require observation, active treatment or further investigation to enable a decision on safe discharge or the need for admission under the care of an inpatient team.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.12	A designated nursing shift leader (Band 7) to be present in the emergency department 24 hours a day, seven days a week with provision of nursing and clinical support staff in emergency departments to be based on emergency department-specific skill mix tool and mapped to clinical activity.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.13	Triage to be provided by a qualified healthcare and registration is not to delay triage.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.14	Timely access seven days a week to, and support from, onward referral clinics and efficient procedures for discharge from hospital.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.15	Timely access seven days a week to, and support from, physiotherapy and occupational therapy teams to support discharge from hospital.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.16	Emergency departments to have an IT system for tracking patients, integrated with order communications. A reception facility with trained administrative capability to accurately record patients into the emergency department to be available 24 hours a day, seven days a week. Patient emergency department attendance record and discharge summaries to be immediately available in case of re-attendance and monitored for data quality.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf

3.17	The emergency department is to provide a supportive training environment and all staff within the department are to undertake relevant ongoing training.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.18	Consultant-led communication and information to be provided to patients and to include the provision of patient information leaflets.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
3.19	Patient experience data to be captured, recorded and routinely analysed and acted on. Review of data is a permanent item on the trust board agenda and findings are disseminated.	https://www.england.nhs.uk/wp-content/uploads/2013/08/lon-qual-stands.pdf
4. Acute Medicine (In addition to Section 1)		
4.1	All patients admitted to AMU should have an early warning score measured upon arrival.	http://www.acutemedicine.org.uk/wp-content/uploads/2017/12/Society-for-Acute-Medicine-Benchmarking-Audit-2017-National-Report.pdf
4.2	All patients should be seen by a competent clinical decision maker *within 4 hours* of arrival on AMU who will perform a full assessment and instigate an appropriate management plan.	http://www.acutemedicine.org.uk/wp-content/uploads/2017/12/Society-for-Acute-Medicine-Benchmarking-Audit-2017-National-Report.pdf
4.3	All patients should be reviewed by the admitting consultant physician or an appropriate specialty consultant physician within 14-hours of arrival on AMU.	http://www.acutemedicine.org.uk/wp-content/uploads/2017/12/Society-for-Acute-Medicine-Benchmarking-Audit-2017-National-Report.pdf
4.4	Individual consultants' duties on the AMU should be for two or more consecutive days; any variation must be specifically designed to optimise continuity of care on the AMU.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
4.5	Appropriate diagnostic and support services should be provided 7 days per week.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit

	Appropriate diagnostic and support services should be provided 7 days per week to ensure that the full benefits of consultant delivered-care to patients are realised.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
4.6	During the period of consultant presence on AMU, all newly admitted patients should be seen within 6 to 8 hours, with the provision for immediate review as required according to illness severity.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
4.7	Consultant presence on the AMU should start no later than 8am.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
4.8	Extended evening working until 10pm should be considered, depending on local patterns of patient referral and arrival.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
4.9	Calculation of numbers of consultants required on the AMU should be based on anticipated number of patient contacts during the core hours of service.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
4.10	Greater numbers of consultants may be required in larger or high-volume units, or those managing patients with greater dependency.	https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-4-delivering-12-hour-7-day-consultant-presence-acute-medical-unit
4.11	All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of admission to hospital. Although the December 2013 document stipulated that the standard was to be measured 'from time of arrival' this has now been changed to reflect the original source document for this standard (Royal College of Physicians acute care toolkit number 4).	https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/02/guidance-major-7ds.pdf
5. Urgent Treatment Centre (In addition to Section 1)		

5.1	Urgent treatment centres must conform to the following minimum standards. STPs and commissioners may also choose to build upon or add to these, according to their requirements. Urgent treatment centres should be open for at least 12 hours a day seven days a week, including bank holidays, to maximise their ability to receive streamed patients who would otherwise attend an A&E department. Typically, this will be an 8-8 service, but commissioners will wish to tailor to local requirements based on locally determined demand.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.2	Urgent treatment centres should provide both pre-booked same day and "walk-in" appointments, however patients and the public should be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.3	Urgent treatment centres, and NHS 111, should support patients to self-care and use community pharmacy whenever it is appropriate to do so. Urgent treatment centres should promote and record the numbers of patients offered self-care management and patient education.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.4	The urgent treatment centre should ensure that there is an effective and consistent approach to primary prioritisation of "walk-in" and pre-booked appointments, and the allocation of pre-booked routine and same day appointment slots.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.5	For patients who require an appointment in the urgent treatment centre this should be booked by a single phone call to NHS 111; locally patients should be encouraged to use NHS 111 as the primary route to access an appointment at an urgent treatment centre.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.6	Patients who "walk-in" to an urgent treatment centre should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

5.7	Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.8	Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.9	Protocols should be in place to manage critically ill and injured adults and children who arrive at an urgent treatment centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance 'Quality standards for cardiopulmonary resuscitation practice and training' 3 , should be immediately available. At least one member of staff trained in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of 'design for the usual, and plan for the unusual'.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.10	An appropriately trained multidisciplinary clinical workforce will be deployed whenever the urgent treatment centre is open. The urgent treatment centre will usually be a GP-led service, which is under the clinical leadership of a GP. There will be an option for bookable appointments with a GP or other members of the multi-disciplinary team. Where the centre is co-located with an emergency department there may be justification for joint clinical leadership from an ED consultant.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.11	The scope of practice in urgent treatment centres must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.12	All urgent treatment centres should have access to investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms (ECG) should be available, and in some urgent treatment centres near-patient troponin testing could also be considered.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

5.13	Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are desirable and considerably increase the assessment capability of an urgent treatment centre, particularly where not co-located with A&E. Where facilities are not available on site, clear access protocols should be in place. Commissioners will need to consider patient throughput in their cost benefit analysis where capital investment will be required.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.14	All urgent treatment centres should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.15	All urgent treatment centres should be able to provide emergency contraception, where requested.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.16	All urgent treatment centres must have direct access to local mental health advice and services, such as through the on-site provision of 'core' liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.17	All urgent treatment centres should have arrangements in place for staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient's best interests in an emergency situation where the patient lacks capacity to consent.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.18	There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flags or crisis data should be made available for patients.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.19	A patient's registered GP should always be notified about the clinical outcome of a patient's encounter with an urgent treatment centre via a Post Event Message (PEM), accompanied by a real-time update of the electronic patient care record locally. For	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

	children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days.	
5.20	Where available, systems interoperability should make use of nationally defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMEDCT) and nationally-defined record structures.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.21	Urgent treatment centres should make capacity and waiting time data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.22	Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.23	Urgent treatment centres should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.24	Where appropriate, patients attending an urgent treatment centre should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.25	All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience. From October 2018 all urgent treatment centres must return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

5.26	All healthcare practitioners working in urgent treatment centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
5.27	All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.	https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf
6. Mental Health (In addition to Section 1)		
6.1	Ensure that Standards for Inpatient Mental Health Services.	https://www.rcpsych.ac.uk/pdf/RCPsych_Standards_In_2016.pdf
7. Ambulatory Care Unit / Ambulatory Emergency Care (AEC) (In addition to Section 1)		
7.1	Senior clinical input is needed at the point of referral to redirect suitable patients to AEC.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.2	If possible, the AEC service should be closely located to ED.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.3	Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.4	The time standards in AEC should match the Clinical Quality Indicators for ED i.e. time to initial assessment.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf

7.5	Patients should be informed early in their journey (ideally in ED or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight, to manage their expectations and those of their family.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.6	Secondary and primary care services should be geared around patient needs and work together to provide ongoing care outside of hospital to avoid a full admission.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.7	Staff training is needed across the local healthcare system to ensure appropriate patients are streamed to the AEC.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.8	Comprehensive records must be kept. Discharge summaries should be given to each patient as they leave and sent to primary care within 24 hours.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.9	AEC services for 12 hours a day, seven days a week.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.10	Clear measures must be adopted and monitored to record the activity and facilitate the assessment of the impact, quality and efficiency of AEC.	https://www.rcem.ac.uk/docs/RCEM%20Guidance/AECN%20AEC%20Position%20Statement%20July%202017.pdf
7.11	Timely access 7 days a week to onwards referral clinics including hot clinics	Local
7.12	Sufficient space to allow for day case/ short stay intervention	Local
8. Frailty Assessment Unit (In addition to Section 1)		
8.1	An acute crisis in a frail older person should prompt a structured medication review; this may require the support of pharmacists in some settings.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.2	When suspecting lower urinary tract infections in people unable to express themselves, urine dipstick testing should only be considered in patients with	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

	unexplained systemic sepsis (which may manifest as delirium). A urine dip should not be used to diagnose a urinary tract infection in coherent patients without lower urinary tract symptoms, it can be misleading.	
8.3	Older people should not be routinely catheterised unless there is evidence of urinary retention.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.4	End of life care at home should be encouraged and facilitated when appropriate and in keeping with the older person's preferences.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.5	Older people should only be discharged from hospital with adequate support and with respect for their preferences.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.6	Adequate and timely information must be shared between services whenever there is a transfer of care between individuals or services.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.7	Older people being admitted following an urgent care episode (to any bed-based facility) should have an expected discharge date set within 2 hours (14 hours overnight).	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.8	Older people, and where appropriate their carers and families, should be involved in the decision-making process around assessment and management of on-going and future care, and self-care.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.9	Care home providers should be treated as equal partners in the planning and commissioning of care both for individuals and for ensuring the correct processes and procedures are in place in care homes to support best practice.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.10	When preparing for discharge, older people and carers should be offered details of local voluntary sector organisations, other sources of information, practical and emotional support including information on accessing financial support and reablement services.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.11	There should be primary care–led management of long-term conditions which may reduce the number of unscheduled care episodes.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

8.12	General practices should monitor hospitalisation and avoidable ED attendances and determine whether alternative care pathways might have been more appropriate.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.13	Clinicians referring to urgent care should have access to a simple referral system with an agreed policy provided by local geriatric, emergency medicine, acute medicine and social services.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.14	Older people being admitted to community hospitals, whether for 'step-up' or 'stepdown' care, should be assessed and managed in the same way as people accessing urgent care in any other part of the health system.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.15	There should be a distinct area in Emergency Departments which is visually and audibly distinct that can facilitate multidisciplinary assessments.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.16	All units should have ready access to time critical medication used commonly by older people, such as Levo-Dopa.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.17	If a procedure is required for a person who is confused, two health care professionals should perform the procedure, one to monitor, comfort and distract, and the other to undertake the procedure; carers and/or family members should be involved if possible; cutaneous anaesthetic gel should be considered prior to cannulation, particularly if the person is confused.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.18	All urgent and emergency care units should have accessible sources of information about local social services, falls services, healthy eating, staying warm, benefits and for carers of frail older people.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.19	All older people who self-harm should be offered a psychosocial assessment to determine on-going risk of self-harm and to detect and initiate management for any mental health problem that may be present.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.20	There should be easier and greater access to mental health care summary records.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

8.21	Intra and inter-hospital transfers of older people at night, should be minimised as it increases the risk of delirium.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.22	Local 'No secrets' multiagency policies and procedures for adult safeguarding should be easily accessible to assist teams to identify and respond to concerns.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.23	All services should nominate a lead responsible for safeguarding older people within the service whilst accepting that it is everyone's responsibility.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.24	All health and social care facilities must have service specific guidelines for safeguarding older people, in addition to the multi-agency policies and procedures.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.25	Major Incident Plans and Disaster Preparedness Plans need to include explicit contingencies for the management of multiple casualties of frail older people.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.26	Public health agencies, emergency responders, services for older people and Nongovernmental Organisations (e.g. charities) need to be aware of the local demographics and communicate each other's provision and capability so that coordination and response are effective in the event of an incident.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.27	Each area/region needs to have up to date lists of named key clinicians and social care personnel with contact numbers, who have specific responsibilities for older people in the event of a major incident.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.28	Local Major Incident Plans need to be updated to include a specific plan for older people that identifies alternative appropriate local accommodation should they be unable to return immediately to their own home, residential or nursing home.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.29	Appropriate public information on emergency preparedness in appropriate formats for older adults and their carers and details of local voluntary sector organisations that can offer information and practical support should/must be provided.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.30	Access to a telecare system in rural and remote areas that will permit professional health and social care workers to reach housebound older people in the event of a major incident should be provided.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf

8.31	Health and social care commissioners and those responsible for commissioning support arrangements must always reflect a joint approach across all disciplines which takes account of the multi-disciplinary nature of care for and working with older people.	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
8.32	Commissioners should ensure that all providers of acute or emergency care for older people conduct audit against the standards set out in the Silver Book as well as participating fully in all relevant national audits (e.g. stroke, hip fracture, dementia, fall and bone health, continence).	http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf
9. General Surgery (In addition to Section 1)		
9.1	All patients considered as 'high risk' have their operation carried out under the direct supervision of a consultant surgeon and consultant anaesthetist; early referral for anaesthetic assessment is made to optimise peri-operative care.	NELA: % of high-risk operations directly supervised by a consultant surgeon and anaesthetist
9.2	If the patient is admitted but not taken to theatre (i.e. they are admitted for observation and conservative treatment), as a minimum they are seen by a consultant surgeon within a maximum of 14 hours of admission. Active and continued monitoring of the patient takes place.	(i) NELA: % of patients reviewed by a consultant within 14 hours (ii) Job plans and rotas showing 2 consultant ward rounds per day, 7 days a week for review of new admissions
9.3	The service submits data to prescribed national audits, including NELA, National Bowel Cancer Audit, National Oesophago-gastric Cancer Audit.	(i) NELA case ascertainment (ii) Latest audit reports for bowel and OG cancer to be submitted
9.4	There is 24-hour cover of Critical Care by a named consultant with appropriate experience and competences. Level 2 and 3 patients are cared for within a closed critical service in which admissions are agreed by Intensive Care Medicine consultants and primary responsibility for ongoing care lies with the critical care team, with input as required from parent specialty consultants/teams.	Critical Care Network Peer Review Report Def. 'appropriate experience and competences' refer to being a consultant who is a Fellow of the Faculty of Intensive Care Medicine - or direct equivalent as per FFICM/GPICS definition
9.5	A consultant in intensive care medicine reviews all emergency surgical admissions to the ICU within 12 hours.	https://www.ficm.ac.uk/sites/default/files/Core%20Standards%20for%20ICUs%20Ed.1%20(2013).pdf

9.6	Level 2 and level 3 capacity is sufficient to support the emergency surgical workload, such that timely care is provided.	Local standard
9.7	The timescale of intervention is defined and achieved e.g. Patients with ongoing haemorrhage require immediate surgery.	(i) Policy and local audit in place (ii) NELA % of patients who arrived in theatre within a timescale appropriate to their operative urgency EGD257-261 assessed as one bundle using above NELA measure, also supported by sepsis policy and local audit.
9.8	Patients with septic shock who require immediate surgery are operated on within 2 hours of the decision to operate as delay increases mortality significantly.	
9.9	Patients with severe sepsis (with organ dysfunction) who require surgery are operated on within a maximum of six hours to minimise deterioration into septic shock.	
9.10	Patients with sepsis (but no organ dysfunction) who require surgery should have this within a maximum of 18 hours.	
9.11	Patients with no features to indicate systemic sepsis can be managed with less urgency but in the absence of modern and structured systems of care, delay will result in unnecessary hospital stay, discomfort, illness and cost.	
9.12	Each patient has his or her expected risk of death estimated and documented prior to surgical or interventional radiological intervention using recognised methods (see RCS2011b for examples) or an equivalent method; and due adjustments are made in urgency of care and seniority of staff involved.	NELA: % of EGS patients who have risk of death documented before surgery
9.13	Patients with an estimated risk of death of >5% are admitted to a Critical Care Unit (level 2 or 3), unless there is an active and documented decision that it is contraindicated (for example, the patient is on a palliative/end of life pathway).	(i) NELA % of EGS patients who have risk of death documented before surgery (ii) Ideally local audit of % of patients with predicted mortality >10% directly admitted to critical care (iii) If (ii) not available with assess on NELA % of patients with predicted mortality >10% directly admitted to critical care
9.14	Critically ill patients have priority over elective patients This includes the delay of elective surgery to accommodate emergency surgical patients if necessary.	% of elective surgical cancellations (National Critical Care Dashboard)

9.15	All services are consultant-led.	CEM standard for “consultant sign-off” HES Time to initial assessment [emergency ambulance cases only] HES Time to Treatment A&E - Median Time to treatment in minutes (HQU13).
9.16	Services are consultant-delivered.	CEM standard for “consultant sign-off” HES Time to initial assessment [emergency ambulance cases only] HES Time to Treatment A&E - Median Time to treatment in minutes (HQU13).
9.17	In cases with predicted mortality of >5%, a consultant surgeon and consultant anaesthetist are present for the operation except in specific circumstances where adequate experience and the appropriate workforce is otherwise assured.	% of high-risk operations directly supervised by a consultant surgeon and anaesthetist, ‘in hours’ and ‘out of hours’ (National Emergency Laparotomy Audit)
9.18	As an absolute minimum, for patients not considered high risk, all emergency surgical admissions are discussed with the responsible consultant within 12 hours of admission.	% of EGS patients reviewed by a consultant within 12 hours (NELA)
9.19	In specialties with a high emergency workload, the surgical team is free of elective commitments when covering emergencies.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf
9.20	In specialties with a high emergency workload, consultants do not cover (i.e. are expected to be available on-site) more than one site.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf
9.21	Wherever possible, emergency and elective surgical pathways are separated Both services are managed effectively to minimise the adverse impact of one upon the other.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf

9.22	Adequate emergency theatre time is provided throughout the day to minimise delays and avoid emergency surgery being undertaken out of hours when the hospital may have reduced staffing to care for complex postoperative patients.	NHS KH03 Bed Availability and Occupancy – Total number of available bed days and total number of occupied bed days by speciality
9.23	Accurate profiling of workload across the surgical specialties takes place to define the number and type of theatres required In busy units with a heavy workload more than one emergency theatre is identified and available.	CCG Outcome Indicator Set 1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare
9.24	There is a separate, dedicated theatre for orthopaedic surgery and, where necessary, for other specialties as defined by audit of the requirements of each specialty.	CCG Outcome Indicator Set 1.1 Potential years of life lost (PYLL) from causes considered amenable to healthcare
9.25	A dedicated, separate team is established for the emergency theatre(s) 24/7.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf
9.26	Bed occupancy rates are measured on ward-by-ward basis. Average occupancy rates should not exceed 82% and outlying should be exceptional and addressed as soon as possible by relocating the patient to the next available specialty bed.	NHS KH03 Bed Availability and Occupancy – Total number of available bed days and total number of occupied bed days by speciality
9.27	Hospitals accepting undifferentiated medical patients have access to 24-hour surgical opinion (i.e. of ST3 or above or a trust doctor with equivalent ability (i.e. MRCS with ATLS (r) provider status). The ST3 is available to see/treat acutely unwell patients at all times within 30 minutes and is able to escalate concerns to a consultant.	HES Time to Initial assessment (ambulance cases only)
9.28	There is a regular, multidisciplinary review of patient outcomes involving all relevant specialties at least monthly.	Compliance records, Provisional Accident and Emergency Quality Indicators - England, by provider generated from Hospital Episode Statistics (HES) A&E data, sets out data coverage, data quality and performance information
9.29	Regular M&M/MDT reviews of individual cases take place to identify areas of good practice and areas for improvement.	Compliance records, Provisional Accident and Emergency Quality Indicators - England, by provider generated from Hospital Episode

		Statistics (HES) A&E data, sets out data coverage, data quality and performance information
9.30	Processes for identifying critical incidents and monitoring action plans are in place, for example, engagement with clinical quality review processes of commissioners.	Compliance records, Provisional Accident and Emergency Quality Indicators - England, by provider generated from Hospital Episode Statistics (HES) A&E data, sets out data coverage, data quality and performance information
9.31	There is regular and systematic capture of patient-reported outcomes, including those admitted for unscheduled care.	Compliance records, Provisional Accident and Emergency Quality Indicators - England, by provider generated from Hospital Episode Statistics (HES) A&E data, sets out data coverage, data quality and performance information
9.32	Risk and clinical governance groups review the outcomes of emergency surgery Summary hospital-level mortality indicator (SHMI) data are reviewed within organisations for unscheduled surgical care at specialty level.	Compliance records, Provisional Accident and Emergency Quality Indicators - England, by provider generated from Hospital Episode Statistics (HES) A&E data, sets out data coverage, data quality and performance information
9.33	Ensure adequate beds are available across the network to reduce delays for patients being transferred.	Local standard
9.34	In all hospitals receiving undifferentiated patients to their EDs, a patient for whom an emergency surgical assessment is required will receive the same within 30 minutes of referral being made in the case of a life- or limb-threatening emergency, and within 60 minutes for a routine emergency referral.	HES Time to Initial assessment (ambulance cases only)

9.35	The member of the on-call surgical team responding to the request is at ST3 level or above, or a trust doctor with equivalent ability (i.e. MRCS with ATLS® or CCrISP® provider status).	HES Time to Initial assessment (ambulance cases only)
9.36	There is a consultant-led, 24-hour laboratory service.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf
9.37	The intensive care service is consultant led.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf
9.38	Clear defined parameters for monitoring and detecting deterioration in surgical ward patients are in place, with guidelines and defined responsibilities for escalation of care and involvement of senior staff from critical care and surgery.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf
9.39	Ongoing care and rehabilitation occurs in an appropriate place, as close to the patient's home as possible (and not necessarily where the admission took place). Pathways should be implemented to ensure that all patients aged over 70 years who undergo an emergency laparotomy receive postoperative screening and assessment by an MCOP consultant (Multidisciplinary Teams).	NELA - although 'Ongoing care and rehabilitation occurs in an appropriate place, as close to the patient's home as possible (and not necessarily where the admission took place).' additional to NELA standard
9.40	The location of emergency patients within a single area greatly facilitates an effective service and enhances patient safety.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/emergency--elective.pdf
9.41	High risk patients are defined by a predicted hospital mortality ≥5%: they have active consultant input in the acute diagnostic, surgical, anaesthetic and critical care elements of their pathway.	CEM standard for “consultant sign-off”
9.42	Each operative patient has their risk of death re-assessed and documented by the surgical and anaesthetic teams at the end of surgery, using an ‘end of surgery bundle’ to determine optimal location for immediate post-operative care.	% of EGS patients who have risk of death documented before/after surgery (National Emergency Laparotomy Audit)

9.43	An acutely unwell general surgical patient, whether in A&E or an inpatient includes all with a medium (or worse) Early Warning Score (e.g. a NEWS aggregate score of 5 or more), or a RED score, i.e. an extreme variation in an individual physiological parameter (a score of 3 in any one parameter which is colour coded RED on the NEWS observation chart).	Local standard
9.44	All patients are managed after surgery in a location determined by risk and staff competence.	https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/the-higher-risk-general-surgical-patient--towards-improved-care-for-a-forgotten-group.pdf
9.45	An estimated risk of death of >5% are admitted to a critical care location (level 2 or 3), unless there is an active and documented decision that it is contraindicated (for example, the patient is on a palliative/end of life pathway).	Local standard
9.46	All patients that do not currently require level 2 or 3 critical care, receive postoperative care specifically tailored to their risk and staff competencies, be that in a PACU, in co-located ward bays for medium risk patients or in a surgical ward.	Local standard
9.47	Outcomes for emergency general surgery should be reviewed and shared locally at least annually Such audits include: outcomes (death, length of stay) from emergency general surgery; frequency of observations in higher risk group; accuracy of risk estimate prior to surgery; accuracy of risk estimate at end of surgery; time to CT from emergency admission or deterioration; time from deterioration to operation for higher risk group; compliance with the standard for intra-operative surgical team seniority compliance with post-surgery pathway for higher risk patients; unplanned surgical readmissions to critical care within 48 hours of discharge back to the ward.	Local standard
10. Urgent Care (In addition to Section 1)		
10.1	Warm transfer of patients should be facilitated between organisations with the avoidance of re-triage whenever possible and appropriate.	https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf

10.2	Commissioners should ensure access to a range of multidisciplinary clinical expertise and services in addition to nurses and paramedics. We expect that the clinical hub (physical or virtual) will be the source of this expertise.	https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf
10.3	Patients with complex problems needing to speak to a clinician will be identified quickly and transferred to speak to the appropriate clinician. It is advised that commissioners work together with providers and clinical governance leads to identify and utilise safe and effective process for this purpose.	https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf
10.4	Integrated Urgent Care will have the capability to make an electronic referral to the service that can best deal with a patient's needs as close to the patient's location as possible.	https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf
10.5	Integrated Urgent Care should aim to book face to face or telephone consultation appointment times directly with the relevant urgent or emergency service whenever this is supported by local agreement.	https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf
10.6	To support effective Integrated Urgent Care it is recommended that commissioners include an "urgent care clinical advice hub" in specifications. To improve working relationships, dialogue, and feedback, some of the clinicians that make up this hub should be physically co-located. For clinical specialisms and care expertise which is consulted less frequently it may be more appropriate to make arrangements to contact an individual who is off site through the creation of a "virtual urgent care clinical hub".	https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf
11. Specialist Medicine (In addition to Section 1)		
11.1	Specialist care and advice is available 7 days a week	Local standards developed by the Clinical Lead
11.2	Consultant review available and junior team support	Local standards developed by the Clinical Lead
11.3	Access to specialist hot clinics	Local standards developed by the Clinical Lead
11.4	Specialist emergency services available 7 days a week	Local standards developed by the Clinical Lead
11.5	Supporting services available 7 days a week, including admin support	Local standards developed by the Clinical Lead

11.6	Access to non-medical specialities- referral after 24 hours, in reach within 48 hours	Local standards developed by the Clinical Lead
11.7	Early discharges coupled with discharge plans	Local standards developed by the Clinical Lead
11.8	Ability to MDT in department (including junior team)	Local standards developed by the Clinical Lead
11.9	Intelligent triage to access patients	Local standards developed by the Clinical Lead
11.10	SPA Cancellation	Local standards developed by the Clinical Lead
11.11	Cover of key services especially lab based	Local standards developed by the Clinical Lead
11.12	Cardiology	https://www.nice.org.uk/guidance/qs9
11.13	Respiratory	https://www.brit-thoracic.org.uk/standards-of-care/quality-standards/
11.14	Gastroenterology	https://www.bsg.org.uk/clinical/bsg-guidelines.html
11.15	Acute upper gastrointestinal bleeds in over 16 (including the use of Endoscopy)	https://www.nice.org.uk/guidance/cg141
11.16	Diabetes	https://www.nice.org.uk/guidance/qs125
11.17	Renal	https://renal.org/guidelines/ https://www.nice.org.uk/guidance/QS72
12. Specialist Care		
	Standards/ guidelines to consider for individual specialities include:	
12.1	Midwife Led Unit	https://www.nice.org.uk/guidance/ng4

12.2	PACU	https://www.rcoa.ac.uk/system/files/GPAS-2018-04-POSTOP.pdf
12.3	Ophthalmology	https://www.rcophth.ac.uk/standards-publications-research/quality-and-safety/quality-standards/
12.4	Orthopaedic surgery	https://www.boa.ac.uk/publications/boa-standards-trauma-boasts/
12.5	Vascular surgery	https://www.vascularsociety.org.uk/_userfiles/pages/files/Resources/POVS%202015%20Final%20version.pdf
12.6	Urology surgery	https://www.nice.org.uk/guidance/conditions-and-diseases/urological-conditions
12.7	Oncology surgery	https://www.nice.org.uk/guidance/conditions-and-diseases/cancer
12.8	Gynaecology	https://www.nice.org.uk/sharedlearning/implementation-of-nice-guidelines-obstetrics-gynaecology
12.9	Breast surgery	https://www.nice.org.uk/guidance/qs12/documents/draft-quality-standard https://associationofbreastsurgery.org.uk/clinical/guidelines-archive/
12.10	Special Care Dentistry	http://www.bsdh.org/documents/BSDH_GA_in_SCD_2009.pdf
12.11	ENT Surgery	https://www.entuk.org/members/guidelines

12.12	Plastics and burns surgery	http://www.bapras.org.uk/professionals/clinical-guidance
12.13	Obstetrician and Gynaecology surgery	https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/gynaestandards.pdf
12.14	General and Upper GI surgery	http://www.augis.org/wp-content/uploads/2016/06/Provision-of-Services-June-2016.pdf
12.15	Neurology surgery	https://www.sbns.org.uk/index.php/policies-and-publications/
12.16	Dermatology surgery	http://www.bad.org.uk/library-media/documents/Dermatology%20Standards%20FINAL%20-%20July%202011.pdf
13. Performance Targets		
13.1	A&E	https://www.england.nhs.uk/statistics/statistical-work-areas/ https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/04/Monthly-performance-statistics-summary-Feb_Mar-18.pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

13.2	NHS 111	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.3	Ambulances	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.4	Delayed Transfer of care	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.5	Referral to Treatment	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.6	Diagnostics	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.7	Mixed Sex Accommodation	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.8	NHS Continuing Healthcare and NHS-funded nursing care	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.9	Patient Reported Outcome Measures	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf
13.10	Cancer waiting times	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

13.11	Cancer Registrations	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

Our Health Our Care

Service Co-dependency Framework

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Section 1: Introduction

A “co-dependency framework” describes the dependency between hospital services, specifically identifying where:

- clinical services need to be **co-located together** on a hospital site and
- clinical services need to be able to access each other, but don’t need to be co-located on the same site.

The purpose of understanding these dependencies is to inform the design of the options.

For example, unless a hospital is very large, the same Consultant team will typically deliver both paediatric inpatients and neonatal services (care of premature or sick new-born babies). These services therefore need to be “co-located” on the same site, not split across different sites. Similarly, an A&E, which might see the sickest patients arriving, should always be co-located with critical care. Understanding these requirements is important when designing how hospitals should operate.

This section of the report describes the co-dependency framework that has been developed to support the design of the options for the Lancashire Teaching Hospitals NHS Foundation Trust sites.

Section 2: Methodology used to develop the co-dependency framework

In 2014 the South East Coast Clinical Senate (SECCS) developed guidance on the co-dependency of the services found in typical acute hospitals; “The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review”, December 2014. The Our Health Our Care programme undertook to review this framework and update, adapt or add to it where necessary. The workstream was led by Professor Mark Pugh and Clinical Oversight was provided by the Trust Medical Director. The framework was signed off by the Our Health Our Care Clinical Design Group.

2.1 How the South East Coast Clinical Senate (SECCS) framework was developed

The remit of the SECCS review was “to provide generic advice, not region or locality-specific, and to identify evidence where it exists, or clinical consensus where it did not, to describe what services needed to be provided in the same hospital (either based there, or in-reaching), and what could be provided on a networked basis.”

The Senate conducted a literature review and a clinical reference group was established to lead the work. “Eleven acute services were chosen as the principle components of current acute hospitals: A&E (Emergency Medicine), Acute Medical Take, Acute Surgical Take, Critical Care (ITU), Trauma, Vascular Surgery, Cardiac, Stroke, Renal, Consultant-led Obstetric Services and Acute General Paediatrics.”

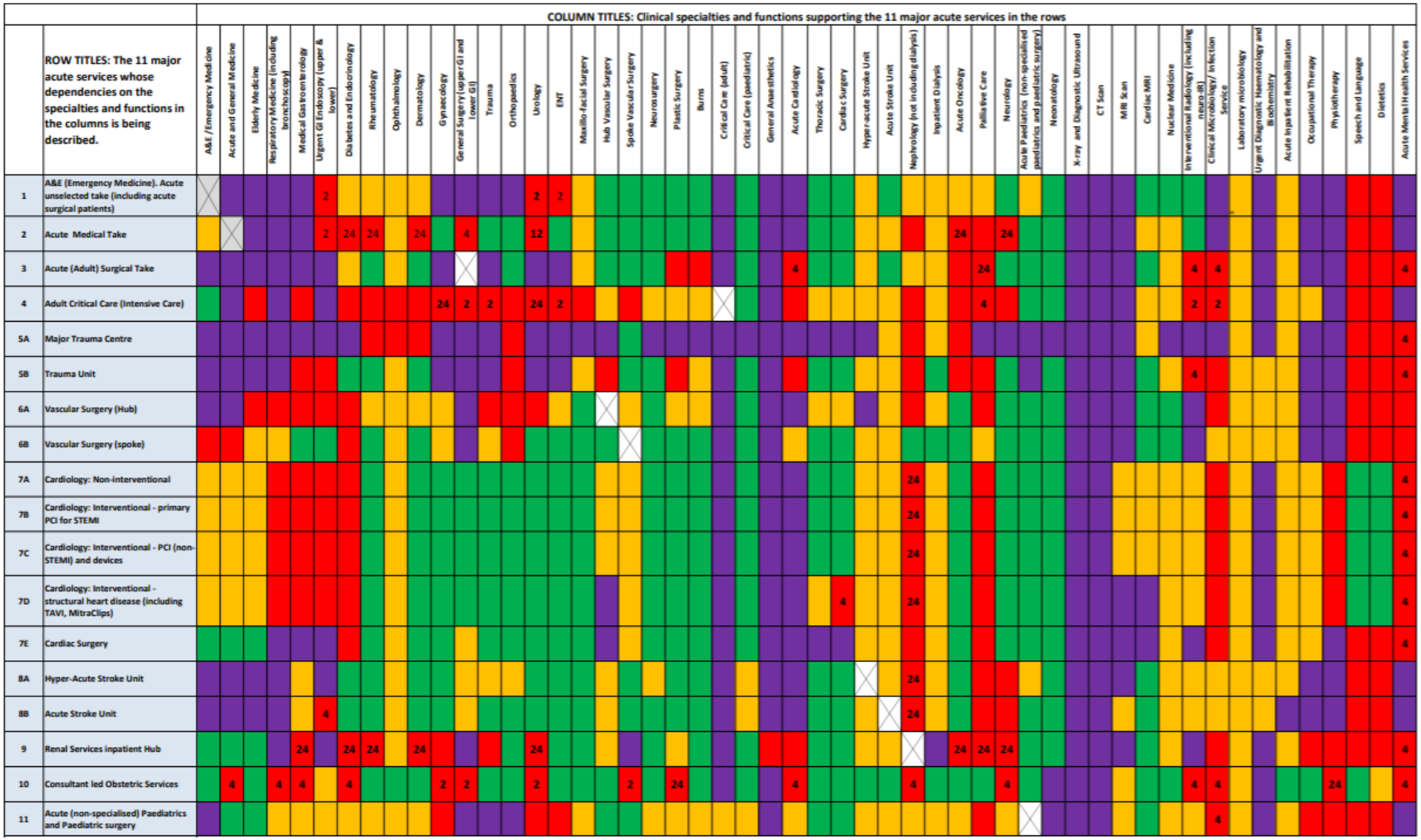
The clinical dependencies of those 11 major acute services on 52 hospital-based services was categorised as follows: “Purple (needing to be based on the same site); Red (visiting or in reach services sufficient); Amber (patient could transfer to another hospital or site for ongoing care through network arrangements); or Green (loose or no direct relationship).”

Figure 1: Co-dependencies definitions (“The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review”, December 2014)

CO-DEPENDENCIES DEFINITIONS: COLOUR KEY The colour describes the dependency of the service in the row, on the support service in the column. Note that both the Purple and Red dependencies describe column services that should not require the patient to move hospitals	
PURPLE	
Service should be co-located (based) in same hospital	
RED	
Service should come to patient (patient transfer not appropriate), but could be provided by visiting/inreach from another site (either physically, or via telemedicine links) if not based in the same hospital	
2	Within 2 hours
4	Within 4 hours
24	Within 24 hours
	Not specified
AMBER	
Ideally on same site but could alternatively be networked via robust emergency and elective referral and transfer protocols	
GREEN	
Does not need to be on same site. Appropriate arrangements are in place to obtain specialist opinion or care	

The resulting grid is shown on the following page.

Figure 2: Co-dependency of key acute hospital services (Source: "The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review", December 2014)



Commenting on the above grid, which can be used to identify whether services need to be co-located together, the Senate noted that there is a core group of services that need to be provided onsite where there is an A&E.

> **"Hospitals with emergency departments** (A&Es) receiving all acute adult patients (an 'unselective take') need on-site **acute and general medicine**, **acute surgery**, and **critical care** (ICU).
>
> Such hospitals need to provide the supporting clinical services that are required by all or any one of these four core interrelated acute specialties.
>
> These amalgamated requirements delineate what an emergency hospital should provide on-site as a minimum."

On-site services recommended for hospitals with emergency departments (with an "unselected take") were listed as follows:

Services that should be based on-site (Purple-rated dependencies)

- Acute and General Medicine
- Elderly Medicine
- Respiratory Medicine (including bronchoscopy)
- Medical Gastroenterology
- Urgent GI endoscopy (Upper and Lower)
- Cardiology (non-invasive)
- General (Adult) Surgery
- Gynaecology
- Trauma
- Orthopaedics
- Urology
- ENT
- Critical Care (adult): Level 2 and 3
- General Anaesthetics
- X-ray and Diagnostic Ultrasound, CT Scan, MRI Scan, urgent Diagnostic Haematology and Biochemistry, Clinical Microbiology/Infection Service
- Occupational Therapy and Physiotherapy
- Acute Mental Health Services (Liaison Psychiatry)

Services identified as needing to in-reach if not based on-site (Red-rated dependencies)

- Diabetes and Endocrinology
- Rheumatology
- Dermatology
- Acute Oncology
- Palliative Care
- Neurology
- Nephrology
- Maxillo-Facial Surgery
- Plastic Surgery

- Burns
- Interventional Radiology
- Speech and Language
- Dietetics

The work was validated through:

- A clinical senate summit
- Internal CRG consistency check, whereby grid squares that involved a row and column lead who were different discussed and confirmed the colour rating.
- External validation; CRG members shared grid ratings with a range of clinical colleagues to sense-check their conclusions (e.g. Strategic Clinical Network advisory groups).

Commenting on the limitations of the work the senate noted that "it is important to understand that clinical senates are advisory bodies, not statutory, so the recommendations from this report are not mandatory. Given the absence of a large evidence base for this co-dependency review, and a reliance on clinical consensus and judgment in many areas, it must be also be acknowledged that consensus of any kind is open to bias on a range of fronts, is not cast in stone, and is challengeable. However, this independent, clinical report aims to provide a baseline from which to have detailed local discussions about necessary co-dependencies and colocations, and to explore different ways in which services could be delivered if not physically based on the same site."

The work provides an evidence base from which to build and has underpinned other transformation programmes, such as Greater Manchester's Healthier Together programme. The Our Health Our Care programme therefore undertook to assess where it can be adopted or adapted to underpin the design of the options for Lancashire Teaching Hospital sites.

3.2 Adapting the SECCS Co-dependency Framework for the OHOC Programme

The methodology to assess what to adopt and what to adapt is described below.

Figure 3: Adopt or adapt methodology

Step	Methodology
1	What should the final output look like i.e. should the OHOC programme produce a similar grid format?
2	Are the SECCS grid column and row headers appropriate and complete for the OHOC programme, or do they require amendments?
3	What additional grids should be produced for the OHOC programme?
4	Is the local assessment of dependencies consistent with those determined by SECCS? Where there are variations what is the rationale (in terms of local circumstances and mitigations)?

This approach was shared for review and comment at the first set of Model of Care workshops (at both Preston and Chorley), finalised by the clinical workstream lead, Prof Mark Pugh and agreed with the Trust Medical Director Dr Geraldine Skailes.

The following section summarises the "adopt or adapt" decisions that were made based on that approach.

1. *What should the final output look like i.e. should the OHOC programme produce a similar grid format?*

The SECCS co-dependency framework was considered by Clinical Leads to be an authoritative evidence and clinical consensus base and as such, as a minimum, a similar grid was required.

2. *Are the SECCS grid column and row headers appropriate and complete for the OHOC programme, or do they require amendments?*

To generate a grid that describes the co-dependencies of the specific services provided by Lancashire Teaching NHS Foundation Trust, services that are not provided by the Trust have been removed, including:

- Cardiology: Interventional - primary PCI for STEMI
- Cardiology: Interventional - PCI (non-STEMI) and devices
- Cardiology: Interventional - structural heart disease (including TAVI, MitraClips)
- Cardiac Surgery
- Hyper-Acute Stroke Unit

In addition, changes have been made for Thoracic Surgery and Cardiac Surgery as these are provided by Blackpool Teaching Hospitals. For Thoracic and Cardiac Surgery, both of these only have one purple dependency, as per the SECCS co-dependency framework, this is for the Major Trauma Centre. As such, for the OHOC programme these dependencies have been re-assessed to Red.

In relation to pathology services (and in line with expected work on the Lancashire and South Cumbria Pathology Collaboration) Clinical Microbiology / Infection services have been reassessed for the OHOC programme as amber dependency.

3. *What additional grids should be produced for the OHOC programme?*

Specialty specific co-dependency frameworks were produced for ED and Critical Care to provide additional detail and insight, as below.

Figure 4: Additional Major Trauma/ED and UCC grid

Clinicial Service OHOC Programme is potentially dependent upon	MTC (includes ED and UC provision)	Emergency Department	UCC with minor injuries	UCC
Accident and Emergency	1	1	4	4
Oncology	2 (4)	2 (4)	5	5
Cardiology	1	1	5	5
Clinical immunology	5	5	5	5
Dermatology	5	5	5	5
Diabetes	1	1	5	5
Elderly rehabilitation	5	5	5	5
ENT	1	4	5	5
General medicine including acute elderly	1	1	4	4
General surgery – emergency and elective	1	1	4	4
Genito urinary	5	5	5	5
Gynaecology – elective	5	5	5	5
Haemotology	2 (4)	2 (4)	5	5
HSDU	5	5	5	5
Intensive care	1	1	5	5
Nephrology	2 (4)	2 (4)	5	5
Neurology	2 (4)	2 (4)	5	5
Neurosurgery	1	4	5	5
Obstetrics – midwife led unit	5	5	5	5
Ophthalmology	2 (2)	4	5	5
Oral surgery and orthodontics	5	5	5	5
Orthopaedic surgery	1	1	4	4
Outpatient services	5	5	5	5
Paediatrics – medical and surgery	1	1	4	4
Palliative care	2 (24)	2 (24)	5	5
Pathology	1	1	1	1
Plastic surgery	1	4	4	5
Radiology and imaging (Interventional Radiology, CT and MRI)	1	1	1	1
Renal dialysis	4	4	5	5
Respiratory and cardiovascular	1	1	5	5
Theatres	1	1	5	5
Trauma	1	5	5	5
Stroke ward	1	1	5	5
Stroke rehabilitation	5	5	5	5
Vascular surgery	1	4	5	5
Urology	1	1	4	4
OMFS	1	5	5	5
Gynaecology - emergency	1	1	4	4
Therapies (PT/OT)	1	1	5	5
SALT	1	1	5	5
Nutrition	1	1	5	5
Mental health	1	1	4	4
Respiratory Medicine	1	1	5	5
Gastroenterology	1	1	5	5
Obstetrics	4	4	5	5
Transfusion	1	1	5	5

Figure 5: Additional Critical Care grid (services dependent on Critical Care)

	In-Scope Specialties		
Clinicial Service OHOC Programme is potentially dependent upon	**HDU**	**PACU**	**Critical Care**
Accident and Emergency Unseslected	1	5	1
Accident and Emergency selected triage	4	5	4
Major Trauma Unit	1	5	1
Cancer	1	5	4
Cardiology	1	Can be used for cardioversions and pacing	4
Clinical immunology	4	5	5
Dermatology	4	5	5
Diabetes	4	5	4
Elderly rehabilitation	4	5	4
ENT Major cancer	1	5	1
ENT DGH level	1	5	4
General medicine including acute elderly	1	5	1
Robotic lap colorectal	1	1	4
Open Colorectal	1	1	4
General surgery – emergency and elective	1	1	1
Genito urinary	5	5	5
Gynaecology Oncology Open hysterectomy	1	1	1
Gynaecology Laparoscopic incl ovarian Ca	1	1	4
Gynaecology Oncology Lap/robotic hysterectomy	1	1	4
Gynaecology – elective	1	1	4
Haemotology	4	5	4
HSDU	5	5	5
Intensive care	X	X	X
Nephrology	1	5	1
Neurology	1	5	1
Neurosurgery	1	5	1
Obstetrics High Risk and Tertiary	1	5	1
Obstetrics – midwife led unit	4	5	4
Ophthalmology	5	5	5
Maxillo facial cancers	1	5	1
Oral surgery and orthodontics	5	5	5
Orthopaedic surgery	1	1	4
Outpatient services	5	5	5
Paediatrics – medical and surgery	4	5	5
Palliative care	4	5	5
Pathology	5	5	5
Plastic reconstruction surgery	1	1	1
Plastic surgery	4	5	5
Radiology and imaging (Interventional Radiology, CT and MRI)	1	1	1
Renal dialysis Community unit	4	5	4
Respiratory and cardiovascular	1	5	1
Theatres	1	1	1
Trauma	1	1	4
Spinal surgery	1	1	4
Stroke ward	4	5	4
HASU	1	1	1
Stroke rehabilitation	4	5	4
Upper GI bilary	4	1	4
Upper GI Reflux	4	1	4
Upper GI Oncology/Perforation	1	1	1
Urology Oncology	1	1	4
Urology	1	1	4
Vascular surgery	1	1	1
Urgent Care Centre	4	4	4

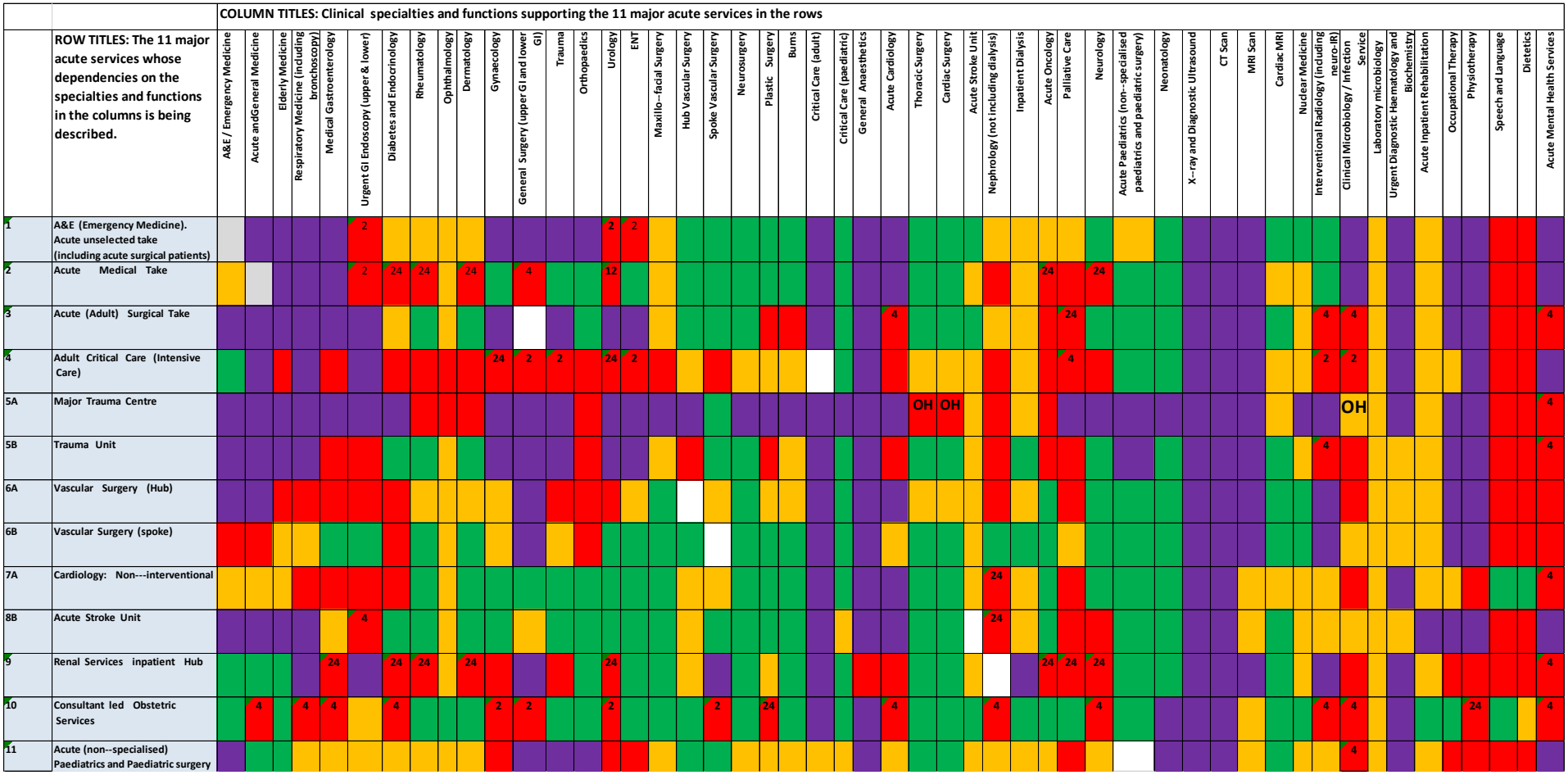
Figure 6: Additional Critical Care grid (services that Critical Care is dependent on)

	In-Scope Specialties	
Clinicial Service OHOC Programme is potentially dependent upon	**Tertiary Critical Care**	**General Critical Care**
Accident and Emergency	5	5
Oncology (prognosis,chemo/radio advice)		
Interventional Cardiology (pacing not angio)	2 (2)	2 (2)
Cardiology		
Clinical immunology	5	5
Dermatology		
Diabetes	5	5
Diagnostic Upper GI Endoscopy	1	1
Elderly rehabilitation	5	5
ENT major head and neck cancer	1	5
ENT	2 (2)	2 (2)
General medicine including acute elderly		
Lower GI surgery – emergency and elective	1	1
Genito urinary	5	5
Gynaecology – elective	1	2 (4)
Haemotology		
Hepatobilary	4	4
HSDU	5	5
Intensive care		
Nephrology	2 (24)	2 (24)
Neurology	2 (24)	2 (24)
Neurosurgery	1	5
Obstetrics High Risk and Tertiary	1	4
Obstetrics – midwife led unit	1	4
Ophthalmology		
Oral surgery and orthodontics	1	
Orthopaedic surgery	5	5
Outpatient services	5	5
Paediatrics – medical and surgery	5	5
Palliative care		
Pathology	1	1
Plastic surg	1	4
Radiology and imaging (Interventional Radiology, CT and MRI)	1	1
Renal dialysis	2 (4)	2 (4)
Respiratory and cardiovascular		
Theatres	1	1
Trauma	1	1
Spinal Surgery		4
Hyper Acute Stroke Unit	1	5
Stroke ward	5	5
Stroke rehabilitation	5	5
Upper GI surgery	1	4
Urology	1	2 (4)
Urgent Care Centre	5	5
Vascular	1	4

4. *Is the local assessment of dependencies consistent with those determined by SECCS? Where there are variations what is the rationale (in terms of local circumstances and mitigations)?*

No further amendments were made and the resulting co-dependency framework for the OHOC programme (Acute Sustainability workstream) is shown in Figure 7 below.

Figure 7: OHOC determination of co-dependency for key acute hospital services



Conclusion

The SEC Clinical Senate Co-dependencies framework has been adopted in full with the exclusion of a small number of services that are not provided by the Trust, and with the addition of detail in relation to Major Trauma, ED/UCC and critical care dependencies. This framework has informed the design of site options; only viable options that achieve (or do not worsen) the co-location of services will be generated and proposed for consultation.

References

South East Coast Clinical Senate (SECCS, 2014), *The Clinical Co-Dependencies of Acute Hospital Services: A Clinical Senate Review.*

http://www.secsenate.nhs.uk/files/5514/2255/2355/The_Clinical_Co-dependencies_of_Acute_Hospital_Services_SEC_Clinical_Senate_Dec_2014.pdf?PDFPATHWAY=PDF

NHSE (2017), *Urgent Treatment Centres – Principles and Standards*.

https://www.england.nhs.uk/wp-content/uploads/2017/07/urgent-treatment-centres%E2%80%93principles-standards.pdf

NHSE (2014), *Safe, compassionate care for frail older people using an integrated care pathway: Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders*.

https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf

Appendix D - Lancashire Teaching Hospitals Existing Improvement Initiatives

Central Lancashire Urgent and Emergency Care Workstreams

There is some excellent work taking place to develop truly patient centred and care fit for the future. One example of this is the Maternity Service which has received a Beacon Award for its model. This means it will work with other health and care systems to support and share best practice. Lancashire Teaching Hospitals NHS Foundation Trust also has in place several improvement programmes targeting urgent and emergency care. These improvements will and are taking place outside the scope of this programme. It is however important that these initiatives and their impacts are fully understood to inform any need for any potential future transformation change.

Value Stream Analysis

This has been informed by system wide work to review current pathways and highlight the need for re-design, using system data in order to remove non-value adding activity and eliminate variation.

From this Value Stream Analysis (VSA), eight work streams were established, including:

- Emergency Department
- Admission Avoidance
- NWAS and 111
- Care co-ordination
- Integrated therapy pathways
- Discharge
- Mental Health
- Paediatrics

Highlights from some these key workstreams are provided below:

Emergency department workstream

This work has focused on pathways related to the triage and streaming of patients at the front door, including the development of pathways for direct streaming to Ambulatory Care and Go to Doc (Urgent Care Service). Significant work has also been progressed to support the transfer of the minor injuries work stream to the Go to Doc service.

Work is also being undertaken with the Emergency Department and Surgical teams at the Royal Preston Hospital (RPH) to ensure that appropriate pathways are in place for the direct transfer of patients from the Rapid Assessment and Treatment clinical area and to the Surgical Assessment Unit when these become operational.

Care Co-ordination workstream

This work stream has involved collating a directory of services and scoping a single care co-ordination hub for the Trust (which will require business case development if the early scoping indicates sufficient value).

Discharge workstream

A new pathway and process to ensure that patients are supported to leave hospital in a timely way has been designed by system partners. The aim is to simplify and standardise the process from when a decision to admit a patient is made, working backwards from the expected discharge date to teams (acute and community) proactively planning discharges. A system wide discharge charter has been developed and agreed by all system partners to

ensure all partners are fully committed to delivering improvements. There are five key enablers to this process:

- Central Lancashire Discharge Charter
- A ward-based Discharge Facilitator on every ward
- Estimated Discharge Date set within 24 hours of admission
- One Discharge Planning Document
- Consistent Board Rounds

To support this work a delayed transfers of care diagnostic was undertaken by Newton Europe[44]. The process included workshops with frontline staff and case file audits to identify opportunities to reduce delays. The diagnostic identified that 80% of delays related to processes and decisions within the acute footprint (decisions taken by acute, community and social care colleagues). It also showed there were further opportunities identified to introduce service level governance, improve patient outcomes and remove the variation in decision making.

In addition to the VSA work, the trust is also leading the following improvement programmes.

NHS Improvement ECIST- SAFER

The trust is participating in the NHS Improvement (ECIST) collaborative focused on the reliable implementation of the SAFER flow bundle.

The SAFER patient flow bundle:

S - Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F - Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

This will see the adoption of a new approach with ward teams working together to systematically implement each element of the bundle. The wards have had real success in implementing the 'R' of SAFER (all patients will have a multidisciplinary review at seven days focused on planning continued care and discharge) which has delivered a reduction in the stranded patient metric.

[44] Information supplied by Newton Europe to Lancashire Teaching Hospitals

The current focus is on the ‘F’ of SAFER (improving flow with wards testing ‘pulling’ a patient from an assessment area by 10am every morning). As part of this work peer review visits are being undertaken with another Trust.

The divisional nursing directors have also successfully led small teams to deliver the national target of achieving a 25% reduction in our long length of stay patients (over 21 days), through implementation of the Emergency Care Intensive Support Team (ECIST) guidance.

This work has been recognised nationally by ECIST and the team have been filmed to share the work with other trusts. This work has seen the Trust move from the lowest position in the region to the third highest. Work is underway to maintain this position and deliver further improvements.

Ambulance Turnaround Times

The Trust has been selected to participate in an ambulance turnaround improvement programme, delivered with the North West Ambulance Service (NWAS) and ECIST. This has seen the Trust improve from one of the lowest performers in the region to the third best performer.

Local Level Improvement Programme

Working with the Health Foundation Flow academy, the Trust is looking to target improvements in 4 pathways/wards in Year 1 and then roll this out to 12 pathways/wards in Year 2.

Impact of improvement programmes

Key improvements have been seen by these work programmes and is outlined below (as of September 2018):

- Triage times have reduced by 50% to 17 mins (a further reduction is required to achieve the 15-minute standard consistently);
- Ambulance handovers >60 mins have reduced by 82%. The Trust has improved from the position of the lowest performer in the north of England to the top three in September 2018;
- Improvements in Type 1 Emergency Department performance equating to 10% improvement in the last 6 months;
- Long length of stay patient metric has seen a step change reduction to 132 patients which represents a shift from the worst performer in the North to the top three and achievement of the national target for the Trust;
- The step change reduction in Delayed Transfer of Care has been maintained; for the first time the discharges before midday has improved to 22.4% with plans in place to achieve the 33% as part of the Value Stream Analysis;
- Reduction in non-elective Length of Stay, the step change reduction has been maintained with a further reduction seen in September;
- The 50% reduction in Medical Outliers from Winter has been maintained; and
- Elective activity has increased compared to 2017/18.

<END>

APPENDIX A - Our Health Our Care Engagement Log

Patient and public engagement in the OHOC programme commenced in September 2016. This initial period of engagement which continued until March 2017, began conversations with the public about what was important to them about their health services. During this time (referred to as Engagement Period 1), 18 events were held and around 1400 people were reached through the communications and engagement activities. Following a 12-month hiatus, public engagement in the programme recommenced in March 2018 (Period 2) with various service user groups and public workshops being held in the following months. The engagement work of the previous period was built on taken further during this stage.

In total 28 public engagement events were held across both engagement periods.

All patient, public and staff engagement activities were promoted via the OHOC social media platforms – Twitter and Facebook. Additionally, various public events were advertised in local newspapers in an effort to attract a wide and diverse audience.

The Engagement Log below details the activities which have taken place during both periods to engage and involve individuals, groups and communities in the development of the different stages of the OHOC programme.

Governance
Model of Care clinical engagement
Finance & Modelling
Patient & public engagement
Other (wider stakeholders)

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Patient and public engagement period one	September 2016- March 2017	18 public engagement events held across Chorley, South Ribble and Greater Preston as well as targeted engagement (approx. 1400 people across all the activities). Groups include: Chorley Equality Forum Galloway's Society for the Blind Preston and District Carers Support Group Preston College Ingleton Congregational Church Preston Health Mela Patient representation at Solution Design Events	Discussion themes across the period were to discuss three key themes: What's important to you? What would you do? What do you think?
Frailty Workshop	21/06/2017	Attended by clinicians and managers from LTH, LCFT, CCG, NWAS, AFN (Acute Frailty Network) ANPs, CNS and representatives from the 3rd sector (Age Concern and Care & Repair) . A total of 32 delegates attended the workshop	The first Frailty workshop – entitled Frailty Show and Tell – was held in June 2017. This was a showcase of Central Lancashire's Frailty Models. - LTH – Acute Frailty Network and LIFT Project - LCFT – Community Frailty Model - Ambulatory Care Model - Table discussions took place to ask: - Thoughts on what had been shared re the various models - Opportunities highlighted - How to bring services together
Respiratory Workshop 1	27/07/2017	27 Attendees from LTH/LCFT/NWAS/Primary Care – GPs, Practice nurse, / CSU/ CCG /LCC/BLF /Breathe Easy/NHSE /St Catherines Hospice/Pharmacy /patient reps	To map the COPD Respiratory patient pathway for prevention, wellbeing, self-care & Primary Care, Community Care, Hospital and End of Life Care. To identify what does add value and what does not add value.
Frailty Workshop 2	13/09/2017	The workshop was attended by reps from LTH, CCG, LCFT, GPs 3rd sector, GTD and NWAS- approx. 25 delegates.	This was to map the current Frailty pathways. Aims and objectives of the workshop – to map the Frailty patient pathway for prevention, wellbeing, self-care and primary care, community care and hospital care to identify what added value. The mapping exercise reinforced the need to agree an integrated pathway. He further suggested getting a smaller group of clinicians together who could design the components of a future pathway building on the information received as well as looking at best practice elsewhere with an aim to creating an aunt sally at the next wider workshop
Respiratory Workshop 2	05/10/2017	27 attendees – LTH, LCFT, CCGs, GPs and practice nurse, LCC, NWAS, Pharmacy – hospital & Community, patient reps, Breathe Easy, Home Oxygen Team. Workshop supported by AQuA	Review COPD patient pathway maps produced at workshop 1 to redefine the maps to gain agreement on the current state as the baseline for future design. Identify what does and does not add value to the COPD pathway. To sense check and consider the issues and opportunitie identified at the first workshop, identifying further opportunities for COPD pathway. Sharing of info on existing projects underway.
Frailty Clinical Steering group	18/10/2017	Clinicians (Consultants, GPs, Community Matrons, Nurse Specialists)	The meeting was held to review and progress the feedback suggestions generated at workshop 1. The group reached consensus on - using the Rockwood Frailty score across the health economy. Use an amended version of the Bournemouth criteria (age ranges and the abbreviated mental test (AMT) score removed. - Use the LCFT CGA (Complete Geriatric Assessment) template for all patients referred into LTH LIFT service to replace their current template (however, this when put into practice, has proved unsuccessful). •Further development of the blue, green, amber and red pathways to standarise referral, care and treatment across the health economy, depending upon the severity of condition
Preston Peer Group	09/01/2018		LCFT Michaela Toms and Anne Kirkham shared the work from the Frailty workshops – specifically the pathway redesign to encompass prevention, health & wellbeing through to supporting patients with end of life care with Primary Care. The delegates were aked to discuss and develop the key components of the proposed re-designed pathways within PC.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Chorley & South Ribble Group	17/01/2018		LCFT Michaela Toms and Anne Kirkham shared the work from the Frailty workshops – specifically the pathway redesign to encompass prevention, health & wellbeing through to supporting patients with end of life care with Primary Care. The delegates were aked to discuss and develop the key components of the proposed re-designed pathways within PC. Presentations from Age Concern and Preston Care & Repair with regard their input to frailty were also shared
Frailty Clinical Development Session	07/02/2018	15 people from clinicians/AHPs/GTD	This session was to look specifically at urgent care pathways, to build alignment and improve the frailty pathway between EDs, Urgent Care and Community models of care and the role NWAS could provide.
Respiratory Steering group	07/03/2018	6 clinicians 1 manager	A small steering group to look at Dr Paul Marsden's COPD "Perfect pathway" , how to use data to support the pathways and the review and develop KPIs
Stakeholder feedback event	19/03/2018	71 Attendees	Public event to share progress and next steps, and build public engagement
OHOC Comms & Engagement meeting	12/04/2018	Erin Portmouth, Lisa Roberts, Lorraine Kelly, Madeleine Bird	Reset of communications meeting to begin plans for the governance meeting and communication and engagement planning.
Approach to Modelling	13/04/2018	Brian Johnson, Fiona Morrall	Initiall discuss the approach to the modelling that will be required for the PCBC
Medical leadership meeting	16/04/2018	Syed Ali, Anna Bewlay, Mark Brady, Vanita Brookes Steve Canty, Irfan Chaudry, Fiona Crosfill, Rejith Dayanandan, Christopher Dobson, Tracy Earley, Ansy Egun, Graham Ellis, Alison Gale, Richa Gupta, Martin Hogg, Somnath Kumar, George McLauchlan, Mohammed Munavvar, Martin Myers, Valerie O'Donnell, Chooi Oh, David Orr, Thomas Owen,Satyan Raijbhandari, David Shakespeare, Abi Sharma, Gerry Skailes, Philip Shields, Karnam Sugumar, Nick Wood	The Team introduced themselves to the group and gave a brief presentation on the work so far and also proposed the strategy towards the public consultation. A plea was made for substantial clinical engagement in each of the work streams and the setting up of Clinical Reference Groups.
Frailty workshop 3	19/04/2018	22 delegates	The aims and objectives for this workshop was to hear about good practice going on in other areas of the world to see what could be learnt, adopted or adapted for central Lancashire. To look at some examples of care within our area and focus on prevention and living well with frailty within the blue/green pathways.
ICP Shadow Board	26/04/2018	Prof Heather Tierney-Moore (Chair),Matt Gaunt, Denis Gizzi, Gary Hall, Sarah James, Dr Khandavalli, Dr Sumantra Mukerji,Sue Musson, Karen Partington, Gerry Skailes, Louise Taylor, Brenda Vernon	As part of the governace route, the Programme Director, Our Health Our Care outlined key pieces of work undertaken by the Our Health Our Care Programme during the period 15 March to 26 April 2018, and priorities for the month ahead. The new format of reporting contained updates on two key projects. It was noted that additional projects would be added to report as they were included in the programme.
ED Pre meet	04/05/2018	Michael Stewart, Anne Kirkham	An introductary session for the clinical leads to meet the project team. Initial discussions began around understanding the curent state of service.
CC Pre meet	04/05/2018	Huw Twamley, Anne Kirkham	An introductary session for the clinical leads to meet the project team. Initial discussions began around understanding the curent state of service.
Baseline Model Build Position	08/05/2018	Brian Johnson, Fiona Morrall	Discussions and agreement around the Baseline Model. The meeting was to establish key contacts for data and further information and what benchmarking data OHOC team need for capital bid.
Respiratory Steering group	09/05/2018	10 clinicians from LCFT/LTH/CCG & St Catherines	Objectives of the meeting were to; review data – scoping data/national COPD Audit/Right Care Update packs; review and development of self-management plans. Exacerbation of COPD plan and rescue meds. Review of the nebuiliser pathway and discussion on digital apps for self-care and exercise
Acute Med Pre Meet	09/05/2018	Lee Helliwell, Helen Bradley, Hayne Sargeant, Tracy Sherrington, Andrew Higgins	An introductary session for the clinical leads to meet the project team. Initial discussions began around understanding the curent state of service. The group recognised immediate change is required and a super hospital would not accommodate this; an interim solution is required.
Surgical Pre meet	10/05/2018	Tracy Earley,	An introductary session for the clinical leads to meet the project team. The clinical lead ambiguity around scope and remit. Discussions began around individual speciality.
Specialist Med Pre meet	10/05/2018	Somnath Kumar, Anne Kirkham	An introductary session for the clinical leads to meet the project team. An understanding of the current state of the service. Initial Model ideas around MAU and Ambulatory Care. Thought given to the scope and remit of the speciality.
One-to-one	10/05/2018	Matt Gaunt	One to one meeting to discuss an approach to modelling
Surgical subgroup	14/05/2018	Tracy Earley, Kate Howarth, Mark Westwood, Jane Grassham, Anne Kirkham	An introductary session for the subgroup attendee's to meet the project team. The session was also used for the group to understand the aims of the project and understand the urgency of the project. Initial Model ideas and an understanding of the complexities of the specialities. Data provided to understand high-acuity surgeries. Approach for engagement discussed and agreed around one-to-one clinical meetings.
Acute & Surgical/Specialist Med Service User Group	15/05/2018	1 patient	Service users group to understand the experience of patiences within the system. An understanding of the individual patients story using the services. Detailed feedback provided around engaging with the public.
CC Subgroup	16/05/2018	Thomas Owen, Jane Platt, Huw Twamley, Sally Fray, Anny Kirkham	An introductary session for the subgroup attendee's to meet the project team. For the group to understand the aims of the project and understand the urgency of the project.
ED Subgroup	16/05/2018	Jen Ashcroft, Anita Snowdon, Michael Stewart, Lynn Sime, Alison Sykes, Kath Davies	An introductary session for the subgroup attendee's to meet the project team. For the group to understand the aims of the project and understand the urgency of the project. There was also discussion around the complexity of the service.
Ed & CC Service User Group	17/05/2018	1 patient	Service user groups to understand the experience of patients within the system. Feedback was also given around the individual patient experience when using the service.
Modelling: 3 Phases	17/05/2018	Matt Gaunt	Meeting to cover the 3 phases of the modelling work and the limitations of the modelling work in relation to wider health economy. Agreement to ensure that the team are aware of the technical detail of the modelling work.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Acute Med Subgroup	18/05/2018	Sarah Clayton, Simon Howell, Robert Nipper, Helen Bradley, Aurelia McCann, Joanne Bingham, Jayne Sargeant, Steve Canty, Tahir Nazir	An introductary session for the subgroup attendee's to meet the project team. For the group to understand the aims of the project and understand the urgency of the project. Understand what is 'good' about the curent state of play. Consideration for current pathwya- from point of entry (after ED) to point of discharge. Discussions around pathway refresh and around a 'call taker'
One to One phone call	21/05/2018	Graham Ellis	Catch up phone call about the programme and the current state of play.
OHOC Workshops	21/05/2018	Angela Adkis, Syed Ali, James Allan, Alison Anton, Joanne Bingham, Rosie Blades, Claire Capewell, Sarah Clayton, Fiona Crosfill, Christian DeGoede, Tracy Earley, Nigel Gurusinghe, Alison Haughton, Lee Helliwell, Fergus Jepson, Anne Kirkham, Somnath Kumar, Kathryn Maddsion, Kenneth McGrattan, George McLauchlan, Liz Mcmullin, Catherine Mitchell, Martin Myers, Choii Oh, Finbar O'Mahony. Jane Platt, Sanjeer Prashar, Nina Russell, Jayne Sargeant, David Shakespear, Catherine Silcock, Gerry SKailes, Laurie Solomon, Michael Stewart, Kevin Turner, Huw Twamley	At the initial workshop the first exercise focussed on the 'discovery phase' adopting a positive thought process to describe the current service for each of the clincial sub-groups areas. This was designed to build a clear picture of the existing service provision, areas requiring improvement, drawing upon existing good practice within the organisation, explore best practice and clincial evidence base/standards, and identifying 'quick win' opportunities. The second exercise then explored 'what good looks like' and asked the clinicians to create the vision for the future by describing it, drawing it, asking what patients will say about it in the future and the benefits they will experience, what staff will say and how they will be working differently and how it connects and integrates with the holistic health and social care system.
OHOC Workshops	24/05/2018	John Agbenu, Gaurav Agrawal, Amanda Bellis, Amol Chitre, Maria Debattista, Andrew Fletcher, Richa Gupta, Charles Kattakayam, Somnath Kumar, Tina Lawrenson, Gerry Skailes, Michael Stewart, Thomas Thorp, Huw Twamley, Sally Fray, Karen Fisher, Helen Bradley, Tracy Sherrington, Batra Munish	At the initial workshop the first exercise focussed on the 'discovery phase' adopting a positive thought process to describe the current service for each of the clincial sub-groups areas. This was designed to build a clear picture of the existing service provision, areas requiring improvement, drawing upon existing good practice within the organisation, explore best practice and clincial evidence base/standards, and identifying 'quick win' opportunities. The second exercise then explored 'what good looks like' and asked the clinicians to create the vision for the future by describing it, drawing it, asking what patients will say about it in the future and the benefits they will experience, what staff will say and how they will be working differently and how it connects and integrates with the holistic health and social care system.
Specialist Med subgroup	29/05/2018	Somnath Kumar, Anne Kirkham, Simon Howell,	An introductary session for the subgroup attendee's to meet the project team. The session was also used for the group to understand the aims of the project and understand the urgency of the project. The session was also used to define 'Speciality Medicine' and the services included in that scope. Low attendance was recongised and discussions around a change in engagement tactics took place. A subsequent email was sent out with detailed questions to all clinical directors and physicians.
CC Subgroup	29/05/2018	Thomas Owen, Huw Twamley, Sally Fray, Irfan Chaudry	More detailed discussions around the emerging model of care. Discussions around co-dependencies and feedback from the initial workshops.
Surgical subgroup	31/05/2018	Tracy Earley, Alison Anton, Amanda Sumner, Jane Grassham	More detailed discussions around the emerging model of care. Discussions around co-dependencies and feedback from the initial workshops
One to One phone call	31/05/2018	Lee Helliwell	Catch up call to discuss the upcoming subgroups and workshops.
OHOC Comms & Engagement meeting	31/05/2018	Neil Greives, Helen Curtis, Erin Portmouth, Lisa Roberts, Lorraine Kelly	Whilst the meeting was stood down, updates on the programme were shared to members of the group.
Acute Med Subgroup	01/06/2018	Lee Helliwell, Anne Kirkham, Helen Bradley, Andrew Higgins, Tracy Sherrington, Kayne Sargeant, Steve Canty, Arnab Bhowmich, Simon Howell, sarah Clayton, Ayo Olatoye, Joanna Bingham	The attendees were in broad agreement of the direction of travel and supported the draft model of care. The group completed a co-dependency exercise Lee had designed. A lot of the discussion centred around a central communication point for acute medicine, in essence a 'command centre' type of model.
ED Subgroup	04/06/2018	John Whittaker, Michael Stewart, Stewart Durham, Ayam Jundi, Kirsty Challen, Alison Sykes, Graham Ellis, Lynn Sime	More detailed discussions around the emerging model of care. Discussions around co-dependencies and feedback from the initial workshops
Greater Preston Membership Council	05/06/2018	27 members (this includes the 4 GP Directors who attended as reps) 6 practice managers.: Avenham Lane Surgery, Berry Lane Medical Centre, Briarwood Medical Centre, Doclands Medical Centre, Dr CM Wilson and Partners, Fishergate Hill Surgery, Frenchwood Surgery, Geoffrey Street Surgery, Gutteridge Medical Centre, Issa Medical Centre - Dr Patel, Longton Health Centre, Lostock Hall Medical Centre, Lytham Road Surgery, North Preston Medical Practice, Park View Surgery, Penwortham St Mary's Medical Group, Ribble Village Surgery, Ribbleton Medical Centre, Riverside Medical Centre, St Walburge's Medical Practice, St Fillan's Medical Centre, Stonebridge Surgery, The Health Centre (Dr Rossall), The New Hall Lane Practice, The Park Medical Practice, The Surgery, Preston	The programme attended to provide an update of the programme so far.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Exec Team meeting	06/06/2018	Karen Partington, Chief Executive Paul Havey, Finance Director/Deputy Chief Executive Gail Naylor, Nursing, Midwifery and AHPs Director Dr Gerry Skailes, Medical Director Faith Button, Interim Operations Director Karen Swindley, Director of Workforce and Education Phebe Hemmings, Company Secretary	The team provided a detailed presentation explaining the case for change, timelime and an explained the workstreams of the programme.
OHOC Workshops	07/06/2018	Shakeel Ahmed,Guarav Agrawal, Alison Anton, Amanda Bellis, Rosie Blades, Edward Denison Davis, Tracy Earley, Andrew Fletcher, Patha Ganguli, Richa Gupta, Lee Helliwell, Som Kumar, Tina Lawrenson, Eamonn McKiernan, Syed Mehdi, Finbar O'mahony, Sanjeev Prashar, Mark Pugh, Abhishek Sharma, Catherine Silcock, Gerry Skailes, Michael Stewart, Mandy Summer, Catherine Taurozzi, Huw Twamley	The emerging Models of Care for each of the clinical areas was presented alongside a programme plan update and overview of the approach to the modelling.Discussions took place focusing on feedback to the draft model of care presented, assessing connectivity with primary care and assessing potential benefits to both patients and staff.
Pathway to Excellence phone call	08/06/2018	Gerry Skailes, Dr Shahid Wahid, Patrick Garner, Denis Gizzi, Sarah James	Collaborative phone call with Pathway to Excellence to understand the challenges and lessons learnt from the programme
Specialist Med subgroup	11/06/2018	Somnath Kumar, Anne Kirkham, Joanne Burn, Suzanne Gifford, SR2 Student- Dr James, Nadine Blakeman, Catherine Taurozzi	More detailed discussions around the emerging model of care. Discussions around co-dependencies and feedback from the initial workshops.
Joint Clinical Leads meeting	12/06/2018	Huw Twamley, Lee Helliwell, Tracy Earley, Somnath Kumar, Michael Stewart, Mark Pugh, Anne Kirkham	A joint clinical leads meeting to discuss the model of care and the practicalities of changing services. . There was a clear understanding of the co-dependencies which were also being developed.
LMC	13/06/2018	Dr Andrew Littler – LMC Chair Peter Higgins – LMC Chief Exec & Secretary Jessica Tomlinson – Executive Lead Maria Mulberry – LMC Support Officer	The programme presented presented to the Executive of the LMC the programme so far and the emerging model of care. The discussion was To understand the impact of GPs and to gain support for the emerging model of care. The LMC are keen to remain engaged with agreement to run update sessions. the Exec asked noted that a acute hospital solution wuld only work if it was joined up with the 'whole system solution'/ They offered to support for other GPS to become engaged in the process.
GP Engagement Event	14/06/2018	Eva Craven, Dawn Edge, Eamonn McKiernan, Jayne Mellor, Simon Shaw, Gerry Skailes, Michael Stewart, Lee Helliwell, Doma Roberts	The event was to provide a background to the programme and to engage and gain feedback from GPs across the system. GPs were asked to consider the following points: What are your thoughts on the proposed models? Discuss the integration with Primary Care? Consider the benefits: For patients? For staff? The group then looked at the co-dependency framework and were updated on the next steps of the programme.
OHOC Comms & Engagement meeting	14/06/2018	Neil Greives, Helen Curtis, Erin Portmouth, Lisa Roberts, Kelly Lorraine, Sarah James.	A monthly governance meeting, the meeting focused on engagement so far and engagement planned for the programme.
Clinical Senate Meeting	15/06/2018	Anne Kirkham & Mark Pugh + Clinical senate members	Initial meeting with the clinical senate attended by the clinical leads.
Individual Surgeons	15/06/2018	Mr Haqq, Mr Alan	One-to-one clinical meeting to talk through the programme and to understand co-dependencies for the speciality. Discussions around the current provision of services. Detailed information provided around the current state of play. Further discussions around future services and the Model of Care, especially around a fully intergrated unit.
Individual Surgeons	18/06/2018	Dr Tony Helm	One-to-one clinical meeting to talk through the programme and to understand co-dependencies for the speciality. Discussions around the current provision of services. Detailed information provided around the current state of play. Further discussions aroun
Phase 2 Modelling: Prevention	18/06/2018	Helen Curtis	One-to-one meeting to establish the elements of the prevention framework that need to be included in the Overlay Model. An agreement that currently the quantification of benefits for Framework are not developed enough to include in the Overlay Model.
Chorley & South Ribble Membership Council	20/06/2018	27 members (Including 4 GP Directors) 4 practice managers from the below practices: Adlington Medical Centre, Beeches Medical Centre, Buckshaw Village Health Centre, Central Park Surgery, The Chorley Surgery, Clayton Brook Surgery, Coppull Medical Practice, Acreswood Surgery, Croston Medical Centre, The Village Surgeries Croston and Eccleston, Dr Baghdjian and Partner (Chorley Health Centre), Dr Hamad and Partner (The Surgery), Eaves Lane Surgery, Euxton Medical Centre, Granville House Medical Centre, Kingsfold Medical Centre, Leyland Surgery, Library House Surgery, Medicare Unit Surgery, Moss Side Medical Centre, New Longton Surgery (Village Surgery), Regent House Surgery, Roslea Surgery, Sandy Lane Surgery, Station Surgery, Ryan Medical Centre, The Surgery Chorley, Village Surgery (Mashayekhy) – Lostock Hall, Whittle Surgery, Withnell Health Centre, Worden Medical Centre	The programme were asked to attend and present to the membership council on the programme. The presentation focused on the timeline and logistics of the programme.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Phase 2 Modelling: Out-of-Hospital	20/06/2018	Jayne Mellor, Donna Roberts	To establish the elements of the Out-of-Hospital Strategy that need to be included in the Overlay Model. Agreed to include the initiatives with ratified Form 1s and quantified benefits into the Overlay Model
ICP shadow board	21/06/2018	DR Gora Bangi, Matt Gaunt. Denis Gizzi, Bill Gregory, Gary Hall, Paul Harvey, Sarah James, Dr Khandavalli, Dr Sumantra Mukerji, Sue Musson (Chair), Louise Taylor, Shaun Turner, Brenda Vernon	The Programme Director, Our Health Our Care outlined key pieces of work undertaken by the Our Health Our Care Programme during the period 26 April 2018 to 21 June, and priorities for the month ahead. Both Acute Sustainability and Integrated Care Partnership developments were discussed in more detail at items within the agenda.
OHOC Workshops	22/06/2018	Angela Adkins, Rosie Blades, Steve Canty, Claire Capewell, Alistair Craig, Sandra Davey, Tracy Earley, Andrew Fletcher, Patha Ganguli, Sharada Gudur, Lee Helliwell, Eamon McKiernan, Peter Mitchell, Alison Muir, Valerie O'Donnell, Meena Ranka, Anjum Shahzad, Abhishek Sharma, Janet Purcell, Gerry Skailes, Jane Grassham, Robert Nipah, James Allan, Jayne Sargeant, Joanne Bingham	To provide an update on the Clinical Led Model of Care. The workshop looked to generate discussion around the draft model of care; to understand any issues, to capture benefits, as well as assessing any areas of concern.
Joint Service User Group	25/06/2018	4 services users	To understand the experience of patients within the system to help shape the clinically led model of care.Detailed discussions around patient experience of the current system and their thoughts on future services.
Patient Experience Survey	25/06/2019	34 Completed Survey responses	A patient experience survey was designed to get patient feedback on the current services that are available, what they use and what their thought are on these services. It was promoted at public engagement events, through Healthwatch engagement, via social media channels and the OHOC website.
NHS E Mike Smith Meeting	25/06/2018	Mike Smith and Sarah James	These were planning sessions discussing the requirements for NHSE Stage one.
Phase 2 Modelling: In-Hospital	26/06/2018	Ailsa Brotherton, Moira Roberts	To establish the elements of the In-Hospital Strategy that need to be included in the Overlay Model. Discussion took place around cost improvement plans underway in the Trust.
Joint Service User Group	26/06/2018	2 Service users	To understand the experience of patients within the system to help shape the clinically led model of care. Detailed discussions around patient experience of the current system and their thoughts on future services.
One-to-one meeting	26/06/2018	Mark Pugh	Discussions around the co-dependency framework
One-to-one meeting	26/06/2018	Sarah James, Denis Gezzi, County Councillor Turner and C Gooch	One-to-one meeting with elected members to discuss the emerging model of care.
Joint Negotiating Cosultative Committee	26/06/2018	David Bibby Karen Harrison June Hughes Richard Maitland Carol Marsh Nick Stubbs Fiona Underwood	Update on the programme plan, NHS England assurance process and Case for Change Update on Model of Care work-to-date Update on the Clinical Senate visit Discuss of next steps
One-to-one meeting	27/06/2018	Dr Martin Hogg	One-to-one clinical meeting to talk through the programme and to understand co-dependencies for the speciality
One-to-one meeting	28/06/2018	Mr Stuart McKirkby	One-to-one clinical meeting to talk through the programme and to understand co-dependencies for the speciality
Preston Elected Memebers	28/06/2018	35 members from Preston City council	The programme presented to the members around the programme. The presenation detailed the clinical case for change and the local picture. The presentation then looked at how the health system could work differently. The presentation ended by looking at next steps for the programme.
Phase 2 Modelling: VSA	02/07/2019	Emma Ince	To discuss what initiatives should be included in the Overlay Model.
Specialist Med subgroup	02/07/2018	Dr Somnath Kumar, Sandra Davey, Mark Brady, Anne Kirkham, Munavvar Mohammed , Nadene Blakeman , Catherine Taurozzi	Dr Kumar gave an update and introduction to the subgroups and their remit. The subgroup discussed the specialities in question in the subgroup in detail regarding how the services could change in the future model.
Joint Clinical Leads meeting	02/07/2018	Anne Kirkham, Lee Helliwell, Somnath Kumar, Huw Twamley, Tracy Earley	At the meeting there was discussion around the last workshop. An update of the programme was also given. It was an opportunity for the workstreams to get together and talk in a broader context. It was confirmed which services are currently on each site. There was also need for the clinical leads to have media training
Overlay Model Assumptions	02/07/2018	Brian Johnson	Meeting to discuss the model assumptions
Overlay Model Assumptions	02/07/2018	Brian Johnson	Meeting to discuss the model assumptions

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Joint Preston and Chorley & South Ribble Peer Group	03/07/2018	60 people- from Library House Surgery, Moss Side Medical Centre. New Longton Surgery, Regent House Surgery, Sandy Lane Surgery, The Chorley Surgery, The Ryan Medical Centre, The Surgery Chorley, Whittle Surgery, Withnell Health Centre, Worden Medical Centre. Avenham Surgery Berry Lance Medical Centre, Briarwood Medical Centre, Dr Wilson and Partners, Frenchwood Surgery, Fishergate Hill Surgery, Geoffray Street Surgery, Guttridge Medical Centre, ISSA Medical Centre, Longton Health Centre, Lostock Hall Medical Centre, Lytham Road Surgery, Medicom, New Hall Lane Practice, North Preston Medical Practice, Park Medical Practice, Park View Surgery, Ribbleton Medical Centre, Ribble Village Surgery, St Fillans Medical Centre, St Marys Health Centre, Stonebridge Surgery, The Surgery	Update from the OHOC programme on the programme to date. There was a reminder of the primary event to be held on 14/06/18. Discussions focused on the emerging model of care, especially around considering patient journeys- with outreach specialist from secondary care into primary care and also intergreted examples from the diabetes pathway.
Health Scrutiny Committee	03/07/2018	Helen Curtis, Gerry Skailes, Sarah James, CC P Britcliffe, CC J Burrows, CC G Dowding, CC C Edwatds, CC N Hennessy, CC S Holgate, CC H Khan, CC S C Morris, CC M Pattison, CC E Pope, CC P Steen, C B Ashworth, C David Borrow, C M Brindle,, C B Hilton, C J Robinson, C M Tomlinson,C V Wilder, Gary Halsall	Update from the OHOC programme on the programme to date.Helen Curtis and Gerry Skailes presented an update and opened the session to questions. http://council.lancashire.gov.uk/ieListDocuments.aspx?CId=182&MId=7636&Ver=4
NHS E Stage one	03/07/2018	Matt Gaunt, Sumantra Mukerji, Karen Partington, Gerry Skailes, Sarah James, Jean Wright, Graham Urwin, Jane Cass, Nicola Allen, Elaine Collier, Linda Buckley, Mike Smith	The team had submitted detailed evidence of progress in advance and on the day provided a presentation which covered the following areas in terms of progress, risks/issues/challenges, next steps and evidence. The purpose of the session and NHSEs role was established as: • Consultation can only go ahead if NHSE sign off the proposal • Clear focus on the 5 tests • Stage one is a check in with NHSE acting as a critical friend providing advice and support in terms of what needs to be done to ensure the programme is ready • A decision will be made in terms of the level of NHSE sign off required: o <£50m regional, o >£50m NHSE Chief Finance Officer o Large scale new build would require NHSE Committee approval o The higher the approval process equates to greater level of review
OHOC Comms & Engagement meeting	04/07/2018	Lisa Roberts, Kelly Lorraine, Sarah James, Madeleine Roberts, Catherine Brown, Helen Curtis	Update from the OHOC programme on the programme to date. The OHOC team provided an update on the Public Engagement events occuring across the next week detailing who would be attending and what information they would be providing.
ICS Board	04/07/2018	Andrew Bennett, Jane Cass, Ian Cherry, Amanda Doyle, Stephen Downs, Stephen Hardwick, Michael Hearty, Helen Lowey, Mike Maguire, Kevin Mcgee, Karen Partington, Gary Raphael, Wendy Swift, Heather Tierney Moore, Shaun Turner, Graham Urwin, Sue Musson, Isla Wilson, Graham Cain, Andy Curran, Aaran Cummins, Harry Catherall, Peter Thorton	The OHOC/ TU presented a Model of Care development update to the board for July. The presentation included information regarding the development of the model of care including; the programme plan, details of the workshops and subgroups, and information regarding engagement.
LTH Board of Directors	05/07/2018	Sue Musson, Tim Watkinson, Jim Whitaker, Jeanette Newman, Geoff Rossington, Ann Pennell, Karen Partingotn, Paul Harveym Geraldine Skailes, Gail Naylor,Karen Swindley	Slides were produced to provide an update to the Trust board.
Medical Divisional Leadership Team	09/07/2018	Medical Divisional Leadership Team and CBMs	The programme was asked to speak to the Divisional Leadership Team and CBMs about the OHOC programme. A presentation was given, providing an update on the programme.
NHS I Telecom	09/07/2018	Sarah James, Karen Partington, Paul Havey	The team had a phone call with NHSI to discuss the assurance process.
Preston Hospital Ward Walk Engagement	09/07/2018	Anne Kirkham led the visit, range of clinical staff engaged from variety of wards	Ward – 2a/2b/2c/2/4/9/10/11/12/14/15/16/17/18/19(MAU)/20/21/CCU/23/24/25/Cath Lab/Major Trauma/ critical care/ Emergency Department/Ambulatory care all visited and discussions about the programme held with clinical staff
Heathwatch Engagement - Royal Preston Hospital	09/07/2018	The programme directed activity, reaching between 150 – 200 members of the public across the hospital sites and in Preston City Centre, promoting the July (phase 5) public engagement events, programme updates and a patient experience survey.	In July and August 2018, Our Health Our Care (OHOC) worked with Healthwatch Lancashire to increase the awareness of the OHOC programme, the upcoming public engagement events, and the subsequent programme updates. This activity was a mix of on-foot engagement and the Healthwatch 'chatty van', a Healthwatch branded van which can be parked in key locations, and provide a covered, seated, private space within the community. OHOC representatives were supported by Healthwatch engagement specialists. The programme directed activity, reaching between 150 – 200 members of the public across the hospital sites and in Preston City Centre, promoting the July (phase 5) public engagement events, programme updates and a patient experience survey. Following this period of engagement it was decided that the ongoing costs associated with continuing with the chatty van would be prohibitive, and alternative plans are proposed for future engagement.
Healthwatch Engagement - Royal Preston Hospial	10/07/2018		
Healthwatch Engagement - Chorley & South Ribble Hospital	11/07/2018		
Healthwatch 'chatty van' on Chorley site	11/07/2018		
Healthwatch Engagement - Preston Flag Market	03/08/2018		

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
OHOC Public Engagement Event Leyland	10/07/2018	Following this period of engagement it was decided that the o	The public engagement event took place to seek the publics opinion on the emerging model of care. The public were presented with the background of the programme and why there was a need for change. The case for change was presented and a number of patients stories to explain the current challenges. Following this public were asked to they understand the draft model, do they think it could address the challenges and if there was anything missing.
OHOC Public Engagement Event Preston	11/07/2018	11 attendee's from the public	The public engagement event took place to seek the publics opinion on the emerging model of care. The public were presented with the background of the programme and why there was a need for change. The case for change was presented and a number of patients stories to explain the current challenges. Following this public were asked to they understand the draft model, do they think it could address the challenges and if there was anything missing.
OHOC Public Engagement Event Chorley	12/07/2018	13 attendee's from the public	The public engagement event took place to seek the publics opinion on the emerging model of care. The public were presented with the background of the programme and why there was a need for change. The case for change was presented and a number of patients stories to explain the current challenges. Following this public were asked to they understand the draft model, do they think it could address the challenges and if there was anything missing.
Nursing, Midwifery and AHP Board	10/07/2018	Karen Partington, Chief Executive Gail Naylor, Nursing and Midwifery Director Michael Dudley, Head of Nursing David Jones, Associate Director Pharmacy Liz McMullin, Associate Director AHPs Debbie O'Mahoney, DND DCS Catherine Silcock, DND Surgery Anne Tomlinson, Lead Cancer Nurse Anne Kirkham, OHOC Sue Sherlock, Midwife Kelly Fielding, CEG lead Steph Iaconianni, Patient Experience Lead Bev Duncan, Education Team Philippa Olive, Research Maryanne Parkinson, RCN	The programme was asked to speak to the Nursing, Midwifery and AHP Board to provide an update.
FIAG	12/07/2018	Bill Gregory, Brian Johnson, Catherine McCourty, Dominic McKenna, Edna Nolan, Jean Wright, Jessica Boothroyd, Katherine Disley, Matt Gaunt, Michelle Stas, Natalie Gauld, Paul Havey, Rebecca Tunstall, Sarah James, Andrew Wilson (membership)	The baseline assessments were submitted for approval.
LCC Elected Members	16/07/2018	Helen Curtis, Michael Stewart, CC Edwards, CC Turner, CC Green, CC Riggott, CC Iddon, CC Gooch, CC rear and CC Driver	The programme was asked to speak to LCC Elected Members.An update on the programme and the emerging model of care was presented to members of the LCC. The LCC were in support of the emerging model.
NHS E Mike Smith Meeting	16/07/2018	Mike Smith and Sarah James	Discussion focused on feedback from the NHS Stage one Assurance review
ICP Shadow Board	19/07/2018	DR Gora Bangi, Matt Gaunt. Denis Gizzi, Bill Gregory, Gary Hall, Paul Harvey, Sarah James, Dr Khandavalli, Dr Sumantra Mukerji, Sue Musson (Chair), Louise Taylor, Shaun Turner, Brenda Vernon, Jean Wright, Gerry Skailes, Karen Partington, David Evra, Carl Ashworth, Professor Heather Tierney- Moore	The programme was asked to provide an update on the Acute sustainability programme. An update on the programme and the emerging model of care was presented to members of the ICP Board for comments.
Staff Engagement: Drop in session at Chorley Hospital	24/07/2018	2 attendees (one ward sister, one finance team member)	Drop in session to update staff on the OHOC programme and gather their views
Staff Engagement: Drop in session at Preston Hospital	24/07/2018	18 Attendees	Drop in session to update staff on the OHOC programme and gather their views
Staff Engagement: Drop in session at Preston Hospital	25/07/2018	5 Attendees	Drop in session to update staff on the OHOC programme and gather their views
Informal Clinical Senate meeting	25/07/2018	Donal O'Donoghue Caroline Baines Gerry Skailes Michael Stewart Tracy Early Lee Helliwell Mark Pugh Anne Kirkham Lynn Chadwick Lee Hay	An informal discussion took place with the clinical senate who would be acting as critical friend to the programme.
OHOC Comms & Engagement meeting	26/07/2018	Catherine Brown, Cathy Stuart, Edna Boampong, Helen Curtis, John Underwood, Anne Kirkham, Kelly Lorraine, Mitch Gadd, Neil Greaves	The meeting took place to continute to plan communication and engagement activities alongside the programme- feedback was also provided from the clinical senate review.
Staff Engagement: Drop in session at Preston Hospital	27/07/2018	16 attendees	Drop in session to update staff on the OHOC programme and gather their views
South Ribble Council Elected Members briefing	30/07/2018	50 elected members	An update on the programme and the emerging model of care was presented to elected members for comments informally.
Staff Engagement: Drop in session at Chorley Hospital	31/07/2018	Staff from Chorley Hoospital	Drop in session to update staff on the OHOC programme and gather their views
LTH Council of Governors	31/07/2018	25 governors	An update on the programme and the emerging model of care was presented to governors.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
NWAS EMT Meeting	01/08/2018	Mr M Forrest Mr S Desai Mrs T Ellery Prof M Power Dr D Ratcliffe Mr N Barnes Mr S Hynes Ms L Ward Mrs A Wetton Mr M House Mrs P Ward Mrs A Maden Ms C Offer	An update on the programme and the emerging model of care was presented to the NWAS meeting.
NHS E follow up meeting	02/08/2018	Mike smith	The programme updated NHSE on the progress of the emerging model of care.
Chorley Council Elected Member Briefing	02/08/2018	Aaron Beaver, Terry Brown, Gordon France, Margaret France, Margaret Lees, Roy Lees, June Molyneaux, Alistair Morwood and John Walker.	An update on the programme and the emerging model of care was presented to elected members for comments.
LTH Board of Directors	02/08/2018	Sue Musson, Tim Watkinson, Jim Whitaker, Jeanette Newman, Geoff Rossington, Ann Pennell, Karen Partingotn, Paul Harveym Geraldine Skailes, Gail Naylor,Karen Swindley	An update of the programme was provided and a number of questions answered. The presentation focused on the development of the emerging model of care and next steps for the programme.
Staff Engagement: Drop in session	09/08/2019	9 attendees	Drop in session to update staff on the OHOC programme and gather their views
Communications and Engagement Steering *(Runs on the first and third Tuesday of every month)*	09/08/2018	Catherine Brown, Cathy Stuart, Edna Boampong, Helen Curtis, John Underwood, Anne Kirkham, Kelly Lorraine, Mitch Gadd, Neil Greaves	Review of draft Evaluation Criteria at the Comms & Engagement Steering Group
One-to-one with Michael Stewart	09/08/2018	Michael Stewart, Clinical lead	Review of the UTC Spec
One-to-one Anne Kirkham	15/08/2018	Anne Kirkham	Review of Frailty and UTC Specs
C&E Steering Group Meeting	16/08/2018	Erin Portsmouth, Madeleine Bird, Usman Nawaz, Anne Kirkham, Lee Hay, Lorraine Kelly, Jonathon Bridge, Mellanie Patterson, Helen Curtis	The meeting focused on engagement activity so far included: Elected Members briefings MP Briefings Staff Engagement Communications timeline – information to be shared on-line, via social media, in print and with press. Plus materials to be shared at Public Engagement Events Public Engagement Events in Preston, South Ribble and Chorley prior to formal consultation – Including a decisions on the content we are sharing to ensure these events provide the link between the models of care conversations held to date, development of possible ways to deliver the model and the formal consultation regarding options Stakeholder Panel meetings – including what we plan to share and gain input from stakeholder panel on Consultation Plan (for submission with PCBC)
NHSE Mike Smith meeting	20/08/2018	Lee Hay, Jean Wright and Mike Smith	Update on the programme
One-to-one with Dr Tom Thorpe	21/08/2018	Tom Thorpe	Review of Frailty Spec with Dr Tom Thorpe
Joint Informal CCGs Governing Body Session	23/08/2018	Gora Bangi, Sumantra Mukerji, Denis Gizzi, John Cairns, Lindsey Dickinson, Helen Curtis, Matt Gaunt, Praphulla Methukunta, Sandeep Prakash, Bridgid Finlay, Hari Nair, Linda Chivers, Ian Chery, Geoffrey O'Donoghue, Sarah Mattocks, Debbie Corcoran, Paul Richardson, Alan Stuttard, Jayne Mellor, Satyendra Singh, Ann Robinson, Tricia Hamilton, Eamonn McKiernan,	An informal governing body session taking a look at the programme timeline and clinical assurance.
NHS E Mike Smith Meeting	29/08/2018	Lee Hay, Jean Wright and Mike Smith	Monthly meeting to update on the programme
One-to-one Michael Stewart	29/08/2018	Michael Stewart, Clinical lead	One to one meeting to discuss the emerging model of care
One-to-one with Ian Ward	30/08/2018	Ian Ward, Contract Management Locality Lead	Meeting to discuss the impact on current UTC services (provided by GoToDoc) with Ian Ward, Locality ;ead for Greater Preston/ Chorley and South Ribble, NHS Midlands and Lancashire CSU
HLSC Care Professionals Board	31/08/2018	Clinical and care professionals from across Lancashire. https://www.healthierlsc.co.uk/boards-and-committees/care-professionals-board	An explanation of the overall programme was given and its context. It was recognised that there was a huge amount of work to be done but quality of care was the main driver. Discussion focused on the importance of learning from previous experiences and the importance of engagement.
One-to-one Peter McCann	31/08/2018	Peter McCann	Peter McCann reviewed the Frailty Specification as the clinical lead for fraility
Stakeholder reference Panel meeting	04/09/2018	Gary Hall, Councillor Peter Moss, Councillor Margaret France, Councillor Edwards, Janet Miller, Debbie Corcoran, Geoff O'Donoghue, Lionel Barker, Sue Stevenson, Craig Smith, Iain Pearson,	This was the first Stakeholder Reference Panel so the programme context was outlined. The team provided an understanding of the programme today and updated members on their role within the programme.
One-to-one Gerry Skailes	04/09/2018	Gerry Skailes	One to one meeting to discuss the model of care
ICS Board	05/09/2018	Michael Hearty,Dr Amanda Doyle, Andrew Bennett, Jane cass, Jackie Hanson, Gary Raphael, Talib Taseen,Andy Curran, Dr John Caine, Sue smith, Bill Gregory, Shaun Turner, Graham Urwin, Ian Cherry, Sue Musson, Isla Wilson, Mike Wedgeworth, Tim Bennett	A new timeline was presented. Information was also presented around the governance routes for the programme and roles/ responsibilites of the ICP/ JC CCGs, as well as the NHSE assurance process.
LTH Exec Team Meeting	05/09/2018	Karen Partington, Chief Executive Paul Havey, Finance Director/Deputy Chief Executive Gail Naylor, Nursing, Midwifery and AHPs Director Dr Gerry Skailes, Medical Director Faith Button, Interim Operations Director Karen Swindley, Director of Workforce and Education Phebe Hemmings, Company Secretary	The programme gave an update on the programme, the timeline, governance meetings and routes. The exec were further updated on the NHS England assurance process and feedback from the strategic sense check 1.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
LTH Board of Directors	06/09/2018	Sue Musson, Tim Watkinson, Jim Whitaker, Jeanette Newman, Geoff Rossington, Ann Pennell, Karen Partingotn, Paul Harveym Geraldine Skailes, Gail Naylor,Karen Swindley	The programme gave an update on the programme, the timeline, governance meetings and routes. The board were further updated on the NHS England assurance process and feedback from the strategic sense check 1.
C&E Steering Group meeting	06/09/2018	Catherine Brown, Cathy Stuart, Edna Boampong, Helen Curtis, John Underwood, Anne Kirkham, Kelly Lorraine, Mitch Gadd, Neil Greaves	The programme continued to prepare for upcoming public engagement events.
Clinical Leads meeting	06/09/2018	Anne Kirkham, Lee Helliwell, Somnath Kumar, Huw Twamley, Tracy Earley, Michael Stewart,	The team updated on the MoC development and the upcoming engagement meetings. The clinical leads also reviewed a number of the specifications.
ICS Provider Board	07/09/2018	CEO's for the Acute Trusts on the STP footprint	The OHOC programme presented at the board and provided an overview of the programme, the progress, the clinical case for change, the emerging model of care and information around the next steps.
LMC	12/09/2018	Dr L Atherton, Dr S Baier, Dr A Bisarya, Dr D Bisarya, Dr PM Blake, Dr E Craven, Dr J Eyre, Dr PS Ganguli, Dr R Jaidka, Dr MS Jandu, Dr U Kanitkar, Dr AD Littler, Dr P Methukunta, Dr AD Reid, Dr JK Shah, Dr SN Singh, Dr A Umapathy, Dr R Yates, Dr R Gokul, Dr S Dontula , Dr SJ Shaw	The update provided an overview of progress in the acute sustainability work stream (timeline and design approach), public engagement events and GP engagement. There was also mention of recent media coverage. It was noted that progress is currently behind schedule to where it initially planned but that a lot of work has been put into the programme and over the next few months engagement will be needed and GPs are critical to this
Clinical Design Group	12/09/2018	Gora Bangi, Sumantra Mukerji, Geraldine Skailes, Jean Wright, Helen Curtis, Jayne Mellor, Lindsey Dickinsen, Hari Nair, Dave Rigby, Tracey Book-Scowan, Anne Kirkham, Sakthi Karunanithi, Mark Pugh, Som Kumar, Kelly Bishop. Lynn Chadwick	The Clinical Design group looked at the co-dependencies framework and the clinical standards.
Staff Engagement: Drop in session Preston	13/09/2018	13 attendees	Engagement session with staff to update on the OHOC programme and gather views
Staff Engagement: Drop in session Chorley	13/09/2018	Chorley Staff	Engagement session with staff to update on the OHOC programme and gather views
One-to-one Anne Kirkham	13/09/2018	Anne Kirkham	Initial discussion about OoH, fact finding and understanding stakeholder involvment
One-to-one Vicky Webster	14/09/2018	Vicky Webster (Deputy lead Nurse, Central Lancs CCG)	One-to-one meeting to discuss the model of care
One-to-one Steph Lacanianni	16/09/2018	Steph Lacanianni (Patient Engagement Lead, LTH)	One-to-one meeting to discuss the model of care
One-to-one Donna	17/09/2018	Donna Roberts	Initial meeting with Donna to discuss the Out of Hospital strategy.
Staff Engagement: Drop in session Preston	17/09/2018	Preston Staff	Engagement session with staff to update on the OHOC programme and gather views
Staff Engagement: Drop in session Chorley	17/09/2018	4 attendees	Engagement session with staff to update on the OHOC programme and gather views
Lancashire Health & Wellbeing Board	18/09/2018	http://council.lancashire.gov.uk/mgMeetingAttendance.aspx?ID=7483	The Our Health Our Care Change programme updated on the emerging Model of Care, potential benefits and the design principles through which the ICP would operate. Going forward, plans were in place to develop the big seven strategic platforms to deliver the change required in Central Lancashire,
Leyland Public Engagement Event	18/09/2018	78 stakeholders	The engagement events focused on gaining engagement around the emerging model of care. The events focused on gaining views on Out of Hospital and 'joined up' care, Urgent Care in the hospital and Planned care (treatments and opreations) in the hospital. This event was promoed via social media and local newspaper adverts
Chorley Public Engagement	19/09/2018	128 stakeholders	The engagement events focused on gaining engagement around the emerging model of care. The events focused on gaining views on Out of Hospital and 'joined up' care, Urgent Care in the hospital and Planned care (treatments and opreations) in the hospital. This event was promoed via social media and local newspaper adverts
FIAG	19/09/2018	Bill Gregory, Brian Johnson, Catherine McCourty, Dominic McKenna, Edna Nolan, Jean Wright, Jessica Boothroyd, Katherine Disley, Matt Gaunt, Michelle Stas, Natalie Gauld, Paul Havey, Rebecca Tunstall, Sarah James, Andrew Wilson (membership)	FIAG looked at Modelling assumptions- clinical scenarios, the financial case for change, financial modelling and interdepedencies.
Preston Public Engagement event	20/09/2018	23 stakeholders	The engagement events focused on gaining engagement around the emerging model of care. The events focused on gaining views on Out of Hospital and 'joined up' care, Urgent Care in the hospital and Planned care (treatments and opreations) in the hospital. This event was promoed via social media and local newspaper adverts
One-to-one Sarah Cullen	20/09/2018	Sarah Cullen, Deputy Director or Nursing, LTH	One-to-one about the emerging model of care
One-to-one Michael Stewart	20/09/2018	Michael Stewart, Clinical lead	One-to-one about the emerging model of care
One-to-one Lee Helliwell	20/09/2018	Lee Helliwell, Clinical Lead	One-to-one about the model of care
Clinical Visit, Go to Doc at CDH, Anita Snowden GTD Clinical Lead,	20/09/2018	Anita Snowden	Clinical visit to GoToDoc
Clinical Visit to Blackpool UTC, Emma Edwards - Head of Fylde Co	21/09/2018	Emma Edwards	Clinical Visit to Blackpool UTC
Frailty workshop 4	21/09/2018	20 delegates	Progression of VSA work from May and the OHOC Frailty work with a view for both quick wins to help with flow through the hospital over the winter months and more long term improvement for the frailty pathway.
One-to-one Somnath Kumar	24/09/2018	Somnath Kumar, Clinical Lead	One-to-one about the emerging model of care
Overview Health Scrutiny Committee- formal	25/09/2018	http://council.lancashire.gov.uk/mgMeetingAttendance.aspx?ID=7637	Denis Gizzi, Anne Kirkham, Sumantra Mukerji and Mark Pugh attending OSC and provided an update to the committee on the programme. A number of actions were discussed and the programme were asked to present back in 2019.
Out of Hospital Meeting	27/09/2018	Brian Johnson, Fiona, Donna Roberts, Anne Kirkham	Meeting to update Denis on OoH work
Frailty workshop 5	28/09/2018	20 delegates	This workshop looked at: - How as a health system can we support frail patients this winter? - Action to implement integrated frailty and KPIs - Recap of identified actions, allocation of leads and deadlines

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Discussion with Lisa Roberts (OHOC Programme Co-ordinator)	01/10/2018	Lisa Roberts	Meeting to discuss the original Evaluation Criteria in 2016
Phone call with Frailty Assessment Service	02/10/2018	Unsure of name- Frailty Assessment Service	Phone call to discuss the Frailty Assessment service in the build up of knowledge of current service offerigns.
Central Lancashire Health and Wellbeing Partnership	02/10/2018	Sarah Ashcroft, Denis Gizzi, Gary Hall, Amanda Housley, Donna Hussain, Sarah James, Debbie King, Annie Kirkham, Paula Lister, Sumantra Mukerji, Peter Moss, Jennifer Mullin, Laura Pollard, Craig Sharp, K Walton	The programme updated on progress and the assurance process.
One-to-one Arnab Bhowmick	02/10/2018	Arnab Bhowmick, Clinical Director for Surgery LTH	One-to-one about the emerging model of care
One-to-one Huw Twamley	02/10/2018	Hugh Twamely, Clinical Lead	One-to-one about the emerging model of care
One-to-one Cathy Atherton	02/10/2018	Cathy Atherton, Divisional Midwidery and Neonatal Nursing Director, LTH	One-to-one about the emerging model of care
Governing Body Development Session	03/10/2018	Gora Bangi, Sumantra Mukerji, Denis Gizzi, John Cairns, Lindsey Dickinson, Helen Curtis, Matt Gaunt, Praphulla Methukunta, Sandeep Prakash, Bridgid Finlay, Hari Nair, Linda Chivers, Ian Chery, Geoffrey O'Donoghue, Sarah Mattocks, Debbie Corcoran, Paul Richardson, Alan Stuttard, Jayne Mellor, Satyendra Singh, Ann Robinson, Tricia Hamilton, Eamonn McKiernan,	The development session was used to take a deep dive into the programme, to understand the programme plan, assurance process and role of the Joint Committee.
ICS Board	03/10/2018	Andrew Bennett, Jane Cass, Ian Cherry, Amanda Doyle, Stephen Downs, Stephen Hardwick, Michael Hearty, Helen Lowey, Mike Maguire, Kevin Mcgee, Karen Partington, Gary Raphael, Wendy Swift, Heather Tierney Moore, Shaun Turner, Graham Urwin, Sue Musson, Isla Wilson, Graham Cain, Andy Curran, Aaran Cummins, Harry Catherall, Peter Thorton	Denis provided an verbal update on the OHOC programme.
LTH Exec Team Meeting	03/10/2018	Karen Partington, Chief Executive Paul Havey, Finance Director/Deputy Chief Executive Gail Naylor, Nursing, Midwifery and AHPs Director Dr Gerry Skailes, Medical Director Faith Button, Interim Operations Director Karen Swindley, Director of Workforce and Education Phebe Hemmings, Company Secretary	The programme presented to the Executive by firstly updating on the progress of OHOC and the emerging design work. A brief update was provided on each of the workstreams; Prevention and Wellbeing, Out of hospital and the Acute Sustainability. An overview was then given of the delivery of products.
Review of draft Evaluation Criteria by Prof Mark Pugh (Clinical Le	04/10/2018	Mark Pugh, Clinical Lead	Review of draft Evaluation Criteria by Prof Mark Pugh (Clinical Lead - Co-dependencies)
One-to-one with Ceri Mansell	04/10/2018	Ceri Mansell	To discuss the recent COPD pilot and the outcomes.
LTH Board	04/10/2018	Sue Musson, Tim Watkinson, Jim Whitaker, Jeanette Newman, Geoff Rossington, Ann Pennell, Karen Partingotn, Paul Harveym Geraldine Skailes, Gail Naylor,Karen Swindley	The programme updated on progress and the assurance process.
JC CCGs x8	04/10/2018	The Joint Committee of Clinical Commissioning Groups consists of GPs and lay members from each of the Clinical Commissioning Groups in Lancashire and South Cumbria. Chief Executives from Lancashire County Council, Blackburn with Darwen Council, Blackpool Council, representatives from district Councils and local Healthwatch attend the meetings.	A verbal update was presented to the board about the programme
CDH A&E visit with Michael Stewart	05/10/2018	Michael Stewart, Clinical lead	Clinical visit to A&E
CDH Ambulatory Care Unit Clinical Visit with Sarah Clayton, Nurse Lead/Matron	05/10/2018	Sarah Clayton	Clinical visit to CDH Ambulatory Care Unit
OHOC Exec Oversight Meetings	08/10/2018	Matt Gaunt, Helen Curtis, Jayne Mellor, Denis Gizzi, Lee Hay, Sarah James	Internal Executive meeting to discuss the progress of the programme
One-to-one Rahael Taylor	09/10/2018	Racheal Taylor	Meeting to discuss the community COPD service
Jean Wright & Brian Johnson	09/10/2018	Jean Wright and Brian Johnson	Meeting to discuss the Out of Hospital slides to be shared with stakeholders
LTH Nursing, Midwifery and AHP Board	09/10/2018	Karen Partington, Chief Executive, Gail Naylor, Nursing and Midwifery Director, Michael Dudley,, Head of Nursing, David Jones, Associate Director Pharmacy, Liz McMullin, Associate Director AHPs, Debbie O'Mahoney, DND DCS, Catherine Silcock, DND Surgery, Anne Tomlinson, Lead Cancer Nurse, Anne Kirkham, OHOC, Sue Sherlock, Midwife, Kelly Fielding, CEG lead, Steph Iaconianni, Patient Experience Lead , Bev Duncan, Education Team, Philippa Olive, Research , Maryanne Parkinson, RCN	The team went to the board to update on the programme and to answer any questions they had. brief update was provided on each of the workstreams; Prevention and Wellbeing, Out of hospital and the Acute Sustainability. They then looked at the timeline and next steps.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
OHOC and Integrated Partnership development in Central Lancashire	09/10/2018	Sarah James, Denis Gezzi, County Councillor Turner and C Gooch	Informal conversations with Lancashire County Council Councillors to discuss the programme and any issues they may have.
Joint Clinical Leads Meeting	11/10/2018	Michael Stewart, Lee Helliwell, Huw Twamley, Tracey Earley, Mark Pugh, Gerry Skailes, Anne Kirkham, Somnath Kumar	Joint clinical leads meeting discussing the emerging model of care and the out of hospital strategy. The clinical leads also discussed the evaluation criteria.
Stakeholder reference Panel meeting	17/10/2018	Stakeholder Ref Panel	To provide an update on the programme and seek input from stakeholders
ICP Shadow Board	18/10/2018	Paul Connellan, Gora Bangi, Matt Gaunt, Denis Gizzi, Bill Gregory, Gary Hall, Joseph Havey, Sarah James, Sumantra Mukerji, Prof Heather Tierney- Moore, Jean Wright,	The board were presented a number of deliverables included: Phase 1 Baseline and Phase 2 Overlap specification summary, Co-dependencies framework and the Clinical standards.
NHSE Mike Smith meeting	22/10/2018	Jason Pawluk, Mike Smith & Jean Wright	Monthly meeting to discuss the programme. The assurance process and timeline was discussed.
OHOC Exec Oversight Meeting	22/10/2018	Matt Gaunt, Helen Curtis, Jayne Mellor, Denis Gizzi, Jason Pawluk, Sarah James	Internal meeting to discuss the programme
One-to-One with the Programme SRO	23/10/2018	Denis Gizzi	Meeting to discuss the Out of Hospital progress and to understand the vision
NWAS Board	31/10/2018	Wyn Dignan, Chair. Michael Forrect- Interim Chief Executive, Ged Blezard- Director of Operations, Salman Desai- Director of Strategy & Planning, Tracy Ellery- Director of Finance, Maxine Power- Director of Quality, Innovation and Improvement, David Ratcliffe- Medical Director, Angela Wetton- Director of Corporate Affairs, Michael O'Connor- Senior Independent Director, Peter White- Vice Chairman	Presentation and update to the board to report back on the progress of the programme and emerging model of care.
LTH Exec Team Meeting	31/10/2018	Karen Partington, Chief Executive Paul Havey, Finance Director/Deputy Chief Executive Gail Naylor, Nursing, Midwifery and AHPs Director Dr Gerry Skailes, Medical Director Faith Button, Interim Operations Director Karen Swindley, Director of Workforce and Education Phebe Hemmings, Company Secretary	Gerry Skailes attended the Exec and provided a verbal update. The update focused on the process surround NHSE Strategic Sense Check 2. discussion also focused on the delay in the timeline due to a number of issues.
LTH Board of Directors	01/11/2018	Sue Musson, Tim Watkinson, Jim Whitaker, Jeanette Newman, Geoff Rossington, Ann Pennell, Karen Partingotn, Paul Harveym Geraldine Skailes, Gail Naylor,Karen Swindley	Gerry Skailes attended the Exec and provided a verbal update. The update focused on the process surround NHSE Strategic Sense Check 2. discussion also focused on the delay in the timeline due to a number of issues.
ICS and ICP Alignment meeting	01/11/2018	Amanda Doyle, Gary Raphael, Talib Yaseen, Andy Curran, Denis Gizzi, Sumantra Mukerji, Gora Bangi, Matt Gaunt, Helen Curtis, Jayne Mellor, Heather Tierney-Moore, Karen Partington, Sue Musson, Gerry Skailes, Paul Havey, Louise Taylor, Alex Heritage, Lee Hay, Sarah James, Jean Wright, J Pawluk	Wider system meeting to work ensure communication between the ICS and ICP.
OHOC Exec Oversight Meeting	05/11/2018	Matt Gaunt, Helen Curtis, Jayne Mellor, Denis Gizzi, Jason Pawluk, Sarah James	Internal Executive meeting to discuss the programme
Clinical Oversight Group	08/11/2018	Gora Bangi, Sumantra Mukerji, Geraldine Skailes, Jean Wright, Helen Curtis, Jayne Mellor, Lindsey Dickinsen, Hari Nair, Dave Rigby, Tracey Book-Scowan, Anne Kirkham, Sakthi Karunanithi, Mark Pugh, Som Kumar, Kelly Bishop. Lynn Chadwick	The clinical vision was presented to the group for review and comments.
Patient Experience Improvement Group Meeting	12/11/2018		Review of outline model of care by Patient Experience Improvement Group Meeting
ICP Shadow Board	15/11/2018	DR Gora Bangi, Matt Gaunt. Denis Gizzi, Bill Gregory, Gary Hall, Paul Harvey, Sarah James, Dr Khandavalli, Dr Sumantra Mukerji, Sue Musson (Chair), Louise Taylor, Shaun Turner, Brenda Vernon, Jean Wright, Gerry Skailes, Karen Partington, David Evra, Carl Ashworth, Professor Heather Tierney- Moore	An update was provided on the programme through a status report.
One-to-one Donna Roberts	15/11/2018	Donna Roberts	Meeting to discuss the Out of Hospital chapter progress and for Donna to review and provide comments.
OHOC Exec Oversight Meeting	19/11/2018	Matt Gaunt, Helen Curtis, Jayne Mellor, Denis Gizzi, Jason Pawluk, Sarah James, Jean Wright	Internal leadership meeting
NHSE Mike Smith meeting	19/11/2018	Mike Smith, Jean Wright, Jason Pawluk	Monthly meeting with NHSE

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Development Joint Committee session	21/11/2018	Gora Bangi, Sumantra Mukerji, Denis Gizzi, John Cairns, Lindsey Dickinson, Helen Curtis, Matt Gaunt, Praphulla Methukunta, Sandeep Prakash, Bridgid Finlay, Hari Nair, Linda Chivers, Ian Chery, Geoffrey O'Donoghue, Sarah Mattocks, Debbie Corcoran, Paul Richardson, Alan Stuttard, Jayne Mellor, Satyendra Singh, Ann Robinson, Tricia Hamilton, Eamonn McKiernan,	The Governing Body development session was used to work informally through the revised case for change. Members were asked to provide constructive feedback on the document and to ask any questions they may have to members of the TU team.
Joint Executive Meeting	22/11/2018	Matt Gaunt, Helen Curtis, Jayne Mellor, Denis Gizzi, Jason Pawluk, Sarah James, Jean Wright	Following on from the governing body meeting, the revised case was change was presented to members .
Meeting with Lisa Roberts and TraceyCook-Scowen	22/11/2018	Lisa Roberts and Tracy Cook-Scowen	Meeting with Lisa and Tracy to discuss the prevention chapter
Informal COG	22/11/2018	Gora Bangi, Sumantra Mukerji, Geraldine Skailes, Jean Wright, Helen Curtis, Jayne Mellor, Lindsey Dickinsen, Hari Nair, Dave Rigby, Tracey Book-Scowan, Anne Kirkham, Sakthi Karunanithi, Mark Pugh, Som Kumar, Kelly Bishop. Lynn Chadwick	The draft model of care was presented to the clinical body.
One-to-one Phil Gooden	26/11/2018	Phil Gooden	Meeting with Phil Gooden LDFT to discuss the prevention chapter
Chorley and South Ribble Governing Body	28/11/2018	Denis Gizzi, Gora Bangi, Alan Stuttard, Dr Satyendra Singh, Dr John Cairns, Dr Ann Robinson, Dr Lindsey Dickinson, Linda Chivers, Geoffrey O Conoghue, Tricia Hamilton, Dr Eamonn McKiernan, Matt Gaunt, Helen Curtis	An executive summary report was taken detailing updates from the development session on 21st November
Greater Preston Governing Body	29/11/2018	Denis Gizzi, Dr Sumantra Mukerji, Paul Richardson, Brigid Finlay, Dr Hari Nair, Dr Sandeep Prakash, Dr Praphulla Methukunta, Ian Cheery, Debbie Corcoran, Tricia Hamilton, Dr Eammon McKiernan, Matt Gaunt, Helen Curtis	An executive summary report was taken detailing updates from the development session on 21st November
Central Lancashire Health and Wellbeing Partnership	29/11/2018	https://www.preston.gov.uk/thecouncil/preston-partnership-working/groups-delivering-the-preston-partnership-priorities/central-lancashire-health-wellbeing-partnership/	Anne Kirkham presented a verbal update on the programme.
HLSC Care Professionals Board	30/11/2018	Clinical and care professionals from across Lancashire. https://www.healthierlsc.co.uk/boards-and-committees/care-professionals-board	Kelly Bishop presented around the development of the model of care
OHOC Exec Oversight Meeting	03/12/2018	Matt Gaunt, Helen Curtis, Jayne Mellor, Denis Gizzi, Jason Pawluk, Sarah James, Jean Wright	The exec received updated documents prior to them being sent to the Joint Committee members.
Greater Preston Membership Council	04/12/2018	All GP Practices within the area include: Avenham Lane Surgery, Berry Lane Medical Centre, Briarwood Medical Centre, Doclands Medical Centre, Dr CM Wilson and Partners, Fishergate Hill Surgery, Frenchwood Surgery, Geoffrey Street Surgery, Gutteridge Medical Centre, Issa Medical Centre - Dr Patel, Longton Health Centre, Lostock Hall Medical Centre, Lytham Road Surgery, North Preston Medical Practice, Park View Surgery, Penwortham St Mary's Medical Group, Ribble Village Surgery, Ribbleton Medical Centre, Riverside Medical Centre, St Walburge's Medical Practice, St Fillan's Medical Centre, Stonebridge Surgery, The Health Centre (Dr Rossall), The New Hall Lane Practice, The Park Medical Practice, The Surgery, Preston	A verbal update was presented to members around the programme, providing an update on the timeline and emerging model of care.
OHOC Monthly Executive meeting	05/12/2018	Matt Gaunt, Helen Curtis, Jayne Mellor, Denis Gizzi, Jason Pawluk, Sarah James, Jean Wright	An internal executive meeting to discuss the programme.
LTH Board of Directors	05/12/2018	Sue Musson, Tim Watkinson, Jim Whitaker, Jeanette Newman, Geoff Rossington, Ann Pennell, Karen Partingotn, Paul Harveym Geraldine Skailes, Gail Naylor,Karen Swindley	An update paper was provided on the programme.
Telephone interviews	10/12/2018-11/01/2019	214 interviews	Market research of a representative sample of the general public within the areas of Preston, Chorley and South Ribble. The interviews were asked about the use of NHS services, satisfaction, issues and any areas of concern. The interviews also discussed the OHOC programme in general.
Stakeholder reference Panel meeting	11/12/2018	Stakeholder Ref Panel	To provide an update on the programme and seek input from stakeholders
LMC	12/12/2018	Dr L Atherton, Dr S Baier, Dr A Bisarya, Dr D Bisarya, Dr PM Blake, Dr E Craven, Dr J Eyre, Dr PS Ganguli, Dr R Jaidka, Dr MS Jandu, Dr U Kanitkar, Dr AD Littler, Dr P Methukunta, Dr AD Reid, Dr JK Shah, Dr SN Singh, Dr A Umapathy, Dr R Yates, Dr R Gokul, Dr S Dontula , Dr SJ Shaw	A verbal update was presented to the meeting around the programme

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Joint Committee x2	13/12/2018	Chief Accountable Officer (Chair of Committee), Chief Finance and Contracting Officer (Vice Chair of Committee), Chair and Clinical Leader of NHS Chorley South Ribble CCG, Chair and Clinical Leader of NHS Greater Preston CCG, Vice Chair (Lay Member) of NHS Chorley South Ribble CCG, Vice Chair (Lay Member) of NHS Greater Preston CCG, GP Directors of both CCGs, Lay Members for Finance, Audit and Conflicts of Interest of both CCGs, Lay Members for Patient and Public Involvement of both CCGs, Governing Body Nurse , Secondary Care Doctor, Director of Quality and Performance, Director of Transformation and Delivery	The case for change was presented at the formal Joint Committee. The Joint Committe formally approved the revised case for change.
JNCC	13/12/2018	Members from the following unions:UNITE UNISON LNC CSP RCM BDA RCN	Kelly Bishop presented around the development of the emerging model of care
NHSE Mike Smith meeting	17/12/2018	Mike Smith, Jean Wright, Jason Pawluk	Internal discussions with NHSE around the programme
Chorley and South Ribble Membership council	19/12/2019	Adlington Medical Centre, Beeches Medical Centre, Buckshaw Village Health Centre, Central Park Surgery, The Chorley Surgery, Clayton Brook Surgery, Coppull Medical Practice, Acreswood Surgery, Croston Medical Centre, The Village Surgeries Croston and Eccleston, Dr Baghdjian and Partner (Chorley Health Centre), Dr Hamad and Partner (The Surgery), Eaves Lane Surgery, Euxton Medical Centre, Granville House Medical Centre, Kingsfold Medical Centre, Leyland Surgery, Library House Surgery, Medicare Unit Surgery, Moss Side Medical Centre, New Longton Surgery (Village Surgery), Regent House Surgery, Roslea Surgery, Sandy Lane Surgery, Station Surgery, Ryan Medical Centre, The Surgery Chorley, Village Surgery (Mashayekhy) – Lostock Hall, Whittle Surgery, Withnell Health Centre, Worden Medical Centre	Kelly Bishop presented a verbal update around the emerging model of care and provided an update on the programme and timeline.
Greater Preston Peer Group	08/01/2019	GPs and Managers from the below practices: Avenham Lane Practice Berry Lane Medical Centre Briarwood Medical Centre Dr CM Wilson & Partners Fishergate Hill Surgery Frenchwood Surgery Geoffrey Street Surgery Guttridge Medical Centre ISSA Medical Centre - Patel Lane Ends Surgery Longton Health Centre Lostock Hall Medical Centre Lytham Road Surgery North Preston Medical Practice Park View Surgery Penwortham St Mary's Ribble Village Surgery Ribbleton Medical Centre Riverside Medical Centre St. Fillans Medical Centre Stonebridge Surgery The New Hall Lane Practice The Park Medical Practice	Anne Kirkham presented a verbal update on the programme updating on the emerging model of care and timeline.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Clinical Oversight Group	10/01/2019	Gora Bangi, Sumantra Mukerji, Geraldine Skailes, Jean Wright, Helen Curtis, Jayne Mellor, Lindsey Dickinsen, Hari Nair, Dave Rigby, Tracey Book-Scowan, Anne Kirkham, Sakthi Karunanithi, Mark Pugh, Som Kumar, Kelly Bishop. Lynn Chadwick	This was a development session to work through the emerging model of care, discussing end to end pathways
Face-to-face interviews	14/01/2019-01/02/2019	213 interviews	Interviews with representatives spread across the population of Preston, Chorley and South Ribble. The interviews were asked about the use of NHS services, satisfaction, issues and any areas of concern.The interviews also discussed the OHOC programme in general.
Stakeholder reference Panel meeting	15/01/2019	Councillor Peter Moss, County Councillor Charlie Edwards, Craig Smith, Gary Hall, Geoff O'Donoghue, Iain Peason, Janet Miller, Lionel Barker, Madeleine bird, Margaret France, Rosie Patterson, Sue Stevenson,	Programme update and feedback from the initial market research phone calls.
Communication and Engagement Group	15/01/2019	Madeleine bird, Catherine brown, Cathy Stuart, Edna Boampong, Helen Curtis, John Underwood, Anne Kirkham, Mitch Gadd, Neil Greaves, Brian Johnson, Dawn Clarke, Glenis Tansey, Jason Pawluk	The meeting discussed the upcoming development session of the Governing Body and the continuted communication and Engagement plans for the programme.
Chorley and South Ribble Peer Group	16/01/2019	GPs and Managers from the below practices: Adlington Medical Centre Beeches Medical Centre Buckshaw Village Health Centre Central ParkSurgery Clayton Brook Surgery Coppull Medical Practice, Acreswood Surgery Croston Medical Centre Dr Baghdjian & Partner (Chorley Health Centre) Dr Hamad & Partner (The Surgery) Eaves Lane Surgery Granville House Medical Centre Kingsfold Medical Centre Leyland Surgery Library House Surgery Medicare Unit Surgery Moss Side Medical Centre Regent House Surgery Roslea Surgery Sandy Lane Surgery Station Surgery The Chorley Surgery The Euxton Medical Centre The Ryan Medical Centre The Surgery Chorley The Village Surgeries Croston and Eccleston Village Surgery (New Longton Surgery) Village Surgery (Mashayekhy) Whittle Surgery Withnell Health Centre	Anne Kirkham presented a verbal update on the programme updating on the emerging model of care and timeline.
One-to-one Richard Maitland	16/01/2019	Richard Maitland, chair of LTH Staff side, JNCC	One-to-one meeting to discuss the emerging model of care and the potential impact on staff.
Governing Body Development session	17/01/2019	Chief Accountable Officer (Chair of Committee), Chief Finance and Contracting Officer (Vice Chair of Committee), Chair and Clinical Leader of NHS Chorley South Ribble CCG, Chair and Clinical Leader of NHS Greater Preston CCG, Vice Chair (Lay Member) of NHS Chorley South Ribble CCG, Vice Chair (Lay Member) of NHS Greater Preston CCG, GP Directors of both CCGs, Lay Members for Finance, Audit and Conflicts of Interest of both CCGs, Lay Members for Patient and Public Involvement of both CCGs, Governing Body Nurse , Secondary Care Doctor, Director of Quality and Performance, Director of Transformation and Delivery	The governing body were presented with a presentation detailing 'What composes a Model of Care'. The Governing Body also discussed the emerging model of care, the co-dependencies and clinical standards.
Patient Advisory Group	22/01/2019		A programme update was given and also details around the Public Sector Equality Duty, and our approach to delivering the Equalities Impact Assessment (EIA) for the programme.
One-to-one Gora Bangi	23/01/2019	Gora Banji	One-to-one meeting to following the informal development session and to discuss next steps
Lancashire Care	24/01/2019	Paul white, Anne Kirkham, Beverley Liddle, Elaine Watts, Carole Nicholson, Vicki Holderness	Meeting with Lancashire care to discuss the emerging model of care.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Targeted engagement	25/01/2019	Patient Advisory Group- nursing	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
OHOC Exec Oversight Group	28/01/2019	Denis Gizzi, Matt Gaunt, Helen Curtis, Sarah James, Jason Pawluk	Internal Executive meeting to discuss the programme
Targeted engagement	28/01/2019	Voice for All supported by Brothers of Charity, Learning disability	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
Focus group- Preston	29/01/2019	10 participants	The objective of the focus groups was to explore in greater details some of the views which emerged from the previously conducted quantitative research and provided an opportunity to gain more in-depth feedback regarding the proposed Model of Care and OHOC key messaging.
Targeted engagement	29/01/2019	Patient Advisory Focus group- two people- Autism, Dementia	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
Targeted engagement	29/01/2019	Bay 6 Barnardo's- Adolescents	
Targeted engagement	30/01/2019	Patient Advisory representative	
Focus group- Chorley	30/01/2019	10 participants	The objective of the focus groups was to explore in greater details some of the views which emerged from the previously conducted quantitative research and provided an opportunity to gain more in-depth feedback regarding the proposed Model of Care and OHOC key messaging.
Focus group- Leyland	30/01/2019	10 participants	The objective of the focus groups was to explore in greater details some of the views which emerged from the previously conducted quantitative research and provided an opportunity to gain more in-depth feedback regarding the proposed Model of Care and OHOC key messaging.
One-to-one phone call Geoffrey O'Donoghue	30/01/2019	Geoffrey O' Donoghue	Phone call to discuss the model of care and next steps for the programme as a member of the Joint Committee.
One-to-one meeting with Anitha Rangaswamy	31/01/2019	Anitha Rangaswamy	Meeting to discuss the model of care and next steps for the programme as a member of the Joint Committee.
Targeted engagement	01/02/2019	Tribal project, Patient Advisory Group rep	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
One-to-one meeting with Sandeep Prakash	01/02/2019	Sandeep Prakash	Meeting to discuss the model of care and next steps for the programme as a member of the Joint Committee.

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
One-to-one meeting with Jayne Mellor	01/02/2019	Jayne Mellor	To discuss the model of care and the clinical contents
One-to-one meeting with Linda chivers	04/02/3019	Linda Chivers	Meeting to discuss the model of care and next steps for the programme as a member of the Joint Committee.
Targeted engagement	04/02/3019	Patient Advisory Focus group - 4 people,Audiology services, Urgent Care services, Older age, earning disability	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
Targeted engagement	04/02/3019	Patient Advisory representative- Multi – PPC to be rearranged.	
Targeted engagement	04/02/3019	Patient Advisory representative- Care homes GP services	
NHSE meeting	04/02/2019	Mike Smith	Internal NHSE meeting to update on the programme.
Greater Preston Peer Group	05/02/2019	GPs and Managers from the below practices: Avenham Lane Practice Berry Lane Medical Centre Briarwood Medical Centre Dr CM Wilson & Partners Fishergate Hill Surgery Frenchwood Surgery Geoffrey Street Surgery Guttridge Medical Centre ISSA Medical Centre - Patel Lane Ends Surgery Longton Health Centre Lostock Hall Medical Centre Lytham Road Surgery North Preston Medical Practice Park View Surgery Penwortham St Mary's Ribble Village Surgery Ribbleton Medical Centre Riverside Medical Centre St. Fillans Medical Centre Stonebridge Surgery The New Hall Lane Practice The Park Medical Practice	GP input in the Frailty pathways for the Model of Care – specifically looking at - what is working within Primary Care, - what could be improved on - what the future looks like
Communications and Engagement group	05/02/2019	Neil Greives, Helen Curtis, Erin Portmouth, Lisa Roberts, Kelly Lorraine, Sarah James.	There was a update during the group on the recent market research and focus groups that had taken place and as well as other various other stakeholder meetings.
One-to-one meeting with Alan Stuttard	06/02/2019	Alan Stuttard	Meeting to discuss the model of care and next steps for the programme as a member of the Joint Committee.
Targeted engagement	06/02/2019	Community Group- 1 person	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
One-to-one meeting with Brigid Finlay	07/02/2019	Brigid Finaly	Meeting to discuss the model of care and next steps for the programme as a member of the Joint Committee.
Targeted engagement	07/02/2019	Patient Advisory representative- Police	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement
Targeted engagement	07/02/2019	Patient Advisory representative- Carers	

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Targeted engagement	07/02/2019	Maternity Voices Partnership planning meeting	Recruitment to the CCGs patient groups and networks
One-to-one phone call with Ian Cherry	07/02/2019	Ian Cherry	Phone call to discuss the model of care and next steps for the programme as a member of the Joint Committee.
Clinical Oversight Group	07/02/2019	Gora Bangi, Sumantra Mukerji, Geraldine Skailes, Jean Wright, Helen Curtis, Jayne Mellor, Lindsey Dickinsen, Hari Nair, Dave Rigby, Tracey Book-Scowan, Anne Kirkham, Sakthi Karunanithi, Mark Pugh, Som Kumar, Kelly Bishop. Lynn Chadwick	Detailed looks at the individual chapters of the emerging model of care, to discuss the detail, flow and clinical contents.
Targeted engagement	11/02/2019	Patient Advisory representative	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
Targeted engagement	12/02/2019	Community Transport disabilities	
Stakeholder reference Panel meeting	11/12/2018	Stakeholder Ref Panel	To provide an update on the programme and seek input from stakeholders
Phonecall with LCC	12/02/2019	Scott Gregory, Lynn Chadwick, Andrea Smith, Andrew Ascroft	Call to discuss the prevention elements of the Model of Care and how LCC can contribute their knowledge and experience. Andrew to send Scott information
Targeted engagement	13/02/2019	Street link	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
Targeted engagement	14/02/2019	Saulo	
Targeted engagement	14/02/2019	Community Transport - older people	
Targeted engagement	15/02/2019	Rough sleeprs- breakfast club	

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Chorley & South Ribble Peer group	20/02/2019	GPs and Managers from the below practices: Adlington Medical Centre Beeches Medical Centre Buckshaw Village Health Centre Central ParkSurgery Clayton Brook Surgery Coppull Medical Practice, Acreswood Surgery Croston Medical Centre Dr Baghdjian & Partner (Chorley Health Centre) Dr Hamad & Partner (The Surgery) Eaves Lane Surgery Granville House Medical Centre Kingsfold Medical Centre Leyland Surgery Library House Surgery Medicare Unit Surgery Moss Side Medical Centre Regent House Surgery Roslea Surgery Sandy Lane Surgery Station Surgery The Chorley Surgery The Euxton Medical Centre The Ryan Medical Centre The Surgery Chorley The Village Surgeries Croston and Eccleston Village Surgery (New Longton Surgery) Village Surgery (Mashayekhy) Whittle Surgery Withnell Health Centre	GP input in the Frailty pathways for the Model of Care – specifically looking at - what is working within Primary Care, - what could be improved on - what the future looks like
Targeted engagement	25/02/2019	Tribal project Patient Advisory Group representative	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement
Governing Body Development Session	27/02/2019	Chief Accountable Officer (Chair of Committee), Chief Finance and Contracting Officer (Vice Chair of Committee), Chair and Clinical Leader of NHS Chorley South Ribble CCG, Chair and Clinical Leader of NHS Greater Preston CCG, Vice Chair (Lay Member) of NHS Chorley South Ribble CCG, Vice Chair (Lay Member) of NHS Greater Preston CCG, GP Directors of both CCGs, Lay Members for Finance, Audit and Conflicts of Interest of both CCGs, Lay Members for Patient and Public Involvement of both CCGs, Governing Body Nurse , Secondary Care Doctor, Director of Quality and Performance, Director of Transformation and Delivery	The governing body met to discuss the emerging model of care.
Targeted engagement	01/03/2019	Disability North West	Targeted engagement to identify people and groups to engage with, beyond the protected characteristics. - Utilise the feedback from previous engagement activity. - Gain insight into preferred communication and engagement methods. - Identify the most appropriate way to work with each group. - Understand perceptions regarding access and experiences of healthcare services Gauge awareness of: the need for change the OHOC programme Gain an understanding about key issues and concerns that are relevant to specific equality groups in relation to health and care services Collect contact details for further engagement Recruitment to the CCGs patient groups and networks
Targeted engagement	01/03/2019	Penwortham Carers Group	

Name of the meeting	Date of the meeting	Who was invited	Aims of the meeting
Communications and Engagement Steering group	05/03/2019	Madeleine bird, Catherine brown, Cathy Stuart, Edna Boampong, Helen Curtis, John Underwood, Anne Kirkham, Mitch Gadd, Neil Greaves, Brian Johnson, Dawn Clarke, Glenis Tansey, Jason Pawluk	OHOC Joint Committee and the Model of Care, Highlight report

OHOC communication and engagement promotion

Promotion for OHOC communications and engagement activities was undertaken through the following channels and groups.

Event Invitations distributed to:

- Our Health Our Care mailing list (email and postal)
- CCG involvement network
- CCG Young Persons Health Advocates
- LTH membership / governors
- GP practices- to circulate with patients
- Healthwatch

Social media channels:

- OHOC Twitter
- CSR, GP CCGs Facebook
- CSR, GP CCGs Twitter
- LTH Facebook
- LTH Twitter
- Share requests with partners through social media

Flyers and posters:

- Hospital sites
- GP practices through Practice managers
- Healthwatch

Print and online advertising:

- July – ¼ page full colour adverts – Lancashire Evening Post and Chorley Guardian
- September – ½ page full colour adverts – Lancashire Evening Post, Chorley Guardian and Leyland and Chorley Citizen

Press:

Press release sent and follow up ahead of each round of public engagement events.

Online

Model of care information and survey available on OHOC website and promoted via:

- Healthwatch Chatty Van activity
- Age Concern
- Callon Kids Club
- Caritas Care
- The Childrens Society
- Community Enterprise & Skills CIC
- CRAB (Community Residents & Business)
- Crossgate Church
- Dig in North West
- Disability Equity – Lancashire Victims Services
- Emmaus
- Enterprise 4 all
- Fareshare
- Faringdon Community Centre
- Fishwick Rangers
- Friends of Avenham & Miller Park
- Galloways Society for the Blind
- Gujarat Hindu Society Centre
- Heartbeat North West
- Hello Preston
- I-cann
- Intact
- Intergrate Preston & Chorley
- Lancashire BME Network
- Lancashire Community Finance
- Lancashire Wellbeing Service
- Lancashire Women's Centre
- Larches & Savick Community Association
- Let's Grow Preston
- ME CFS Support Group
- Millbank Wellbeing Centre
- N-Compass
- Peoples Production Lab – They eat culture
- Plungington Community Centre
- Preston City of Sanctuary
- Preston Community Transport
- Preston Muslim Forum
- Preston North End Community & Education Trust
- Pukar Disability Resource Centre
- Recycling Lives
- Royal Voluntary Service
- Sahara
- Sion Hub
- St Barnabus Place
- St Matthews Mission
- The Foxton Centre
- The Larder
- Together Lancashire
- Tribal Project
- YMCA