

Providing independent strategic clinical advice

Clinical Senate Review of the Central Lancashire Acute Sustainability Workstream

**Written for:
Greater Preston and
Chorley & South Ribble CCGs
by
Greater Manchester, Lancashire & South
Cumbria Clinical Senate**

September 2019

Chairs' Foreword

Greater Preston Clinical Commissioning Group (CCG) and Chorley & South Ribble CCG commissioned Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate to undertake an independent clinical review, in line with the NHS England stage 2 assurance process, of the proposed "Our Health Our Care" acute models of care for Central Lancashire.

From the paperwork received and the conversations held during the review visit, it is clear that an enormous amount of hard work and difficult conversations have taken place, and are still taking place, to provide the best possible services for the population of Central Lancashire. The commitment of staff, who continue to provide good care in difficult circumstances, should be congratulated.

We would like to thank the clinicians and managers in Central Lancashire who contributed to this review. The passion to provide great patient care and to make the best of any situation was clearly apparent.

We offer our sincere thanks to the clinical senate review team who travelled from across England and Wales to provide their time and advice freely. We are grateful to members of the Clinical Senate for their ongoing support and commitment to the provision of robust clinical advice.

The clinical advice and recommendations within this report are given in good faith and with the intention of supporting commissioners. This report sets out the methodology and findings of the review. It is presented with the offer of continued assistance should it be needed.



A handwritten signature in black ink that reads "Donal J. O'Donoghue".

Professor Donal O'Donoghue
Clinical Senate Chair / Review Panel Co-Chair



A handwritten signature in black ink that reads "Jaydeep Sarma".

Dr Jaydeep Sarma
Review Panel Co-Chair

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1. Introduction

1.1. “Our Health Our Care” (OHOC) is the joint system transformation programme for health and care services in Greater Preston, Chorley and South Ribble (referred to as “Central Lancashire”). The aim of the programme is to deliver transformational change that leads to improved health outcomes for the populations served. The lead partners are:

- NHS Chorley and South Ribble CCG (CSRCCG)
- NHS Greater Preston CCG (GPCCG)
- Lancashire Teaching Hospital NHS Foundation Trust (LTH)
- Lancashire Care NHS Foundation Trust (LCFT)
- Lancashire County Council (LCC)

Working closely with:

- Central Lancashire district councils (Chorley, South Ribble and Preston)
- NHS England, including specialised commissioning

1.2. As with many health and care systems, the area covered by OHOC is facing a number of significant challenges in their acute system, including:

- Changing population demographics
- Health inequalities
- Limited workforce
- High and inconsistent bed occupancy
- Unwarranted variation in standards
- Decreased planned surgery

1.3. Consequently, the acute sustainability workstream has been established in the OHOC programme to focus on four key areas, with a specific view on the interdependencies with specialty medicine:

- Acute and General Medicine
- Critical Care
- Planned Surgery
- Urgent and Emergency Care

1.4. The aim of this review was to undertake an independent clinical review of the proposed “Our Health Our Care” acute models of care for Central Lancashire with a focus as described in 1.3, in line with the NHS England stage 2 assurance process.

1.5. The Terms of Reference for the review include the following objectives:

- 1.5.1. Do the options reflect relevant clinical guidelines and best practice?
- 1.5.2. Are the options sustainable in terms of the clinical capacity to implement them?

- 1.5.3. Do the plans identify mechanisms to address organisational and cultural challenges?
 - 1.5.4. Has the workforce impact, including impact on education, recruitment, retention been considered in each of the options?
 - 1.5.5. Have the clinical staff that may be affected by the changes, been involved in their development?
 - 1.5.6. Is the proposed workforce adequate for the service needs of each option?
 - 1.5.7. Do the options deliver the current and future health and care needs of the target population?
 - 1.5.8. Do the options maintain access to services for the population? (e.g. have waiting times and travel for patients and their families been considered?)
 - 1.5.9. Have innovations and improvements that would improve quality and outcomes been considered?
 - 1.5.10. Are there unintended consequences/interdependencies of the options that need to be taken into account? (E.g adult social care, medically unexplained, primary care)
 - 1.5.11. Have the risks and consequences of sustaining the options been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?
 - 1.5.12. Does the risk register identify key programme risks and have robust mitigation plans?
 - 1.5.13. Have patients and carers been involved meaningfully in the design of options?
 - 1.5.14. To what extent have the views and experiences of patients and carers been included in the options?
 - 1.5.15. Are the plans for IT and interoperability robust, realistic and able to deliver the requirements of the options?
- 1.6. A copy of the full Terms of Reference is included as Appendix 1.

1.7. The Clinical Senate Review Team members were:

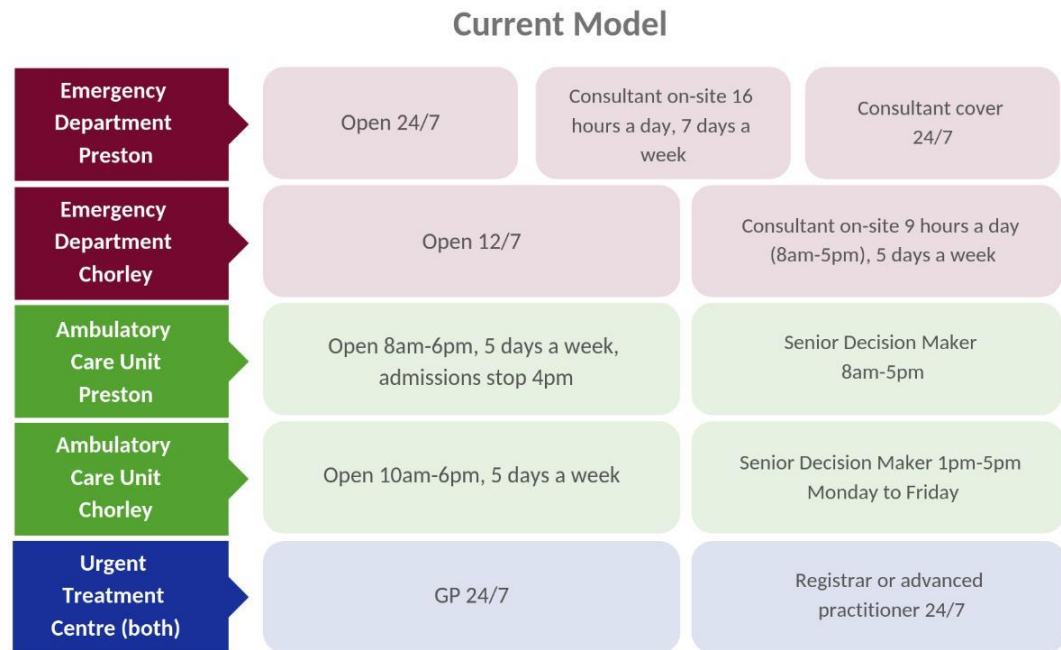
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Mr Andrew Simpson	Consultant in Emergency Medicine	North Tees and Hartlepool NHS FT
Dr Adam Wolverson	Clinical Director (Theatre / Anaesthetics)	United Lincolnshire Hospital NHS Trust

1.8.1 Managerial and business support to the panel was provided by Caroline Baines (Senate Manager) and Pamela Bailey (Senate Project Manager) from the NW Clinical Senates management support team.

2. Background

- 2.1 Our Health Our Care (OHOC) is a whole system transformation programme with a clear vision to deliver the best possible clinical outcomes for the people of central Lancashire. The programme spans three pillars of working – prevention and public health, community services and the acute sustainability programme. Although the focus of this review was acute sustainability, the connections to the wider system are essential.
- 2.2 Central Lancashire covers Greater, Preston, Chorley and South Ribble. It is one of five areas that form part of the Lancashire and South Cumbria Integrated Care System (ICS). Central Lancashire's population is approximately 392,000 people, who reside in a mixture of inner city, town and rural village locations.
- 2.3 There are two Clinical Commissioning Groups (CCGs) in central Lancashire: CSRCCG and GPCCG, which work closely together and share a management team, staff, operational plan and strategic plan. The populations served by each CCG are approximately 182,000 and 210,000 respectively, and their 18/19 budgets were £274.4million and £299.9million respectively. The two CCGs conduct their business for the OHOC programme through the Joint Committee of CCGs (JCCCG).
- 2.4 There are two acute hospitals serving Central Lancashire, both run by LTH: Royal Preston Hospital (referred to as "RPH" or "Preston") and Chorley and South Ribble District General Hospital (referred to as "CSR" or "Chorley"). According to Google maps, there are 13.6 miles between the two sites with a journey time of 22 minutes. The figure of 22 minutes is taken based on private car transport in standard, off-peak conditions. This means the expected middle range figure for a journey which takes place outside of the morning (0730-0930) or afternoon (1630-1830) weekday heavier traffic periods. More details of travel times and alternative modes of transport are being developed by the programme in its travel and access modelling using specific software.
- 2.5 The current model of care is shown in Figure 1:

Figure 1: Current Model of Care



- 2.6 The constitutional standard performance position delivered by the trust generally depict a declining or systemically worsening position, with notable exceptions. The trust indicates that causal factors include increasing demand for acute care, increasing pressures on inpatient capacity arising from delayed transfers of care and workforce deficits, particularly across medical, and nursing disciplines.
- 2.7 In response to these hospital pressures, and those within the wider system (described in Paragraph 1.2), OHOC have developed 13 service options.
- 2.7.1 **Option 1:** Do nothing. Continue with 12 hours a day, Monday to Friday only, ED provision at Chorley. Keep existing configuration of other services including surgery and acute medicine.
- 2.7.2 **Option 2:** Do nothing with hospital configuration as with Option 1 but fully implement system transformation programmes. This would include initiatives through the enhanced care home service, frequent flyers and 111 to reduce A&E demand and emergency admissions.
- 2.7.3 **Option 3:** Provide a Type 1 ED at Chorley which complies with the national service specification or extend the existing non-Type 1 compliant model to a 24/7 operating model.
- 2.7.4 **Options 4a-e:** Provide an enhanced Urgent Treatment Centre¹ (UTC) at Chorley with a number of variants (a-e) as described below

¹ An enhanced urgent treatment centre provides a level of care which is in excess of the national service requirements for an Urgent Treatment Centre (or Type 3 A&E) but does not meet all of the requirements for a Type 1 A&E."

2.7.4a **Option 4a** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. Chorley will also have a level three critical care unit, medical assessment beds (MAU) and specialty/general medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure.

2.7.4b **Option 4b** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit and medical assessment beds (MAU) but no general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure.

2.7.4c **Option 4c** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit but no medical assessment beds (MAU) or specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.4d **Option 4d** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will also have a level one Post-Operative Care Unit (POCU) and no MAU or general/specialty medicine beds. The co-dependency framework states that a hospital site cannot support acute medical beds without level three critical care. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.4e **Option 4e** is the provision of an enhanced urgent treatment centre at Chorley with observation beds. The hospital will not have a critical care unit or a Post-Operative Care Unit (POCU). There will be no MAU or general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.5 **Options 5a-e:** Provide an UTC at Chorley as defined by the national specification. The variants for Options 5a-e are the same as those for Options 4a-e, as described below.

2.7.5a **Option 5a** is the provision of an urgent treatment centre at Chorley with observation beds. Chorley will also have a level three critical care unit, medical assessment beds (MAU) and specialty/general medicine beds.

As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure.

2.7.5b **Option 5b** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit and medical assessment beds (MAU) but no general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of specialist medical patients and fewer patients requiring elective and day case surgery.

2.7.5c **Option 5c** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will also have a level three critical care unit but no medical assessment beds (MAU) or specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.5d **Option 5d** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will also have a level 1 Post-Operative Care Unit (POCU) and no MAU or general/specialty medicine beds. The co-dependency framework states that a hospital site cannot support acute medical beds without level three critical care. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.7.5e **Option 5e** is the provision of an urgent treatment centre at Chorley with observation beds. The hospital will not have a critical care unit or a Post-Operative Care Unit (POCU). There will be no MAU or general/specialty medicine beds. As much elective surgery will be performed on the hospital site as can be supported by the described infrastructure. Under this option, the Royal Preston Hospital site would manage a greater volume of medical patients and fewer patients requiring elective and day case surgery.

2.8 The OHOC Joint Committee decided at its last meeting in public on the 28th August to keep all thirteen options on the table, alongside proposals to consider a new build site. A process of enhanced clinical scrutiny was requested. As part of this enhanced clinical scrutiny, the OHOC Joint Committee has asked the Clinical Senate to provide an independent expert clinical view on all thirteen in line with the objectives in Paragraph 1.5.

3. Methodology

- 3.1 Numerous teleconferences, meetings and attendances at Senate Council took place between the Clinical Senate and the Our Health Our Care programme in the period from May 2017 to September 2019 to develop, iterate and agree the Terms of Reference for the review (Appendix 1).
- 3.2 Provisional review information was provided by OHOC colleagues on 26th July 2019. Panel members reviewed these independently, then shared provisional findings during two teleconferences in the week of 19th August 2019. Subsequently a number of requests were made for additional information. The responses to these requests were provided prior to and during the review.
- 3.3 The review panel visited Central Lancashire on the 16th and 17th September 2019 (see Appendix 2 for full itinerary). The panel travelled to the Royal Preston Hospital and Chorley and South Ribble Hospital to see facilities, meet key staff and gain an in-depth understanding of the challenges faced. The panel met with representatives from the OHOC Programme partners at the end of the visit and fed back their initial thoughts.
- 3.4 A draft report was sent to commissioners for accuracy checks on 25th October 2019 with feedback received by 3rd November 2019. The final report was ratified remotely by the GMLSC Senate Council on 25th November 2019 and sent to the review commissioners on 26th November 2019.

4. Discussion

The sub-sections below contain summary findings, conclusions and recommendations in line with the review objectives. These are based on the panel's discussions and deliberations. They are not intended to capture the totality of the conversations. Recommendations are highlighted in bold text and summarised in Table 1 in Section 5.

4.1 Do the options reflect relevant clinical guidelines and best practice?

The methodology used by the OHOC programme to develop the options utilises a broad range of the relevant guidelines across the range of specialties in scope of this review. These have been well-considered and appraisal of each of the options against these is apparent.

The acute medicine service needs to be designed and configured to ensure that patients can be seen by a relevant consultant within the timescales recommended by NICE and NHS seven-day working.

The Society for Acute Medicine, NHS seven-day guidance² and NICE³ all advocate that this timescale should be a maximum of 14 hours of the time of arrival at hospital or within 12 hours of the decision to admit. In practical terms, this would require the workforce, especially consultant workforce, to have a shop-floor presence which extends beyond the current provision of 9am to 8pm. The panel stresses that this a maximum time for unwell patients to wait to see a consultant.

The panel are unanimous in their views that options 1, 2 and 3 are not viable (meaning that they cannot be delivered sustainably) as Emergency Department services at Chorley would not be compliant with essential clinical standards, largely due to the absence of core on site specialties in particular emergency surgery and paediatrics.

Additionally, the panel are clear that for critical care, options 4a, 4b, 4c, 5a, 5b and 5c are not viable in addition to options 1-3 inclusive. This is due to the unsustainability of the critical care services at Chorley. Currently the service is losing £1 million per year and sees one of the lowest, if not the lowest, number of patients of any critical care service in the country. The patient throughput is not sufficient to allow staff to maintain and develop their skills. None of the options would be likely to increase that utilisation, and most would reduce utilisation.

Due to the compelling clinical evidence that options 1, 2, 3, 4a, 4b, 4c, 5a, 5b and 5c are not clinically viable, due to safety and sustainability issues, the remainder of this report will only consider options 4d, 4e, 5d and 5e in its

² <https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf>

³ <https://www.nice.org.uk/guidance/qs174/chapter/quality-statement-3-consultant-assessment-and-review#quality-statement-3-consultant-assessment-and-review>

analysis and recommendations. **The panel recommends that, clinically, these four options should be short-listed for further work and public consultation.**

4.2 Are the options sustainable in terms of the clinical capacity to implement them?

Looking from an Emergency Department perspective all of the sub-options from options 4 and 5 are possible. However, the lack of clinical capacity to sustain critical care under options 4a-c and 5a-c inclusive, along with the interdependencies of ED with critical care, render options 4a-c and 5a-c unsustainable from an ED perspective as well.

There is a lack of nursing information within the documentation and the trust seems to have had mixed success with ACPs, ranging from only two qualified and two in training for ED to a number of keen and motivated ICU ACPs. The trust seems to lack ambition and be missing opportunities with its ACCP / ACP workforce, with them being part of the tier 1 rota. In other trusts ACCPs form part of the tier 2 rotas. This has helped them in part to address the widening gaps in the supply and retention of the consultant medical and middle grade workforce, a problem which is experienced nationally.

Concerns that closing Chorley ED would lead to Preston, or neighbouring trusts such as Wrightington, Wigan & Leigh, Bolton, Southport & Ormskirk, or the broader Greater Manchester health system, being overwhelmed did not materialise when there was a temporary closure previously. Therefore, it seems highly likely that any of the clinically viable options would lead to a strengthening of the ED workforce at Preston by bringing the Chorley workforce in to strengthen the existing fragile staffing situation.

The transformation of the wider system is, in part, reliant upon the Primary Care Networks (PCNs) being able to support the hospital by increasing the volume and type of out of hospital care. **OHOC partners need to be realistic about how much the PCNs can deliver and when, as they are currently largely immature in their development.** The programme advised the panel that all of the options anticipate a phased implementation plan through up to and including the 2024/5 financial year (i.e. five years).

4.3 Do the plans identify mechanisms to address organisational and cultural challenges?

Cultural challenges are frequently present when there are services operating over more than one site. This would certainly be expected between two hospitals such as Preston and Chorley where the former is a large busy tertiary centre and the latter a quieter DGH. Despite these differences, the panel felt that there were some excellent examples of cross-site, joined-up working, particularly in critical care. There remain opportunities to extend this good practice in to other specialties.

The panel were struck by how many of the conversations they had were focussed on WHERE services would be provided and not HOW based on a whole-pathway approach. It seems as though the years of uncertainty regarding the future delivery of services has led to this and may be stifling innovation in looking at how services can be delivered differently.

4.4 Has the workforce impact, including impact on education, recruitment and retention, been considered in each of the options?

A strategic workforce document was provided with the pre-review documentation. This document included details of the trust's recruitment and retention strategy, examples of the creation of new workforce roles and skill-mix and the development of the Education Centre and partnership working between the trust and academic institutions. However, detailed workforce modelling of each option has not been undertaken due to the scale of the long-list. **The panel recommends that detailed workforce impact modelling is undertaken on the "feasible" options (4d, 4e, 5d, 5e).**

There has clearly been consideration of some of the workforce issues, but not all. It is encouraging to hear that new staff contracts include cross-site working. Although there will be existing staff who will not move, this is a good approach for the long term. **Therefore, the panel recommends that the trust continues to offer cross-site contracts.**

Overall, medical vacancies have fallen in the last couple of years, and critical care have had no vacancies or staffing issues other than losing people to community services. The panel thought the success in critical care may be a result of considerable thought and planning going into changing the way staff work in ICU. There was evidence of good educational options for both doctors and nurses in this area. However, care must be taken in the wider decision-making to ensure that Chorley is still seen as an attractive place to work. Some current practices do not reflect this, such as ICU nurses being seconded to wards when they are not busy. Additionally, some nurses in critical care don't want to progress to band 6 or above because they do not want to go to Chorley: it must be made clear that this is more because of the exposure they feel at Chorley rather than the experience of working at Chorley itself. **The Critical Care Network and commissioners should be involved in these discussions if they are not currently, as their endorsement will be needed.**

ACP roles are beneficial, and it is good to see that there is ambition to recruit, train and employ more across disciplines. Success in this has been somewhat mixed by discipline to date, and the panel recommends that this is examined for reasons why and initiatives implemented to increase uptake.

There is no organisational bank system for Physician Associates (PAs) wanting to work over their contracted hours. When overtime is worked, it can be difficult and convoluted for these staff to get paid. Additionally, there was some reported disagreement between consultants and managers regarding

the use of PAs to cover bank shifts on weekends and bank holidays. **The panel recommends that the trust reviews the current practices and establishes a system for PAs to work, and be promptly paid for, bank shifts based on medical need.** The report “*An employer’s guide to physician associates*⁴” should be of assistance. This would make the role of PA more attractive to other colleagues and LTH a more attractive trust to work in as a PA.

In Acute Medicine, there are no dedicated consultants and a lack of frailty provision and expertise. The opportunities for staff education and development were also lacking with one member of staff not having been aware of any quality improvement or audit taking place within the last three years. **The panel recommends that the trust considers employing dedicated consultants in acute medicine and who are able to lead and shape the department through the forthcoming period of change.**

Preston is a Major Trauma Centre and the Major Trauma System in existence in England has been shown to save lives. Consequently, it is essential that the Emergency Department, and all supporting specialties, meet the staffing requirements of a Major Trauma Centre.

4.5 Have the clinical staff that may be affected by the change been involved in their development?

The panel saw evidence from their conversations that some senior medical staff had been involved in the development of options. However, there was less evidence of a wider range of staff involvement, including more junior medical staff, nurses, PAs, AHPs, support staff, etc. There was evidence of staff involvement being attempted, although this had not generally been very successful. An air of “change fatigue” was evident in some areas which was understandable given that there has been uncertainty regarding the future of services for quite some time.

The panel felt they were given a good view of the services at present but not clear clinical visions and aspirations. The clinical leaders clearly know the best options to ensure safe and sustainable future services in their disciplines. It is important that any “noise” either outside of the programme or in the wider health and care system does not detract from the ability of the clinical voice to direct both WHERE and most crucially HOW services are best provided in future.

The panel therefore recommend that **greater active meaningful involvement from a range of colleagues across seniority and discipline (including both clinical and non-clinical staff) is required.**

⁴ Royal College of Physicians / Faculty of Physician Associates. (2017). *An employer’s guide to physician associates*. www.fparcp.co.uk/employers/guidance

4.6 Is the proposed workforce adequate for the service needs of each option?

Workforce modelling has not been undertaken for each of the options, so the panel were unable to comment on this objective. **The panel recommends that detailed workforce modelling is done on the four clinically viable options (4d, 4e, 5d, 5e).**

4.7 Do the options deliver the current and future needs of the target population?

The target population is diverse with wide-ranging needs. The population is projected to grow (particularly in the Chorley area) and, as with most areas, experience a significant ageing effect. For these plans to be successful and sustainable in the long-term, there needs to be major transformation of primary care, community and public health provision. There is evidence of a lot of work and planning being done in these areas, but there are concerns regarding when they will come to fruition to deliver benefits to the system (such as reduced admissions).

The four clinically viable options deliver what is needed to modernise the local processes and services, but not what all of the population want to see. **The panel recommends that the OHOC programme uses examples from previous successes, such as vascular and major trauma, to demonstrate to opponents of these options how they might deliver improved care and services.**

The options need to include greater investment in, and planning for, frailty services.

The panel recommends that OHOC look to other systems who have done similar work to identify learning and innovation that could be beneficial in central Lancashire.

4.8 Do the proposals maintain access to services for the population? (e.g. having waiting times and travel for patients and their families been considered?)

The focus of this programme needs to ensure that patients can access the right services first time rather than having to face numerous transfers in care. To do this successfully in clinical terms, there are four viable options as described. This will necessitate further travel times for some patients in some cases and less travel for others depending upon the place of residence and the nature of the medical condition.

This population does not meet the definitions of a “rural community”, and therefore associated considerations should not be applied here. During the

visit the programme identified that the population growth projections for central Lancashire for the next 25 years would not create a default population health requirement for two or more accident and emergency services, based on the formula last developed by the Royal College of Surgeons in 2006.

The panel believes that any increase in travel times will be offset by improved quality of services, improved outcomes, reduced transfers and reduced waiting times. It is also clear that some parts of the care pathway will be delivered closer to home across all of the options where clinically viable, for instance outpatient care at the local hospital or outside of the acute environment.

By focussing on consolidation of services, there is scope to develop Chorley to be a centre of excellence for certain services, which will improve both access and quality of service to the local population for conditions such as orthopaedic day surgery and frailty services.

4.9 Have innovations and improvements that would improve quality and outcomes been considered?

One option not on the list is to build a new hospital on a new site in between Chorley and Preston. There is a strong case for this option in terms of access, consolidating and strengthening the workforce, building a modern fit for purpose facility and improving health and care outcomes. The obvious hurdle to this option is cost. It is also clear that a new hospital would take between 7 and 12 years to develop, depending on the process followed. This means that such a solution would not provide a short to medium term answer to the issues with current services as reported to the panel.

There were some pockets of innovation identified, such as the “COPD singing” group.

The panel recommends the following approaches are considered to maximise the improvement of quality and outcomes:

- **The infrastructure at Preston needs to be reviewed and considerably improved to support delivery of first-class services. This is particularly pertinent to ED and critical care, both of which the panel found to be inadequate, for patients and staff. Despite these significant challenges, staff are providing excellent services and this is a credit to them.**
- **Changes have been made within the confined footprint of the ED to increase capacity and ease flow, however, in order to future proof the service a new ED is absolutely essential. This would not only make the care of patients easier but would also attract more staff of all grades and professions.**
- **A whole system approach to frailty**

- The ambulatory care vision needs to be listened to and implemented with dedicated consultant leadership.

4.10 Are there unintended consequences/interdependencies of the model that need to be taken into account? (E.g. adult social care, medically unexplained, primary care)

There has been a lot of thought and consideration given to the consequences and interdependencies within the hospitals. This includes with NWAS who have clearly been involved in the planning.

There did not appear to have been much thought regarding the exact impacts of the options on neighbouring trusts / areas, which may become busier if Chorley ED is downgraded. The pre-review documentation indicated that a high proportion of care for central Lancashire residents is delivered in central Lancashire and the numbers of patients accessing care out of area is modest. When the service was previously downgraded, neighbouring services were not overwhelmed. However, **OHOC need to consider the impacts outside of the Central Lancashire footprint.**

Some of the less viable options would have an impact on the infrastructure and surrounding area at Preston Hospital, such as busier roads causing access issues for ambulances, staff, patients and the general public travelling in the area. However, the panel are not recommending these options, and so this is unlikely to be a concern.

There needs to be greater partnership working with primary care and social care, particularly regarding what is realistically deliverable, when and how to mitigate the transitional period. The panel were concerned that there was an unrealistic expectation on these services.

There are some actions that could be taken in the short-term to improve access without the need for restructure, including access to mental health provision in ED and the development of a system-wide frailty approach.

4.11 Have the risks and consequences of sustaining the options been identified? Are there mitigating actions and monitoring arrangements for risks? Have organisational mechanisms to manage such risks been considered / put in place?

The risks and consequences of maintaining the current approach are well-documented and well-articulated. The mitigating actions have so far worked well, due to the commitment and dedication of staff, but they are not sustainable.

Depending on which option is implemented, the risks may be reputational and political rather than clinical. This certainly applies to the four options that the panel is supporting.

4.12 Does the risk register identify key programme risks and have robust mitigation plans?

The risk register was not made available to the panel prior to the review. However, it was disseminated after and comments were received. The panel view is that the documents are comprehensive, including the key risks and mitigations that would be expected for a redesign programme. It is clearly not possible to identify and mitigate all risks as transformational work such as this is somewhat unpredictable in nature. The risks are reported through the programme governance process.

4.13 Have patients and carers been involved meaningfully in the design of options?

There has clearly been a lot of work done to engage with a broad range of groups, and this was particularly apparent in the session that some of the panel members had with representatives from the communications team. The panel felt these methods may have been a little too traditional at times (e.g. large public meetings which only a small minority of people attend) and seemed to be reactive to the vocal MP and pressure groups, rather than always proactive. Indeed, these groups have at times dominated events that were planned to be genuine engagement opportunities.

The panel was pleased to hear that OHOC will be working with the Consultation Institute in the near future, who they are sure will support them to conduct further engagement and consultation activities to a targeted “good practice” standard, including ensuring that the reach of the communications and engagement activities is further broadened.

The panel recommends that clinical champions talk to people about why these changes are the right things to do and services will be better. This can be done by using evidence of where they have already made changes that have benefitted patients (e.g. major trauma centre and stroke care at Preston) and saved lives. Also, OHOC should use case studies to illustrate this.

The panel recommends that OHOC adopt some more modern approaches to their engagement, such as campaigns on YouTube and purchasing targeted advertising on Facebook/Twitter/Google. The panel were impressed with the video they saw at the start of Day One, so there is clearly expertise to do this within the area.

4.14 To what extent have the views and experiences of patients and carers been included in the options?

Work has been ongoing for some years and there have been feedback loops to different groups. “However, the voice of the patient is not wholly clear in the way in which the developed options have been communicated to date, particularly in terms of “why would this be better for me”. A patient impact assessment may help so that the programme can continue to meaningfully co-design the proposals with the patients and carers. The panel recognises that the options have not yet been formally consulted on and that this will occur as part of the forthcoming public consultation process. However, they would like to have seen some more tangible examples and evidence.

The panel recommends that OHOC take future opportunities to involve patients and the public (including carers) meaningfully in the design of services.

4.15 Are the plans for IT and interoperability robust, realistic and able to deliver the requirements of the options?

The Digital Plan shared with the panel is a high-level document, and consequently provides little to no reassurance that the IT infrastructure will be able to deliver as required. There are different systems in the hospital and primary care, and the hospital is the only trust using their electronic patient record. This was described as “clunky” by many colleagues during the visit and it seems as though it is robust but not popular.

The Trust is willing to consider a new system as part of an ICS level solution, though the timing of that and the timing of the implementation of the preferred service option is not clear.
There is an excellent PACS system in place within the trust.

5. Conclusions and Recommendations

- 5.1 The panel were unanimously impressed with the high-quality documentation they received before the review, as well as the excellent responses to their queries.
- 5.2 The panel would like to give recognition to the staff in the ED and Critical Care departments at Preston, who were delivering good services and were very enthusiastic and positive despite working in very difficult circumstances and inadequate infrastructure.
- 5.3 There are some excellent examples of cross-site working evident across Preston and Chorley.
- 5.4 There is clearly a joined-up approach to this work across the CCGs and LTH at the most senior levels.
- 5.5 Due to safety, sustainability and clinical capacity issues, only options 4d, 4e, 5d and 5e are included in further discussion. The panel's preferred model is 4d.
- 5.6 There are opportunities to improve services for the population by developing acute medicine and frailty services, and by turning Chorley into a centre of excellence for a number of elective services.
- 5.7 The panel makes the following recommendations in Table 1 which are intended to be supportive and constructive.

Table 1: Summary of Recommendations

- 1) The acute medicine service needs to be designed and configured so that patients can be seen by a relevant consultant within timescales recommended by NICE and NHS seven-day working.
- 2) Clinically, only options 4d, 4e, 5d and 5e are viable.
- 3) OHOC partners need to be realistic about how much the PCNs can deliver and when.
- 4) Detailed workforce and impact modelling are undertaken on the clinically feasible options.
- 5) The trust continues to offer cross-site contracts.
- 6) The Critical Care Network and commissioners should be involved in discussions.
- 7) The trust reviews the current practices and establishes a system for Physician Associates to work, and be promptly paid for, bank shifts based on medical need.
- 8) The trust employs dedicated consultants in acute medicine who are able to lead and shape the department through the forthcoming period of change.
- 9) Greater active meaningful involvement from a range of colleagues across seniority and discipline (including both clinical and non-clinical staff) is required.
- 10) OHOC use examples from previous successes, such as vascular and major trauma, to demonstrate to opponents of these options how they might deliver improved care and services.
- 11) The options need to include greater investment in, and planning for, frailty services.
- 12) OHOC should look to other systems who have done similar work to identify learning and innovation that could be beneficial in Central Lancashire.
- 13) The infrastructure at Preston needs to be reviewed and considerably improved.
- 14) Turn Chorley into a centre of excellence offering elective services.
- 15) A whole system approach to frailty needs to be developed.
- 16) The ambulatory care vision needs to be implemented with dedicated consultant leadership.
- 17) OHOC need to consider the impacts of the options outside of the Central Lancashire footprint.
- 18) Greater partnership working with primary care and social care takes place, particularly regarding what is realistically deliverable, when and how to mitigate the transitional period.
- 19) Clinical champions talk to people about why these changes are the right things to do, how services will be better and use case studies to illustrate this.
- 20) OHOC take future opportunities to involve patients and the public (including carers) meaningfully in the design of services.

Appendices

FOR RATIFICATION

Appendix 1 - Terms of Reference

1. STAKEHOLDERS

Title: Our Health Our Care – Acute Sustainability Workstream

Sponsoring Commissioning Organisation: Greater Preston CCG and Chorley & South Ribble CCG

Lead Clinical Senate: Greater Manchester, Lancashire and South Cumbria

Terms of reference agreed by: Prof Donal O'Donoghue (Senate Chair) and Denis Gizzi (Accountable Officer of Sponsoring Commissioning Organisation)

Date: May 2019 (agree Terms of Reference) – November 2019 (final report)

Panel Chair: Prof Donal O'Donoghue, Consultant in Renal Medicine, Salford Royal NHS FT

Deputy Panel Chair: Dr Jaydeep Sarma, Consultant Interventional Cardiologist, Manchester University NHS FT

Citizen Representatives: Ian Linford, Cheshire & Merseyside Clinical Senate Council

Clinical Senate Review Team Members:

NAME	JOB TITLE	ORGANISATION
Dr Mary Backhouse	GP Partner	Tyntesfield Medical Group, North Somerset
Dr Mark Holland	Consultant Physician in Acute Medicine	Salford Royal NHS FT
Gill Johnson	Nurse Consultant	Manchester University NHS FT
Dr Akram Khan	GP & Lead CCG Clinician	Bradford City CCG
Julie McCabe	Network Director, Programme Director	NW Neonatal ODN
Mr Kirt Patel	Consultant General Surgeon	Sheffield Teaching Hospitals NHS FT
Dr Andrew Simpson	Consultant in Emergency Medicine	North Tees and Hartlepool NHS FT
Dr Adam Wolverson	Clinical Director (Theatre/Anaesthetics)	United Lincolnshire Hospital NHS Trust
Dr Niall Lynch	Consultant Clinical Radiologist	Stockport Foundation NHS Trust

2. QUESTION & METHODOLOGY

Aim of Review:

To undertake an independent clinical review (in line with NHS England & Improvement's Stage 2 assurance process) of the proposed "Our Health Our Care" acute models of care for Central Lancashire with a focus upon the following aspects of acute sustainability:

- Acute Medicine
- Critical Care
- Planned Surgery Performance
- Urgent and Emergency Care

Main objectives of the clinical review:

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

Scope of the review:

In scope: Services within the acute sustainability workstream of the Our Health Our Care programme, namely, the provision at Chorley Hospital and Royal Preston Hospital of:

- General and Specialty Medicine
- Critical Care
- Planned Surgery
- Urgent and Emergency Care

Out of scope: Community services, mental health services, maternity and paediatric services⁵, regional specialist services

Outline methodology:

A formal review will be undertaken on 16th and 17th September 2019 to support the NHS England & Improvement Stage 2 assurance process. The methodology for this review will comprise a desktop review of paperwork, face to face conversations with key clinical and managerial colleagues and site visits of the two acute sites within scope.

Reporting arrangements:

The formal review panel will be led by Professor Donal O'Donoghue, Chair of the Greater Manchester, Lancashire & South Cumbria (GMLSC) Clinical Senate. The panel will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the media handling of the report and subsequent publication of findings will be agreed within 3 months of delivery.

⁵ Maternity and paediatrics services have already been consolidated on a single site at Royal Preston Hospital.

3. KEY PROCESS AND MILESTONES

Process	Timescale
Information for formal review submitted by Commissioner and distributed to review panel	26 th July 2019
Review panel initial Meeting/WebEx/Teleconference and requests for clarification/further information from Commissioners	w/c 9 th August 2019
Formal review panel / site visits – interviews and overview	16 th -17 th September 2019
Panel submit initial findings	22 nd September 2019
1 st draft sent to panel for checks	27 th September 2019
Panel submit final edits for submission	13 th October 2019
Final draft sent to commissioners for accuracy checks	25 th October 2019
Feedback on accuracy of report from OHOC	3 rd November 2019
Final report completed	8 th November 2019
Ratification of final report by Clinical Senate Council	22 nd November 2019
Final report provided by Senate to commissioner	25 th November 2019 (assuming ratified)

4. REPORT HANDLING

A draft clinical senate report will be made to the sponsoring organisation for fact checking prior to publication on 25th October 2019.

Comments/corrections from Commissioners to be received by the senate on 3rd November 2019. The final report will be submitted by the Clinical Senate to the sponsoring organisation by 25th November 2019, assuming it is ratified by the Clinical Senate Council on 22nd November 2019.

5. COMMUNICATION AND MEDIA HANDLING

The Clinical Senate aims to be open and transparent in the work that it does. The Clinical Senate would request that the sponsoring commissioning organisation publish any clinical advice and recommendations made.

All media enquiries will be handled by the sponsoring organisation.

Name of Communication Lead Sponsoring Commissioner: Jason Pawluk

The detailed arrangements for any publication and dissemination of the clinical senate assurance report and associated information will be decided by the sponsoring organisation.

6. RESOURCES

The clinical senate will provide administrative support to the review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

7. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the North Region Clinical Senates accountability and governance structure.

The Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring commissioning organisation.

The sponsoring commissioning organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

8. FUNCTIONS, RESPONSIBILITIES & ROLES

The sponsoring organisation will:

1. Provide the clinical review panel relevant information, this may include: the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance, service specifications. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two- and five-year plans and commissioning intentions). The sponsoring organisation will provide any other additional background information requested by the clinical review team.
2. Respond within the agreed timescale to the draft report on matter of factual inaccuracy.
3. Undertake not to attempt to unduly influence any members of the clinical review team during the review.
4. Submit the final report to NHS England for inclusion in its formal service change assurance process.

Clinical senate council and the sponsoring organisation will:

1. Agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.
2. Appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
3. Advise on and endorse the terms of reference, timetable and methodology for the review.
4. Consider the review recommendations and report (and may wish to make further recommendations).
5. Provide suitable support to the team and
6. Submit the final report to the sponsoring organisation.

Clinical review team will:

1. Undertake its review in line with the methodology agreed in the terms of reference.
2. Follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.

3. Submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
4. Publish lists of documents we are provided with, those which we request that are unavailable and those not provided to the review team.
5. Keep accurate notes of meetings.

Clinical review team members will undertake to:

1. Commit fully to the review and attend all briefings, meetings, interviews, panels, etc that are part of the review (as defined in methodology).
2. Contribute fully to the process and review report.
3. Ensure that the report accurately represents the consensus of opinion of the clinical review team.
4. Comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally, they will declare any potential conflicts, to the chair or lead member of the review panel.

FOR RATIFICATION

Appendix 2 - Programme for visit on 16th and 17th September 2019

DAY 1: Monday 16th September 2019 – Chair: Professor Donal O'Donoghue

Time	Item	Details
10.00 – 10.30	Review Panel meet for initial discussions prior to the start of the review	Meeting Room, Macdonald Tickled Trout Hotel
10.30 – 11.00	Minibus to collect panel members for travel to Royal Preston Hospital	Macdonald Tickled Trout Hotel, Preston New Road, Salmesbury, Preston, PR5 0UJ
11.00 – 13.00	Welcome & Introductory Sessions <ul style="list-style-type: none"> Background Presentation Group Discussion 	Programme Director/Clinical Directors/Team Representation (followed by lunch) Seminar Room 3 EC1
13.00 - 14.30	Walking tour of Royal Preston Hospital - Opportunity to speak to clinical teams / nursing staff	
	Groups 1: ICU and Surgery	Group 2: ED, MAU and Ambulatory Care
14.30 – 15.00	Discussion with Trainees	Seminar Room 2 EC1
15.00 - 15.30	Travel to Chorley Hospital	Minibus to collect panel at 15:00
15.30 – 15.45	Arrival & Meet & Greet	Chorley Hospital, Preston Road, Chorley, PR7 1PP Clinical Team Representation - Meet & Greet / Coffee Break Seminar Room C EC3
15.45 – 16.15	Discussion with Trainees	Seminar Room D EC3
16.15- 17.15	Walking tour of Chorley Hospital - Opportunity to speak to clinical teams / nursing staff / trainees	
	Group 1: ICU and Surgery	Group 2: ED, MAU and Ambulatory Care
17.30 – 17.45	Minibus to collect panel from Chorley Hospital at 17:30 and return to Macdonald Tickled Trout Hotel	Free time at hotel / check-in
18.30 – 20.30	Review Panel Discussion and Feedback including evening meal	Meeting Room (t.b.c.) Macdonald Tickled Trout Hotel

DAY 2: Tuesday 17th September 2019 – Chair: Dr Jaydeep Sarma

Time	Item	Details
08.30 - 9.00	Minibus to collect panel members at 8.30am from Macdonald Tickled Trout Hotel to go to Royal Preston Hospital	
09:00 – 09:30	Discussion with Communication Leads/Confidential Drop in session	Seminar Room 4/ Confidential drop in session room tbc
09:30 – 10:30	Discussion with Clinical Teams	Seminar Room 4
10:30 – 11:30	Discussion with Executive Teams	
11:30 – 12:00	Discussion with Clinical Teams and Exec Teams	
12.00 – 13.15	Review Panel Discussion & Reflections over light working lunch	Seminar Room 4
13:15 – 13.45	Conclusions, Feedback and Next Steps: Panel to commissioners and other stakeholders as per commissioners' wishes	Seminar Room 4
13:45 – 14:15	Minibus to take panel members from Royal Preston Hospital to Macdonald Tickled Trout Hotel at 14.15	

Group 1 ICU & SURGERY	Group 2 ED, MAU & AMBULATORY CARE
Jaydeep Sarma	Donal O'Donoghue
Akram Khan	Gill Johnson
Kirtik Patel	Ian Linford
Adam Wolverson	Mary Backhouse
Niall Lynch	Julie McCabe
	Andrew Simpson
	Mark Holland