



Northern England Clinical Senate

Northern England Clinical Senate advice to the Southport and Ormskirk Hospital NHS Trust

Report of Prof Andrew Cant – Chair, Northern England Clinical Senate

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1. Chair's introduction

In September 2017, the Northern England Clinical Senate was approached by the Clinical Leadership Group of Southport and Ormskirk Hospital NHS Trust (with the support of its local clinical commissioning groups) who sought independent clinical advice and support as part of the development of their Care For You programme.

Having listened to their description of the challenges they faced it seemed the Clinical Senate could best provide this support by acting as a "Critical Friend", identifying clinical experts across the range of areas covered by the Care For You programme who could provide advice and challenge to each of the specialty and service level models being developed, so as to help create more detailed, workable options. More importantly, we could then also give a view on the likely ability of these individual models to mutually support each other and present a coherent and clinically sustainable plan for the future of hospital and related community services in Southport and Ormskirk.

This report summarises our initial findings following a series of discussions held with local clinicians and other health professionals both within Southport and Ormskirk Hospital NHS Trust and from some of the other providers and commissioners that they work with.

I would like to sincerely thank the staff that met with us during the first week in December 2017 during our visit. In each case, and without exception, the Senate Team found dedicated hardworking staff that are passionate about providing a high quality service for patients, often in difficult circumstances and despite a long period of organisational uncertainty.

Many elements for a clinically sustainable future for health services across Southport and Formby, South Sefton and Ormskirk already exist within these teams. However, the lack of consistent leadership at executive level and the challenges of maintaining services in an unbalanced configuration across two hospitals which together serve a population barely large enough for one hospital presents considerable challenges. The current arrangements are not sustainable and simply trying to maintain the status quo will not work.

It is incumbent on the incoming leadership of the Trust, the local commissioning organisations, the responsible Sustainability and Transformation Partnerships and the regional offices of the national regulatory bodies to come together to enable these plans to be fully developed in a way that is congruent with proposed changes in Cheshire, Merseyside and West Lancashire.

I hope that the findings, together with recommendations for next step changes, as well as the analysis of potential options for reconfiguration will contribute to the start of a route-map for what could be an exciting future for Southport and Ormskirk through the Care For You programme.



Prof Andrew J. Cant
Chair – Northern England Clinical Senate

Independent Clinical Report

2. Summary of main findings

The Clinical Senate Team met a wide range of clinicians and other health professionals during the week of our visit and heard a frank, candid and honest assessment of the challenges faced by their specialties/services and the organisation as a whole. A summary of these challenges are outlined in section 3.

After consideration of these challenges and in the view of the Clinical Senate Team, the route-map to long-term clinical sustainability should take place in three phases of distinct but mutually supportive work:

- Phase 1 – Implementing changes that can be taken without the need to re-configure services. These changes should begin immediately to improve operational performance and improve clinical sustainability. In many instances Southport and Ormskirk will be able to implement them internally whilst there are other that require more networked solutions (or new/clearer service level agreements established) with neighbouring acute providers. There are also some changes that will require a whole-system place-based approach across primary, community and acute providers with aligned CCG commissioning and social care engagement. These proposed changes are outlined in section 4.
- Phase 2 – Reconfiguring services across the current Southport and Ormskirk sites. Once the recommended changes in Phase 1 have taken place, a second phase of transformation will be needed. Phase 2 includes the service challenges that can only be solved by reconfiguring services across the two current hospital sites. The current configuration is inefficient, unsustainable and potentially dangerous but each potential future option has implications for the level of service Southport and Ormskirk can sustain. These changes can only be introduced within the wider STP(s) context as there will undoubtedly be changes to patient flows that will have a consequence for neighbouring providers. Planning for Phase 2 can run concurrently with the implementation of Phase 1 but a further analysis of activity and population flows and travel and transport implications (with local authority input) is needed before a definitive view on the preferred option can be given. Our initial thoughts however are outlined in section 5.
- Phase 3 – Even if Phase 1 and Phase 2 of these changes are implemented successfully, maintaining a clinically sustainable organisation across the current Southport and Ormskirk sites will be difficult for a population of 230,000 as it is hard to sustain viable services for one district hospital for such a size of population, let alone two. This risk may be mitigated if the local NHS is successful in commissioning and building a new hospital situated between Southport and Ormskirk during this time. Should this not be achievable however the STP(s) should consider establishing “chain” arrangements between the two current sites and other larger providers in Cheshire and

Merseyside and Lancashire. Maintaining the physical capacity in these sites but bringing the workforce into larger networks (offering a wider range of experiences and potential rotation for staff) may give the best chance for long-term clinical sustainability into the future. Further comment on these considerations is given in section 6.

Having outlined a three phase approach to achieving clinical sustainability, it is also important to remember the well-used adage “*culture eats strategy for breakfast*”. The lack of consistent executive leadership in recent years has clearly led to uncertainty within the clinical teams of Southport and Ormskirk and a lack of confidence in the delivery of any new clinical models. Whilst outside of the scope of this work, it will clearly impact on the delivery of the recommendations contained within this report and as such needs to be addressed as a matter of urgency by the Trust Board, STP(s) and national regulators.

A line also needs to be drawn under the past by all organisations across the wider health economy and a new relationship created across commissioners and providers that will support the introduction of the new care models that is centred around patients and not individual organisational needs.

Finally, despite highlighting a series of service and organisational challenges, there is much to be positive about within Southport and Ormskirk Hospital NHS Trust. The Clinical Senate Team were very impressed by the cadre of young clinical leaders within the trust, each with a vision for their own service areas and how to improve care for patients, although it is telling that none are considering apply for the substantive Medical Director post. It is this body of clinicians, leading their teams in the transformation process, that can deliver an exciting new model of care should the Trust leadership give them the confidence to do so. With such clinical leaders in place there is hope for the future and a foundation to build on.

3. Service and organisational challenges

The following observations regarding the specialty / service areas covered by the review are based on the documentation provided to the Senate and the discussions held with the local clinical teams. In some instances further information was requested to ascertain the scale of certain issues or cover gaps that have arisen due to lack of appropriate representation in some of the sessions.

3.1 Emergency Department and Acute Medicine

The Senate Team members met with a clinical team who they found to be working very hard in difficult circumstances. The main issues outlined to the Senate Team were as follows:

- The disjointed flow of patients though Southport Hospital constitutes the biggest challenge facing the ED and Acute Medical Services. The Senate Team heard that the 4 hour wait standard is achieved for only about 60% of patients, with 40-50 medical admissions a day. The AMU has only 22 beds, and the six ambulatory care spaces are almost always converted to bed spaces
- The practice of all patients including GP admissions coming through the ED adds to the strain in the department which clearly does not have the physical capacity to cope with the number of patients. Whilst medical support may come from in-hospital teams, it is not clear that the number of nurses is increased to cope with the excess number of patients. It is essential that some immediate change is instituted to help alleviate the flow issue
- To alleviate this disjointed and inadequate flow of patients, efforts are made to improve the discharge process for acute patients (a significant issue also for the Frail Elderly pathway which impinges greatly on the issue for the ED - see below).
- There is a belief with those working in the ED and Acute Medicine that there are sufficient beds within the Trust to meet the needs of the local populations, but that these beds are not in the correct place
- That whilst the Trust has an impressive approach to the retention and developing of Middle Grade ED staff, this is a diminishing and fragile resource
- The lack of stroke staff is leading to middle grade staff delivering thrombolysis in the ED which is not in keeping with national standards and is taking middle grade staff away from other acute work in ED.

3.2 Frail Elderly

The Senate Team members met with staff from primary community and secondary care who were clearly passionate about the development of a high quality service that worked seamlessly across the sectors and organisation for the benefit of patients. Unfortunately in the clinical discussion there was no representation from GPs from West Lancashire CCG or their main community provider so there are gaps in our assessment related to patients from this area.

- The Trust serves a significantly older population than in most of the country.
- Approximately 20% of the population are over 65 and have higher than average rates of non-elective admission and length of stay in hospital. Over half of the people over age 70 admitted as emergencies have been assessed as frail (as part of the frail elderly action plan in November 2017) which is approximately 15 % of all emergency admissions (based on 2013 – 14 data).
- Whilst there is a Frail Elderly Short stay unit (FESSU) in Southport hospital it is always at capacity and often people needing longer term care are brought here. The unit used to have a space for assessment and therapy as part of the ward but this is no longer available (with patients taken for therapy sessions from the ward to the rehabilitation suite at Southport Hospital).
- There has been a fracturing of provision along the Frail Elderly pathway following the re-procurement of community services (which also had an impact on organisational relationships at executive level that hindered the development and implementation of the pathway).
- There is a lack of step-up and step-down capacity available to GPs trying to avoid admitting Frail Elderly patients to hospital, or ensure prompt discharge.
- Significant parts of the current pathway are reliant on individuals who are working over and above their job plans on good-will to provide the current service whilst trying to develop the future models of care. The number of geriatricians would appear to be very low considering the demography of the local population.
- The efforts so far to improve care for the frail elderly have been impaired by the lack of financial commitment to the plans and trials (for example a long term plan is required for the discharge to assess beds that are currently only funded until March 2018). There has not been a coordinated approach to commissioning and this has led to significant variation in the services available to the whole population. The panel heard anecdotally that variation in services directly impacts the length of stay in hospital for people from West Lancashire CCG but data was not available to quantify this during the visit.
- That whilst the current Palliative Care service is working really well, the lone consultant largely responsible for it is approaching retirement and there is currently no succession plan in place.

3.3 Emergency Surgery

The Senate Team Emergency Surgery members only met one Consultant Surgeon but were able to spend more time with a Consultant Anaesthetist. There was evidence of some good and committed practice. However, there is a pressing need to change practice to bring it rapidly up-to-date to meet modern ways of working.

Whilst the Terms of Reference asked the Clinical Senate to consider emergency surgery and the deteriorating patient, elective surgery was also considered as it became clear that the issues between the two (and into the in-scope acute medical service) are interdependent.

- There appears to be significant variation in surgical practice with some working models supported by single consultant, and variation in practice across the team (both internally and with the wider Trust)
- The current pathway for acute surgical admissions is ineffective and the lack of “hot clinics” appears to result in needless admissions and whilst there are plans to address this, the definite implementation date was unclear
- Out-dated practice (e.g. admitting the day before a surgical procedure or in-patient investigation that could be done as an out-patient, and the under-provision of day case surgery) is significantly impacting on bed availability and patient flow.
- Approximately one third of surgical beds are boarded by medical patients, and surgical wards are used for bed escalation when there are surges in admissions. There appears to be reluctance by the surgical teams to utilise the theatre capacity on the Ormskirk site for elective surgery, particularly for increased day case activity.
- The lack of a GI Bleed service/rota and lack of 24/7 availability of specialist interventional endoscopic skills combined with no access to Interventional Radiology is of concern.
- The current anaesthetic on-call arrangements (two consultants on call with the first on call covering both sites supported by one middle grade resident on each site) are operating effectively presently but are vulnerable in the medium term

3.4 Women and Children's

3.4.1 Paediatric services

The Senate Team found a paediatric unit that was well organized and welcoming, with staff that are rightly proud of the service they deliver. The consultants who contributed to the session were engaged, motivated and keen to deliver as high a quality service as possible, and appeared to be largely succeeding in doing so. Whilst the unit did not seem very busy with inpatients during the visit (despite it being winter) the activity figures shared with the Senate Team in relation to child attendances at ED (circa 27,000 a year) indicate sufficient patient numbers to justify the service and the 15% attendance-to-admission conversion rate close to what would normally be expected.

The challenges facing the paediatric service were found to be:

- Staffing levels are insufficient to meet the Royal College of Paediatrics and Child Health standard for acute paediatric care that require a consultant presence in the hospital at "busy" times (evenings & weekends) and the 7 day services standard (relating to consultant review within 14 hours for all admitted patients). We understand that there often is consultant on-site presence during busiest working times, but that the commitment to be so is not reflected in their job plans. A further two consultants (at least) would need to be recruited to bring the total up to 10 to make this possible while maintaining the other services of the hospital.
- There is a dwindling pool of non-training grade doctors which makes replacement challenging when this grade of doctor moves on or retires
- There is no on-site surgical opinion available with all children & young people requiring surgical input transferring to Alder Hey
- There is inequity in the commissioning of the children's community nursing service for patients using the Southport and Ormskirk Hospital NHS Trust paediatric service leading to different levels of care for patients using the same unit based on their registered GP. The children's community nursing service is only commissioned by two of three main CCGs – children living in areas covered by the other CCG cannot be discharged early for outpatient parenteral antibiotics or receive community nursing support (which are particularly important for neuro-disabled children). The children's epilepsy specialist nursing service is also commissioned by two of three CCGs – children living in areas covered by the other CCG do not receive specialist epilepsy nurse input (e.g. school / nursery liaison & training)

3.4.2 Maternity and Neonatal services

The Senate Team again found a well organised and committed team offering high-quality care in a warm environment. The challenges included:

- The unit sees a very small number of births annually. Although the large drop in recent birth numbers was explained by an artificially high number the previous year due to changes in maternity provision in neighbouring providers, the total number of births (2,273 according to NHS Digital Maternity Statistics 2016-17) is still considered relatively low.
- During the Senate session in Ormskirk, the transfer rate of women to ITU was given as 4 a year. Whilst this may be slightly higher than expected for a unit of this size, this was explained by an appropriately low risk threshold when considering transfer options. The service does not currently have on-site access to Emergency Surgery,
- ITU or a 24 hour blood bank (which is considered a high risk as recently identified in the recent review of the Liverpool Women's Hospital). An adequate "make do" work-around has been established where high risk patients such as those with identified placenta accrete are transferred to other units. For major postpartum haemorrhage some blood is kept on site and the lab technician will then come across to the Ormskirk side to deal with blood request. However this is not a long term solution.
- The service faces some staffing issues i.e. there is currently locum cover for consultant paediatric sessions and cover is needed for the junior rota (with the current short term solution being the use of locum consultant covering the registrar shifts at night not sustainable). The temporary arrangements that have been put in place are perfectly reasonable in the circumstances (and are typical of those put in place by many others in similar situations), but they are not sustainable (in even the medium term) and mean that the unit remains vulnerable to recurrent and / or staffing crises as a result of either further staff attrition and / or sudden absences due to sickness.
- The lack of A&E and resident surgeon on the same site is a problem
- The small number of admission of babies <34 weeks makes the maintenance of skills difficult

3.5 Organisational challenges

As well as these specialty / service area level challenges, each clinical team outlined critical over-arching issues that are contributing to significant difficulties within their areas. These relate to a lack of consistent leadership at executive level within the Trust. Clinical teams believe this has three main consequences:

1. Known issues that compromise services are left unchallenged and allowed to continue whilst ideas for improvement coming from the clinical teams are not taken up
2. That vital relationships and influence with other providers and commissioning bodies has been lost leading to a fracturing of the local health system which ultimately end up as operational issues for the Trust (e.g. inability to meet the 4 Hour A&E standard or discharge patients effectively)
3. That the Trust is left on the fringes of STP discussions in both Cheshire and Merseyside and North Lancashire which, given the geographical positioning of the two sites on the edges of these areas, is even more important so as not to become an afterthought or not appropriately considered as a viable option in wider transformation proposals

Furthermore, the local CCGs are not aligning commissioning plans with each other nor understanding the impact of one decision on the overall effectiveness of the wider health economy. In addition that short-term financial planning by both commissioners and the Trust is exacerbating the current operational difficulties and driving inefficiency and waste into clinical process

In the light of these service/specialty and organisation challenges and the ideas put forward by the local clinical teams, the Clinical Senate Team puts forward the following three phase approach.

4. Phase 1 – Implementing changes not requiring re-configuration

There are three main priorities for improvement in Phase 1 – each inter-linked with the other and of equal importance:

- Improving flow for acute medical patients through Southport Hospital supported by a coherent Urgent Care strategy agreed and owned by commissioners and providers across Southport and Formby, South Sefton and West Lancashire.
- Improving emergency surgery facilities in Southport counter-balanced by modernising practice and increased usage of Ormskirk for day case surgery.
- Developing an over-arching plan for the implementation of the Frail Elderly Pathway also agreed and owned by commissioners and providers across Southport and Formby, South Sefton and West Lancashire.

4.1 Improving flow

The Senate Team believe that a significant improvement can be achieved through the implementation of a number of incremental steps resulting in the accumulation of marginal gains.

- Increasing the number of assessment beds in the Emergency Department. At approximately 20, there are too few assessment beds for the number of daily admissions. Significantly increasing the number of assessment beds to as close to sixty as possible (the current guidance is to have at least the same number of assessment beds as daily admissions plus 10%) would enable the unit to turn many more patients around in a 48 hour period. Whilst there is already a multidisciplinary therapy team present, more nursing staff would probably need to be found (as well as the physical space to accommodate these beds. This increased capacity would alleviate pressure on the ED and would have the benefit of better 4 Hour performance and should be an operational priority for the Trust.
- Resolving issues between senior medical staff predominately delivering elective care and those whose work is mainly emergency focused. These issues need to be addressed as a matter of urgency to develop a cohesive plan for the future of the trust. The (unofficial) holding of beds for elective surgical patients to reduce waiting lists and secure tariff related payments together with admitting elective patients as in-patients who elsewhere would be treated as day cases is impacting on flow through the Southport hospital, affecting A&E performance and patient experience (see section 4.2 for further information).

- The Urgent Care / Walk-in Centres/ Out-of-Hours services and the Emergency Departments in the area appear to work in an individualistic manner rather than collaboratively (the sizeable number of patients staying less than 1 day would suggest that there is scope for improvement in the out-of-hospital element of the urgent care system). Collaboration is difficult with multiple providers and commissioning organisations but constructive clinical and organisational leadership is required to make the Urgent Care system work effectively.
- The opening hours of the Urgent Care and Walk In services should also be reviewed with 10pm (or even midnight) being preferable to the current 7:30pm closing times.
- A decision will need to be made on the ongoing provision of hyperacute stroke services. If it is to continue at the Southport site then a separate area (either totally separate or clearly delineated within the ED) needs to be created where suspected patients can be seen by stroke specialist (either consultant or nurse) and thrombolysed when appropriate. However, if this cannot be achieved or if the number of confirmed strokes (not including mimics) presenting falls/stays below 600 cases annually, then arrangements should be made for a neighbouring hyper-acute stroke unit to take on these patients.

4.2 Transforming surgical services

Based on the documentation provided, what was seen during the tour of the unit and the discussions with the clinical staff, the Senate Team believe that the transformation of this service can be achieved through a number of relatively straight-forward steps if supported by committed senior leadership. These steps are:

- To introduce a proper Surgical Assessment Unit as a matter of priority. This would be a major step forward if the Trust can reconfigure the current estate to allow its formation and is a must to improve patient flow. It must be allied to a fully developed “Hot Clinic” and have access to cross-sectional and ultrasound imaging on a daily basis to facilitate the management of the acute patients. The Hot Clinic needs to be led by a senior decision-maker to ensure unnecessary admissions are avoided. The development of a Surgical Admissions Unit at Southport, allied to the Surgical Assessment Unit would also be beneficial.
- To agree a SLA with a neighbouring institution to allow the creation of a “bleeding rota” with a clear management plan for patients presenting with a GI bleed. Currently there is not a formal 24 hour interventional endoscopy service and whilst there are some interventional services on site in Southport, there is not a formal out-of-hours service in place.

Due to the clear critical clinical interdependencies with emergency surgery there must be clear and unambiguous patient pathways to deliver these services through a network solution.

- To cease admitting many planned surgical cases the day before to prevent cancellation because medical boarders occupying beds (e.g. bowel resection and colonoscopy patients being admitted for bowel prep when they could have this at home). This very inefficient practice that has virtually disappeared in many institutions could be easily corrected by clinical leaders committing to change this practice.
- Ormskirk District Hospital is well supplied with theatres but there seems to be reluctance among the General Surgeons perform a significant number of procedures there. There appears no good reason for this and effective usage of this facility would enable better patient flows at Southport. Nurse pre-assessment could be used to identify patients below or approaching ASA Level 3 who could be treated at the Ormskirk site.
- Day-case rates are lower than they should be (e.g. for laparoscopic cholecystectomies and hernias), where a mind-set of *“a day case until proven otherwise”* needs to be adopted (as opposed to the current thinking of *“an inpatient procedure until proven otherwise”*). Again, this will free up beds and improve flow for acute and elective patients.
- Some thought should be given to the timing of the post-take ward round and NCEPOD review. If the volume of admissions is large enough it may be that the morning could be used to see all of the previous day’s admissions and arrange any investigations with the afternoon used for a surgical list. This would enable greater senior input into the acute surgical patient pathway in terms of review, decision making and subsequent surgery. If the number of admissions is low however, the whole process could potentially be fitted into a morning session.
- Arrangements need to be made for there to be a daily review of medical patients boarding on surgical wards, as when we visited one third of surgical beds were occupied by medical “sleep outs”. This could be done by using a peripatetic consultant, or nurse with access to a senior decision-maker. This currently only takes place once or twice a week and there are no discharges at the weekend. This would free up capacity and improve efficiency.
- The proportion of surgeons specialising in colorectal surgery compared with those in upper GI surgery is unbalanced. Workforce planning needs to take place to enable a transition towards a more balanced surgical team across both upper and lower GI surgery when opportunities for recruitment allow.
- With regard to the management of the Deteriorating or Critically Ill Surgical Patient there is good Level 2 and 3 ICU provision but no Level 1 facility. Given the significant co-morbidities in the local population, due to the high proportion of older patients, Southport and Ormskirk would benefit from a PCU (Progressive Care Unit) or Step-down Unit to manage the complex major post-

operative patients which currently go back to the regular ward (unless they have epidurals where these have to go to ICU). There is also a clear and well-founded plan to invest in the Vitalpac Careflow electronic solution to identify the deteriorating patient but it is unclear as to when these will be extant – this should be prioritised and implemented as part of the transformation of this service (whilst it is an IT solution, it resolves a clinical risk so should not be lost in a wider informatics strategy).

4.3 Coordinating the approach to managing the Frail Elderly

From the discussions held with local clinicians and staff from Southport and Ormskirk Hospital NHS Trust and some of its community provider and primary care partners, it is clear that a significant amount of effort is going into the provision and development of services for the frail elderly.

The Senate Team felt that the draft Frail Elderly Pathway that has been developed is fundamentally sound and coherent although additional consideration should be given to which services within the Single Point of Access would benefit from co-location. Further clarifications on the point where appropriate signposting or referral on to formal and informal community services could be coordinated, could be included.

The issue in regards to the approach for the development of services for the Frail Elderly is therefore not the proposed model of care but instead the piecemeal approach to its acceptance and adoption, with only some parts being implemented and some of those not given adequate time to bed-in, has prevented its implementation.

When taking into account the CCGs initiatives in primary care (in the context of the transitional work undertaken by both the new community providers), too many small schemes have been introduced without an overall clear plan to deliver a system wide service.

Short-term evaluations of individual parts of this programme implemented using non-recurring resource will not work for the Frail Elderly as results will always fall outside of the evaluation period and benefits in terms of reduced levels (or mitigated increases) of demand or lengths of stay will only be evident over the medium- to long-term. Given the elderly demographic of the local population using this service (compared to other parts of the country) and the likelihood that this will not change for the foreseeable future, a more co-ordinated long-term approach to investment and development is the only sensible way forward.

Whilst some recent progress has been made in this regards (particularly between certain individuals at an operational level) it is vitally important that an agreed strategic approach to investment and development is agreed by the leadership of the Trust,

the CCGs and the two community providers, developing the relationships at an executive level that will enable operational clinical staff and other health professionals to work together effectively. This new relationship does not necessarily need a physical structure but will need clear governance. In the past governance has often narrowly focused on compliance, when in this case it should incorporate a focus on behaviours and accountability to the whole system beyond the individual organisation and professional groupings.

In order for this to happen, there is an urgent need for this vision of the future model of care to be owned by all the commissioners, providers and local authorities involved and for there to be a commitment to its implementation. This will require a leap of faith to be taken by all senior leaders (and an understanding of the importance of this by regulators) in committing to the long-term view to be taken on investment decisions that will support this agreed model of care.

Whilst this vision is being developed, there are a series of actions that Southport and Ormskirk NHS Hospital Trust can undertake in its own right to build a more resilient service that can better meet the demands of the local population. The trust should then look to influence its commissioners and work constructively with community providers and social care to ensure the wider frailty pathway works as seamlessly as possible.

4.3.1 Actions within Southport and Ormskirk Hospital NHS Trust

During the senate visit, the Frail Elderly Team in Southport and Ormskirk shared an outline of their view of how they would begin to implement the integrated Frail Elderly Pathway¹.

On review the Senate Team feel that the planned work force numbers in the proposal may be insufficient to provide an effective, resilient and sustainable service and seem to be based on what the Frail Team think they may realistically be able to secure in terms of funding (as opposed what actually may be needed to deliver a clinically sustainable service that meets the needs of the local population).

The Senate would recommend that more detailed modelling against known and expected numbers of patients in different areas of the service would be helpful to effectively plan the workforce needs.

This modelling work should inform the adequate provision of step up/ down beds; palliative inpatient beds and outreach medical and nursing input; out-reach to specialist wards and orthopaedics for the frailty team to improve care of those not

¹ "Draft Frailty phased approach: Practical Implementation" – Dr Fraser Gordon, Southport and Ormskirk Hospitals NHS Trust

currently accommodated in the frailty service; effective primary care identification and assessment of frail elderly; social work and formal caring services.

Whilst it might seem good to start developing the Frail Elderly Pathway by setting up the Frailty Hub, it is much more important to establish effective ways of working in the MDT through a rapid access frailty clinic (i.e. “walk before you can run”). As part of a co-ordinated implementation plan under an over-arching vision for the management of the Frail Elderly, Southport and Ormskirk Hospital NHS Trust should look to implement the following measures.

- Ensure 7 day access to a pharmacist on the FESSU for poly pharmacy assessment and transcription of discharge medications. It would be helpful if this role was flexible to also help patients identified as frail elderly on other wards and it could be a combination of technician and pharmacist roles.
- Start discharge planning from the time of admission with a recommendation to include a social worker on the initial frailty assessment team
- To train and integrate a Frailty practitioner team to take part into the initial frailty assessment service with flexibility to arrange follow up on other specialty wards without requiring additional referral from the ward
- Consider a flying squad from the Single Point of Access (SPA) for rapid assessment
- Complete the work in the trust on electronic discharges emailed direct to practices or sent out via Integrated Clinical Environment (ICE)
- Consider setting up referral / advice and guidance processes before the Hub has been established. The electronic referral system ERS would be a good tool to use for this.
- Consider setting up a ‘delirium’ and / or frailty investigations tab on ICE.

4.3.2 Actions in collaboration with CCGs

Whilst the in-hospital elements of the Frailty Pathway are being implemented, Southport and Ormskirk NHS Hospital Trust should work in conjunction with its community providers and primary care to support the systematic implementation of the pathway can begin to achieve the four main elements of the Frail Elderly integrated pathway:

- Supporting people to remain healthy and independent;
- Appropriate assessment for and provision of care in the community;
- Preventing unnecessary admissions; and
- Effective treatment and avoidance of long hospital stays

The key features of the out-of-hospital pathway that support the in-hospital service within Southport and Ormskirk are outlined in table 1.

Key features of out-of-hospital services within the Frailty Pathway	
Supporting people to remain healthy and independent	<ul style="list-style-type: none"> • Identifying lifestyle and social needs for individuals and signposting / supporting people to access services in the community. • Access to healthy lifestyle including diet and exercise and harm reduction around stopping smoking and alcohol. • Social support - housing, accessibility to community services, tackling loneliness
Appropriate assessment for and provision of care in the community	<ul style="list-style-type: none"> • Proactive identification of health needs and risks to health. Early access to therapy services to address falls risks and mobility. • Identification and active assessment of and intervention for polypharmacy. • Appropriate assessment of and management of long term conditions. • Effective and appropriate use of Emergency health care plans. • Early discussions about preferred place of palliative/ end of life care
Preventing unnecessary admissions	<ul style="list-style-type: none"> • Rapid assessment and access to short medium term increased social care packages and 'intermediate level care in the home for: acute infection – including parenteral antibiotics; management of heart failure and COPD – including access to oxygen. • Access to 'Step up' beds • Access to appropriate palliative/ end of life care in the most appropriate setting / preferred place of care
Effective treatment and avoidance of long hospital stays	<ul style="list-style-type: none"> • Holistic needs assessment from the care of the elderly team including pharmacist, appropriate therapist and discharge planning from time of admission. • Access to timely diagnostics, therapy services. • Effective care and support to reduce impact of delirium • Access to appropriate palliative care in the most appropriate setting / preferred place of care

During the discussion with primary care clinicians, the Senate Team heard that in the last three months work has begun to align care homes with GP practices.

There is information available from other areas that were involved in the 5 Year Forward View Vanguards for Enhancing Health in Care Homes that may be useful to support this process (e.g. the Newcastle-Gateshead care home project²). This information may help inform how this can be done most effectively and the additional service that could be offered. In the Southport and Ormskirk integrated pathway these additional services may be coordinated by the community support hub.

2

<https://static1.squarespace.com/static/5893239037c581b39142e013/t/5955239637c581b92a71485f/1498751895481/OUR+MODEL+DOC-updated-June+%281%29.pdf>

5. Phase 2 – Determining future configuration

Even if the incremental changes outlined in Phase 1 are undertaken, further reconfiguration of services across sites will be required. As has been found in previous reviews in the Southport and Ormskirk area, a new build hospital site with good road access to both Southport and Ormskirk purpose built to support a population of 230,000 would be the ideal solution for the Trust (a view held by all concerned as shown by the Deloitte Options Appraisal carried out in November 2015). However, in the current financial climate access to the capital funding required to finance such build seems far from certain and the lead in time for this option would still mean that an interim service reconfiguration across the two current sites and with better working with neighbouring acute providers is still be required.

The main driver behind this further reconfiguration is the need to co-locate the separate Paediatric Emergency Department and maternity services currently on the Ormskirk site with the adult Emergency Department, Emergency Surgery and Intensive Care Services (currently on the Southport site) as a matter of priority.

Trying to staff two EDs with the total number of ED consultants available will be both extremely difficult to operate in the present and will be harder to sustain over the longer term. Whilst there is an attraction in having a Paediatric ED, maintaining it on a separate site to the adult ED is not sustainable and relocating all emergency care on to the single site would seem to be the most appropriate way forward for the Trust.

Co-location of paediatrics with the adult emergency department might help in terms of recruitment and retention, with the possibility of interest from candidates interested in paediatric emergency medicine (from a paediatric or an emergency medicine background).

Co-location of paediatric services with general surgery on a single “hot” site could allow a reduction in the transfer of patients (typically with abdominal pain) to paediatric surgery at Alder Hey. Co-location of paediatric services with adult ED would allow more robust services for the small number of children who require more complicated trauma input (without needing transfer to the Major Trauma Centre).

Further analysis of the attendances at the Paediatric Emergency Department is required to understand what proportion of these attendances do not need to convert to an admission and so could probably have been seen in an Urgent Care setting. Any co-location of the two EDs (Adult and Paediatric) would require estate remodelling to ensure a physically “separate” environment for attending children.

It is the view of the Clinical Senate that the most sustainable of these options would be to introduce the hot site / cold site model as soon as is practically possible. This model is currently being tested at four sites across England and the early evaluations are showing improved efficiency and reduced bed usage.

Clearly there are pro's and con's with both of the potential options for this two site approach with no simple answer to resolution – the 2015 Deloitte options appraisal showed differing views between Trust and CCGs on the preferred option of each. What is clearer now than in 2015 however is that the “do nothing” option (that prevailed through the scoring system established by the process) cannot be preferable to either option now given the fragile nature of the services.

The challenge of introducing a hot site / cold site model across Southport and Ormskirk is that one site has the better building and estate capacity with a population requiring access to maternity and paediatric services (Ormskirk District General Hospital) whilst the other has greater demand for acute services driven by the aged population but in a building which is more cramped and in need of investment (Southport). However, given the current vulnerable state of the services, the declining current operational performance, and the serious financial position, there must be a serious risk of the Trust entering a downward spiral from which it cannot recover; thus a decision does need to be made.

5.1 The case for Ormskirk as the “Hot” site in a reconfigured service

The Ormskirk District Hospital would appear to be a good location for the Hot site in the future configuration until a new build hospital can be realised. Ormskirk has the better estate, significant space to grow, extensive unused theatre and bed capacity and would be cheaper in terms of transitional capital to implement this hot site model.

This additional capacity would improve patient flow and delivery of the NHS Constitutional Standards of a 4 Hour maximum wait in A&E (in higher quality and more affordable estate). To enable this to happen, there would need to be significant development of the current Southport site in particular in regards to the development of an Urgent Care Centre and Step-Down facilities for Frail Elderly patients being discharged from the acute medical unit which would now be in Ormskirk.

This model would also need to be supported by better identification of the frail elderly population within Southport by primary care with access to sufficient Step-Up capacity to avoid a patient's condition deteriorating to the point where acute medical admission is required (which could put an unmanageable strain on ambulance services).

Fuller engagement of North West Ambulance Services is needed to fully model and cost the transport and transfer arrangements needed to make this new service work.

By utilising Ormskirk as the “Hot” site, there would be better use of ED clinical resource as ED consultants based at Southport will no longer need to travel one day a week to Ormskirk to support the Paediatric ED as is the case in the current model. It would also mean the maternity service would be better supported by having enhanced on-site adjacencies at the site closest to the population more likely to utilise the service.

For paediatric services, Ormskirk, due to its central and inland location, offers easier access across a wider area and fewer children and young people and their families would have to travel. It would allow the service to continue to be offered from new, purpose built paediatric facilities whilst continuing to be co-located with obstetric services. In this configuration, there would need to be a paediatric triage site in Southport with children and young people requiring admission needing to travel to Ormskirk.

In terms of the provision of maternity services in this configuration, the relatively low number of births however would mean that the medium- to long-term sustainability of unit would still need to be considered through the Cheshire and Merseyside Women and Children’s Partnership review.

The risk associated with this option is that patients who currently self-present to the Southport ED would choose to attend neighbouring providers to the south of Southport rather than travel to Ormskirk (if alternative urgent care provision was not implemented as part of the changes). It is unclear if these providers would have the capacity to cope with this additional demand. Further analysis and modelling will be necessary to understand this.

5.2 The case for Southport as the “Hot” site in a reconfigured service

Whilst the Ormskirk site would appear be the more attractive option as the future “Hot” site, there is also a case to be made for Southport Hospital to be the hot site, given the concentration of the Frail Elderly population around the site (and with future population projections showing that this is unlikely to change in the next decade).

This option would present a real opportunity for the development and exploitation of Ormskirk as a “Cold” site where the quality of estate and readily available theatre and bed capacity mean that a centre of excellence for low acuity elective work, not only for the current population but also to providers in surrounding areas facing

waiting time and bed capacity challenges. There may also be potential to repatriate elective work currently being commissioned by independent sector providers by neighbouring CCGs.

However, relocation of maternity and paediatric services to the Southport site could bring a significant risk that perhaps a third of expectant mothers would choose to deliver in Wigan, Whiston or Liverpool. The number of births would then fall below the level required to ensure clinical sustainability and so maternity and neonatal services would need to be relocated. The consequences of such a change on surrounding hospitals would need to be carefully modelled to determine how many deliveries would no longer take place locally in this scenario.

In the same way the transfer of inpatient paediatric services to the Southport site might lead to more children attending other hospitals (e.g. how many paediatric A&E attendances would return to Alder Hey Children's Hospital), further work to understand if the effects of such a change in patient flow needs to be modelled and reviewed in the light of plans for paediatric inpatient provision in West Lancashire (currently one or two units out of Ormskirk, Whiston and Warrington as described in the Cheshire and Merseyside Women and Children's Partnership: Options development for future service configuration).

In light of this, and in an attempt to better meet the Facing the Future standards, the Trust could consider the implementation of the Short Stay Paediatric Unit (SSPAU) model at the Southport site which could be run in partnership with a bigger neighbouring provider with a full inpatient paediatric service (e.g. Alder Hey) to ensure consultant posts remain attractive to staff.

Having said this, the geography and travel links might not lend themselves so easily to this model as SSPAUs to work best in urban areas where the population density is reasonably high e.g. Salford's relationship with Manchester, Birmingham City Hospital's current relationship with Sandwell and Newcastle's relationship with Gateshead – all located within the same conurbation with distances of only 5-6 miles and travel times under 15 minutes. Given these factors and the current activity levels at the provider, careful evaluation would be needed before deciding not to maintain a full inpatient paediatric service within Southport and Ormskirk Hospital NHS Trust.

5.3 Current view on preferred “Hot” site

Should the full range of services currently provided at Southport and Ormskirk Hospital NHS Trust be retained by the provider (in particular Obstetrics and Paediatrics), then on balance we think Ormskirk as a “Hot” site is the marginally better option. This is due to:

- a) the need to collocate adult and paediatric A&E services and emergency surgery, critical care and the blood bank with consultant-led obstetric services; and
- b) the population using Women’s and Children’s services originating substantially from around the Ormskirk site.

Were the full range of services provided out of a hot site at Southport, the demand for maternity services would almost certainly drop to unsustainable levels and the demand for paediatric services would also be severely undermined.

In the Ormskirk “hot site” model, great care would need to be taken with the frail-elderly pathway and great consideration given to the transport arrangements for patients moving between the sites given the congestion on the roads for non-blue-light vehicles.

However, should additional capacity be available for maternity and paediatric inpatient services in neighbouring providers allowing services to be reconfigured on a footprint wider than Southport and Ormskirk Hospital NHS Trust, then this fundamentally changes the view on the location “hot site”, and Southport would be preferable because of the closer proximity to the Frail Elderly population in Southport and the significant potential to develop a “cold site” centre of excellence (ideally on a much wider footprint and potentially in partnership with other providers) at Ormskirk Hospital.

Ultimately the poor quality of the estate would mean that further redevelopment of the Southport site would be needed in the medium term regardless of the services provided from it.

6. Phase 3 - Long term sustainability

Whilst a move to a “Hot” site / “Cold” site model would take Southport and Ormskirk Hospital another step nearer to clinical sustainability, it will always be difficult for Trusts serving small populations to achieve ever-increasing clinical standards whilst competing for scarce workforce in specialist areas. They cannot offer the range of experience or attractiveness of working arrangements (such as frequency of on-call) that larger units can, which will put them more and more at risk of workforce pressures. This will need to be addressed to ensure that the appropriate level of service is still provided in Southport and Ormskirk.

One approach would be to look towards more formalised network arrangements with other local providers through the creation of hospital chains involving the Trust (or its component sites) and larger providers in Cheshire and Merseyside and Lancashire. By maintaining the physical capacity in these sites but bringing the workforce into larger networks (offering a wider range of experiences and potential rotation) may give the best chance for long-term clinical sustainability into the future.

The geographical positioning of the two sites and the divergent population flows into Cheshire & Merseyside and Lancashire mean that natural clinical networks rather than organisational form may be the long-term solution for this Trust.

Under a networked arrangement, the most sustainable model for the Southport and Ormskirk Hospital NHS Trust could be to have A&E, Urgent Care, Frail Elderly Care, Short Stay Paediatric Assessment and Mental Health Crisis service on the Southport site, with inpatient acute medical and acute surgical care also there, whilst other larger neighbouring providers take on provision of obstetrics, inpatient paediatrics and certain aspects of urgent care for conditions such as Stroke, GI bleeding and Acute Cardiac Ischaemia. This would allow Ormskirk to be developed as a dedicated elective surgical centre with no risk of bed closures due to emergency medical pressures and efficient patient centred pathways of care that could then offer a much enhanced patient experience and be more cost effective.

7. Creating the environment for transformation

As outlined earlier, the lack of consistent leadership which has led to the “turmoil of planning” we heard described during our clinical session both demotivates staff and undermines efforts to bring Southport and Ormskirk “back onto its feet”. Nevertheless, difficult but vital decisions need to be made.

In order for this to happen there needs to be consistent and clear leadership from the Trust Executive who will give support to the cadre of excellent clinical leaders that exists at associate medical director and clinical specialty team level.

The Executive should work through the local STP to ensure both alignment with plans for the larger area and also engagement of the local clinical commissioning groups needed to support the transformation of Southport and Ormskirk Hospital NHS Trust, particularly in regards to their responsibility to lead public consultation on service change.

Again, working through the local STP leadership ensure that the correct regulatory environment is formed by NHS Improvement and NHS England to allow time for the clinical strategy to embed and the long-term investment decisions linking to its implementation take precedence over short-term financial decision-making.

8. Next steps

This report gives the view of the Northern England Clinical Senate Team based on the initial assessment of the challenges (and opportunities) facing Southport and Ormskirk NHS Foundation Trust. It is for the Trust to ultimately determine how it responds to this advice but it is hoped that it presents a pragmatic and rational set of actions that can begin immediately whilst setting the direction for the next phase of work that is necessary.

At the point of writing this report, a more definitive view cannot be given on either the location of the “hot site” in the “hot site / cold site” model or the potential for the “cold-site / cold-site” model as the appropriate level of activity and transport modelling was not available and service provision / configuration outside of Southport and Ormskirk Hospital NHS Trust is outside of the Terms of Reference for this piece of work.

Involving the relevant STPs and having a full analysis of activity, patient flows and transport and travel implications of potential future configuration options will be necessary – firstly to ensure the time and effort associated with reconfiguration is worthwhile (and sustaining) and secondly to ensure that neighbouring providers are not adversely affected by any unintended consequences in changes to the location of services.

The Clinical Senate will continue to make itself available to provide independent clinical advice to the Trust and STP(s) as the plans for Southport and Ormskirk Hospital Trust are developed further.

Independant Clinical Report

Appendix 1 - Terms of Reference

The Northern England Clinical Senate has been asked for support to co-design clinically sustainable options for the Trust and the wider community, in addition to its advisory role in providing strategic independent advice and guidance to commissioners and other stakeholders. As a result of this support it is envisaged a further Clinical Senate will be required to undertake the review and assurance stages of the formal review process to maintain the independence and integrity of subsequent reporting to regulators.

The Sefton Transformation Programme wishes to bring together Trust, local clinicians and Clinical Senate to co-design clinically sustainable options for the future in order to:

1. Understand, develop, establish and assess the overall service needs for the population.
2. Identify and confirm the services provided locally that are facing challenges to their sustainability.
3. Undertake a service level assessment of existing services, categorising them into;
 - a) Services delivered locally by the local providers.
 - b) Services delivered locally by local providers in partnership with other off patch providers.
 - c) Services provided at a distance, accessed by the local population.
4. Consider previous work undertaken when identifying options for in-hospital service provision e.g. The Deloitte Review etc. and use this as a platform upon which to propose options, based on “place based” need.
5. Conduct an options appraisal process for the future delivery of services to be provided for the population, based upon;
 - a) Services delivered locally by the local providers.
 - b) Services delivered locally by local providers in partnership with other off patch providers.
 - c) Services provided at a distance, accessed by the local population
6. Make recommendations to the Trust and commissioners on clinical sustainability options.

Aims, objectives and scope of the Clinical Senate Co-design (co-design, advice, guidance and support)

The aim of the independent clinical co-design, advice and support is to co-design with local clinicians sustainable clinical options, and provide advice on these to the Sefton Transformation Programme. In doing this it is assumed:

- These services are identified within the Scope section of these Terms of Reference below;
- The co-design, advice and support will take account of the demographic, geographical and population context. It will provide an assessment of the ability of the co-developed options to deliver good clinical outcomes and positive experiences for service users;
- Due consideration is made of 'left shift' out of hospital solutions within these options
- Consideration is made of the full range of possibilities within the system, i.e. options are not limited to existing organisational structures or locations but stem from the core purpose of delivering the best sustainable health and care services for the population of Sefton.

The objectives of the independent clinical co-design team are to:

- Support the development of sustainable clinical pathway options for the future.
- Assess the strength of the clinical case for change, identifying where the co-developed models are credible and robust, highlighting any areas of concern and making suggestions for improvement.
- Identify, consider and recommend opportunities for specialties/services, using suggested best practice.
- Provide clinical advice on the emerging clinical models by assessing the supporting evidence and adherence to national guidelines. In addition, an assessment of the ability of the models to achieve patient choice and seven day working will be undertaken.
- Ensure alignment with the 5YFV and commissioning priorities.
- Consider the potential impact of service change proposals on interdependent services, e.g. implications for provision of other specialties or for specialised services

Scope of the co-design

The Clinical Senate will look at the clinical evidence base and co-design with other local clinicians a range of options to support the Acute Services and Care Pathway re-design work streams, offering advice, guidance and support in regards to the safety, quality and sustainability of future models of care.

The scope of this work will include the following services/specialties:

- Establishing an integrated approach to caring for our frail elderly population, ensuring that a robust integrated pathway is in place across the whole health and care system
- Establishing a model for A&E & Urgent Care, including patient flow, linked to the 5YFV Acute Hospital Review
- Providing clarity on the safety of emergency surgery and emergency care and care for the deteriorating patient at Southport & Ormskirk
- Co-production of options for the future of Women's and Children's Services across Sefton
- Co-design of plans for collaboration with other local providers in the following specialties - Cardiology, Stroke and Respiratory

For these services the clinical senate will focus on the co-design of:

- all hospital based services
- options for sites at which in-hospital services will be located and their co-dependencies, considering network opportunities, new hospital build and co-production of services
- options for providing services in the community that are currently provided in-hospital

The following areas are out of scope:

- Assessing the financial viability and sustainability of individual service lines;
- Back-office administrative and non-clinical support services
- Managerial models of delivery of clinical support services across different trusts (although the requirements for access to these services in an appropriate timescale is within scope)
- Clinical services already provided (or where there are already plans for them to be provided) by a regional or sub-regional network (e.g. major trauma, vascular surgery, hyper-acute stroke service)

Appendix 2 - Panel Membership

Core Team

- Prof Andrew Cant - Consultant in Paediatric Immunology and Infectious Diseases and Director of the Children's Bone Marrow Transplant Unit, The Newcastle upon Tyne Hospitals NHS Foundation Trust. Northern England Clinical Senate Council Chair
- Dr Robin Mitchell - Clinical Director for the Northern England Clinical Networks. Northern England Clinical Senate Member. Formerly Consultant in Anaesthetics and Intensive Care at County Durham and Darlington NHSFT

Emergency Department and Acute Medicine

- Mr Andy Simpson - Consultant in Emergency Medicine, North Tees and Hartlepool NHS Foundation Trust. Northern England Clinical Senate Council Member
- Dr Peter Weaving – GP in Carlisle and Emergency Department clinician for the North Cumbria University Hospitals NHS Trust. Northern England Clinical Senate Council Member
- Dr Jean MacLeod - Associate Medical Director and Consultant in Diabetes Acute Medicine North Tees and Hartlepool NHS FT. Director of Quality, Research and Standards, Royal College of Physicians of Edinburgh. Northern England Clinical Senate Council Member.
- Dr Mike Jones - Consultant Acute Physician, University Hospital of North Durham. Director of Training, Royal College of Physicians of Edinburgh and Clinical Lead for the Acute and General Medicine Workstream of the Get It Right First Time Programme. Northern England Clinical Senate Council Member

Emergency Surgery

- Mr John Ausobsky - Consultant (General) Surgeon, Bradford Teaching Hospitals and Regional Advisor to the General College of Surgeons and Training Programme Director for General Surgery for Yorkshire and Humber. Yorkshire and Humber Clinical Senate Member
- Mr Barry Slater - Consultant Colorectal Surgeon, Northumbria Healthcare NHS Foundation Trust. Northern England Clinical Senate Assembly Member

Frail Elderly Services

- Dr Jon Scott - Consultant Physician / Geriatrician, South Tyneside NHSFT Northern Foundation and School Director, Health Education North East. Northern England Clinical Senate Council Vice-Chair
- Prof David Colin-Thome - Ex-National Director of Primary Care, DH and now independent health care consultant. Northern England Clinical Senate Council Member
- Dr Katie Elliott - Salaried GP, CRUK Strategic GP and Deputy Clinical Lead Northern England Cancer Alliance. Northern England Clinical Senate Council Member

Women and Children's Services:

- Dr Steve Sturgiss – Consultant Obstetrician at The Newcastle Upon Tyne Hospitals NHS Foundation Trust and Clinical Lead for the Northern England Maternity Clinical Network. Northern England Clinical Senate Council Member
- Dr Geoff Lawson - Consultant Paediatrician Obstetrician, City Hospitals Sunderland NHS Foundation Trust and Chair of Northern England Child Health Network. Northern England Clinical Senate Council Member
- Dr Helen Simpson – Consultant Obstetrician, South Tees Hospitals NHS Foundation Trust. Northern England Clinical Senate Assembly Member
- Dr Mark Anderson - Consultant Paediatrician, The Newcastle upon Tyne Hospitals NHS Foundation Trust. Northern England Clinical Senate Assembly Member

Appendix 3 - Documentation reviewed

The following documentation was provided by Southport and Ormskirk Hospital NHS Trust prior to the review sessions:

- Southport and Ormskirk Hospital NHS Trust – Clinical and Financial Sustainability Review: Final Case for Change (November 2015)
- Southport and Ormskirk Hospital NHS Trust – Clinical and Financial Sustainability Review: Final Options Evaluation Report (November 2015)
- Draft Integrated Frailty Pathway
- Care For You Service Review Challenge Session output plan on a page
- Draft Integrated Frailty Pathway Project Initiation Document
- Draft Emergency Surgery, Emergency Care and Deteriorating Patient Project Initiation Document
- Draft Model for A&E and Urgent Care Project Initiation Document
- Draft Sustainable model for Women and Children's Services Project Initiation Document
- Cheshire and Merseyside Women and Children's Partnership: Options development for future service configuration (July 2017)
- Cheshire and Merseyside Women and Children's Partnership: Women and Children's Services Programme Update (September 2017)

The following information was provided by the trust following the review sessions:

- Details of opening hours of local walk-in centres
- Copy of draft Mortality Dashboard
- Details of paediatric urgent care activity at the Ormskirk District General Hospital site
- Details of the clinical leadership structure of Southport and Ormskirk Hospital NHS Trust
- CQC Insight report November 2017
- Draft Frailty phased approach: Practical Implementation (Dr Fraser Gordon, Southport and Ormskirk Hospital NHS Trust)

Appendix 4 – Clinical Senate visit programme

Date and session	Senate Team	S & O Representatives
Wednesday 6 th December ED and Acute Medicine	<ul style="list-style-type: none"> • Mr Andy Simpson • Dr Mike Jones • Dr Peter Weaving • Dr Jean MacLeod • Prof Andrew Cant • Dr Robin Mitchell 	<ul style="list-style-type: none"> • Dr Dave Snow - Clinical Director and Consultant in Adult and Paediatric Emergency Medicine • Dr Paddy Macdonald - Associate Medical Director, Medicine, • Jacqui Flynn - Assistant Director of Operations • Ruth Stubbs - Head of Nursing Urgent Care, • Jane Lawson - Matron Urgent Care • Tracy Greenwood - Programme Lead, Patient Flow • Dr John Caine - GP, Chair of West Lancashire CCG • Dr Tim Quinlen - GP, Clinical Director for Urgent Care' Southport & Formby CCG and 'Chairman of the Regional A&E Delivery Board Sub-Committee'
Thursday 7 th December Frail Elderly	<ul style="list-style-type: none"> • Dr Jon Scott • Dr Katie Elliott • Prof David Colin-Thome • Prof Andrew Cant • Dr Robin Mitchell 	<ul style="list-style-type: none"> • Dr Fraser Gordon - Consultant Physician and RCP Tutor • Nicola Ivanovich - Head of Therapy and Rehabilitation Services • Dr Emily Ball - GP, Southport & Formby • Dr Emily Arnold - GP, Southport & Formby, • Amanda Houghton - Transition Service Manager, Lancashire Care NHS Foundation Trust • Jane Ayres, Senior Practice Pharmacist
Thursday 7 th December Site visit to Ormskirk	<ul style="list-style-type: none"> • Prof Andrew Cant • Dr Robin Mitchell 	<ul style="list-style-type: none"> • Lynne Eastham, Head of Midwifery & Nursing • Dr Helen Bradshaw, Consultant Gynaecologist and Obstetrician
Thursday 7 th December Options for future hospital provision	<ul style="list-style-type: none"> • Prof Andrew Cant • Dr Robin Mitchell 	<ul style="list-style-type: none"> • Karl McLuskey - Director of Strategy & Outcomes, South Sefton Clinical Commissioning Group and Southport & Formby Clinical Commissioning Group • Stuart Jackson - Associate Director of Finance & Strategic Financial Planning, Southport and Ormskirk Hospital NHS Trust
Friday 8 th December Emergency Surgery	<ul style="list-style-type: none"> • Mr Barry Slater • Mr John Ausobsky • Dr Robin Mitchell 	<ul style="list-style-type: none"> • Penny Sinclair - Matron for Planned Care • Dr Chris Goddard - Consultant in Anaesthesia and Intensive Care Medicine and Associate Medical Director for Patient Safety • Mr Paul Ainsworth - Consultant Colorectal and General Surgeon • Dr Rob Cauldwell - GP and Chair of Southport & Formby CCG • Helen Baythorpe – Assistant Director of Operations Planned Care • Kath Higgins - Head of Nursing, Planned Care

<p>Friday 8th December</p> <p>Women and Children's</p>	<ul style="list-style-type: none"> • Dr Helen Simpson • Dr Stephen Sturgiss • Dr Geoff Lawson • Dr Mark Anderson • Prof Andrew Cant 	<ul style="list-style-type: none"> • Dr Ted Adams - Consultant Obstetrician and Gynaecologist, Clinical Director and Chief Clinical Information Officer/Clinical Audit Lead/ NCEPOD Ambassador • Lynne Eastham - Head of Midwifery & Nursing • Shirley Coward - Matron in Paediatrics • Dr May NG - Associate Medical Director for Specialist Services and Consultant in Paediatrics and Paediatric endocrinology • Dr Shyam Mariguddi - Clinical Director Paediatrics and Neonates and Consultant Paediatrician
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Independent Clinical Report