NHS Lancashire and South Cumbria

NHS Cheshire and Merseyside

# Shaping Care Together Joint Committee

**Friday 04 July 2025 (Meeting held in Public)**
**10:30am - 12:00pm**
The Community Room, Ormskirk Civic Hall, Southport Road, Ormskirk L39 1LN

## Agenda

Chair: Prof. Hilary Garratt

| AGENDA NO. & TIME | ITEM | LEAD | ACTION / PURPOSE | Page No |
|---|---|---|---|---|
| **10:30am** | **Preliminary Business** | | | |
| SCT/25/07/01 | Welcome, Introductions and Apologies | Chair | - | Verbal |
| SCT/25/07/02 | Declarations of Interest | Chair | To note | Page 2 |
| SCT/25/07/03 | Minutes of the Shadow Joint Committee meeting | Chair | To approve | Page 4 |
| SCT/25/07/04 | Action Log | Chair | To approve | Page 9 |
| SCT/25/07/05 | Matters raised with advance notice to the Chair | Chair | To note | Verbal |
| **10:35am** | **Business Items** | | | |
| SCT/25/07/06 | Shaping Care Together Programme Governance and future reporting | Halima Sadia | To endorse | Page 11 |
| SCT/25/07/07 | Shaping Care Together draft Pre-Consultation Business Case and draft Consultation Document | Rob Cooper / Halima Sadia | To approve | Page 17 |
| SCT/25/07/08 | Key Programme Timelines | Halima Sadia | To note | Page 205 |
| **11:45am** | **Any other business** | | | |
| SCT/25/07/09 | Any items raised in advance | Chair | To consider | - |
| SCT/25/07/10 | Closing remarks, review of the meeting and any communications from it | Chair | - | - |
| **12:00pm** | **CLOSE OF MEETING** | | | |
| **Date and time of next scheduled meeting:** date tbc November 2025. Venue tbc | | | | |

**Consent Items**

All Consent items have been read by Committee members and the minutes of the 04 July 2025Committee meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.

| Agenda No | Item | Reason for presenting | Page No |
|---|---|---|---|
| SCT/25/07/10 | Committee Terms of Reference | To note the Committee Terms of Reference as approved by the Boards of NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria | Page 210 |

# REGISTER OF DECLARATIONS OF INTEREST FOR THE SHAPING CARE TOGETHER JOINT COMMITTEE 2025/26

| Name | Position | Organisation | Committee Status | Nature of declared Interest | Financial Interest | Non-Financial Professional Interest | Non-Financial Personal Interest | Indirect | Date of interest from/to | Action taken to mitigate risk |
|---|---|---|---|---|---|---|---|---|---|---|
| **Prof. Hilary Garratt** | Non-Executive Member | NHS Cheshire & Merseyside ICB | Member (Chair) | Director of 90 Days Health Consultancy | | | | Y | 31.12.23 - ongoing | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |
| | | | | Director of Hilary Garratt Associates | Y | | | | 25.07.23 - ongoing | |
| | | | | Honorary Professor at university of Salford | | Y | | | 2023 - ongoing | |
| | | | | Visiting professor at Chester University | | Y | | | 25.07.23 - ongoing | |
| **Clare Watson** | Assistant Chief Executive | NHS Cheshire & Merseyside ICB | Member | Nil | | | | | | |
| **Mark Bakewell** | Director of Finance (Interim) | NHS Cheshire & Merseyside ICB | Member | Spouse employed by NHS England in national role regarding Learning Disability and Autism | | | | Y | 01.07.24 - ongoing | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |
| **Jim Birrell** | Non-Executive Member | NHS Lancashire & Cumbria ICB | Member (Deputy Chair) | Nil | | | | | | |
| **Dr Andy Knox** | Interim Medical Director | NHS Lancashire & Cumbria ICB | Member | Partner Ash Trees Surgery | Y | | | | 2013 - ongoing | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |
| | | | | Director of Ash Trees Pharmacy | Y | | | | 2018 – ongoing | |
| | | | | Director of The Well CIC (unpaid) | | | Y | | 2017 – ongoing | To declare when decisions made re social prescribing contracts and alcohol/drug services |
| | | | | Associate of the Kings Fund | | | | | Jan 2022 – ongoing | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |
| | | | | Vice Chair of the Trustees Westmorland Multi-Academy Trust | | | | Y | Sept 2020 – ongoing | |
| | | | | Chair of The Well CIC | | | Y | | 18.06.24 – ongoing | To declare when decisions made re social prescribing contracts and alcohol/drug services |
| | | | | Board Member of the Clinical Leaders Network | | Y | | | Jan 2023 – ongoing | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |
| | | | | Faculty Member of the IHI | Y | | | | Oct 2024 – ongoing | |
| | | | | Associate of the Centre for Population Health | | Y | | | Jan 2024 – ongoing | |
| | | | | Honorary Professor at Lancaster University Management School | | Y | | | Jan 2025 – ongoing | |
| **Debbie Eyitayo** | Chief Nurse | NHS Lancashire & Cumbria ICB | Member | Member of the board of trustees of a charity providing counselling, support and education in UK and Ireland | | Y | | | 29/06/23 - present | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |
| **Sarah James** | Integrated Place Leader – Central Lancashire | NHS Lancashire & Cumbria ICB | Regular Attendee | Father is Chair of Lancashire and South Cumbria NHS foundation Trust | | | | Y | 01.12.22 - ongoing | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |

| Name | Position | Organisation | Committee Status | Nature of declared Interest | Financial Interest | Non-Financial Professional Interest | Non-Financial Personal Interest | Indirect | Date of interest from/to | Action taken to mitigate risk |
|---|---|---|---|---|---|---|---|---|---|---|
| **Tracy Jeffes** | Associate Director of Strategy and Transformation (Sefton Place) | NHS Cheshire & Merseyside ICB | Regular Attendee | Nil | | | | | | |
| **Rob Cooper** | Chief Executive | Mersey and West Lancashire Teaching Hospitals NHS Trust | Regular Attendee | Chief Executive of Mersey and West Lancashire Teaching Hospitals NHS Trust | Y | | | | | Declare as necessary in any meeting or discussion and withdraw from any discussions as appropriate where it is perceived to be of material conflict |
| **Halima Sadia** | Programme Director Shaping Care Together | Mersey and West Lancashire Teaching Hospitals NHS Trust | Regular Attendee | Employee of Mersey and West Lancashire Teaching Hospitals NHS Trust | Y | | | | | Declare as necessary in any meeting or discussion and withdraw from any discussions as appropriate where it is perceived to be of material conflict |
| **Matthew Cunningham** | Associate Director of Corporate Affairs and Governance | NHS Cheshire & Merseyside ICB | Regular Attendee | Spouse is Managing Director of the Middlewood Partnership (Primary Care) | | | | Y | 15.04.24 - ongoing | Declare as necessary in any meeting or discussion and withdraw from any ICB discussions as appropriate where it is perceived to be of material conflict |

# Shaping Care Together Joint Committee

**31 March 2025 (Shadow Committee Meeting)**

**09:15am – 11:30am**

*Unconfirmed* **Draft Minutes**

| ATTENDANCE | |
|---|---|
| **Name** | **Role** |
| **Members** | |
| Dr Ruth Hussey CB, OBE, DL | Non-Executive Member, NHS Cheshire & Merseyside ICB (NHS C&M ICB) |
| Jim Birrell | Non-Executive Member, NHS Lancashire and South Cumbria ICB (NHS L&SC ICB) |
| Sarah O'Brien | Chief Nurse, NHS Lancashire and South Cumbria ICB (NHS L&SC ICB) |
| Debbie Eyitayo | Chief People Officer, NHS Lancashire and South Cumbria ICB (NHS L&SC ICB) |
| Mark Bakewell | Executive Director of Finance, NHS Cheshire & Merseyside ICB (NHS C&M ICB) |
| Clare Watson | Assistant Chief Executive, NHS Cheshire & Merseyside ICB (NHS C&M ICB) |
| **In Attendance** | |
| Matthew Cunningham | Associate Director of Corporate Affairs & Governance / Company Secretary, NHS Cheshire & Merseyside ICB (NHS C&M ICB) |
| Rob Cooper | Chief Executive, Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) |
| Halima Sadia | Programme Director, Shaping Care Together, Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) |
| Tracy Jeffes | Associate Director of Strategy and Transformation, NHS Cheshire & Merseyside ICB (NHS C&M ICB) |
| Sarah James | Integrated Place Leader – Central Lancashire, NHS Lancashire and South Cumbria ICB (NHS L&SC ICB) |
| **Apologies** | |
| Prof. Hilary Garratt | Non-Executive Member, NHS Cheshire & Merseyside ICB (NHS C&M ICB) |

| Item | Discussion, Outcomes and Action Points |
|---|---|
| **Preliminary Business** | |
| **SCT/25/03/01** | **Welcome, Introductions and Apologies** |
| The meeting started with everyone introducing themselves. Following introductions, apologies were noted from Hilary Garratt. Quoracy was confirmed. | |
| **SCT/25/03/02** | **Appointment of Chair and Deputy Chair** |
| It was outlined that the need to appoint a Chair and Deputy Chair from the ICB Non-Executive Members of the Joint Committee, in line with the Committee Terms of Reference (TOR). It was proposed that Hilary Garrett (NHS C&M ICB) would be as the chair and Jim Birrell (NHS L&SC ICB) as the deputy chair, which was supported by the committee. Due to Hilary being absent, it was agreed that for today's meeting that Ruth Hussey would Chair. | |

***Decision:*** Prof Hilary Garratt would be the Chair of the Committee for year one, Jim Birrell would be Deputy Chair

| SCT/25/03/03 | Declaration of Interest and Development of register of interests |
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The Chair asked whether there were any declarations to be raised at today's meeting – none were raised.

Matthew highlighted to the Committee that a combined declaration of interest register, based on those currently in Place for both ICBs and Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) would be prepared for the first meeting in Public of the Committee, which would be circulated in advance and published with the Committee papers.
**Action:** Matthew to develop Declaration of Interest Register for the Committee to bring to first meeting of the Committee in public.

| SCT/25/03/04 | Matters raised in advance notice to the Chair |
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Chair confirmed that no matters had been raised in advance.

**Business Items**

| SCT/25/03/05 | Committee Terms of Reference & Committee Operation |
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It was outlined to Committee members and attendees that the committee terms of reference (TOR) had been approved by the Boards of both ICBs and reaffirmed that if there was a need for any changes to the TOR, as recommended by the Committee, that the changes would need to be approved by both boards. He also discussed the operation of the committee as highlighted within the TOR, including it meeting in public for significant decisions, adhering to the public interest test.

It was highlighted that there were a number of recommendations within the paper for consideration by the Committee with regards the operation of the Committee going forward. The Committee agreed on the following:

- **Location of meetings:** it was supported that meetings held in public would be rotated between the Southport and Ormskirk areas ***(Decision)***
- **Notice of meeting/publications of papers:** it was supported that notification of and papers for the Committee meetings held in public would be made available on the websites of both ICBs and the Shaping Care Together website. ***(Decision)***
- **Public Speaking Sessions:** Matthew discussed the possibility of allowing public speaking sessions during meetings. The committee debated the pros and cons, ultimately deciding to allow written questions to be submitted in advance and answered during the meeting, however there would not be opportunity for a member of the public to speak/raise questions directly at the meeting itself. **(Decision).** The Committee supported the recommendations within the paper regarding the timeframe for people to submit questions and for the Committee to respond and ICBs to publish the question and answers. ***(Decision)***
- **Committee Chairs reports and minutes:** the committee supported the recommendations for Committee Chair reports to be developed in the style of existing Triple A reports and to be provided to the subsequent Board meetings of ICBs along with any confirmed minutes of the Committee. ***(Decision)***

Committee also noted the intention to develop for the Committee the following items:

- risk register
- committee forward plan
- action and decision logs
- reports/minutes from the SCT Programme Board to the Committee

**Action:** Matthew to work with Halima to develop the risk register, committee forward plan, action and decision logs and the reports from the SCT Programme Board to the Committee.

| SCT/25/03/06 | Shaping Care Together Programme Governance and future reporting |
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An overview of the programme governance was provided, explaining the structure and functions of the various groups involved, detailing the roles of the SCT programme governance, statutory bodies, and the joint committee. She emphasized the importance of clear reporting lines and accountability.

The importance of managing risks within the programme was discussed, ensuring that risks are identified, assessed, and mitigated effectively. Committee were informed of the role of the programme board in overseeing risk management.

**The Committee noted the report.**

| SCT/25/03/07 | Update from NHSE Stage 2 Reviews |
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The Committee was updated on the recent Stage 2 NHS England (NHSE) review meeting on 18 March 2025. It was broadly positive with most questions and concerns addressed during the meeting; however, it was highlighted that there were some outstanding questions related to maternity services and urgent emergency care services. It was discussed that the recent clinical senate highlighted the following:

- **Maternity services:** concerns about the plans for maternity services, noting limited assurance in this area. They highlighted the need for more detailed plans and options appraisals

- **Urgent and emergency care:** raised issues regarding the overall configuration of urgent and emergency care services, emphasising the need to address co-dependencies and the impact of service changes

- **Clinical Adjacencies and Specialist Availability** - The importance of clinical adjacencies and the availability of specialist advice on-site was discussed, with the Senate seeking assurance that these factors would be adequately addressed in the proposed changes

The committee acknowledged the need to provide detailed responses to the points raised by the Senate and to address the concerns raised.

The Committee was informed that the Programme was still waiting for formal feedback from NHSE, which will be shared with Committee members once received.

**The Committee noted the update.**

| SCT/25/03/09 | Shaping Care Together Pre-Consultation Business Case |
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The SCT pre-consultation business case (PCBC) was presented to the Committee. In summary the following was covered:

- **Need for Change:** citing workforce challenges, infrastructure issues, financial pressures, and the need to improve patient care as key drivers for the proposed changes.
- **Clinical Benefits:** clinical benefits of the proposed changes, including improved workforce sustainability, increased consultant input, and better continuity of care and link to specialities
- **Strategic Fit:** the strategic fit of the proposed changes, aligning with local and national healthcare strategies. There was an emphasis on the importance of integrating services and improving patient pathways.
- **Engagement Process:** the engagement process undertaken around the case for change was detailed, including surveys, public meetings, and focus groups, to gather input from patients, public, and stakeholders. The insights gained were used to inform the options appraisal.

- **Options Appraisal:** The options appraisal process was explained, with ten core options considered and evaluated. The preferred option of co-location at Southport was identified based on a thorough evaluation of clinical, financial, and operational factors.
- **Programme Risks:** included judicial reviews, and the impact on maternity services. There was an emphasis on the importance of having robust mitigations in place.
- **Consultation Plans:** the consultation plans were discussed, including the development of a draft consultation engagement strategy and the importance of targeted MP engagement. There was emphasis on the need for a transparent and inclusive consultation process.

The Committee thanked members from the MWL team in attendance for presenting the PCBC, and the following concerns and areas for further detail were raised/requested:

- **Lack of Detail on Services Left Behind** –concerns raised about the absence of information on what services would be put in place at Southport and Ormskirk if services were to be moved.
- **Depth of Local Support** – question on the level of support from local councils and MPs, particularly in Ormskirk, regarding the proposed changes.
- **Impact on Primary Care** - concern regarding the lack of detailed information on the impact of the changes on primary care services.
- **Maternity Services** – Concerns raised about the potential predetermined outcome for maternity services and how the changes might affect future discussions about these services.
- **Financial and Revenue Risks** - The need to explicitly include the revenue costs and the impact of capital repayment in the business case was to be highlighted.
- **Public Perception and Communication** - The need to clearly communicate the ongoing improvements at Southport ED to avoid public perception of pre-empting the consultation outcome.
- **Inequalities**: Concerns were raised about the engagement and consultation reaching particular groups, especially in areas of deprivation. The need to address inequalities was highlighted as a potential risk, with plans to ensure robust engagement and involvement of all community groups. It was suggested that this should be noted in the risk register to ensure their voices are heard.

These concerns were addressed in the meeting where further information was provided in response to the concerns raised and requests for further clarity on items. The Committee asked that an update on how the concerns are being addressed or will be addressed is provided to the Committee alongside when bringing the final version of the PCBC and Consultation plans.

**Action:** MWL to address the points raised and ensure that the PCBC and supporting Consultation paper to the next Committee meeting addresses the concerns raised.

**Action:** Matthew to circulate the appendices of the PCBC to the Committee members

**The Committee endorsed the PCBC and noted that it would be considered for approval at the next meeting of the Committee held in public.**

| SCT/25/03/10 | Key Programme Timelines |
|---|---|

An overview of the programme timeline was discussed which highlighed the key milestones and steps required to progress through the consultation. It was highlighted that at the next meeting of the committee (in public) will consider the PCBC with the ask for approval and the commencement of the public consultation, for 12 weeks. At this meeting the Committee agreed that it would also receive the Communication and Engagement Strategy for the consultation process. It was discussed that this, albeit lengthy process, was being done due to the current pre-election period in Lancashire, and the need to be as open and transparent in the decision making and therefore the need to meet again in a public setting.

It was highlighted that after the public consultation insights will be collated and reviewed by the joint committee. The decision-making business case (DMBC) and strategic outline case (SOC) will be

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|---|---|
| developed concurrently. Committee were informed that the DMBC and SOC will require NHSE approval, with the target for submission in February next year.<br><br>**The Committee noted the report.** | |
| **SCT/25/03/11** | **ICB Informing and Reporting Timelines of note, including future Committee Meeting schedule** |
| A number of key dates were highlighted for consideration by the Committee in terms of meetings of the Committee and meetings of the Boards of each ICB and MWL.<br><br>**Action:** Matthew to follow up with Committee members to determine the date of the next Committee meeting in May/early June 2025<br><br>**Action:** Matthew to follow up with Communication colleagues in Cheshire and Merseyside and Lancashire and South Cumbria regarding possible venues for the next meeting of the Committee. | |
| **AOB** | |
| None | |
| **Date of Next Meeting:** *04 July 2025* | |

# Shaping Care Together Committee Action Log 2025

**Updated: 26.06.25**

| Cmmtt Mtg Log No. | Original Meeting Date | Agenda Item Description | Action Requirements from the Meetings | By Whom | By When | Comments/ Updates Outside of the Meetings | Status | Comments / Recommendations |
|---|---|---|---|---|---|---|---|---|
| SCT/25/03/31/01 | 31.03.25 | **Declarations of Interest** | Develop a combined Declaratiosn of Interest so as to be ready for first meeting in public | Matthew Cunningham | Next meeting | Register completed and available at July 2025 meeting | **COMPLETED** | *Committee requested to agree to close action* |
| SCT/25/03/31/02 | 31.03.25 | **Committee Terms of Reference** | Develop the Committee risk register, committee forward plan, action and decision logs and the reports from the SCT Programme Board to the Committee. | Matthew Cunningham & Halima Sadia | Next meeting | Templates for action & decision logs, risk register and reporting to the Committee have been created. Will be populated as Committee business develops | **COMPLETED** | *Committee requested to agree to close action* |
| SCT/25/03/31/03 | 31.03.25 | **draft Pre-Consultation Business Case** | PCBC and supporting Consultation paper that comes to the next Committee meeting to address requested areas of further clarity as well as concerns raised from Clinical Senate and Shadown Committee meeting | Rob Cooper & Halima Sadia | Next meeting | Updated papers coming to 04 July meeting | **COMPLETED** | *Committee requested to agree to close action* |
| SCT/25/03/31/04 | 31.03.25 | **draft Pre-Consultation Business Case** | Circulate the appendices of the PCBC to the Committee members | Matthew Cunningham | Following meeting | Appendices have been circulated | **COMPLETED** | *Committee requested to agree to close action* |
| SCT/25/03/31/05 | 31.03.25 | **Timeline and Committee arrangements** | Matthew to follow up with Committee members to determine the date of the next Committee meeting in May/early June 2025 | Matthew Cunningham | Following meeting | Date agreed as 04 July 2025 | **COMPLETED** | *Committee requested to agree to close action* |
| | | **Timeline and Committee arrangements** | Matthew to follow up with Communication colleagues in Cheshire and Merseyside and Lancashire and South Cumbria regarding possible venues for the next meeting of the Committee. | Matthew Cunningham | Following meeting | Venue agreed as Ormskirk Civic Hall | **COMPLETED** | *Committee requested to agree to close action* |

NHS Lancashire and South Cumbria

NHS Cheshire and Merseyside

# Meeting of the Shaping Care Together Joint Committee

**04 July 2025**

## Shaping Care Together – Programme Governance

**Agenda Item No:** SCT/25/07/06

NHS Lancashire and South Cumbria

NHS Cheshire and Merseyside

# Shaping Care Together – Programme Governance

## 1. Purpose of the Report

1.1 The purpose of the paper is to outline the governance arrangement of the Shaping Care Together Programme including how the programme aligns with the Joint Committees governance arrangements.

## 2. Executive Summary

2.1 The programme governance structure can be found in Appendix 1. Workstreams have been set up to progress the different elements of the programme, which report into the Programme Delivery Group. Oversight of programme delivery sits with the Programme Board which reports into the Joint Committee of the two ICBs, as well as MWL Trust Board, with a reporting line to the joint Health Overview and Scrutiny Committee (HOSC) of Sefton and Lancashire.

## 3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

- Note the programme governance for the Shaping Care Together Programme.

## 4. Reasons for Recommendations

4.1 Informs the committee of the programme governance arrangements that are currently in place and alignment to this committee.

## 5. Background

5.1 This governance arrangement has gone through the following governance routes:

- SCT Programme Board 05 March 25
- NHSE Stage 2 Gateway Assurance 18 March 25

## 6. Officer contact details for more information

Rob Cooper – Managing Director, Mersey and West Lancashire Teaching Hospitals NHS Trust rob.cooper@merseywestlancs.nhs.uk

Halima Sadia – Programme Director – Shaping Care Together, Mersey and West Lancashire Teaching Hospitals NHS Trust halima.sadia@merseywestlancs.nhs.uk

## 7. Appendices

**Appendix One:** Shaping Care Together Programme Governance

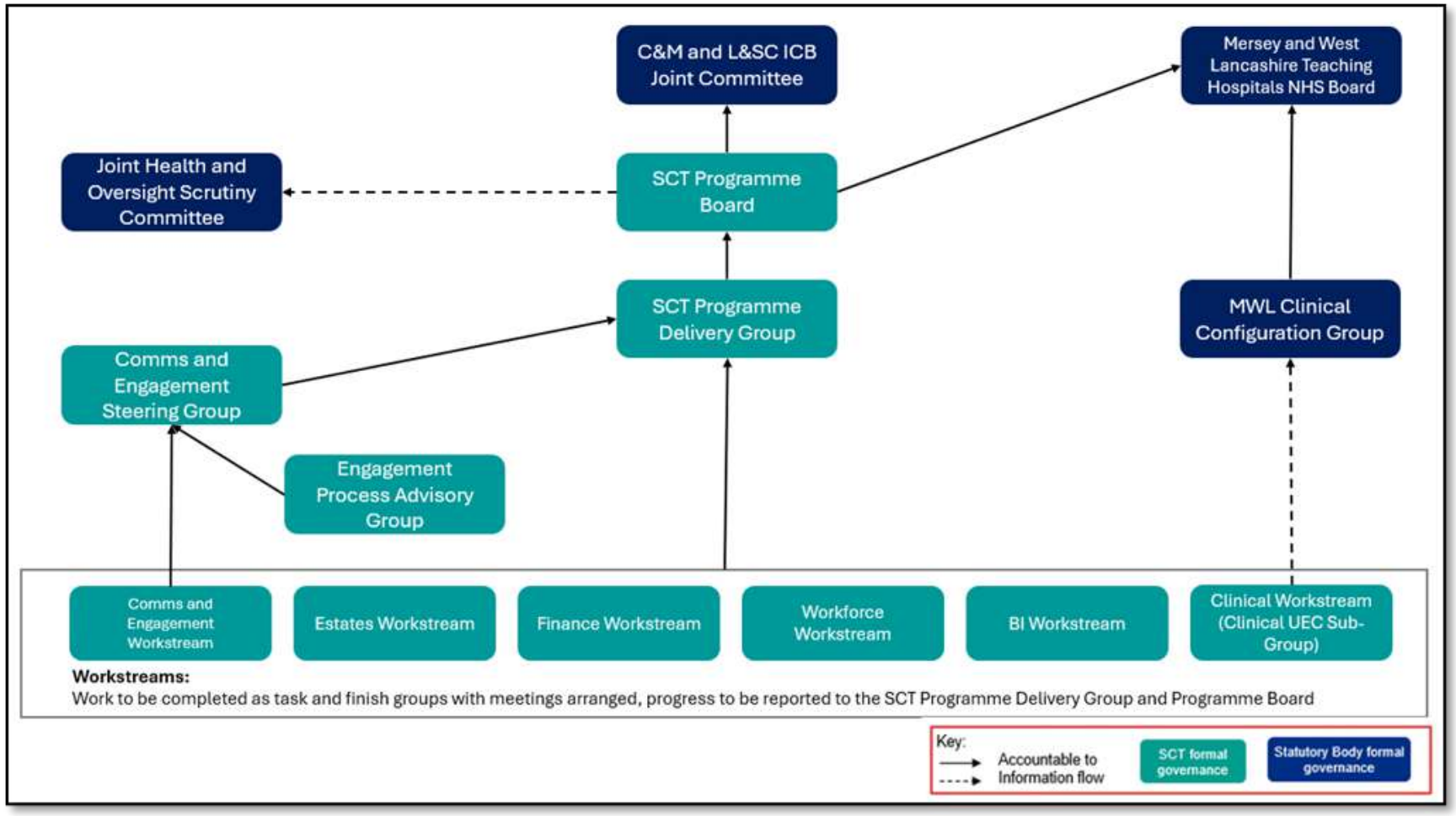
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

SHAPING CARE TOGETHER

# Shaping Care Together Governance

# SCT Programme Governance

NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust




**Joint Committee**
Oversees key decisions for the Shaping Care Together programme, including approving the Pre-consultation Business Case (PCBC) and reviewing public consultation outcomes. It includes Executive and Non-Executive members from each Integrated Care Board (ICB).

**SCT Programme Board:**
Ensures the programme's delivery, achieving outcomes and managing risks. It includes executives and leaders from various NHS bodies and the SCT programme team, meeting monthly under the MWL Chair.

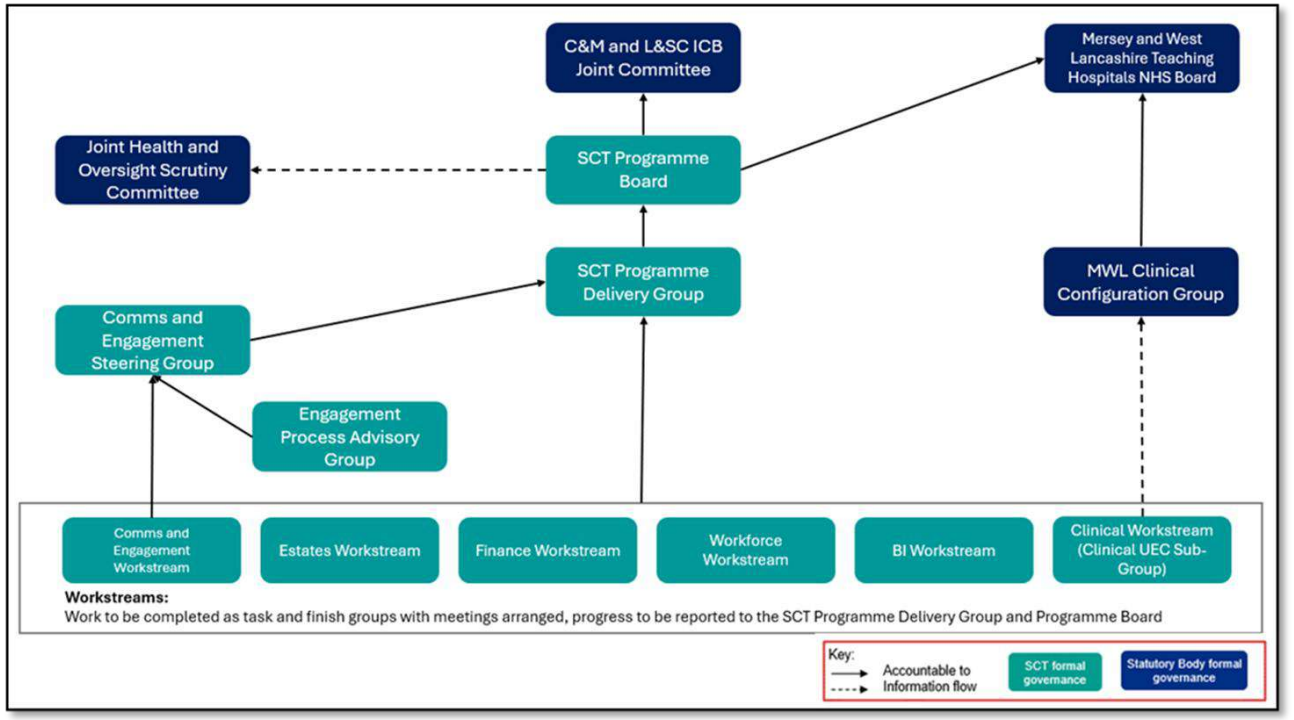
**SCT Delivery Group:**
Manages workstreams, coordinates the PCBC development, and ensures alignment with strategic goals and consultation regulations. It includes senior programme leads and commissioning leads, meeting monthly under the SCT Programme Director.

# SCT Programme Governance (cont.)

NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

**SCT Communications and Engagement Steering Group:**
Ensures effective public engagement and consultation, oversees communication efforts, and addresses risks. It includes communications leads from NHS bodies, the SCT programme team, and representatives from Healthwatch and CVS organizations, meeting monthly under the NHS Cheshire and Merseyside ICB Communications and Engagement Lead.

**Engagement Process Advisory Group (EPAG):**
Advises on engagement strategies for pre-consultation, ensuring broad participation and adherence to the Nolan principles. Members include representatives from Healthwatch, CVS, and various service user groups.




**SCT Workstreams:**
Groups focused on communications, engagement, estates, finance, workforce, Business Intelligence (BI), and clinical components. Each workstream meets monthly to update on key deliverables and milestones.

**SCT Clinical UEC Sub-group:**
Provides clinical leadership for urgent and emergency care services, ensuring changes are based on solid clinical evidence. Members include clinical, operational, and commissioning leads from various NHS bodies and service providers. Meetings are chaired monthly by the MWL Divisional Medical Director for Medicine.

NHS Lancashire and South Cumbria

NHS Cheshire and Merseyside

# Meeting of the Shaping Care Together Joint Committee

**04 July 2025**

## Shaping Care Together – DRAFT Pre-Consultation Business Case (PCBC) and DRAFT Consultation Document

**Agenda Item No:** SCT/25/07/06

NHS Lancashire and South Cumbria

NHS Cheshire and Merseyside

# Shaping Care Together – DRAFT Pre-Consultation Business Case (PCBC) and DRAFT Consultation Document

## 1. Purpose of the Report

1.1 The purpose of the paper is to seek approval from the NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB of the DRAFT Pre-consultation Business Case and Consultation Document (Appendix One and Two) for the Shaping Care Together (SCT) programme, and the commencement of a 13 week consultation with members of the public and stakeholders.

1.2 Review and approval of the DRAFT Pre-consultation Business Case and Draft Consultation Document will allow planning for the start of a 13-week public Consultation.

1.3 No decisions have been made yet and the documentation included in this paper are not decision-making documents on the final outcomes.

1.4 A Pre-Consultation Business Case (PCBC) is the business case on which the commissioner decides to consult. Contains information about case for change, clinical model and review, options appraisal, evidence of pre-consultation engagement, evidence of how proposals meet the government and NHSEs 5 tests. This document forms the basis of further business cases and will be the document that local government scrutinises.

1.5 A consultation document is a clear, public summary of proposed NHS service changes, explaining the case for change, options, and how to give feedback. While not named in law, it is essential to meet legal duties under the NHS Act and to comply with the Gunning Principles, particularly the requirement to provide enough information for the public to give informed, meaningful responses. The document is usually a condensed, easy to understand version of the full PCBC.

## 2. Executive Summary

### 2.1 Introduction

2.2 The Shaping Care Together (SCT) programme is a collaborative initiative by Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) and the Integrated Care Boards (ICB) for Cheshire, Merseyside, and Lancashire and

South Cumbria. It aims to address urgent and emergency care challenges in Southport, Formby, and West Lancashire, ensuring sustainability and excellence in patient care.

2.3 The programme's vision is to provide high-quality care and reduce health inequalities by delivering responsive, safe, and sustainable services. It focuses on improving urgent and emergency care and addresses current pressures such as quality, staffing shortages, infrastructure needs, and funding issues, while preparing for an ageing population.

2.4 The review process began in Spring 2024 with the development of the Case for Change, which highlighted the need for improvements in urgent and emergency care. After thorough stakeholder engagement, a 10-week pre-consultation period gathered feedback through public events, meetings, focus groups, and surveys. This feedback informed the options appraisal process, which identified two main options for co-location of adult and paediatric accident and emergency (A&E) services and a preferred option.

2.5 The programme has adhered to national guidance throughout its development, ensuring that it addresses the urgent and emergency care needs of the local population while maintaining high standards and guidelines and have had a full assurance from NHSE as part of NHSE Stage 2 Gateway Assurance, in line with guidance (see Appendix Four).

**2.6 <u>Case for Change</u>**

2.7 The current healthcare model faces pressures from aging infrastructure, workforce shortages, financial challenges, and rising patient demand. With increasing population aging and complexity in care needs, maintaining duplicate services across two sites is unsustainable. Expert reviews, including Clinical Senate evaluations, have highlighted the necessity for reconfiguration to provide efficient, high-quality care.

**2.8 <u>Options and Preferred Option</u>**

2.9 The programme has followed NHS England and HM Treasury Green Book guidance to ensure stakeholder engagement and transparency in the options appraisal process. Two workshops were held: one for applying hurdle criteria and another for evaluation criteria in November 2024.

2.10 The programme initially considered 10 options, with a number discounted during the pre-hurdle appraisal due to financial constraints, implementation timelines, and the need for significant changes to out-of-scope services. The two options that passed the hurdle criteria were:

- Co-location of a 24-hour adult and paediatric A&E at Ormskirk Hospital.
- Co-location of a 24-hour adult and paediatric A&E at Southport Formby Hospital.

2.11 The evaluation criteria workshop involved internal and external stakeholders including patients and the public who assessed the two longlisted options. Each option was scored based on quality of care, deliverability, access, financial and environmental sustainability, and strategic fit.

2.12 The co-location at Southport option achieved the highest score and was identified as the preferred option. This recommendation was approved by the SCT Programme Board in December 2024, and the programme agreed to proceed to consultation on both options, with co-location at Southport Hospital being the preferred option.

**2.13 Overview Against Proposed Options**

Clinical

2.14 In 2015, Deloitte conducted a review of acute services at Southport & Formby and Ormskirk hospitals, concluding that the services were unsustainable in terms of quality, workforce, and finances. They recommended a hot and cold site solution, which was supported by the Northern England Clinical Senate Review in 2017. A 2018 review by KPMG highlighted ongoing risks and suggested a new-build hospital, but this was deemed unfeasible, leading to a renewed recommendation for a hot and cold site solution. However, the previous programme found the solutions unaffordable and undeliverable, with estimated costs around £1.3 billion and a timeline of 13-16.5 years.

2.15 Following the rescope of the programme to focus on urgent and emergency care, the SCT Clinical Urgent and Emergency Care (UEC) sub-group developed clinical models of care, aligning with national guidelines and aiming to provide safe, high-quality care. These models were created collaboratively by clinical and commissioning leads and approved by various groups, including the NHS England North West Clinical Senate.

2.16 The proposed clinical model focuses on providing 24/7 emergency care for both adults and children, addressing the current lack of 24/7 provision at Ormskirk Hospital. Co-location of services was identified as a strategic solution to enhance integration, optimise resources, and improve patient outcomes following the hurdle criteria workshop. The programme identified clinical co-dependencies as key factors for delivering safe services, in line with the NHS England clinical senate guidance. This demonstrated that more services would need to move to accommodate a co-located adult and paediatric emergency department (ED) at Ormskirk Hospital.

2.17 From the clinical point of view, the preferred option aims to address operational inefficiencies, workforce pressures, and fragmented care delivery, ensuring sustainable and high-quality emergency care for the region.

Workforce

2.18 A review of workforce models for both adult and paediatric ED services highlighted key factors impacting the final workforce structure. The review identified benefits of co-locating ED services, including improved 24/7 medical

cover, consolidated nursing leadership, and reduced reliance on temporary staff, potentially saving £1.5 million annually. The medical workforce is divided into three tiers: consultants, specialty doctors and senior trainees, and clinical fellows and associates. Nursing structures for adults and children are described separately, based on activity levels.

2.19 The review highlighted that the placement of co-located ED services would influence other clinical services and workforce groups. The specific impacts would vary based on whether the ED is situated at Ormskirk Hospital or Southport & Formby Hospital. Co-location at Southport & Formby Hospital would result in fewer disruptions, as it requires fewer clinically co-dependent services to relocate between sites.

**Estates**

2.20 Southport & Formby and Ormskirk Hospitals were evaluated by independent architects to ensure optimal use of public funds and space. The review considered the challenges of executing major capital projects on active hospital sites. The review identified the following:

2.21 ED Co-location Options: Three key variables were assessed for consolidating ED services onto a single site: potential location within the existing site, impact on other clinical services, and parking capacity. The independent architects provided an assessment of options and associated costs.

2.22 Clinical Services and Parking: Several clinical services would need to be relocated to support a co-located ED, with the extent of relocations varying between options. A comprehensive review of parking facilities suggested that adding decked car parks would be the most effective solution.

2.23 Space Requirements: To co-locate the ED and co-dependent clinical services at Ormskirk Hospital, 8,757m² would need to be constructed or refurbished, significantly impacting existing services. The Southport & Formby Hospital option requires 3,501m².

**Finance**

2.24 The costs of the estates reconfiguration for the two options were also completed by an independent financial commission. The capital costs and additional parking facilities for the two options are as follows:

- Ormskirk Hospital ED Co-location: £91,329,000
- Southport & Formby Hospital ED Co-location: £44,477,000

2.25 Whilst the option for a new-build co-located ED was considered, this option was discounted during the pre-hurdle criteria appraisal due to the significantly greater resources required compared to reconfiguring the existing estate. Estates reconfiguration aligns with the rationale and commitments outlined in the business case to integrate Southport and Ormskirk Hospitals with St Helens and Knowsley Teaching Hospitals.

2.26 Additionally, co-locating services and enhancing the working environment could result in an annual saving of approximately £1.5 million due to improved staff retention and reduced reliance on agency or locum doctors.

2.27 The route to funding will be through national funding via the Strategic Outline Case (SOC) in line with national guidance.

**Deliverability**

2.28 **Estate Configuration:** The space required for refurbishment and the number of co-dependent clinical services needing relocation vary significantly between the two co-location options. Co-location at Ormskirk Hospital will lead to more disruption and take longer to deliver compared to Southport & Formby Hospital.

2.29 **Clinical Co-dependencies:** Several clinical services and departments would need to be relocated to support a co-located ED. The extent of these relocations varies between the options, impacting the total space required and the cost implications.

2.30 Deliverability Timeframes: The deliverability timeframes for the two options differ, with co-location at Southport & Formby Hospital being less disruptive and quicker to deliver compared to Ormskirk Hospital.

**2.31 Stakeholder Engagement**

2.32 The communications and engagement strategy for the SCT programme involved a wide range of stakeholders from across Southport, Fomby and West Lancashire including clinical staff (primary and secondary care), local authorities, health and wellbeing boards, media, MPs, the public, regulators, service users, staff, healthcare providers, Healthwatch and voluntary and third-sector organisations. Stakeholder engagement was guided by NHS England's statutory guidance and aimed to ensure broad participation and meaningful conversations.

2.33 Engagement activities included regular briefings, workshops, drop-in sessions, and public events. Staff engagement provided valuable insights, while local authorities and healthcare providers were kept informed through regular updates and meetings. Public engagement involved a variety of events, such as public meetings, roadshows, webinars, and focus groups, to gather feedback and inform the community about the programme.

2.34 Key themes from the engagement included the need for better transport links, consideration of population changes, the desire for local A&E services, and the importance of improving primary care to reduce A&E burden. The programme also focused on enhancing communication, integrating services, and investing in ambulance services. Feedback was recorded in an engagement log, which tracked how the programme responded to stakeholder input and informed the development of service options.

**2.35 Impact assessments**

2.36 Impact assessments on quality, travel, equalities, and the environment have been completed, along with an integrated impact assessment.

2.37 The Quality Impact Assessment was developed with the SCT Clinical UEC sub-group and approved by the Cheshire & Merseyside ICB quality team and developed with both ICBs and partner organisations. It highlights potential benefits in patient safety, clinical effectiveness, and patient experience, while noting risks related to increased travel times.

2.38 The Equalities and Inequalities Impact Assessment has been developed using external support and identifies risks to protected characteristics and localities, ensuring decision-makers consider these risks. It involves continuous analysis, from evaluating current services to post-implementation testing, to mitigate any inequalities.

2.39 The Travel Impact Assessment shows that patients and staff live closer to Southport & Formby Hospital, which has shorter car journey times. Ormskirk Hospital, though better connected by road and public transport, lacks direct bus routes from the Sefton Coast, necessitating shuttle bus services. Cost analysis indicates bus travel is cheapest but longer, highlighting the need for improved public transport and road infrastructure.

2.40 The Environmental Impact Assessment, aligned with NHS climate change duties, finds opportunities to improve carbon impact with new materials, with minimal differences in other environmental factors between options.

2.41 The Integrated Impact Assessment evaluates co-locating A&E services at Ormskirk Hospital or Southport & Formby Hospital. Ormskirk Hospital co-location could improve workforce flexibility and patient accessibility but requires significant investment and may disrupt services. Southport & Formby Hospital co-location could enhance clinical outcomes but may negatively impact West Lancashire patients due to increased travel times. Both options aim to improve patient safety and experience, with distinct challenges and impacts on health equity and workforce.

**2.42 <u>Governments and NHS England Five Tests</u>**

2.43 The Government has established four tests to guide service reconfiguration proposals, ensuring they prioritise patient and public interests. NHS England has added a fifth test specifically addressing bed reductions. The four tests include robust public and patient engagement to ensure affected voices are heard, alignment with patient choice in care options, a strong clinical evidence base to justify changes, and support from clinical commissioners, such as ICBs, to validate the proposals' feasibility and benefit. This process emphasises meaningful involvement in planning, developing, and deciding on service changes while maintaining access to high-quality care within sustainable financial constraints.

2.44 Additionally, compliance with these principles is demonstrated through rigorous patient and public stakeholder involvement and engagement, analysis of clinical evidence, and collaborative decision-making with commissioners and providers. For example, commissioners like NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB have been integral to every phase, including pre-consultation, evaluation, and impact assessment. Neighbouring healthcare providers were also consulted to ensure cohesive service delivery.

2.45 Since April 1, 2017, NHS England requires commissioners to meet a specific test when proposing significant hospital bed reductions, demonstrating either sufficient alternative services, reductions in admissions through new treatments, or improved bed efficiency. However, as the SCT programme does not propose any bed closures, this test is not applicable for the programme.

## 3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

- **Review** and **approve** the draft Pre-consultation Business case
- **Review** and **approve** the draft Consultation Document
- **Approve** the commencement of the consultation with the public and stakeholders

## 4. Reasons for Recommendations

4.1 Approval of the draft Pre-consultation Business Case and Consultation document from both ICBs and Trust will enable the start of a 13-week consultation with patients, public, staff and various key stakeholders for urgent and emergency care services in Southport, Formby and West Lancashire.

## 5. Background

5.1 This draft PCBC and draft Consultation document has gone through the following governance routes:

- SCT Programme Board: 22nd January 25 and 12 February 25, 4th June 25
- NHSE Stage 2 Gateway Assurance 18th March 25

## 6. Officer contact details for more information

Rob Cooper – Chief Executive Officer, Mersey and West Lancashire Teaching Hospitals NHS Trust rob.cooper@merseywestlancs.nhs.uk

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## 7. Appendices

| | |
|---|---|
| **Appendix One:** | Draft Pre-consultation Business Case and appendices<br>**CLICK HERE** to access all the supporting appendices referenced within the PCBC |
| **Appendix Two:** | Draft Consultation Document |
| **Appendix Three:** | NHS C&M and NHS L&SC ICB Joint Committee PCBC Presentation |
| **Appendix Four:** | NHSE Stage 2 Assurance letter |

SHAPING CARE TOGETHER

NHS

# Shaping Care Together
# Pre-consultation business case

| Version | Date | Author | Amendment history |
|---|---|---|---|
| 0.1 | 22nd January 2025 | HS | Initial draft |
| 0.2 | 10th February 2025 | HS | Updates following feedback from Programme Board |
| 0.3 | 12th February 2025 | HS | Updates to Section 4 (Clinical Models) |
| 0.4 | 17th June 2025 | HS | Updates following NHSE Stage 2 Assurance Check and feedback from ICB Joint Committee |

# Contents

# 1. Executive summary

## Introduction

The Shaping Care Together (SCT) programme is a collaborative initiative by Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) and NHS Cheshire and Merseyside Integrated Care Boards (ICB) and NHS Lancashire and South Cumbria ICB. It aims to address urgent and emergency care challenges in Southport, Formby, and West Lancashire, ensuring sustainability and excellence in patient care.

The programme's vision is to provide high-quality care and reduce health inequalities by delivering responsive, safe, and sustainable services. It focuses on improving urgent and emergency care and addresses current pressures such as quality, staffing shortages, infrastructure needs, and funding issues, while preparing for an ageing population.

The review process began in Spring 2024 with the development of the Case for Change, which highlighted the need for improvements in urgent and emergency care. After thorough stakeholder engagement, a 10-week pre-consultation period gathered feedback through public events, meetings, focus groups, and surveys. This feedback informed the options appraisal process, which identified two main options for co-location of adult and paediatric accident and emergency (A&E (also referred to as Emergency Department (ED)) services and a preferred option.

The programme has adhered to national guidance throughout its development, ensuring that it addresses the urgent and emergency care needs of the local population while maintaining high standards and guidelines.

Over the past decade, expert reviews have consistently highlighted the need for action to address challenges at the former Southport and Ormskirk District General Hospitals NHS Trust. By 2021, the trust's board sought external assistance, leading to a partnership with St Helens and Knowsley Teaching Hospitals NHS Trust. This collaboration aimed to improve clinical sustainability, workforce development, and digital integration, among other areas. In 2023, the two trusts merged to form Mersey and West Lancashire Teaching Hospitals NHS Trust, which has successfully stabilised a number of fragile services. Concurrently, the SCT programme continues to explore long-term solutions for high-quality, sustainable care.

## Case for change

The current healthcare model faces pressures from aging infrastructure, workforce shortages, financial challenges, and rising patient demand. With increasing population aging and complexity in care needs, maintaining duplicate services across two sites is unsustainable. Expert reviews, including Clinical Senate evaluations, have highlighted the necessity for reconfiguration to provide efficient, high-quality care.

## Options and preferred option

The programme has followed NHS England and HM Treasury Green Book guidance to ensure stakeholder engagement and transparency in the options appraisal process. Two workshops were held: one for applying hurdle criteria and another for evaluation criteria.

The programme initially considered 10 options, with a number discounted during the pre-hurdle appraisal due to financial constraints, implementation timelines, and the need for significant changes to out-of-scope services. The two options that passed the hurdle criteria were:

1. Co-location of a 24-hour adult and paediatric A&E at Ormskirk District General Hospital.
2. Co-location of a 24-hour adult and paediatric A&E at Southport and Formby District General Hospital.

The evaluation criteria workshop involved internal and external stakeholders who assessed the two longlisted options. Each option was scored based on quality of care, deliverability, access, financial and environmental sustainability, and strategic fit.

The co-location at Southport and Formby District General Hospital option achieved the highest score and was identified as the preferred option. This recommendation was approved by the SCT Programme Board in December 2024, and the programme agreed to proceed to consultation on both options, with co-location at Southport and Formby District General Hospital being the preferred option.

## Clinical

In 2015, Deloitte conducted a review of acute services at Southport & Formby and Ormskirk District General Hospitals, concluding that the services were unsustainable in terms of quality, workforce, and finances. They recommended a hot and cold site solution, which was supported by the Northern England Clinical Senate Review in 2017. A 2018 review by KPMG highlighted ongoing risks and suggested a new-build hospital, but this was deemed unfeasible, leading to a renewed recommendation for a hot and cold site solution. However, the previous programme found the solutions unaffordable and undeliverable, with estimated costs around £1.3 billion and a timeline of 13-16.5 years.

Following the rescope of the programme to focus on urgent and emergency care, the SCT Clinical Urgent and Emergency Care (UEC) sub-group developed clinical models of care, aligning with national guidelines and aiming to provide safe, high-quality care. These models were created collaboratively by clinical, operational and commissioning leads.

The proposed clinical model focuses on providing 24/7 emergency care for both adults and children, addressing the current lack of 24/7 provision at Ormskirk District General Hospital. Co-location of services was identified as a strategic solution to enhance integration, optimise resources, and improve patient outcomes following the hurdle criteria workshop. The programme identified clinical co-dependencies as key factors for delivering safe services, in line with the NHS England clinical senate guidance[1]. This demonstrated that more services would need to move to accommodate a co-located adult and paediatric emergency departments (ED) at Ormskirk District General Hospital.

From the clinical point of view, the preferred option aims to address operational inefficiencies, workforce pressures, and fragmented care delivery, ensuring sustainable and high-quality emergency care for the region.

## Workforce

A review of workforce models for both adult and paediatric ED services highlighted key factors impacting the final workforce structure. The review identified benefits of co-locating ED services, including improved 24/7 medical cover, consolidated nursing leadership, and reduced reliance on temporary staff, potentially saving £1.5 million annually. The medical workforce is divided into three tiers: consultants, specialty doctors and senior trainees, and clinical fellows and associates. Nursing structures for adults and children are described separately, based on activity levels.

The review highlighted that the placement of co-located ED services would influence other clinical services and workforce groups. The specific impacts would vary based on whether the ED is situated at Ormskirk District General Hospital or Southport and Formby District General Hospital. Co-location at Southport and Formby District General Hospital would result in fewer disruptions, as it requires fewer clinically co-dependent services to relocate between sites.

[1] https://secsenate.nhs.uk/wp-content/uploads/2024/01/The-Clinical-Co-Dependencies-of-Acute-Hospital-Services-Final.pdf

## Estates

Southport & Formby and Ormskirk District General Hospitals were evaluated by independent architects to provide an impartial evaluation of the optimal use of public funds and space. The review considered the challenges of executing major capital projects on active hospital sites. The review identified the following:

- **ED co-location options:** Three key variables were assessed for consolidating ED services onto a single site: potential location within the existing site, impact on other clinical services, and parking capacity. The independent architects provided an assessment of options and associated costs.
- **Clinical services and parking**: Several clinical services would need to be relocated to support a co-located ED, with the extent of relocations varying between options. A comprehensive review of parking facilities suggested that adding decked car parks would be the most effective solution.
- **Space requirements:** To co-locate the ED and co-dependent clinical services at Ormskirk District General Hospital, 8,757m² would need to be constructed or refurbished, significantly impacting existing services. The Southport & Formby Hospital option requires 3,501m².

## Finance

The costs of the estates reconfiguration for the two options were also completed by an independent financial commission. The capital costs and additional parking facilities for the two options are as follows:

- Ormskirk District General Hospital ED co-location: £91,329,000
- Southport and Formby District General Hospital ED co-location: £44,477,000

Whilst the option for a new-build co-located ED was considered, this option was discounted during the pre-hurdle criteria appraisal due to the significantly greater resources required compared to reconfiguring the existing estate. Estates reconfiguration aligns with the rationale and commitments outlined in the business case to integrate Southport & Formby and Ormskirk District General Hospitals with St Helens and Knowsley Teaching Hospitals.

Additionally, co-locating services and enhancing the working environment could result in an annual saving of approximately £1.5 million due to improved staff retention and reduced reliance on agency or locum doctors.

The route to funding will be through national funding via the Strategic Outline Case (SOC) in line with national guidance.

## Deliverability

Estate configuration: The space required for refurbishment and the number of co-dependent clinical services needing relocation vary significantly between the two co-location options. Co-location at Ormskirk District General Hospital will lead to more disruption and take longer to deliver compared to Southport and Formby District General Hospital.

Clinical co-dependencies: Several clinical services and departments would need to be relocated to support a co-located ED. The extent of these relocations varies between the options, impacting the total space required and the cost implications.

Deliverability timeframes: The deliverability timeframes for the two options differ, with co-location at Southport and Formby District General Hospital being less disruptive and quicker to deliver compared to Ormskirk District General Hospital.

## Stakeholder engagement

The communications and engagement strategy for the SCT programme involved a wide range of stakeholders from across Southport, Fomby and West Lancashire including clinical staff (primary and secondary care), local authorities, media, MPs, the public, regulators, service users, staff, healthcare providers, Healthwatch and voluntary and third-sector organisations. Stakeholder engagement was guided by NHS England's statutory guidance and aimed to ensure broad participation and meaningful conversations.

Engagement activities included regular briefings, workshops, drop-in sessions, and public events. Staff engagement provided valuable insights, while local authorities and healthcare providers were kept informed through regular updates and meetings. Public engagement involved a variety of events, such as public meetings, roadshows, webinars, and focus groups, to gather feedback and inform the community about the programme.

Key themes from the engagement included the need for better transport links, consideration of population changes, the desire for local A&E services, and the importance of improving primary care to reduce A&E burden. Feedback was recorded in an engagement log, which tracked how the programme responded to stakeholder input and informed the development of service options.


## Impact assessments

Impact assessments on quality, travel, equalities, and the environment have been completed, along with an integrated impact assessment. These assessments are detailed in Section 9.

The Quality Impact Assessment was developed with the SCT Clinical UEC sub-group with support from the NHS Cheshire and Merseyside ICB quality team alongside both ICBs and partner organisations. It highlights potential benefits in patient safety, clinical effectiveness, and patient experience, while noting risks related to increased travel times.

The Equalities and Inequalities Impact Assessment identifies risks to protected characteristics and localities, ensuring decision-makers consider these risks. It involves continuous analysis, from evaluating current services to post-implementation testing, to mitigate any inequalities.

The Travel Impact Assessment shows that patients and staff live closer to Southport and Formby District General Hospital, which has shorter car journey times. Ormskirk District General Hospital, though better connected by road and public transport, lacks direct bus routes from the Sefton Coast, necessitating shuttle bus services. Cost analysis indicates bus travel is cheapest but longer, highlighting the need for improved public transport and road infrastructure.

The Environmental Impact Assessment, aligned with NHS climate change duties, finds opportunities to improve carbon impact with new materials, with minimal differences in other environmental factors between options.

The Integrated Impact Assessment evaluates co-locating A&E services at Ormskirk District General Hospital or Southport and Formby District General Hospital. Ormskirk District General Hospital co-location could improve workforce flexibility and patient accessibility but requires significant investment and may disrupt services. Southport and Formby District General Hospital co-location could enhance clinical outcomes but may negatively impact West Lancashire patients due to increased travel times. Both options aim to improve patient safety and experience, with distinct challenges and impacts on health equity and workforce.

## Government and NHS England five tests

The Government has established four tests to guide service reconfiguration proposals, ensuring they prioritise patient and public interests. NHS England has added a fifth test specifically addressing bed reductions. The four tests include robust public and patient engagement to ensure affected voices are heard, alignment with patient choice in care options, a strong clinical evidence base to justify changes, and support from clinical commissioners, such as ICBs, to validate the proposals' feasibility and benefit. This process emphasises meaningful involvement in planning, developing, and deciding on service changes while maintaining access to high-quality care within sustainable financial constraints.

Additionally, compliance with these principles is demonstrated through rigorous patient and public stakeholder involvement and engagement, analysis of clinical evidence, and collaborative decision-making with commissioners and providers. For example, commissioners like NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB have been integral to every phase, including pre-consultation, evaluation, and impact assessment. Neighbouring healthcare providers were also consulted to ensure cohesive service delivery.

Since April 1, 2017, NHS England requires commissioners to meet a specific test when proposing significant hospital bed reductions, demonstrating either sufficient alternative services, reductions in admissions through new treatments, or improved bed efficiency. However, as the SCT programme does not propose any bed closures, this test is not applicable for the programme.

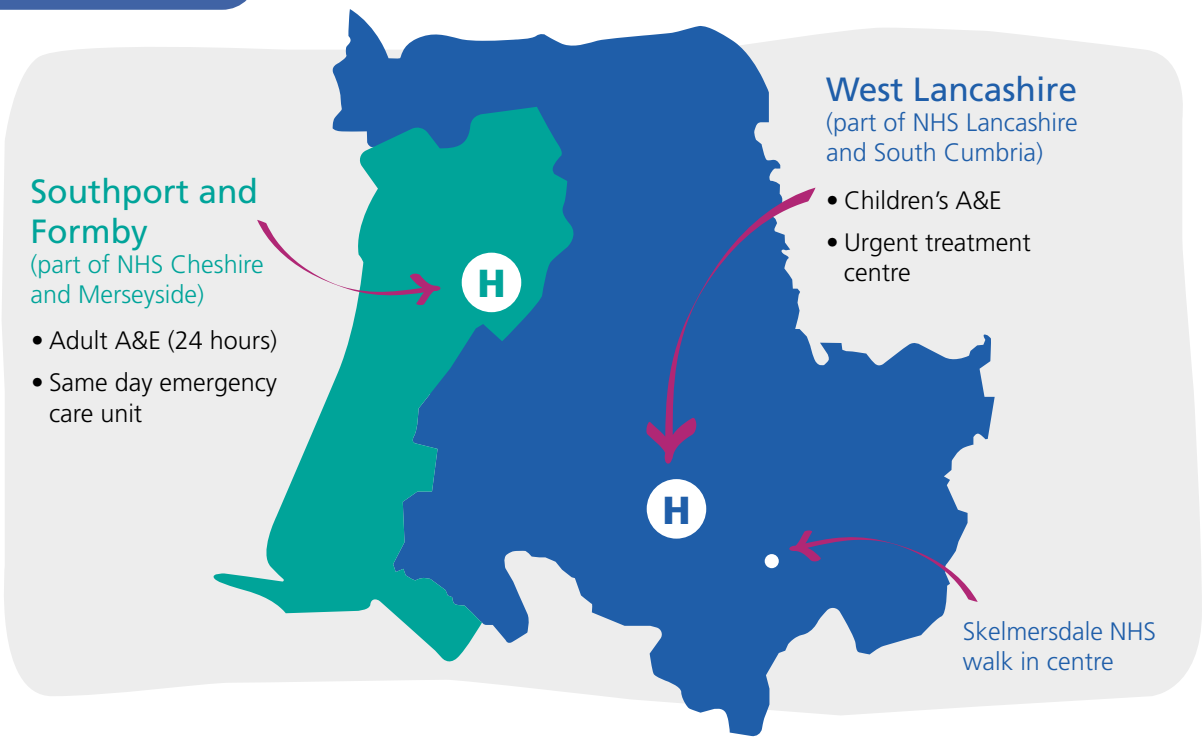
## Next steps

The NHS Cheshire and Merseyside and NHS Lancashire & South Cumbria Integrated Care Boards (ICBs) are committed to an open and transparent public consultation process for the proposed options in the Pre-Consultation Business Case (PCBC). A 12-week public consultation will be held to inform and gather feedback from local communities in Southport, Formby, and West Lancashire on the proposed options.

The consultation will follow best practices and external advice, ensuring all views are considered before final decisions are made in early 2026. Key activities include consultation analysis, updating impact assessments, ongoing business case development, and high-level implementation planning. The final decisions will be presented to the Joint Committee of the ICBs in spring 2026.

# 2. Introduction

## 2.1. Who we are




The Shaping Care Together programme is a partnership between Mersey and West Lancashire Teaching Hospitals NHS Trust, and the integrated Care Boards of NHS Cheshire and Merseyside and NHS Lancashire & South Cumbria. NHS Cheshire and Merseyside are the lead commissioner[2] for this programme.

### Mersey and West Lancashire Teaching Hospitals NHS Trust

The trust serves a population of over 600,000 people and delivers a wide range of local health and care services in Halton, Knowsley, Liverpool, Sefton, St Helens and West Lancashire.

The trust also provides regional services for burns, plastic surgery and spinal injuries across Merseyside, West Lancashire, Cheshire, the Isle of Man and North Wales. A combined workforce of around 9,000 are employed across 21 locations including five hospitals.

### NHS Cheshire and Merseyside ICB

Serving 2.7 million residents, NHS Cheshire and Merseyside is one of the largest Integrated Care Boards in England. It covers Sefton, Liverpool, St Helen's, Knowsley, Halton, Warrington, Wirral, Cheshire East and Cheshire West.

### NHS Lancashire and South Cumbria ICB

Serving 1.8 million residents, NHS Lancashire & South Cumbria serves the areas North Lancashire, East Lancashire, Central Lancashire, Blackpool, Blackburn with Darwen and South Cumbria. Only West Lancashire, which is part of the wider Central Lancashire area, is within the SCT programme area.

[2] An NHS commissioner is responsible for planning, purchasing, and monitoring health services to ensure the best health outcomes for the population. This process, known as commissioning, involves assessing needs, prioritising services, and ensuring that healthcare providers deliver high-quality care. NHS services are commissioned by Integrated Care Boards (ICBs) and are overseen by NHS England.

## 2.2. Our vision

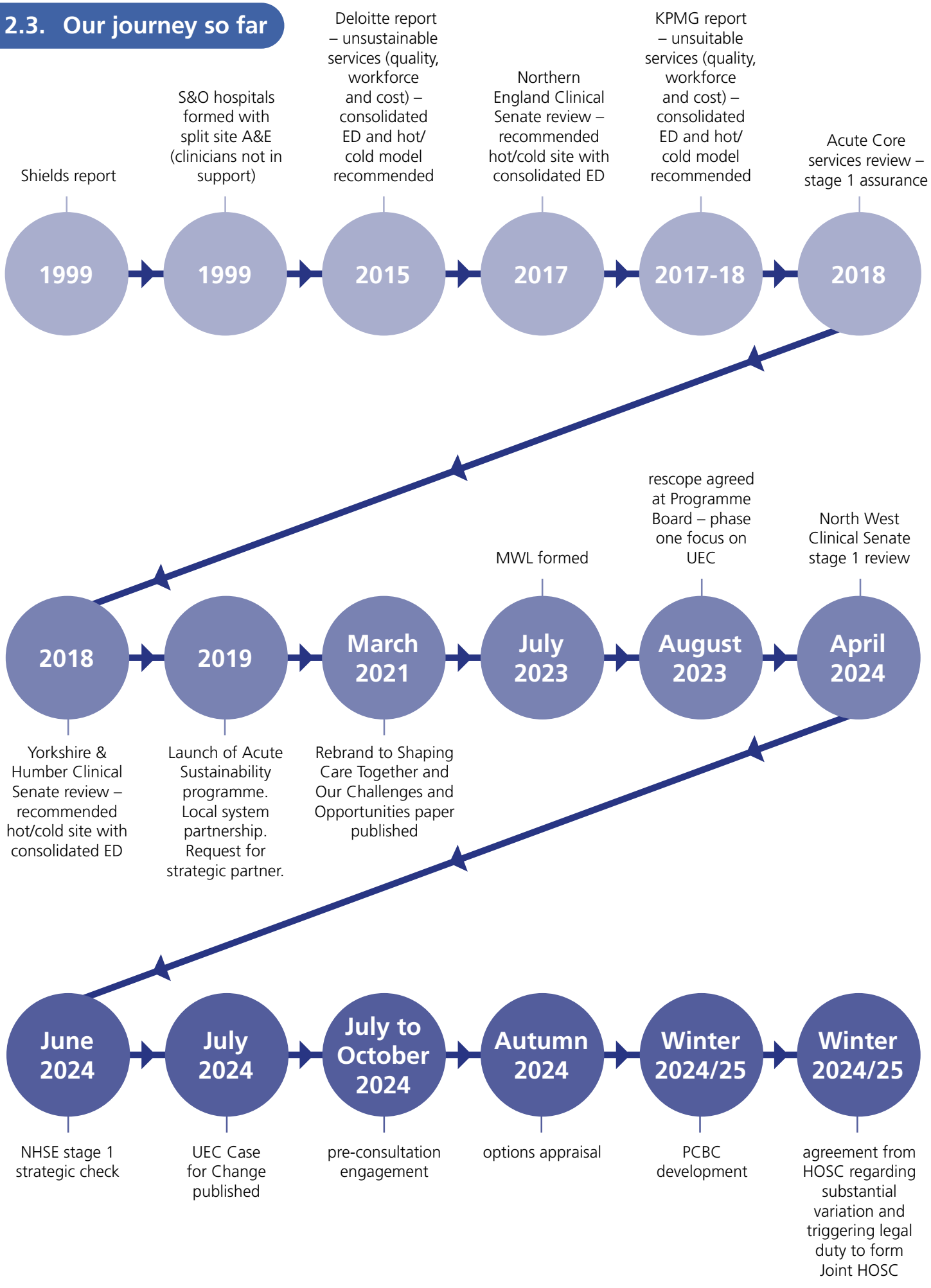
The local NHS in Southport, Formby, and West Lancashire is dedicated to providing excellent quality care to everyone at all times. It is committed to reducing health inequalities for the populations it serves. The SCT programme was established to help achieve these ambitions through the care provided. The goal is to organise NHS services built on the provision of safe and high-quality care, both today and in the future. By working together with patients, dedicated healthcare professionals, and partners, it aims to optimise the use of available buildings, staffing, funding, and other resources.

The programme objectives for the first phase of the SCT programme is to further improve the safety and quality of **urgent and emergency care** in Southport, Formby and West Lancashire. In doing so aim to:

- Deliver urgent and emergency care services that are responsive, safe and sustainable
- Improve the integration of services across the health and care system
- Deliver services close to the local community, wherever possible

The aim is to move into the future with services that are fit for purpose, safe, and effective. However, this cannot be assured without making changes due to increasing patient demand, staff shortages, and significant financial challenges. Considering these factors, replicating all services across two sites is very challenging and unsustainable.

## 2.3. Our journey so far



## 2.4. Why are we conducting this review

Much of the NHS was designed decades ago to address the health needs of the population at that time. Therefore, it is appropriate to occasionally review our practices to ensure the system is equipped to meet today's challenges.

SCT is an NHS programme aimed at improving the way we provide health and care in Southport, Formby and West Lancashire. Our responsibility is to provide the highest quality of care to meet the needs of the patients and communities we serve. However, some pressures that are being felt right across the NHS, are making it harder for us to do this where we live. Staffing shortages, a need to invest in our buildings and estates, and funding challenges are putting services under pressure. We also have an ageing population, which means that demand for services will continue to rise in the future. The last Care Quality Commission report emphasises the need for future adaptations and highlights the challenges of operating across two main hospital sites, despite our commitment to

safe, sustainable, and excellent patient care. We need to prepare our local NHS to meet those future needs and expectations, delivering high-quality services that are both safe and sustainable.

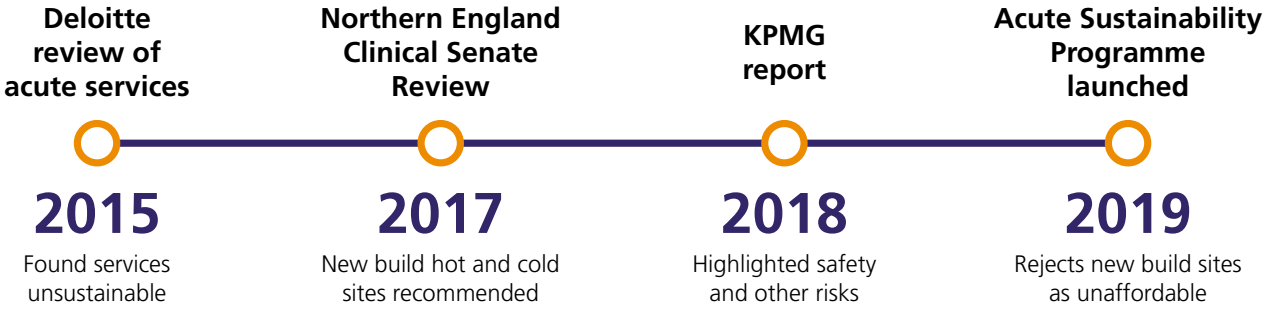
SCT is about finding ways to make the best use of staff, money, and other resources to achieve its goals. It is acknowledged that changing too much and too often can be disruptive and costly, and now is the right time to look for new and better ways to organise the local NHS. By working together with patients, dedicated healthcare professionals, and partners, there is confidence that the right solutions can be found. Since the start of Shaping Care Together, efforts have been made to listen to people and organisations affected by, and involved in, the provision of health and care services. The aim has been to get as many people as possible to share their experiences and to contribute their thoughts and ideas about what works well, what doesn't, and to help define what good should look like.

### Key summary:

The SCT Together programme aims to improve health and care services in Southport, Formby, and West Lancashire by addressing current challenges such as staffing shortages, infrastructure needs, and funding issues, while preparing for an ageing population.

By collaborating with patients, healthcare professionals, and partners, the programme seeks to optimise the use of resources and implement sustainable, high-quality care solutions based on community feedback and experiences.

## 2.5. Why we're starting with urgent and emergency care




Southport & Ormskirk District General Hospitals NHS Trust was established in 1999. At that time, it was decided that critical care services, including adult A&E, would be based at Southport and Formby District General Hospital, while paediatric and maternity services, including children's A&E, would be located at Ormskirk District General Hospital. This decision was not universally supported. Clinicians continue to express concerns about the risks associated with delivering acute services across both sites.

UEC services are experiencing unprecedented strain. Several expert reviews over the past decade have underscored the need for change, highlighting the following factors:

- Children's emergency and urgent care services are not provided 24/7, potentially resulting in a disparity in the quality of care compared to adults.
- Staff shortages can sometimes hinder the provision of the high levels of patient safety we strive for.
- The current model of service delivery is not financially sustainable in the long term.
- Increased pressure in one area of care often impacts the entire system. When urgent and emergency care services in our hospitals are under strain, it is felt across the system.
- Many patients are older individuals who occupy hospital beds for extended periods while awaiting the necessary support to be arranged closer to home.

In summary, now is the opportune time to address these issues. The approach taken and the manner in which services are delivered will significantly impact the success of the entire SCT programme. Consequently, the NHS partner organisations behind SCT have decided to prioritise urgent and emergency care. This decision was presented to and approved by the SCT Programme Board in August 2023, which comprises executives and leads from MWL, NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB, and the NHS England North West regional team.

In April 2020, the difficult decision was made to reduce A&E opening times at Ormskirk District General Hospital. As a result, there is currently no dedicated A&E service for children and young people between midnight and 8:00 am. Importantly, there are not enough appropriately skilled staff to safely re-open the paediatric A&E service overnight.

To provide paediatric A&E services safely and ensure that emergency departments are supported by medical staff with the right training and skills, support is needed from anaesthetics and paediatrics. When the children's service is located at the same site as adult A&E, this support can be available within the wider workforce. If additional support is needed at Ormskirk District General Hospital, it currently requires calling in the consultant from home or transferring staff from Southport and Formby District General Hospital, which increases the risk to adult services.

Due to inefficient use of resource and duplication of staff, if a 24-hour service was resumed the average cost of each patient seen there would be 59 per cent higher than the national average.

## 2.6. What will be better

Over the past decade, several expert reviews have highlighted the need for action to address current challenges. In 2017 and 2018, two separate clinical senate reviews described the former Southport and Ormskirk District General Hospitals NHS Trust as "unsustainable in its current form." In 2019, the Care Quality Commission, the independent regulator for health and adult social care in England, rated the trust as "requires improvement."

In 2021, the trust's board recognised the need for external assistance to address issues related to financial and clinical sustainability. With support from NHS England, the neighbouring St Helens and Knowsley Teaching Hospitals NHS Trust was identified as a suitable partner to assist Southport and Ormskirk. Collaborative efforts then commenced to explore opportunities for improved operations by bringing the two trusts closer together. These efforts included:

- Improved clinical sustainability
- Better ways of organising clinical services
- Opportunities to develop the workforce
- Making better use of buildings and estates
- Benefiting from economies of scale
- Improved digital services and integration

In 2023, the two trusts were formally merged to create Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), marking a significant step towards stabilising fragile services. However, this was only the beginning. Concurrently, the SCT programme has been exploring ways to organise these services for long-term sustainability. The SCT programme is dedicated to providing high-quality, safe care for everyone, both now and in the future. It aims to address current challenges faced by the local NHS and identify the most effective ways to deliver services. Ultimately, the focus is on improving outcomes for the people they serve.

Some of the benefits the programme hopes to realise through the urgent and emergency care phase of the programme are:

- **Reduced waiting times at A&E and for urgent care:** We want to make sure that fewer people come to A&E if they would be better off receiving treatment from another service. This is in everybody's best interest. Of course, we will need to make sure that other services, such as urgent care, are operating smoothly. For some people, we also need to make them aware of the range of services we offer and do all we can in supporting them to access the support they need. Fewer people coming to A&E would mean a better flow of patients through the department and fewer patients needing a hospital bed once they leave A&E. Better patient flow should mean we will be able to get to you quicker once you are in the waiting room.
- **Fewer cancelled operations:** demand for urgent and emergency care is unpredictable, and when services are strained, it affects the entire health system. Busy emergency departments increase hospital admissions, reducing bed availability for scheduled operations, leading to more cancellations and longer waiting lists. While improving A&E operations doesn't guarantee reduced waiting lists, it can help alleviate pressure.
- **Dedicated emergency care for everyone, all-day, every day:** aim to provide 24/7 A&E access for everyone, but since 2020, there has been no overnight children's A&E at Ormskirk District General Hospital. Evidence indicates that re-opening overnight with the recommended staffing would increase costs per patient by 59% above the national average. Additional workforce and financial resources are needed, but they must work within current constraints. Re-opening overnight would require significant new service efficiencies or reallocating resources from other areas.

- **Better urgent care provided closer to home:** urgent and emergency care extends beyond hospitals to include home care, pharmacy advice, and GP treatment. Post-hospital support is often necessary for full recovery. NHS guidance states that people should not be admitted to hospital if they can access the same or higher quality of care in their own home. The focus of service redesign will need to be on UEC services, however, to make this work, we will need to be sure that the wider network of services is able to give people the support they need, closer to home, this includes services such as virtual wards, urgent community response, intermediate care, care coordination and digital health all of which are part the each ICBs wider system UEC plans.
- **An NHS that can meet the needs of the local population, today and in the future:** it is recognised that difficult choices must be made and that some services are currently classified as fragile. Confidence remains that significant improvements can be achieved through the reorganisation of these services. The goal is to ensure the delivery of safe and high-quality care, both now and in the future.

## 2.7. How has the review been carried out

Throughout spring 2024, the SCT programme developed the Case for Change. This process, led by clinicians, aimed to address the needs of our patients and the local population. The Case for Change highlights the necessity for improvements in UEC services across Southport, Formby and West Lancashire. After thorough review by key stakeholders—including clinicians, commissioners, NHS England, Healthwatch, the voluntary sector, and patient and public representatives – the Case for Change was approved in July 2024 by the Boards of MWL and, NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria ICBs. Following its publication, a 10-week pre-consultation engagement period commenced. This engagement included public roadshow events, public meetings (both in-person and online), focus groups, staff roadshow events, staff meetings, and a survey. Further details on the pre-consultation engagement can be found in Section 7.

The feedback and insights gathered during this pre-consultation engagement were instrumental in forming a comprehensive list of potential options for consideration in the options appraisal process. Conducted in autumn 2024, this clinically led process involved the development of hurdle and evaluation criteria, as well as supporting information to assist appraisers during the workshops. Clinicians played a crucial role in both the development and application of these criteria.

More information about the options appraisal process is available in Section 5. Additionally, public and patient representatives significantly contributed to the options appraisal process by participating in the development of the criteria and serving as appraisers during the workshops.

Following the successful application of the evaluation criteria, the two following options were identified on the shortlist of options:

- **Option 1:** colocation of adult and paediatric A&E services at Ormskirk District General Hospital.
- **Option 2:** colocation of adult and paediatric A&E services at Southport and Formby District General Hospital.

Through the scoring process, option 2 scored higher than option 1 and therefore was proposed to SCT Programme Board as a preferred option. Detailed information on the shortlist and the preferred option is available in Section 5.4.

Adherence to national guidance has been paramount. Since the programme's inception, the SCT programme team has rigorously followed NHS England's planning, assuring and delivering service change for patients[3], Addendum to planning, assuring and delivering service change for patients (March 2018)[4] and the HM Treasury Greenbook[5] guidance.

### Key summary:

- The SCT programme developed the Case for Change in spring 2024 to address the urgent and emergency care needs in Southport, Formby, and West Lancashire.
- After extensive stakeholder engagement and evaluation, two options were identified: co-location of adult and paediatric A&E services at:
  - Ormskirk District General Hospital (option 1)
  - Southport & Formby (option 2)
- Option 2, co-location at Southport and Formby District General Hospital, scored higher and is proposed as the preferred option in this document.
- The programme has adhered to national guidance throughout its development.

[3] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf
[4] https://www.england.nhs.uk/wp-content/uploads/2018/03/B0595_addendum-to-planning-assuring-and-delivering-service-change-for-patients_may-2022.pdf
[5] https://www.gov.uk/government/collections/the-green-book-and-accompanying-guidance-and-documents

## 2.8. Strategic fit

### 2.8.1. Local strategies

The Shaping Care Together programme aligns with the strategic priorities of all partner organisations, each of which is committed to developing more sustainable and effective urgent and emergency care services.

While the provision of maternity services is under review by NHS Cheshire and Merseyside ICB and the commissioning of neonatal services is being reviewed by the NHS England North West region specialised commissioning as part of major service change programmes, these services are out of the scope of this programme. However, it is important to note that there is clear interconnectivity between the outcomes of all three programmes. This is further highlighted in Section 9.5.

#### 2.8.1.1. Mersey and West Lancashire NHS Teaching Hospitals NHS Trust

A driving factor behind the creation of Mersey and West Lancashire NHS Teaching Hospitals NHS Trust (MWL) was that there would be opportunities to stabilise a number of services that had been identified as fragile. These opportunities included:

- Improving clinical sustainability.
- Clinical reconfiguration.
- Workforce development.
- Estates optimisation.
- Delivering economies of scale and,
- Improved digital services and integration.

MWL Trust has set up robust governance arrangements to support oversight and scrutiny, at executive level, of all internal transformation programmes which aims to identify and deliver opportunities to manage risk and improve the delivery of clinical services. Current work programmes include the development of the MWL Anaesthetic Strategy to meet the needs for elective and emergency services as a single service delivered across all MWL sites, Urgent and Emergency care improvement aligned to the Cheshire & Merseyside improvement programme and support to implement a new organisational structure to support the ethos of 'One team, One Trust'. MWL is also engaged with wider local and regional programmes to improve Maternity and neonatal services.

The SCT programme was established to harness some of these opportunities and make services sustainable. The programme focuses on possible service reconfiguration across Southport & Formby and Ormskirk District General Hospitals. The hospitals serve communities spread across two healthcare systems (known as ICBs). Southport and Formby District General Hospital and Ormskirk District General Hospitals serves communities in the area covered by NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria ICB,this is why all three organisations are partners in the SCT programme and why it is important that the programme is a good strategic fit with each.

#### 2.8.1.2. Cheshire and Merseyside

NHS Cheshire and Merseyside ICB has developed a Health Care Partnership Strategy and a Joint Forward Plan (2023-2028) which includes the aim to improve urgent and emergency care. These include commitments to:

- Improving waiting times for emergency care.
- Drive uptake of COVID-19, flu and pneumonia vaccines, which in turn will help to reduce hospital admissions.
- Reduce unnecessary emergency department admissions.
- Improve the speed with which patients are discharged through ongoing development of community services and collaborative working.
- Do more to separate planned and emergency care and to maximise use of independent sector capacity.

Urgent care is a key priority for NHS Cheshire and Merseyside ICB. Significant work is ongoing at all levels with key partners, including local developments in the nine Place Partnerships,

around each hospital cluster, and across the entire ICB geography. In Sefton, the establishment of an Urgent Care Board has facilitated the coordination of local developments and plans involving local authority partners, primary care, community services, the voluntary sector, and acute providers. This work feeds into the broader ICB urgent care recovery programmes across Merseyside.

Appendix 1 highlights the key areas where system partners are collaborating to avoid unnecessary hospital admissions by providing appropriate alternatives to hospital care, ensuring a smooth journey through hospital services, and offering good care and support options for patients upon discharge. The Better@Home programme has been driving improvements in system working around the Southport & Formby and Ormskirk District General Hospital sites. Along with all the urgent care developments, it supports the direction of travel anticipated for the 10-year plan. All this work connects to the SCT Programme, emphasising the importance of providing local people with access to high-quality urgent care services, both in hospital and community settings.

## Primary care

Primary care in Sefton is delivered through a range of services that provide rapid access to clinical support for people with urgent, but not life-threatening, health needs. This includes same-day general practice appointments, home visiting services, community pharmacy consultations, urgent dental and eye care, and enhanced access outside normal working hours—all designed to offer timely care close to home and reduce pressure on hospital services.

**General Practice:**
Within Sefton, there are 39 GP practices of which Southport and Formby have 14 GP practices, supported by several urgent and out-of-hours services. The acute visiting service operates weekdays for home visits to acutely unwell housebound patients, handling up to 40 visits daily. The two-hour urgent community response runs daily, including bank holidays, offering rapid care for acute and frailty-related issues without needing GP referral. Both services have low rates of hospital referrals. Enhanced access provides pre-booked evening and weekend appointments with GP practice staff in Southport, while out of hours (OOH) urgent care is delivered across multiple sites.

**Dental:**
Sefton has 32 dental practices, with urgent care coordinated by an urgent dental care helpline and delivered through selected practices offering emergency and ongoing treatment.

**Optometry:**
Sefton Eyecare Services offers several specialised pathways:

- Community urgent eyecare services (CUES) provides urgent eye care via triage, with rapid access to telemedicine or in-person appointments and referrals if needed.
- Pre-cataract service confirms cataracts, counsels patients, and supports informed provider choice.
- Glaucoma repeat readings reduces unnecessary hospital referrals by repeating key tests.
- People with learning disabilities / easy eyecare pathway ensures accessible eye care for people with learning disabilities or autism through specially trained optometrists.

**Pharmacy:**
The Pharmacy First Service is available at most pharmacies across Southport and Formby, offering walk-in consultations for common conditions like sore throats, UTIs, and earaches. Pharmacists can prescribe treatments when needed, refer patients for further care, and automatically update GP records. Additionally, the following services are also available at a number of pharmacies across Sefton; hypertension case-finding service, pharmacy contraception service, lateral flow device service, care at the chemist, emergency hormonal contraception, stop smoking services, needle syringe provision, opioid substitution therapy, naloxone provision, palliative care stock-holding, dressing supply to nursing homes, discharge medicines service and new medicines service.

**NHS111:**
NHS 111 is a free, non-emergency service that provides medical advice, information, and direction to appropriate care 24 hours a day by phone or online.

### 2.8.1.3. Lancashire and South Cumbria

The Lancashire and South Cumbria ICB Joint Forward Plan published in 2024 outlines a clear ambition to make sure people have equal access to high-quality, efficient and joined-up services. The plan includes several commitments to improving service quality and patient outcomes, many of which focus on urgent and emergency care. These include:

- Reducing the number of people needing to enter the hospital 'front door' (A&E departments).
- Moving care closer to home wherever possible.
- Avoiding unnecessary hospital admissions.
- Improving access to urgent care.
- Targeting reduced waiting times for care.

In addition to this, NHS Lancashire and South Cumbria ICB have developed an urgent and emergency care five-year strategy 2024 –2029 (Appendix 2) with a clear vision to create an urgent and emergency care system that enables people to easily access the right care and support, at the lowest level of intervention, that best meet their needs, and delivers better outcomes and affordability.

## Primary care

In West Lancashire, primary care is supported by a coordinated network of services designed to respond promptly to non-life-threatening health concerns. These services include same-day GP appointments, home visits, consultations with community pharmacists, and access to urgent dental and eye care. Extended hours provision also ensures that residents can receive care outside of standard working times, helping to deliver responsive support close to home while easing demand on hospital-based services.

**General Practice:**
Within West Lancashire, 16 GP practices—two operating across multiple sites—are supported by an OOH service. The OOH service provides evening, overnight, weekend, and bank holiday coverage through home visits and surgery-based appointments.

Triage is managed remotely by a virtual clinical team, which assesses all cases and directs patients to appropriate care. Access to the OOH service is via NHS 111. District nurses can also contact the service directly for medication requests or clinical advice.

On average, over 600 cases are triaged monthly, with 50–60% resolved at the triage stage and ED referrals remain low.

**Dental:**
West Lancashire is served by 15 dental practices, with urgent dental care coordinated through a dedicated helpline and delivered by selected practices that provide both emergency and ongoing treatment.

**Optometry:**
Within West Lancashire, the following services are offered:

- CUES offers NHS-funded, same-day or next-day appointments with accredited optometrists for sudden eye problems—such as pain, vision loss, or foreign bodies—without a GP referral, and is available across optometrists in West Lancashire.
- West Lancashire patients have access to three glaucoma services through local optometrists: glaucoma repeat readings, enhanced case finding, and ocular hypertension monitoring, offering advanced assessments and monitoring to reduce unnecessary hospital visits and support early detection and management.
- Patients in West Lancashire with moderate to severe learning disabilities or autism can benefit from the NHS easy eye care service, which provides inclusive and supportive eye tests through trained optometrists, offering flexible appointments and accessible communication tailored to individual needs.
- The Low Vision Service in West Lancashire supports patients with sight loss by providing functional vision assessments, magnification aids, and referrals to additional support, helping individuals optimise their remaining vision and maintain independence.

**Pharmacy:**
The Pharmacy First Service is available at most pharmacies across West Lancashire offering walk-in consultations for common conditions like sore throats, UTIs, and earaches. Pharmacists can prescribe treatments when needed, refer patients for further care, and automatically update GP records. Additionally, the following services are also available at most pharmacies across West Lancashire; hypertension case-finding service, pharmacy contraception service, lateral flow device service, care at the chemist, emergency hormonal contraception, stop smoking services, needle syringe provision, opioid substitution therapy, naloxone provision, palliative care stock-holding, discharge medicines service and new medicines service.

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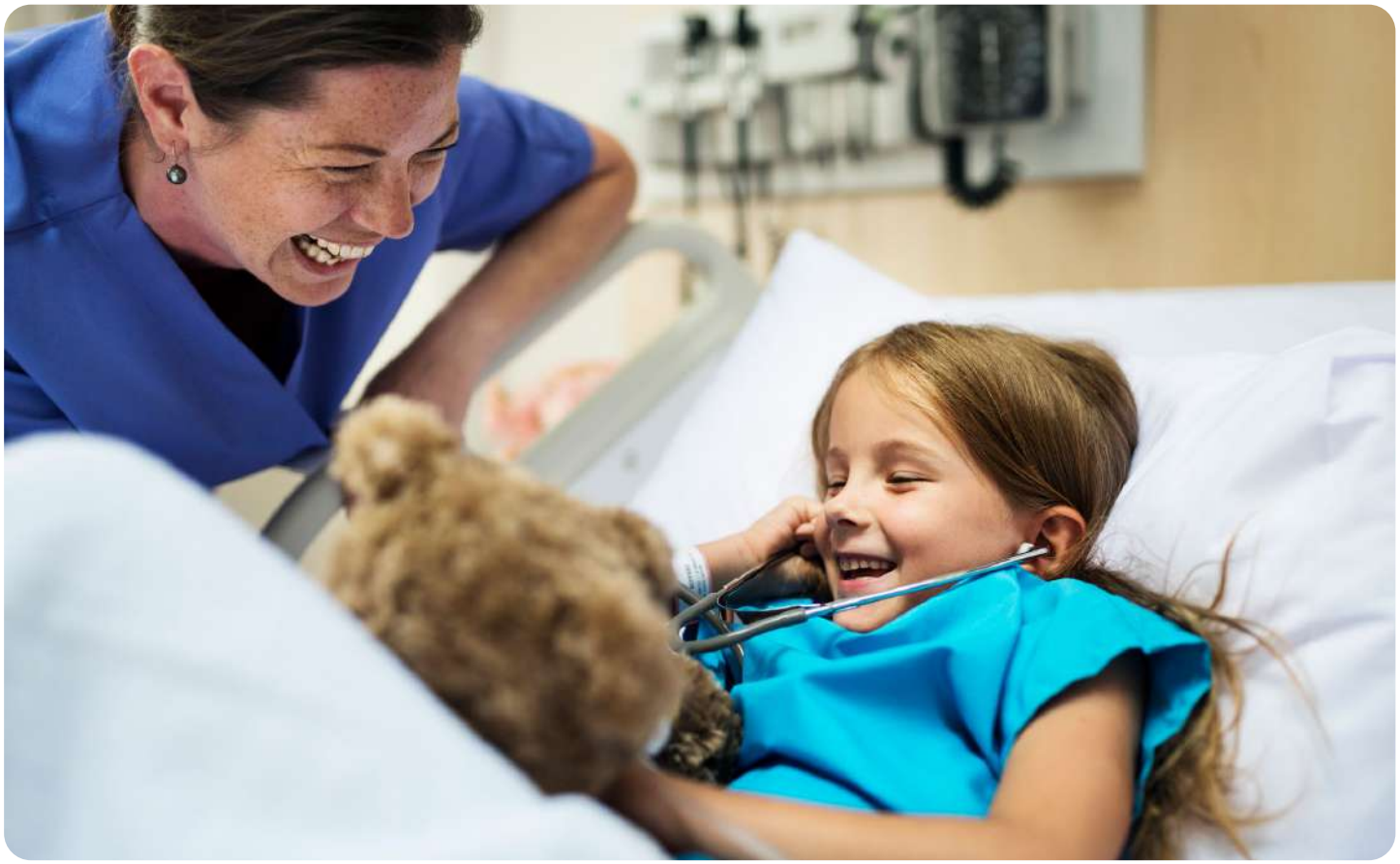
In addition to this, NHS Lancashire and South Cumbria ICB have developed an urgent and emergency care five-year strategy 2024 –2029 (Appendix 2) with a clear vision to create an urgent and emergency care system that enables people to easily access the right care and support, at the lowest level of intervention, that best meet their needs, and delivers better outcomes and affordability.



## 2.8.2. National strategies

Over the last four years, UEC care services have been through the most testing time in NHS history, as demonstrated through the Department of Health & Social Care and NHS England's delivery plan for recovering urgent and emergency care services[7]. With a perfect storm of pressures impacting the whole health and care system. These are perhaps often most visible at the front door – our EDs. Despite the best efforts of staff, the demands of flu and COVID-19 peaking together means we are finding it increasingly difficult to discharge patients to the most appropriate care settings. Alongside this, hospital occupancy is at record levels. This means patient 'flow' through hospitals has slowed. As a result, patients spend longer in A&E and wait longer for ambulances. Hospitals are fuller than pre-pandemic, with 19 out of 20 beds occupied across the NHS in England. Importantly, at any one time, up to 14,000 beds are occupied by someone who no longer needs hospital care. The number of the most serious ambulance callouts is now sometimes one third higher than pre-pandemic levels. These pressures have also taken their toll on staff, who have to work in an increasingly challenging environment.

However, the solutions are not to be found just in ambulance services or EDs. Recovery will require coordination and partnership working between different parts of the NHS. We also know this is not unique to England, with many similar challenges faced by nations across the UK and the world. Even before the pandemic, pressure on urgent and emergency care and demand for services had been growing every year. Our ageing population means that we are going to see this continue. Published in January 2019, The NHS Long Term Plan[8] aims to make the NHS fit for the future. The plan sets out to make sure everyone gets the best start in life, to deliver world class care for major health problems and to support people to age well. It sets out a new NHS service model for the 21st century with a focus on:

- Out of hospital care.
- Reformed and expanded emergency care services.
- People having control over their own health.
- More personalised care for people when they need it.
- Digitally enabled primary and outpatient care.
- A focus on population health.

Building on this, the 2025/26 [9] NHS priorities and operational planning guidance outlines critical measures to address the current UEC crisis. These include:

Reducing avoidable ambulance callouts and improving response times by increasing access to urgent community response (UCR) and virtual wards.

Enhancing hospital flow and discharge by reducing delays, increasing the percentage of patients discharged within seven days of admission, and working with local authorities to expand intermediate care services.

Optimising the use of Same Day Emergency Care (SDEC) and Urgent Treatment Centres (UTCs) to ensure more patients receive timely treatment without unnecessary hospital admissions. Strengthening digital tools and data-driven decision-making, including the expansion of the Federated Data Platform (FDP) to improve real-time resource allocation.

Lord Darzi's 2024[10] review of the NHS highlighted several critical issues:

- Rising demand and resource constraints: The NHS is facing increased demand due to an ageing population and higher rates of chronic illness. However, it has fewer resources compared to other health systems, including fewer doctors, nurses, and hospital beds.

[7] B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf
[8] https://www.england.nhs.uk/publication/the-nhs-long-term-plan/
[9] https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN01625-25-26-priorities-and-operational-planning-guidance-january-2025.pdf
[10] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

- Impact on routine care: The NHS has had to delay or cancel more routine procedures, such as hip and knee replacements, compared to other health system.
- Staff morale and productivity: Low staff morale and productivity were identified as significant challenges. The report emphasised the need for better support and working conditions for healthcare workers.
- Healthcare quality and access: There are disparities in the quality of care and access to healthcare services across different regions. The report called for measures to ensure more equitable healthcare delivery.
- 10-year reform plan: Lord Darzi proposed a comprehensive 10-year plan to reform the NHS, focusing on improving efficiency, increasing funding, and leveraging technology to enhance patient care.

Additionally, Lord Darzi's 2024 review of the NHS emphasises three key shifts to address the current challenges and improve the healthcare system:

- Shift from hospitals to community care: This involves moving more care services from hospitals to community settings and people's homes. By doing so, the NHS aims to reduce the pressure on hospitals, improve patient outcomes, and ensure that care is delivered closer to where people live.
- Embrace digital transformation: The report highlights the need to leverage digital technologies to enhance healthcare delivery. This includes expanding telehealth services, using electronic health records more effectively, and integrating digital tools to streamline operations and improve patient care.
- Focus on prevention over treatment: There is a strong emphasis on shifting the focus from treating illnesses to preventing them. This involves investing in public health initiatives, promoting healthy lifestyles, and implementing early intervention strategies to reduce the incidence of chronic diseases.

These shifts are designed to create a more sustainable, efficient, and patient-centred healthcare system, aligning with the upcoming NHS 10-Year Health Plan, which aims to modernise services by expanding community-based care, embracing digital innovation, and prioritising prevention to improve long-term health outcomes.

These points underscore the urgent need for reforms to ensure the NHS can meet future healthcare demands effectively.

Through collaborative partnerships, the SCT programme clearly aligns with the broader UEC transformation initiatives across NHS Cheshire and Merseyside and NHS Lancashire & South Cumbria, as demonstrated above. This addresses the challenges in UEC services care across both systems by implementing the three key shifts highlighted in the Lord Darzi report. These shifts aim to improve patient flow, reduce hospital occupancy, and enhance the efficiency and effectiveness of emergency care services. Appendix 1 details the strategic alignment between the system transformation programmes and the SCT programme.

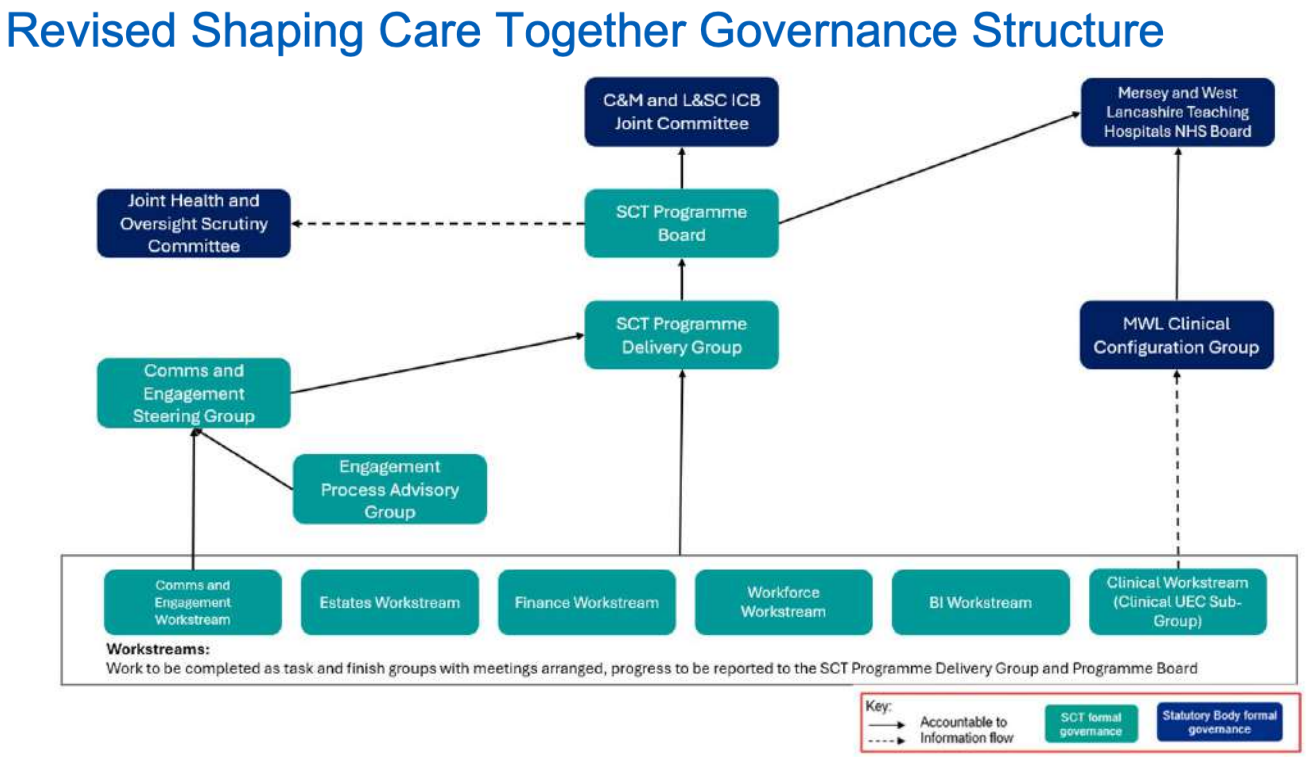
## Key summary:

- All three partners have system UEC programmes that the SCT programme aligns to
- The UEC system programmes all focus on the three shifts outlined in the Lord Darzi review of the NHS (September 2024),:
  - Analogue to digital
  - Acute to community
  - Focus on illness to prevention

## 2.9. Programme governance

The programme governance structure can be found in Figure 1. Workstreams have been set up to progress the different elements of the programme, which report into the Programme Delivery Group. Oversight of programme delivery sits with the Programme Board which reports into the Joint Committee of the two ICBs, as well as MWL Trust Board, with a reporting line to the joint Health Overview and Scrutiny Committee (HOSC) of Sefton and Lancashire.

Figure 1




### NHS Cheshire and Merseyside (C&M) and NHS Lancashire & South Cumbria (L&SC) ICB Joint Committee:

The Joint Committee is responsible for the key programme decisions for the Shaping Care Together programme, supporting the partners to collaboratively make decisions on the planning and delivery of the Programme including the approval/ consideration of: Pre-consultation Business Case (PCBC) in relation to Shaping Care Together; Public Consultation outcomes and ensuring the business case meets all relevant tests/stages as set out by NHS England, including public engagement/ involvement outputs and impact assessments and any Decision-making Case. The Joint committee is made up of and Executive and Non-Executive member from each ICB and an additional ICB executive.

### Programme Board

The purpose of the SCT Programme Board is to oversee the programme's delivery, ensure outcomes and benefits are achieved, and addresses system risks, escalating issues to the relevant ICBs. Membership comprises executives and leaders from MWL, NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB, NHS England Specialised Commissioning, NHS England Service Change Directorate, and the SCT programme team. The Board is chaired by the MWL Chair, with meetings taking place on a monthly basis.

## Programme Delivery Group

The SCT Delivery Group oversees the SCT workstreams, ensuring outputs are delivered and risks managed, while providing leadership and coordination for the development of the PCBC. It also ensures alignment with strategic goals, compliance with consultation regulations, and ensures that NHS England are appraised of the development of the PCBC and feedback is appropriately reflected within the PCBC. Membership comprises the senior programme leads, including the Senior Responsible Officer, commissioning leads from NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB, the leads for each programme workstream, and the SCT programme team. Meetings are held monthly and are chaired by the SCT Programme Director.

## Communications and Engagement Steering Group

The SCT Communications and Engagement Steering Group supports the development and delivery of the SCT Programme's strategy, ensuring effective public engagement and consultation. It oversees communication work, reviews external proposals, aligns activities with organisational work, and ensures equality considerations are prioritised. The group also provides assurance on communication robustness and addresses any arising risks. Membership comprises communications and engagement leads from NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB, and MWL, the SCT programme team, and representatives from Sefton Healthwatch, Lancashire Healthwatch, CVS Sefton, and West Lancashire CVS. Meetings are held monthly and are chaired by the NHS Cheshire and Merseyside ICB Communications and Engagement Lead.

## Engagement Process Advisory Group (EPAG)

The SCT Engagement Process Advisory Group members advise on engagement strategies and process to support pre-consultation for staff, patients, and the public, ensure broad participation, identify contributing groups, and promote extensive engagement. They will also ensure engagement outputs inform NHS changes and adhere to the Nolan principles of public life. Membership includes representatives from Healthwatch Sefton, Healthwatch Lancashire, CVS Sefton, West Lancashire CVS, as well as representatives from service user groups Hesketh Community Bank, Change Grow Live, Community Champions, Galloways, People First, Age UK, Southport Access for Everyone, Myeloma Support Group, Sefton Cancer Support and Breathe Easy North Sefton.

## SCT Workstreams

Workstream groups have been established to advance the communications and engagement, estates, finance, workforce, business intelligence (BI), and clinical components of the programme, with leads identified for each workstream. Each workstream group meets at least monthly with the programme team to update on key deliverables and milestones.

## SCT Clinical UEC Sub-group

The SCT Clinical UEC Sub-group aims to provide clinical leadership and oversight in developing a clinical model of care for safe and effective urgent and emergency services for MWL residents in Southport, Formby, and West Lancashire, ensuring that proposed service changes and business cases are based on solid clinical evidence. Membership includes clinical, operational and commissioning leads across NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB, and MWL, primary care, HCRG Care Group Ltd (Ormskirk Urgent Treatment Centre (UTC) and Skelmersdale Walk-in Centre (WIC) provider), Merseycare NHS Foundation Trust, Alder Hey Children's Hospital NHS Trust, North West Ambulance Service NHS Trust and the SCT programme team. Meetings take place monthly, or more frequent when required, and are chaired by the MWL Divisional Medical Director for Medicine, who is also a consultant in emergency medicine.

## 2.10. Purpose and scope of PCBC

This PCBC demonstrates adherence to the NHS England assurance framework as outlined in Planning, Assuring, and Delivering Service Change for Patients guidance[11] and meets the four tests of service reconfiguration:

- Strong public and patient engagement;
- Appropriate availability of choice;
- Clear clinical evidence based;
- Support for proposals from commissioners.

Public consultation is a statutory requirement for major service changes. It is also a fundamental component of our co-design and continuous engagement approach with service users. The consultation and engagement process is governed by Sections 242 and 244 of the National Health Service Act 2006[12]. The legislative framework has been expanded through guidance published by the Department of Health, which mandates public engagement and consultation activities, as well as the need for a business case explaining any proposed significant changes. NHS England has provided additional guidance on the details that the business case should include to form a PCBC.

The PCBC is a technical and analytical document that provides the necessary information for the ICB Joint Committee to decide whether to proceed to consultation. It details the process undertaken to identify a compelling case for change, explains why maintaining the status quo is untenable, outlines our proposed changes, presents the final set of proposals, and discusses the implications of these proposals. It includes:

- A full case for change (published in full in July 2024) – see Appendix 3
- A summary of our case for change for Urgent and emergency Care[13]
- Our vision, supported by clinical standards
- How we have considered the potential options available to us and evaluated them to move through a full, long and short list for the reconfiguration of urgent and emergency care specifically hospital A&E departments across Southport, Formby and West Lancashire
- The proposals for service change upon which we will consult; and
- What we believe the next steps are to enable us to move to public consultation and to support planning for implementation


[11] NHS England (footnote 3)
[12] https://www.legislation.gov.uk/ukpga/2006/41/section/242
[13] https://yoursayshapingcaretogether.co.uk/library

# 3. Case for Change

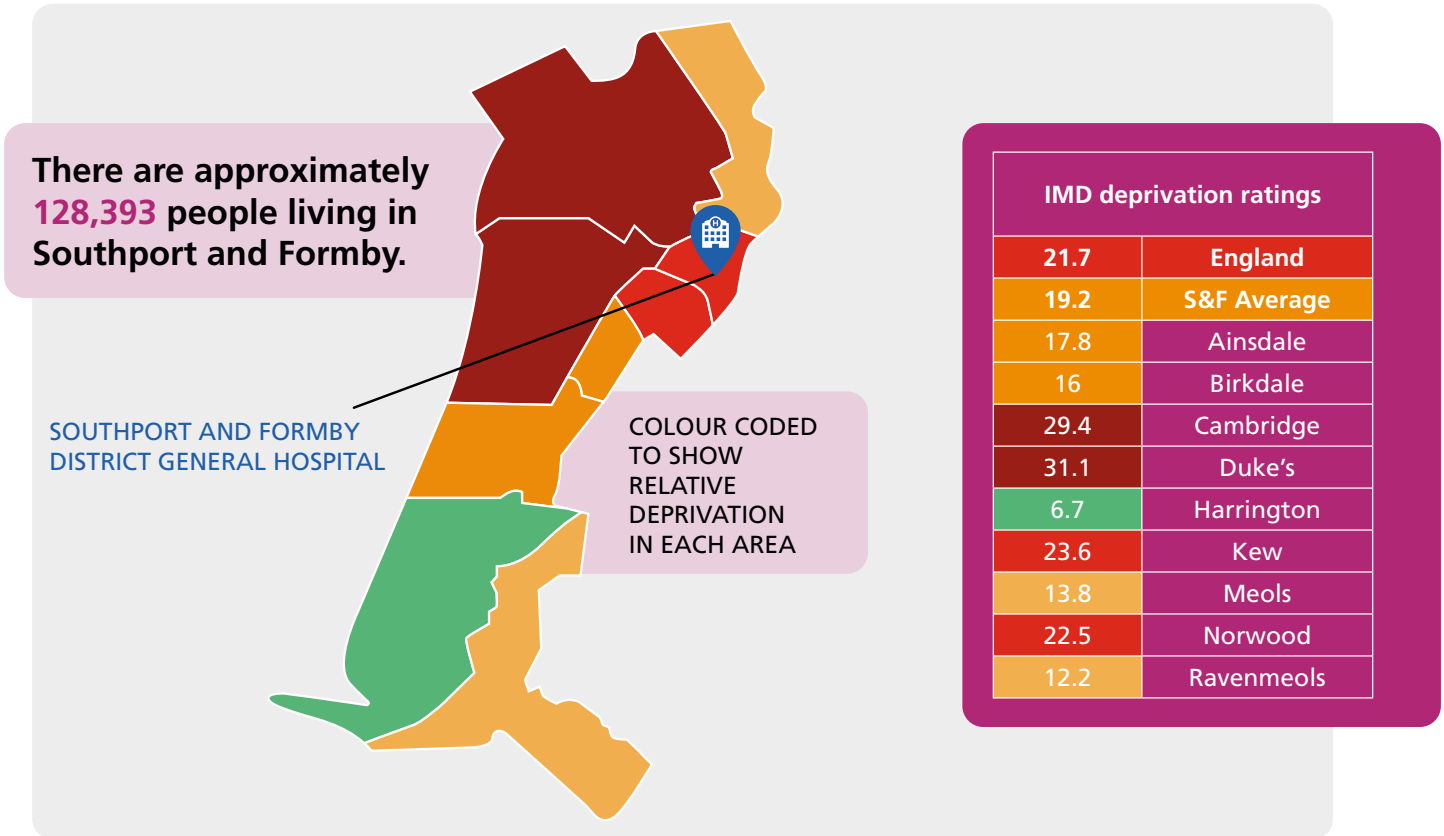
## 3.1. Population need

### 3.1.1. Southport and Formby

The Southport and Formby area, located within the Metropolitan Borough of Sefton to the north of Liverpool, is predominantly coastal and semi-rural, stretching along the Irish Sea coastline. With a population of 128,393, Southport itself is a sizeable coastal town, while the surrounding regions remain more sparsely urbanised. These areas feature scattered villages, suburban residential neighbourhoods, open countryside, farmland, and pockets of woodland. Compared to other parts of Merseyside, the area is generally considered affluent. However, notable social inequalities persist.

Certain areas, such as Ravenmeols and particularly Harrington, are relatively prosperous, with Harrington scoring 6.7 on the Index of Multiple Deprivation (IMD) – see Figure 2. In contrast, areas like Cambridge and Duke's face higher levels of deprivation, with ratings of 29.4 and 31.1, respectively, compared to the all-England average of 21.7 and the Southport and Formby average of 19.2. This disparity is also reflected in income levels, with residents of Harrington earning the highest average income, while those in Cambridge and Duke's have the lowest, falling below both the national and local averages. Similarly, Kew and Norwood exhibit higher overall deprivation, while areas such as Ainsdale, Birkdale, and Meols fare better than the Southport and Formby average.

Figure 2

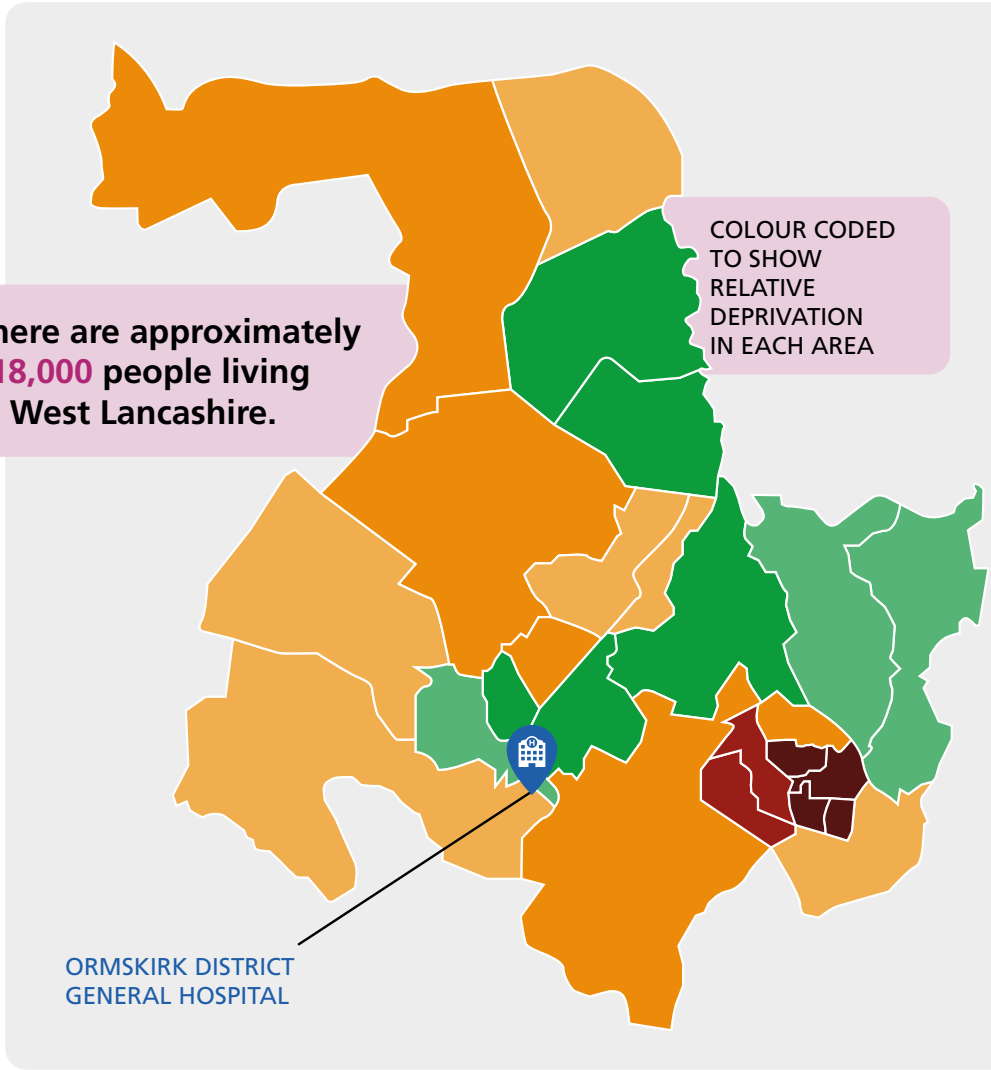


## 3.1.2. West Lancashire

West Lancashire is a predominantly rural district located to the north-east of Liverpool, with a population of 118,000. It encompasses the 1960s new town of Skelmersdale, the historic market town of Ormskirk, and several villages primarily situated in the rural Northern Parishes.

While much of the district is relatively affluent, there are notable pockets of poverty and deprivation. Areas such as Wrightington, Tarleton, Aughton Park, Parbold, Rufford, Newburgh, Knowsley, and Derby all have IMD deprivation ratings of under 10 (see full list in Figure 3), which places them above the all-England average rating of 21.7. However, poverty and deprivation are concentrated in a few electoral wards in Skelmersdale, including Digmoor (IMD rating of 49.9), Birch Green (43.5), Moorside (43.2), and Tanhouse (41.5). This concentration of deprivation contributes to significant social inequalities within the district.

Figure 3




| IMD deprivation ratings | |
|---|---|
| 21.7 | England |
| 18.6 | W Lanc average |
| 19.1 | Ashurst |
| 10.7 | Aughton & Downholland |
| 5.3 | Aughton Park |
| 18.1 | Bickerstaffe |
| 43.5 | Birch Green |
| 13.3 | Burscough East |
| 12.8 | Burscough West |
| 8.2 | Derby |
| 49.9 | Digmoor |
| 14.6 | Halsall |
| 10.6 | Hesketh-with-Beconsall |
| 9.8 | Knowsley |
| 43.2 | Moorside |
| 9.2 | Newburgh |
| 16.9 | North Meols |
| 5.0 | Parbold |
| 8.8 | Rufford |
| 16.7 | Scarisbrick |
| 16.5 | Scott |
| 31.0 | Skelmersdale North |
| 26.5 | Skelmersdale South |
| 41.5 | Tanhouse |
| 8.4 | Tarleton |
| 14.7 | Up Holland |
| 7.8 | Wrightington |

## 3.2. Key challenges

There are a number of challenges the trust faces in providing emergency care for the populations of Southport, Formby and West Lancashire;

- Workforce: The NHS in Southport, Formby, and West Lancashire struggles with recruitment and retention, leading to costly reliance on temporary staff, and despite additional investment, shortages persist due to the limited number of new trainees and an aging population increasing demand for complex care. In addition to this, the medical workforce specifically remains to be a challenge with the separation of adult and paediatric EDs which require separate senior cover, an issue which has resulted in the overnight closure of the paediatric ED at Ormskirk District General Hospital.
- Infrastructure: Continuous investment in healthcare facilities is essential to avoid costly repairs and ensure they are suitable for patient care, especially for older individuals, to provide high-quality, safe services now and in the future.
- Quality: MWL strives to offer safe, sustainable services focused on excellent patient care, but the latest Care Quality Commission report highlights the need for future adaptations and the challenges of operating across two main hospital sites, which can strain staff.
- Financial: MWL's challenge is to deliver high-quality, safe services with current resources by finding innovative and efficient ways to address inefficiencies and eliminate duplication, as new funding is not available.
- Ageing population: The population in Southport, Formby, and West Lancashire is aging faster than the national average, with a significant increase in those over 65 expected by 2036. This has led to higher demand for healthcare services, especially for emergency and long-term care, and more people living with complex health conditions. To maintain a healthier population, it is crucial to focus on preventing and managing diseases effectively. Future care models must include strong prevention programs to ensure safe and excellent care.

# 4. Models of care

## 4.1. Introduction

In 2015, an external review of acute services at Southport & Formby and Ormskirk District General Hospitals was carried out by Deloitte. The review concluded that services were unsustainable from a quality, workforce, and financial perspective, recommending a hot and cold site solution. This recommendation was supported by the Northern England Clinical Senate Review in 2017.

In 2018, a further review by KPMG highlighted ongoing risks around workforce, safety, and financial viability. The Yorkshire & Humber Clinical Senate Review also recognised the need for change, recommending a new-build hospital. As this option was not feasible, they suggested a hot and cold site solution.

In 2019, the Acute Sustainability Programme was launched with the aim of delivering a new model of sustainable acute care. Plans for a hot and cold site model were costed, with the estimated costs around £1.3bn for a remodelling that would take 13–16.5 years to complete. As a result, the hot and cold site solution was ultimately rejected as unaffordable and undeliverable.

Following these reports, and other internal evaluations, a number of services were categorised as 'fragile'. Action was required, and we, along with our partners, have been working to stabilise these services. This included the request for a strategic partnership, resulting in the creation of MWL.

The SCT programme launched in 2021 goes beyond just stabilisin, services; it seeks to find solutions that will ensure we can offer safe, high-quality urgent and emergency care, both today and in the future. Further analysis and benchmarking data can be found in Appendix 4.

## 4.2. Development of models of care

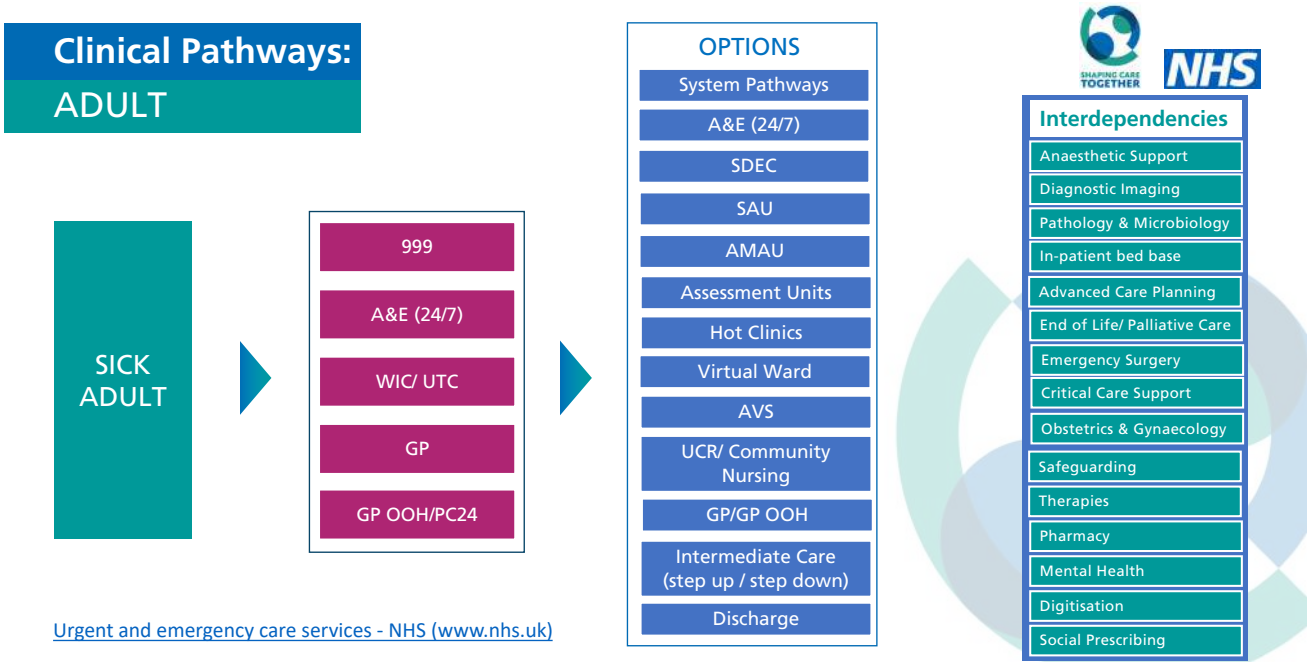
One of the key priorities of the SCT Clinical UEC sub-group was to develop an effective and deliverable clinical model of care for the provision of safe and effective urgent and emergency care services provided to the population of MWL resident within Southport, Formby and West Lancashire; ensuring that any proposed changes to services and the associated business cases have a solid clinical evidence base and align to the MWL principles of 5 star care.

Utilising the initial work of the Clinical Care Congress supporting the Acute Sustainability Programme, the clinical models of care (Figure 4, Figure 5, Figure 6 and Figure 7) have been developed collectively by clinical and commissioning leads across MWL, NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB, primary care and partner urgent care providers for the Southport, Formby and West Lancashire footprint. This was achieved via a workshop which took place in March 2024. Once developed, approval of the models of care were sought from the SCT Clinical UEC sub-group, the MWL Clinical Configuration Group and the SCT Programme Board. These were further presented to the NHS England North West Clinical Senate to support the Stage 1 review.

The following models have been developed in line with NHS England Emergency Care guidance[14&15] , and Royal College of Emergency Medicine (RCEM) guidance[16] and NICE Guidance[17]. With specific reference to care of the under 16s, models align to Royal College of Paediatrics and Children's Health Guidance[18] and CQC Guide for Emergency Departments that treat children[19].

The models are site agnostic and outline the aspiration to enable the local population to access urgent and emergency care services through development of pathways and utilisation of existing networks to improve accessibility and efficiency of resource enabling the local population to be seen by the most appropriate healthcare professional.

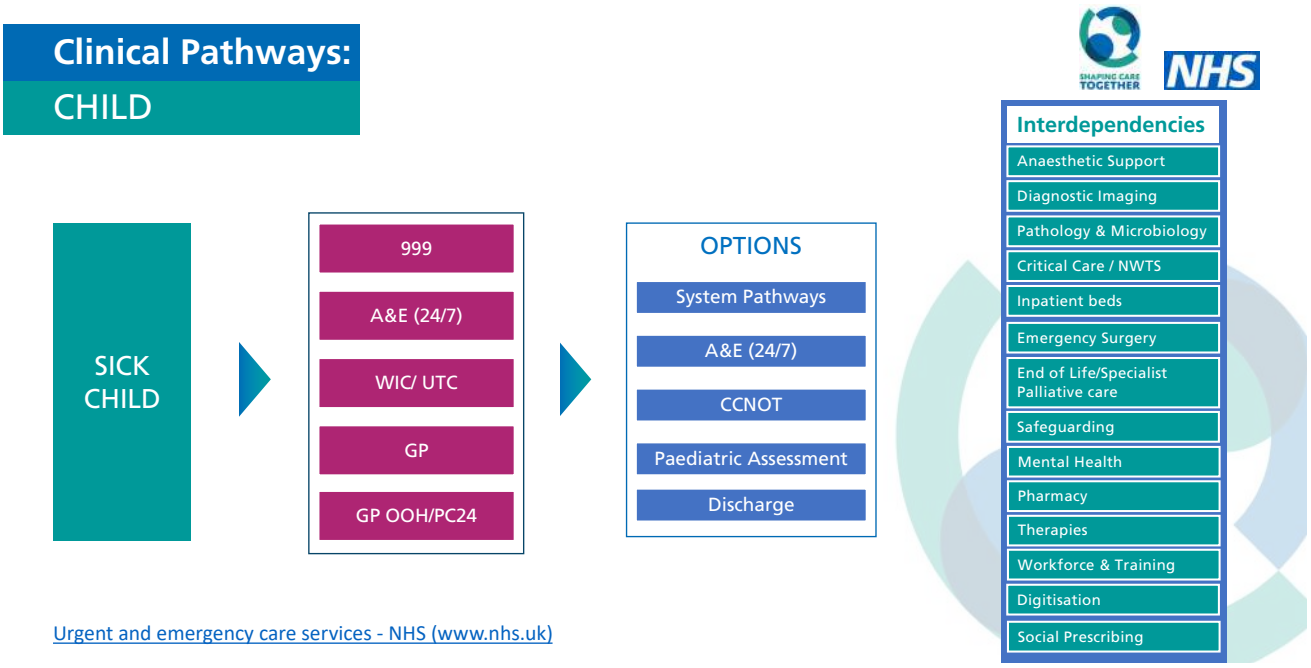
Figure 4




Urgent and emergency care services - NHS (www.nhs.uk)

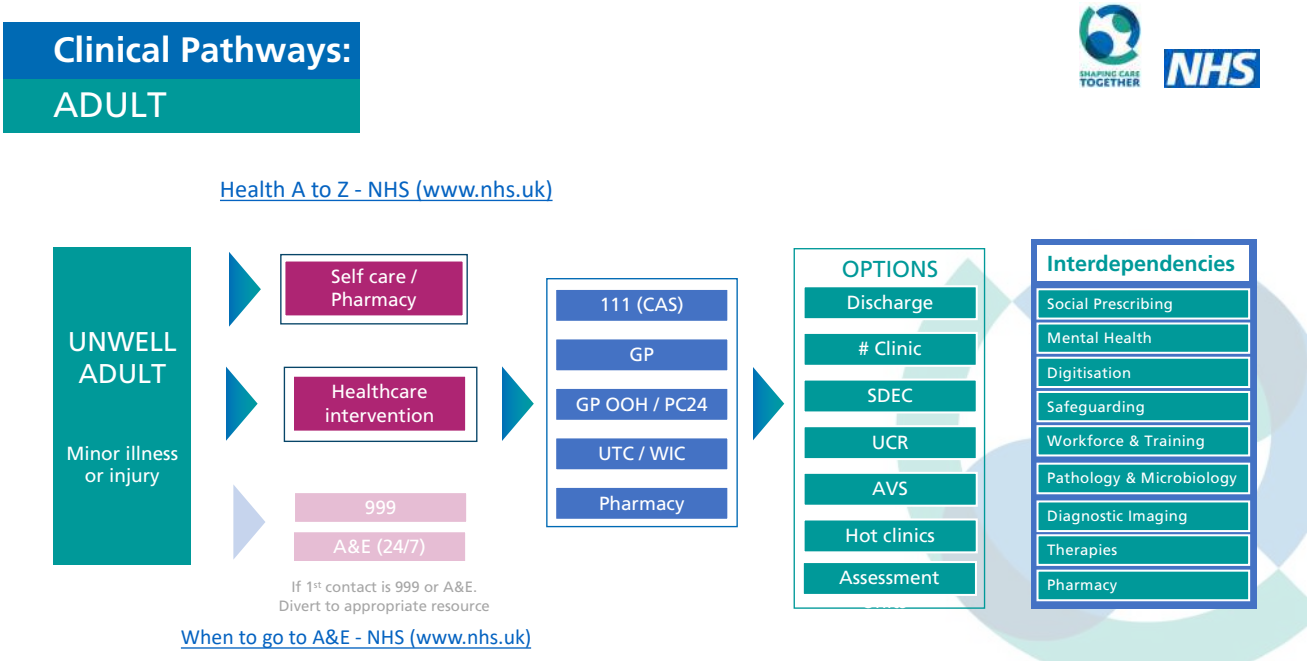
[14] https://www.england.nhs.uk/wp-content/uploads/2023/01/B2034-delivery-plan-for-recovering-urgent-and-emergency-care-services.pdf
[15] https://www.england.nhs.uk/urgent-emergency-care/
[16] https://rcem.ac.uk/clinical-guidelines/
[17] https://www.nice.org.uk/guidance/ng945
[18] https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings
[19] https://www.rcpch.ac.uk/sites/default/files/2020-05/cqc_brief_guide_staffing_in_emergency_departments_that_treat_children.pdf

Figure 5



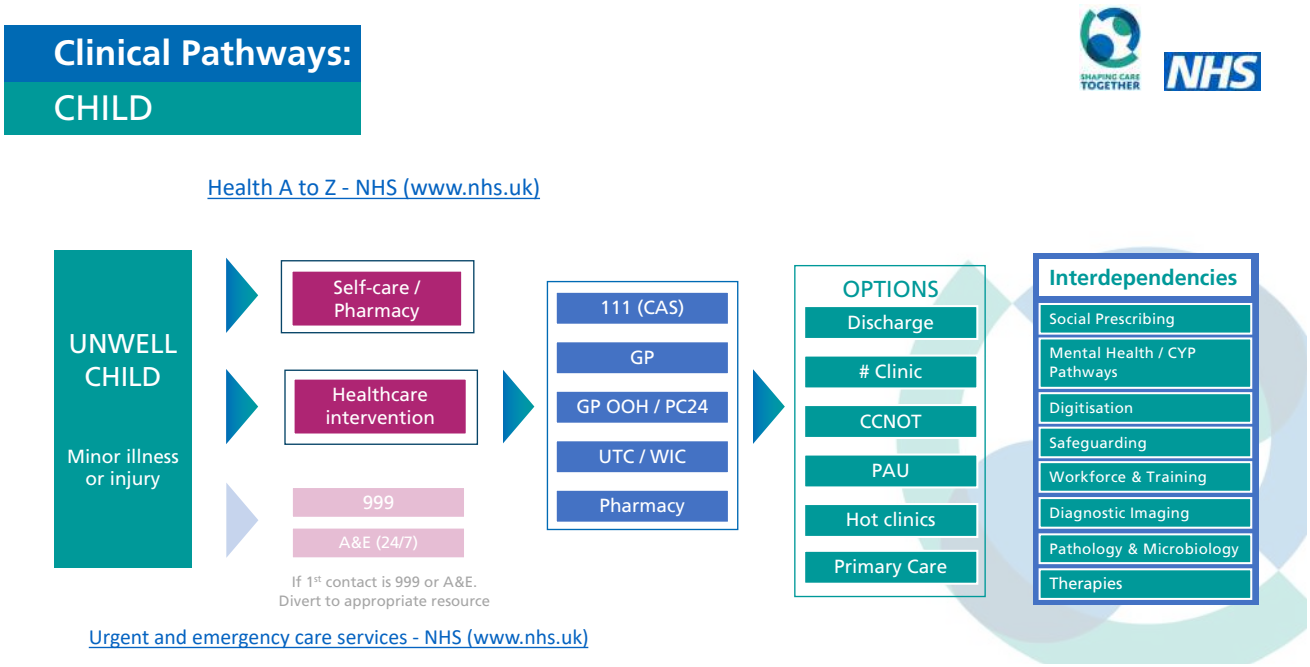

Urgent and emergency care services - NHS (www.nhs.uk)

Figure 6




When to go to A&E - NHS (www.nhs.uk)

Figure 7




## 4.3. Co-dependencies

Clinical co-dependencies are both a driver for change as well as key factors for delivering safe services. This element has been considered and highlighted throughout the reviews of services delivered by the hospitals at Southport and Ormskirk specifically the lack of on-site transfusion services and critical care at the Ormskirk site which currently houses the paediatric emergency department and maternity services. As a result, this has placed increased strain on anaesthetic services delivering acute and emergency care across both hospital sites. It has also resulted in the transfer of care of high-risk pregnant women to Whiston hospital or Liverpool Women's Hospital for delivery. Provision of maternity services across NHS Cheshire and Merseyside has been under review by the ICB and commissioning of neonatal services are under review by NHS England North West within a major service change programme. Therefore, these services are out of the scope of this programme, although the outcomes of all three programmes are interconnected. This programme will reduce the fragility of anaesthetic services and enable delivery of all age emergency services 24/7 for the local population.

Southport and Formby District General Hospital site is also home to the North West Regional Spinal Injuries Unit, a specialist commissioned service for the population of the North West, North Wales and the Isle of Man. Given the complexity and needs of this group of patients, it is essential that the service is co-located with critical care services. NHS England North West has confirmed that there is no strategic intent to re-commission the service, however, if it were to be re-commissioned it would follow a formal process and would likely to be co-located with a neurosurgical and trauma centre.

In January 2024, the South East Clinical Senate published the **Clinical Co-Dependencies of Acute Hospital Services**[20] document which provides guidance on the clinical co-locations of services within an acute hospital. This was reviewed against the services provided at both Southport and Formby District General Hospital and Ormskirk District General Hospital, which demonstrated that of those services which should be co-located with an ED seven services would need to be relocated with the adult ED to Ormskirk District General Hospital, whereas only one service would need to be relocated to Southport and Formby District General Hospital. These can be seen in Figure 8.

[20] https://secsenate.nhs.uk/wp-content/uploads/2024/01/The-Clinical-Co-Dependencies-of-Acute-Hospital-Services-Final.pdf

Figure 8

| Southport<br>Current acute services | Level of co-dependency | Ormskirk<br>Current acute services | Service relocation required | |
|---|---|---|---|---|
| | Non-negotiable | | Option 1 (Ormskirk) | Option 2 (Southport) |
| Acute & General Adult wards | Services which must be colocated with A&E | - | Yes | No |
| Elderly wards | | - | Yes | No |
| Respiratory Medicine & NIV | | - | Yes | No |
| Medical Gastroenterology | | - | Yes | No |
| Acute General surgery | | Day-case surgery | - | - |
| Acute/complex/time critical trauma & orthopaedics | | Low acuity trauma & orthopaedics | - | - |
| Adult critical care | | - | Yes | No |
| General Anaesthetics | | General Anaesthetics | - | - |
| Radiology: Xray, US, CT & MRI | | Radiology: Xray, US, CT & MRI | - | - |
| Pathology | | - | Yes | No |
| OT & Physio | | OT & Physio | - | - |
| Liaison Psychiatry | | - | Yes | - |
| Outpatient gynaecology | | Gynaecology | - | - |
| - | | Paediatric in-patient bed base | - | Yes |
| | Strong | | | |
| Endoscopy | Service should come to patient (patient transfer not appropriate), but could be provided by visiting / in-reach from another site (either physically, or via telemedicine links) if not based in the same hospital | Endoscopy | - | - |
| Acute Cardiology | | - | Maybe | - |
| Clinical microbiology | | - | Maybe | - |
| Urology (in-patient) | | - | Maybe | - |
| ENT (Outpatient) | | ENT Day case & Outpatient | - | - |
| SALT & Dietetics | | - | Maybe | - |
| | Moderate | | | |
| Acute Oncology | Ideally on same site but could alternatively be networked via robust emergency and elective referral and transfer protocols | - | Maybe | - |
| Palliative Care | | - | Maybe | - |
| Diabetes & Endocrinology (inpatient) | | - | Maybe | - |
| Ophthalmology (outpatient) | | Ophthalmology (theatres & outpatient) | - | - |
| Dermatology (outpatient & in-reach) | | - | Maybe | - |

## 4.4. Clinical evidence and guidance

The proposed clinical model focuses on providing 24/7 emergency care services for both adults and children, addressing the current lack of 24/7 provision at Ormskirk District General Hospital. Co-location has been identified as a strategic solution to enhance service integration, optimise resource use, and improve patient outcomes[21].

Currently, Southport & Formby and Ormskirk District General Hospitals are the only District General Hospitals in England that provide both adult and paediatric emergency care across two geographically separate sites. Any proposed changes would ensure that service provision aligns with national practice.

The options appraisal process, as outlined in Section 5, demonstrated that co-location of adult and paediatric emergency services is essential to resolving long-standing issues. Integrating UEC services across Southport, Formby, and West Lancashire represents a critical step towards addressing operational inefficiencies, alleviating workforce pressures, and eliminating fragmented care delivery. National guidance, including NHS England's Delivery Plan for Recovering Urgent and Emergency Care Services and the Royal College of Emergency Medicine's clinical standards, stresses the importance of service integration to improve patient outcomes and operational sustainability. These principles have been central to the development of clinical models and the options appraisal process that underpins this case.

[21] https://adc.bmj.com/content/93/Suppl_2/ps60

## 4.4.1. Clinical risks of current configuration

The current configuration was implemented in the early 2000s following publication of the Shields report in May 1999. The below table outlines the clinical risks of that configuration and the mitigations, some of which have been in place for over 20 years with additional actions needed as standards and guidance has changed over the years.

Table 1

| Service | Current Risk | Current Mitigation | Impact of co-location |
|---|---|---|---|
| **Anaesthetics** | Anaesthetic resource is not available on site to support emergencies in paediatric Emergency Department (ED), maternity and neonates out of hours. | Paediadtric Emergency Department (ED) closed overnight.<br>Additional tiers of on-call. | Ability to utilise resource available to provide 24/7 support to paediatric ED. |
| | Paediadtric Emergency Department (ED) closed overnight. | Opportunities to enhance skills at Alder Hey Children's Hospital (AHCH) with maintenance of core paediatric middle grade workforce. | Greater exposure to paediatric anaesthetic activity to maintain skillset. |
| **Emergency care** | ED Consultant on-call is not able to respond to simultaneous emergencies out of hours in adult and paediatric ED.<br><br>Support from paediatric on-call teams out of hours. | Support from paediatric on-call teams out of hours.<br><br>Historically, rotas were not compliant with European working time directive. To ensure compliance frequency of out of hours working has reduced leaving 'gaps' in cover at potential peak times of attendance. This is covered by ad hoc shifts, investment in training Paediatric Advanced Nurse Practitioners (ANPs) and mutual aid from paediatric medical workforce. | ED Consultant will be able to respond.<br><br>Ability to utilise all ED medical workforce and flex across areas to manage attendance patterns. This will positively impact paediatric wait to be seen in the late evening. |
| **Emergency blood tests** | Urgent blood tests needed for patients on Ormskirk site out of hours are not processed in a timely fashion. | Urgent blood tests out of hours are sent in a taxi to Southport. | Labs will be co-located and function 24/7. |
| **Transfusion** | There may be a delay in receiving blood and blood products for transfusion for patients on the Ormskirk site. | Blood fridge in labour ward and theatre on Ormskirk site.<br><br>Any patient deemed high risk of bleeding has care transferred to another site if any interventions are required. | Transfusion will be co-located with the emergency department. |
| **Trauma & orthopaedics** | There will be significant delays in providing senior orthopaedic input for children attending Ormskirk ED out of normal working hours. | Clinical pathways implemented with direct access to AHCH. | Acute trauma on single site enables equitable access for adults and children. |
| **General surgery** | There will be significant delays in providing senior surgical input for children attending Ormskirk ED. | Clinical pathways implemented with support from AHCH. Admission to paediatric ward to await surgical opinion. | Acute surgical activity on single site enables equitable access for adults and children. |
| **Radiology** | There is only one CT scanner at the Southport site. | There is only one CT scanner at the Southport site.<br><br>Business continuity plans in place, enacted and tested when CT scanner not in action.<br><br>Funding secured for additional CT with building works progressing. | Additional activity on Southport site will minimally increase requests for acute CT as activity relates to paediatrics.<br><br>Additional activity at Ormskirk site will require change in staff and service delivery. |
| | Ability to meet 7-day standard for radiology access on each acute site. | As per national standards, patients will be considered for outpatient and same day access pathways and undergo imaging at an alternative site. | Configuration would require new pathways and different ways of working to maximise access to all imaging modalities including interventional radiology. |
| **Pharmacy** | Insufficient staffing levels to meet professional recommendations. | Pharmacy staff available prioritise workload to support patient safety. Business case in progress to demonstrate efficiencies generated through additional pharmacy workforce. | Resource can be shared across both EDs. This will provide maximal benefit for children in ED by utilising some of the adult pharmacy staffing. |

## 4.4.2. Clinical benefits of 24/7 co-location

The below outlines the benefits of co-location and where this will address some of the risk outlined above:

Clinical Risk Impact:

### Anaesthetics

By co-locating adult and paediatric emergency services, the anaesthetic workforce resident and on-call for emergencies and critical care can be utilised to support paediatric emergencies. It is recognised that co-location at Southport and Formby District General Hospital, which is the preferred option, still poses a risk to the resilience of anaesthetic support for the Ormskirk site. This will be mitigated through the MWL Anaesthetic strategy which has 3 core aims:

1. Implement a single anaesthetic service for MWL. This will bring legacy teams together to create a single workforce with aligned protocols and standards enabling staff to work across sites to improve resilience

2. Provide a critical care medical workforce that ensures all consultants contributing to the on-call rota also deliver daily intensive care activity which is separate to the general anaesthetic on-call rota. (This will require the establishment of a separate anaesthetic on-call tier for the Ormskirk site to support the current configuration and the preferred option)

3. Implement a clinical model to maximise productivity for elective recovery, including consideration of training competencies to support children. This will address the long-standing dependence on Alder Hey Children's Hospital to support training and patient care.

### Emergency care

Both options will enable an emergency medicine medical workforce to deliver care to both adults and children, 24 hours a day, 365 days a year. It has not been possible to re-open Ormskirk ED to provide 24 hour access even with the creation of MWL, as there is still not a sufficient medical workforce with paediatric competencies to staff Ormskirk ED and maintain safe staffing across Whiston and Southport EDs. Through co-location, there will be greater resilience and flexibility of the workforce to manage peaks in demand and enables more opportunities for education and training of paediatric competencies for both medical and nursing workforce.

### Emergency blood tests and transfusion

Ormskirk District General Hospital provides an array of point of care testing for emergency blood tests to support rapid clinical decision-making. Any blood tests that cannot be undertaken at the bedside and requests for blood and blood products are transported to the Southport site for analysis and action. Transport is provided every hour to enable the movement of blood tests and, blood and blood products between the two sites. Emergency stocks of blood and blood products are available at the Ormskirk site to support any emergency and major haemorrhage, and any patient deemed high risk of bleeding will have their care transferred.

### Trauma & orthopaedics and general surgery

Children currently presenting to the emergency department with acute surgical or orthopaedic problems experience delays in specialist assessment or are transferred to Alder Hey Children's Hospital for further care as there is insufficient medical workforce to provide on-site support out of hours. While MWL is reviewing current service provision to try to provide better access or avoid the need for transfer to Alder Hey Children's Hospital, co-location will mean that the on-call team will be based at the same site and therefore assessments will occur earlier and skills can be developed to enable more children to be treated locally.

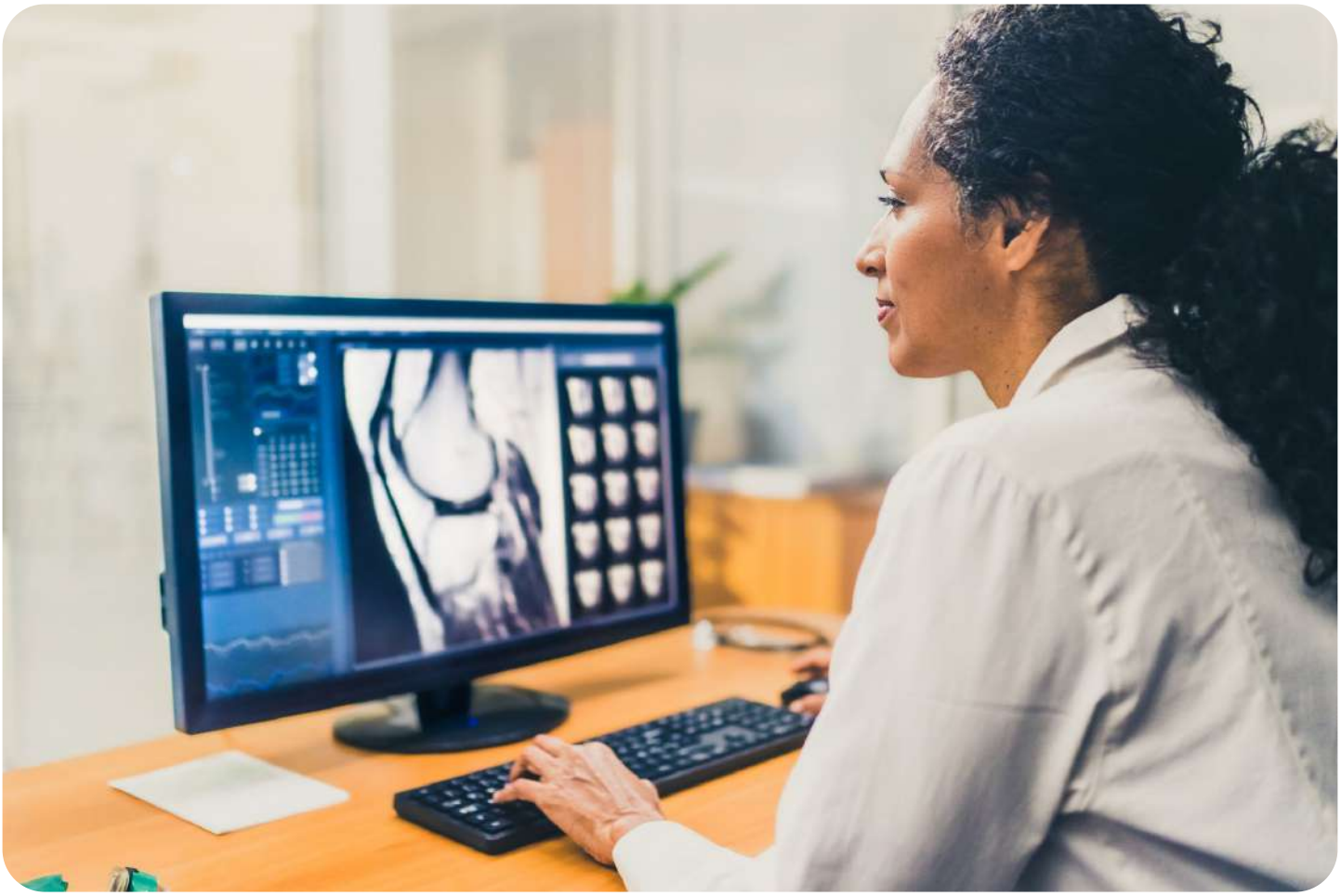
### Radiology

There is a national shortage of radiologists, especially interventional radiology and as such the legacy Southport and Ormskirk Hospital sites have been reliant on other providers. The creation of MWL has provided an opportunity to review and improve in hours intervention radiology provision, out of hours provision requires a system-wide approach.

MWL meets the 7-day standards for access to imaging through utilisation of MRI and non-obstetric ultrasound at the Southport site. The current configuration means that some patients, including children, need to travel for these tests as part of their emergency journey. Wherever possible patients are discharged to outpatient or same day pathways to minimise disruption. Co-location would provide these services at the same site as their emergency attendance.

### Pharmacy

There is dedicated provision for Pharmacy support in the adult ED due to the higher prevalence of patients attending there being on polypharmacy and higher activity and acuity levels requiring pharmacy support. Co-location would enable inter-departmental working. This would provide immediate benefits with co-location at Southport and Formby District General Hospital and would require changes to ways of working and site base if EDs were co-located at Ormskirk District General Hospital.



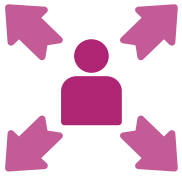
From a service delivery perspective:

**Improved rota management:** Combining adult and paediatric A&E services will streamline rota management, enabling more effective use of staff, reduce reliance on temporary staffing, and contribute to financial sustainability. See Appendix 4 for workforce benchmarking data

**Enhanced supervision and training:** Co-location will provide better supervision and training opportunities for resident doctors and Advanced Clinical Practitioners (ACPs), supporting recruitment and retention.

**Development of workforce skills:** Shared learning between adult- and paediatric-trained nursing staff will broaden competencies and foster a highly skilled, adaptable workforce. Greater opportunities to enhance paediatric skills of anaesthetic workforce.

**Increased consultant input:** Enhanced consultant oversight will provide additional opportunities for education and training, particularly for paediatric workloads where paediatric trained doctors may not consider diagnoses in older children, and to support decision-making.

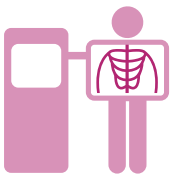


**Staffing flexibility:** emergency medicine tier 2 doctors (with competencies in both adult and paediatric care will be utilised more effectively, reducing reliance on temporary staffing and improving care delivery.

**Emergency response:** Staff working in adult EDs have more exposure to critical situations such as life-threatening emergencies, this is less frequent in children. In critical situations, staff and resources can be more readily identified and prepared to support more comprehensive care. This is particularly relevant to anaesthetic resources.

**Continuity of care:** Improve the experience of patients who may need to transition between adult and paediatric care, reducing transfers and potential risk of errors of handovers.

**Specialist availability:** Provide greater access to specialties such as trauma and orthopaedics, and surgery who currently are unable to provide responsive input to the paediatric emergency department due to the 'on-call' team being based on the adult site.



**Resource sharing:** Equipment, staff and resources can be shared when the departments are co-located, this is particularly relevant to the clinical interdependencies such as pharmacy, radiology, pathology and microbiology, especially out of hours.

**Flow management and escalation:** Better utilisation of resource to manage peak in paediatric attendances and to support paediatric triage and streaming.

## 4.4.3. Development of options

Two options for co-location have been proposed within the Shaping Care Together programme:

- Option 1: colocation of adult and paediatric A&E services at Ormskirk District General Hospital.
- Option 2: colocation of adult and paediatric A&E services at Southport and Formby District General Hospital (the preferred option).

Further details on the options appraisal process, including criteria and evaluation methodologies, can be found in Section 5. This rigorous process demonstrates a commitment to transforming urgent and emergency care to meet the needs of the Southport, Formby, and West Lancashire populations, while staying true to MWL's principles of delivering top-quality care.

## 4.4.4. Clinical evidence against the options and preferred option

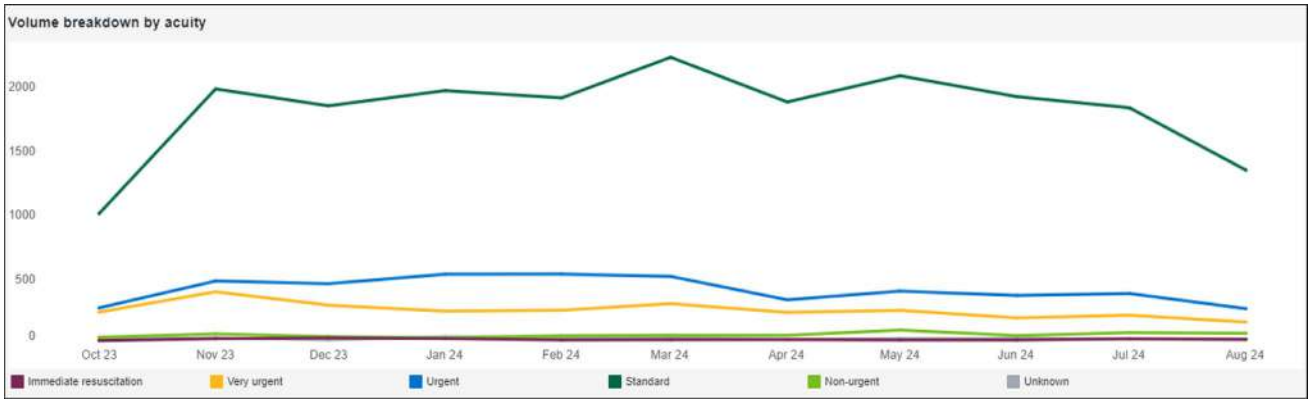
The overnight closure of paediatric A&E at Ormskirk District General Hospital, driven by workforce shortages and unsustainable costs, highlights the critical need for change to ensure 24/7 care is available for all ages, every day. This closure has exposed significant fragmentation in current service provision and underscores that the services were designed at a time when demand for urgent and emergency care was much lower. These challenges, particularly workforce pressures, further emphasise the need for a strategic solution such as co-location.

Co-locating adult and paediatric EDs will directly address these issues by streamlining services, optimising resource utilisation, and reducing reliance on temporary staffing. It will enhance training and supervision opportunities for staff, improve patient flow, and ultimately enhance patient safety and care outcomes. The colocation model offers a clear path to resolving the fragmentation in services and ensuring a sustainable workforce, providing 24/7 emergency care for both adults and children.

While both options align with the proposed clinical model for 24/7 emergency care, the review of the Southeast Clinical Senate's recommendations on clinical co-dependencies revealed that more services would need to be moved from Southport to Ormskirk than from Ormskirk to Southport. This shift would result in greater disruption to services, longer implementation timelines, and significantly higher costs, potentially undermining care quality, outcomes, and operational efficiency. From a clinical and health inequalities perspective, co-location at Southport and Formby District General Hospital lends itself to supporting the preferred option.

Travel analysis (see Section 9.3) has indicated that a significant number of higher attendances at Ormskirk District General Hospital originate from deprived areas in the Southport area. Emergency care data also suggests that a substantial proportion of local children attending Ormskirk District General Hospital could be treated at the UTC located within the Ormskirk District General Hospital site. Taking MWL Ormskirk site data from 2023/24, 71% of attendances were identified as standard or non-urgent. These two categories have been classed as 'UTC-suitable patients' in the SCT modelling work (as detailed in Section 6.3.1) which were agreed by clinicians. Of these attendances only 2.9% were admitted, compared to 24.8% of urgent, very urgent or resus attendances. Please see Figure 9.

Figure 9




Source: Emergency Care Data Set (ECDS) October 2023 to August 2024

Implementation of the clinical pathways outlined in the clinical model would make better use of the UTC at Ormskirk District General Hospital. Pathways are already being agreed and developed to encourage UTC attendance rather than ED. The Integrated Urgent Care (IUC) review undertaken by NHS Lancashire and South Cumbria ICB will consider services delivered at Skelmersdale WIC and the needs of the local population.

# 5. Development of options and options appraisal

## 5.1. Approach

Whilst NHS England's guidance on planning, assuring and delivering service change for patients (March 2018) does not set clear requirements around the full list to long list, and longlist to short list, there are a number of expectations it sets out that the programme has to consider and ensure is included with in its approach.

The HM Treasury Green Book guidance states at least one workshop is recommended for the completion of this section of the Project Business Case, to ensure that the key stakeholders are engaged earlier on and can challenge and assist to shape the direction of the project. Taking this into consideration, the programme planned to hold two workshops: one for the application of the hurdle criteria and one for the application of the evaluation criteria. Stakeholder workshops are a key part of demonstrating active and transparent public and stakeholder engagement at all stages of the programme. There is a duty on commissioners to demonstrate how this undertaken prior to any formal consultation and how public engagement has informed all steps of the process.

## 5.2. Fixed points, hurdle criteria and evaluation criteria

### 5.2.1. Fixed

Fixed points, also known as "Constraints and Dependencies" in the HM Treasury Green Book, are elements that cannot be altered. These include services that must remain at specific locations, national designations, outcomes of previous consultations, road networks, housing developments, locations of academic institutions, and expensive equipment.

The programme did not identify any fixed points for consideration during the options appraisal stage.

### 5.2.2. Hurdle criteria

The hurdle criteria are an integral part of the options appraisal process, designed to allow options to be discounted at a high level without requiring extensive detail, with information known at the time. These criteria for the SCT programme were developed by a clinically led group with additional input from ICB partner groups, Healthwatch, community and voluntary sector (CVS), and service user groups through the SCT EPAG; who collectively represent the voice of service users.

The criteria have been approved by the SCT Clinical UEC sub-group, the MWL Clinical Configuration Group, and the SCT Programme Board. They have been aligned with the Critical Success Factors as outlined in the HM Treasury Green Book.

The list of hurdle criteria can be found in Appendix 5.

## 5.2.3. Evaluation criteria

The next stage in the options appraisal process involves applying the evaluation criteria to identify the shortlist of options from the longlist. This stage requires more detailed information about the proposed options, which are assessed against a stricter set of criteria. In accordance with NHS England guidance, the evaluation criteria have been aligned with the HM Treasury Green Book Critical Success Factors. Similar to the hurdle criteria, the evaluation criteria were developed by a clinically led group and sought input from external stakeholders such as Healthwatch, CVS, and service user groups via the SCT EPAG to ensure stakeholder involvement.

The evaluation criteria have been approved by the SCT Clinical UEC sub-group, the MWL Clinical Configuration Group, and the SCT Programme Board.

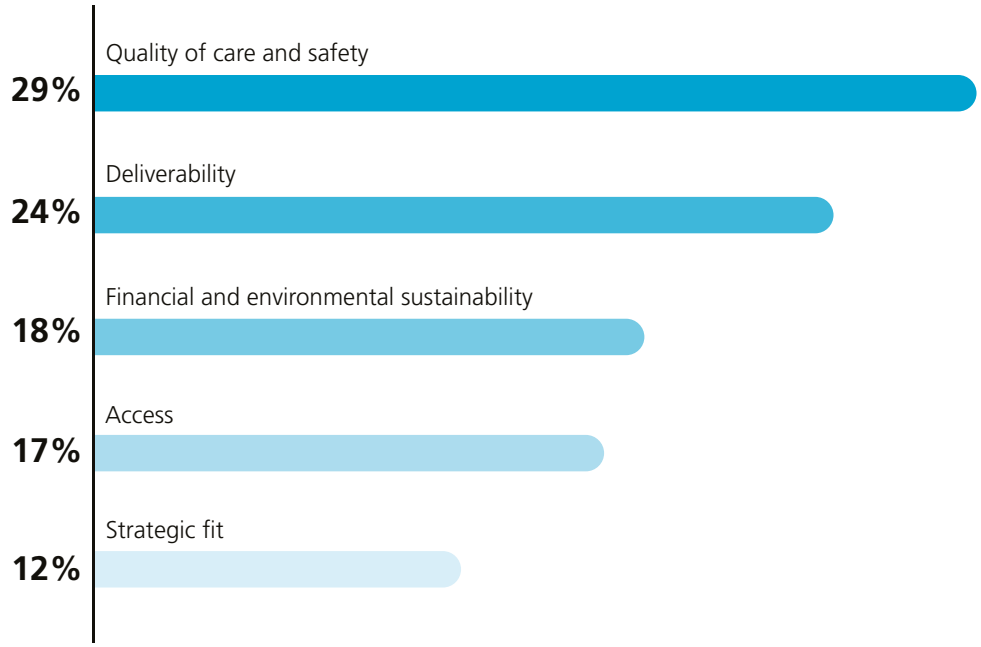
The evaluation criteria can be found in Appendix 6.

### 5.2.3.1. Evaluation criteria weighting

The evaluation criteria were categorised into areas that may hold varying levels of importance to stakeholders. To address this, weighting was applied to each individual criteria area, allowing stakeholders to assign greater importance to areas they deem most critical. The SCT programme used this weighting, determined by stakeholders including patient and public representatives, during the evaluation criteria workshop. The process for selecting these representatives can be found in Section 5.5.1.

Upon completion of the hurdle criteria appraisal, participants were invited to undertake a second task to weight the criteria for the next step in the options appraisal process: the evaluation criteria application. To determine the weighting, the SCT programme utilised the Northern Ireland weighting scoring method[22], with the outcome shown in Figure 10:

Figure 10




[22] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.finance-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2Fpublications%2Fdfp%2FT-he%2520weighted%2520scoring%2520method_0.docx&wdOrigin=BROWSELINK


## 5.3. Longlist of options

Feedback from pre-consultation engagement provided the programme with a comprehensive list of options for the options appraisal process. However, following a pre-appraisal assessment, several options were discounted due to substantial financial investment requirements that could not be secured at the time, timelines exceeding the three to five years specified by the 'implementation' criterion, the need for substantive changes to out-of-scope services such as planned care, or the necessity of commissioning entirely new services. These can be found in Appendix 7. Although no option was entirely discounted, as new evidence could emerge before the Decision-Making Business Case (DMBC) that might render a proposal feasible, ultimately, 10 options were included in the full list for appraisal, detailed in Appendix 7.

The workshop comprised a mix of internal (NHS clinical and operational) and external (non-NHS organisations, e.g. Healthwatch) stakeholders as well as a balance of patients and public representing the geographical footprint of Southport, Formby and West Lancashire, with a panel of experts identified as the SCT programme workstream leads to address questions. These experts maintained neutrality and did not possess voting rights in the appraisal application. Please see full list of appraising stakeholders in Section 5.5. The workshop targeted senior management colleagues, such as divisional or operational/ clinical directors/leads, who had a thorough understanding of their respective areas.

To assist the appraisers in evaluating the full list of options, a SWOT (strengths, weaknesses, opportunities, and threats) analysis was developed by the clinical SCT Clinical UEC sub-group. This analysis was completed in advance and presented at the workshop, providing a summary of the advantages and disadvantages of each option. This can be found in Appendix 7. Each proposal was then reviewed, with appraisers asked to object to any proposals that did not meet the hurdle criteria and would not progress to the next stage. However, appraisers were also asked to consider if any mitigations could be implemented to support a proposal's viability. The SCT programme employed a consensus approach against the hurdle criteria to determine which options would advance to the next stage, resulting in a clearly agreed longlist of options as an outcome of the workshop. The workshop was facilitated by an independent facilitator proficient in the HM Treasury methodology.

**The workshop concluded with the inclusion of the only two options that passed the hurdle criteria with the limited information available at the time and would be included in the longlist for appraisal at the evaluation criteria stage: option 6, the co-location of a 24-hour adult and paediatric A&E at Ormskirk District General Hospital, and option 9, the co-location of a 24-hour adult and paediatric A&E at Southport and Formby District General Hospital. The full appraised list can be seen in** Table 2.

Table 2

| Option | Hurdle criteria outcome | Discounted reason<br>*See appendix 5 for further detail* |
|---|---|---|
| **OPTION 1: No change. Business as usual**<br>Continue with the current configuration of reduced hours paediatric A&E at Ormskirk and 24-hour adult A&E at Southport. | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 2A: Do minimum (Ormskirk)**<br>Re-establish a 24-hour paediatric A&E service at Ormskirk. Adult A&E to remain at Southport. | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 2B: Do minimum (Southport)**<br>Expand adult A&E capacity at Southport and leave paediatric A&E at Ormskirk (with current service hours) | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 3: Two site collocation**<br>24-hour adult and paediatric A&E at both Southport and Ormskirk | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 4: Ormskirk collocation A**<br>Extend Ormskirk paediatric A&E to 24-hour and provide 24-hour adult A&E at Ormskirk. Southport 24-hour adult A&E to remain | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 5: Ormskirk collocation B**<br>24-hour adult A&E at Ormskirk alongside paediatric A&E at Ormskirk and adult A&E in Southport with current service hours | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 6: Ormskirk collocation C**<br>Relocate adult A&E from Southport to Ormskirk with 24-hour A&E for both adults and paediatrics | **Consensus to take forward (all four criteria met)** | |
| **OPTION 7: Southport collocation A**<br>Collocated adult and paediatric 24-hour A&E at Southport. Ormskirk paediatric A&E to be maintained and extended to 24-hour | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 8: Southport collocation B**<br>Collocated adult and paediatric 24-hour A&E at Southport. Ormskirk paediatric A&E to be maintained (current hours of service) | **Do not progress** | • Criteria one – clinically sustainable: not met<br>• Criteria two – strategic fit: not met<br>• Criteria three – implementation: not met<br>• Criteria four – financial viability: not met |
| **OPTION 9: Southport collocation C**<br>Paediatric A&E relocated to Southport. Southport to provide 24-hour adults and paediatric A&E | **Consensus to take forward (all four criteria met)** | |

Following a review of the SCT programme by the North West Clinical Senate on 27th January 2025, the reviewing panel identified a number of additional potential options that had not been included in the original options development process. While the panel acknowledged that these options may not have progressed to the shortlist, to ensure transparency these options are being included in the PCBC so that consultees have the opportunity to comment on them during the public consultation. However, following legal advice and a review of their feasibility, it was concluded that a full reappraisal—requiring the re-running of hurdle and evaluation criteria workshops with the original appraisers was unnecessary and, in any event, would not affect the existing outcome of the appraisal process. This is because the options have been reasonably assessed as unviable, unrealistic, or unsustainable based on current evidence.

The additional options identified by the Clinical Senate are:

- Close both Southport and Ormskirk A&Es and consider a wider system A&E reconfiguration connected with supporting patient pathways to the Southport, Formby and West Lancashire UEC system
- Close or downgrade Ormskirk A&E without moving paediatric services to Southport

It is important to note that no option has been entirely ruled out. Should new evidence emerge ahead of the DMBC, any previously excluded option could be reconsidered if it becomes demonstrably feasible.

## 5.4. Shortlist of options

Similar to the hurdle criteria workshop, a mixture of internal (NHS (clinical and non-clinical)) and external (non-NHS organisations, e.g., Local Authority) stakeholders, as well as a balance of patients and public representing the geographical footprint of Southport, Formby and West Lancashire, were invited to participate in the workshop, with a panel of experts (SCT workstream leads) to answer questions. These experts remained neutral and did not have voting rights in the appraisal application. Please see full list of appraising stakeholders in Section 5.5. To limit bias, different appraisers from those in the hurdle criteria workshop were invited to appraise the longlist of options, where possible. The evaluation criteria workshop targeted executive-level appraisers with decision-making authority. The two options within the longlist were:

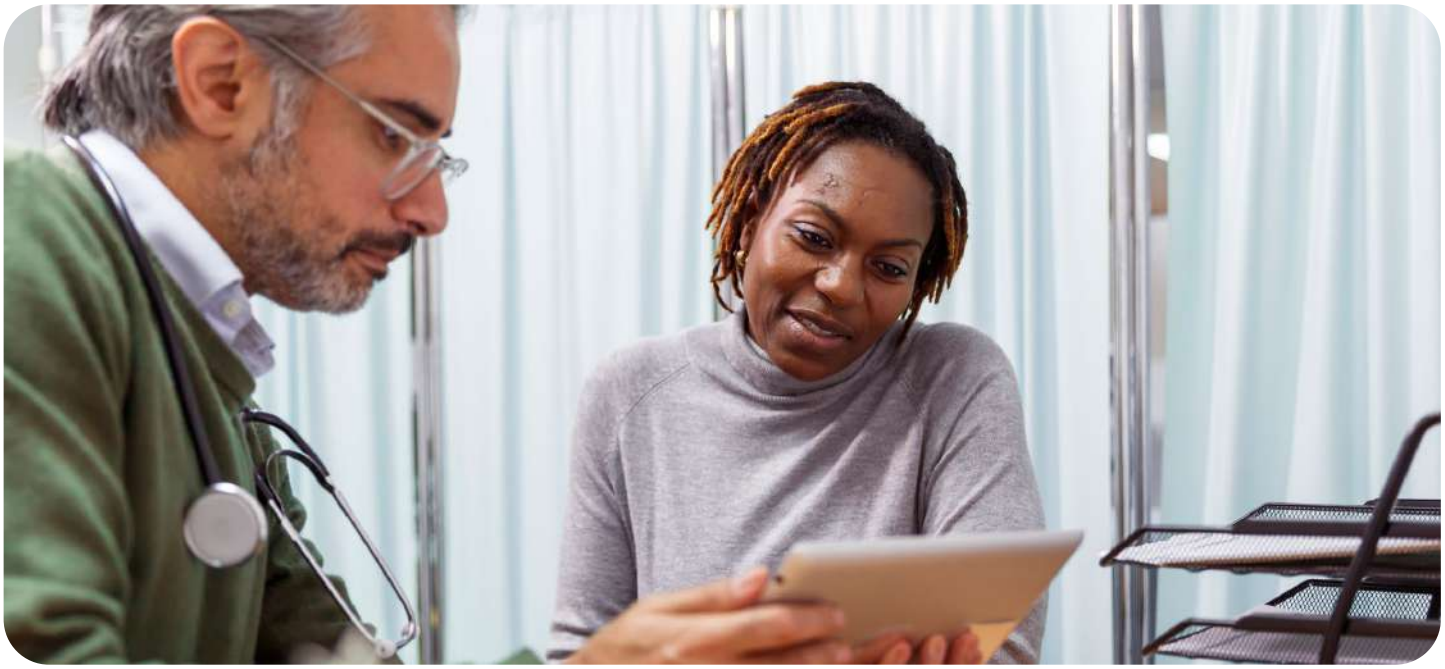
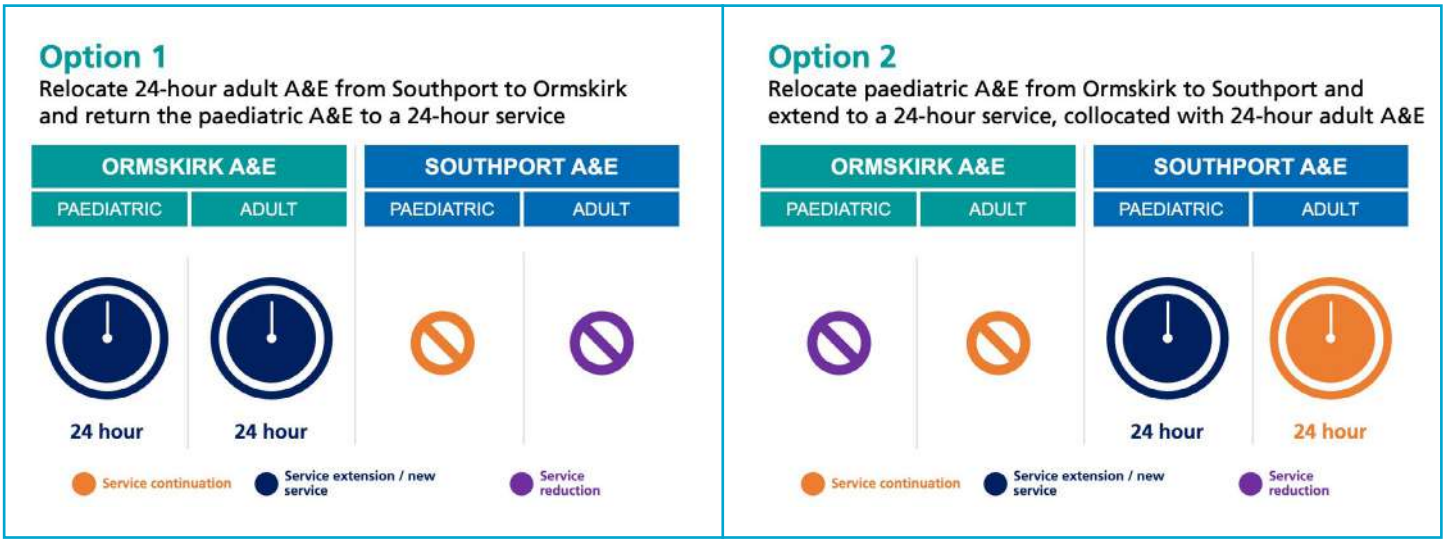


Figure 11




Prior to the workshop, attendees received a pack of evidence to support their assessment of each of the two options against the evaluation criteria. The contents of the evidence pack included:

- SCT models of care
- Environmental sustainability evidence
- Estates proformas
- Demand and capacity modelling
- Workforce
- Engagement insights report
- Clinical co-dependencies
- National and local strategies
- Desktop impact assessment
- Travel assessment analysis

Similar to the hurdle criteria workshop, this workshop was facilitated by an independent facilitator proficient in the HM Treasury methodology. The workshop began with a description of the longlisted options and an explanation of how these were derived. A summary of the evidence pack was then presented, followed by dedicated time for appraisers to ask any clarifying questions to the subject matter expert panel. Appraisers were then divided into breakout groups, mixed to ensure a balanced room, to assess each of the options and to ask further questions on the options or the criteria.

Appraisers were then asked to individually score each option using a set of closed questions to determine the extent to which each option met the evaluation criteria, with a numerical value applied to each answer from one (very bad) to five (very good). An open question was included at the end to allow appraisers to note any specific concerns about either of the two options. The questions were as follows:

Table 3

| Question |
| --- |
| **Q1 ORMSKIRK: Quality of care and safety (criteria 1)**<br>Based on your understanding of the evidence provided, how would you rate the ORMSKIRK option against this criteria?<br>• 1 = Very bad<br>• 2 = Bad<br>• 3 = Average<br>• 4 = Good<br>• 5 = Very good |
| **Q2 ORMSKIRK: Deliverability (criteria 2)**<br>Based on your understanding of the evidence provided, how would you rate the ORMSKIRK option against this criteria?<br>• 1 = Very bad<br>• 2 = Bad<br>• 3 = Average<br>• 4 = Good<br>• 5 = Very good |
| **Q3 ORMSKIRK: Access (criteria 3)**<br>Based on your understanding of the evidence provided, how would you rate the ORMSKIRK option against this criteria?<br>• 1 = Very bad<br>• 2 = Bad<br>• 3 = Average<br>• 4 = Good<br>• 5 = Very good |
| **Q4 ORMSKIRK: Financial and environmental sustainability (criteria 4)**<br>Based on your understanding of the evidence provided, how would you rate the ORMSKIRK option against this criteria?<br>• 1 = Very bad<br>• 2 = Bad<br>• 3 = Average<br>• 4 = Good<br>• 5 = Very good |
| **Q5 ORMSKIRK: Strategic fit (criteria 5)**<br>Based on your understanding of the evidence provided, how would you rate the ORMSKIRK option against this criteria?<br>• 1 = Very bad<br>• 2 = Bad<br>• 3 = Average<br>• 4 = Good<br>• 5 = Very good |
| **Q6 SOUTHPORT: Quality of care and safety (criteria 1)**<br>Based on your understanding of the evidence provided, how would you rate the SOUTHPORT option against this criteria?<br>• 1 = Very bad<br>• 2 = Bad<br>• 3 = Average<br>• 4 = Good<br>• 5 = Very good |

| Question |
| --- |

**Q7 SOUTHPORT: Deliverability (criteria 2)**
Based on your understanding of the evidence provided, how would you rate the SOUTHPORT option against this criteria?

- 1 = Very bad
- 2 = Bad
- 3 = Average
- 4 = Good
- 5 = Very good

**Q8 SOUTHPORT: Access (criteria 3)**
Based on your understanding of the evidence provided, how would you rate the SOUTHPORT option against this criteria?

- 1 = Very bad
- 2 = Bad
- 3 = Average
- 4 = Good
- 5 = Very good

**Q9 SOUTHPORT: Financial and environmental sustainability (criteria 4)**
Based on your understanding of the evidence provided, how would you rate the SOUTHPORT option against this criteria?

- 1 = Very bad
- 2 = Bad
- 3 = Average
- 4 = Good
- 5 = Very good

**Q10 SOUTHPORT: Strategic fit (criteria 5)**
Based on your understanding of the evidence provided, how would you rate the SOUTHPORT option against this criteria?

- 1 = Very bad
- 2 = Bad
- 3 = Average
- 4 = Good
- 5 = Very good

**Q11 And finally, do you still have any specific concerns about either of the two options we've looked at today? If so, please let us know about them, explaining how they relate to the criteria we've used for appraisal.**

Scoring was conducted through an online portal, with each appraiser receiving individual login details to ensure fairness and transparency.

Upon completion, the scores were collated and the agreed weighting applied to produce an overall score. This process resulted in a final shortlist of options, with option 2 (co-location at Southport and Formby District General Hospital) achieving the highest score and being identified as the preferred option. The final scoring, unweighted and weighted, is listed below:

Table 4

| Evaluation Criteria | Unweighted | | Weighted | |
|---|---|---|---|---|
| | Ormskirk | Southport | Ormskirk | Southport |
| Quality of Care and Safety | 76 | 94 | 22.0 | 27.3 |
| Deliverability | 40 | 92 | 9.6 | 22.1 |
| Access | 66 | 79 | 11.2 | 13.4 |
| Financial and Environmental Sustainability | 42 | 90 | 7.6 | 16.2 |
| Strategic Fit | 67 | 88 | 8.0 | 10.6 |
| **Total** | **291** | **443** | **58.5** | **89.5** |

## 5.5. Preferred option

The output of the workshop was presented to the SCT Programme Board in December 2024. The SCT Programme Board reviewed the outcome, along with supporting information, to assist in their decision-making regarding the final shortlist of options and the proposed preferred option (option 2 – co-location at Southport and Formby District General Hospital) based on the scoring. The SCT Programme Board approved this recommendation and agreed to proceed to consultation on both options, with the clear indication that the co-location at Southport and Formby District General Hospital was the preferred option. While these options have been approved for public consultation, no final decision has been made. Decision-makers are not limited to the two options currently proposed, and the consultation process remains open to the presentation of alternative proposals or new evidence that may support the feasibility of other approaches.

## 5.6. Stakeholder involvement

Stakeholders have been integral to the options appraisal process. Their contributions span from supporting the development of the hurdle and evaluation criteria to identifying the full list of options through pre-consultation engagement and actively participating in both the hurdle and evaluation criteria workshops. This extensive involvement underscores the significant role stakeholders have played in shaping and informing this stage of the process. The full list of stakeholders are as follows:

- MWL clinicians
- MWL nursing leads
- MWL A&E staff
- MWL operational leads
- MWL executives
- NHS Cheshire and Merseyside ICB clinical leads (inc. primary care leads)
- NHS Cheshire and Merseyside ICB commissioning and operational leads
- NHS Cheshire and Merseyside ICB executives
- NHS Lancashire and South Cumbria ICB clinical leads
- NHS Lancashire and South Cumbria ICB commissioning and operational leads
- NHS Lancashire and South Cumbria ICB executives
- HCRG Care Group Ltd (Ormskirk UTC and Skelmersdale WIC provider)
- Merseycare NHS Foundation Trust
- Alder Hey Children's Hospital NHS Trust
- North West Ambulance Service NHS Trust
- University Hospitals of Liverpool Group
- NHS England Specialised Commissioning
- Healthwatch Sefton
- Healthwatch Lancashire
- CVS Sefton
- West Lancashire CVS
- Patients and public
- Service user representative groups:
  - Hesketh Community Bank
  - Change Grow Live
  - Community Champions
  - Galloways
  - People First
  - Age UK
  - Southport Access for Everyone
  - Myeloma Support Group
  - Sefton Cancer Support
  - Breathe Easy North Sefton

### 5.6.1. Public/patient selection process

Regarding the selection of patients and public representatives for the options appraisal workshops, individuals who had subscribed to updates from the SCT programme were invited via email to express their interest in participating.

From the respondents, the programme aimed to select representatives from each of the main geographical areas served by Southport & Formby and Ormskirk District General Hospitals, namely Southport, Formby, Ormskirk, Skelmersdale, and the surrounding rural areas.

Additionally, the programme sought to ensure a balanced representation across gender, age, ethnicity, disability, sexual orientation, religion, gender reassignment, pregnancy, marriage/civil partnership, long-term health conditions and carer status, as well as considering any conflicts of interest.

To minimise the risk of bias and enhance the integrity of the engagement process, diverse participants were selected for each workshop to ensure wide ranging representation.

# 6. Non-clinical modelling

## 6.1. Workforce

A review of the current workforce models across the medical and nursing workforce has taken place for both adult and paediatric ED services in Southport and Formby District General Hospitals and Ormskirk District General Hospitals. There are a number of key factors that are yet to be defined which will have a significant impact on the final workforce structure. In order to undertake workforce modelling for the scenarios outlined within the PCBC we have drawn on knowledge of the overall service configuration alongside some assumptions which can be applied to either scenario.

In this section we describe the key benefits of a co-located ED, the overall structure and then expand further on the benefits and issues of the different options with regards to the wider workforce.

Following the PCBC process and development of an ED layout, more detailed workforce planning will be conducted which align to NHSE's business case processes.

### 6.1.1. Co-located adult and paediatric ED workforce

A number of historical issues with the workforce will be improved through co-location of ED services.

The three key improvements from co-location as described elsewhere in this PCBC are:

1. Improved medical cover 24/7 for both adult and paediatric services
2. Consolidated, consistent nursing leadership across both adult and paediatric services and
3. Reducing reliance on temporary workforce

Over time, it is expected a reduction in reliance on more expensive locum and agency staff to reduce premium rates of expenditure by c£1.5m per year.

A summary of the staffing requirements anticipated to deliver co-located services across the medical and nursing workforce are described in the table below.

For the medical workforce, the team has been split into 3 Tiers:

- Tier 3 is the consultant workforce
- Tier 2 consists of specialty doctors and senior trainee doctors (speciality training (ST) trainees)
- Tier 1 staff include clinical fellows, physician associates, GP with speciality training (GPSTs), FY2s and advanced clinical practitioners.

The medical workforce will oversee the co-located ED for both adult and children's services.
Due to the nature of nursing an ED department, the adult and children's nursing structures have been described separately, although an element of general management is included within the adult ED structure. Both are based on the same principles of staffing according to levels of activity. The different bandings describe the level of seniority with the 8A matron as the most senior nurse and qualified nurses from agenda for change bands 7, 6 and 5 and unqualified staff members in band 4, 3 and 2.

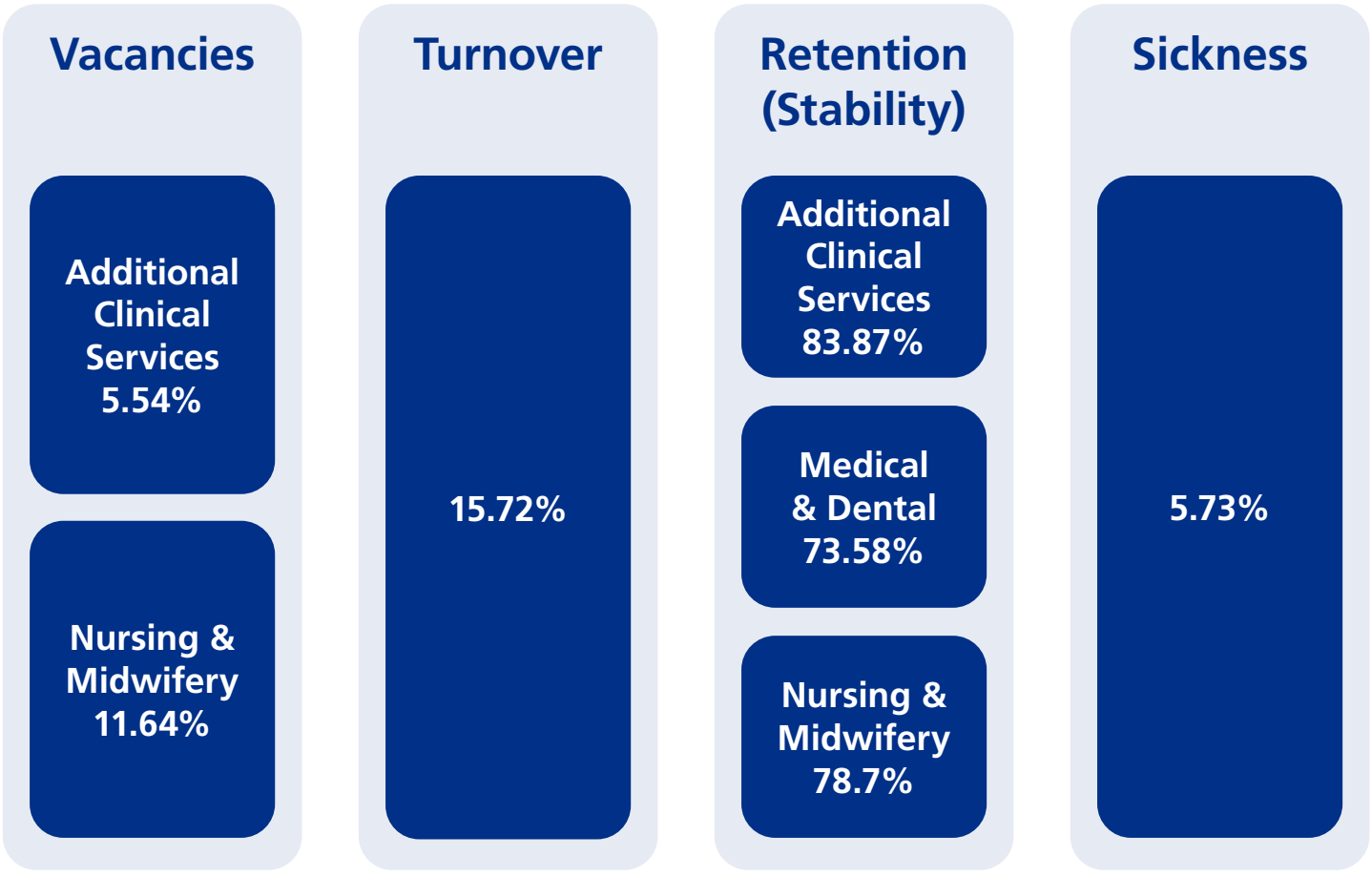
These are indicative figures and will need to be reviewed once the ED layout and forecast activity details have been consulted on following the PCBC process.

Table 5

| Medical Model | Description/ AFC Band | WTE |
|---|---|---|
| | Tier 3 - Consultant | 16 |
| | Tier 2 | 17 |
| | Tier 1 | 41.6 |
| **Paediatric ED Nursing Model** | **Description/ AFC Band** | |
| | 8a | 1 |
| | 7 | 1 |
| | 6 | 5.43 |
| | 5 | 13.7 |
| | 3 | 8.05 |
| **Adult ED Nursing Model** | **Description/ AFC Band** | |
| | 8a | 2 |
| | 7 | 14.46 |
| | 6 | 27.16 |
| | 5 | 73.48 |
| | 3 | 25.3 |
| | 2 | 16.95 |

### Improvements to workforce metrics

There are a number of key metrics MWL expect to improve by having a co-located workforce. From the current position:




Towards meeting and exceeding the Trust targets of:
Sickness – 4.5%; Turnover – 13%; Retention (Stability) – 87%

MWL will also be able to train, recruit and retain workforce that broadens the age demographic, thereby improving any issues with succession within an ageing workforce that the current workforce presents. Currently the ED team has an age demographic considerably higher than other clinical services at the Trust.

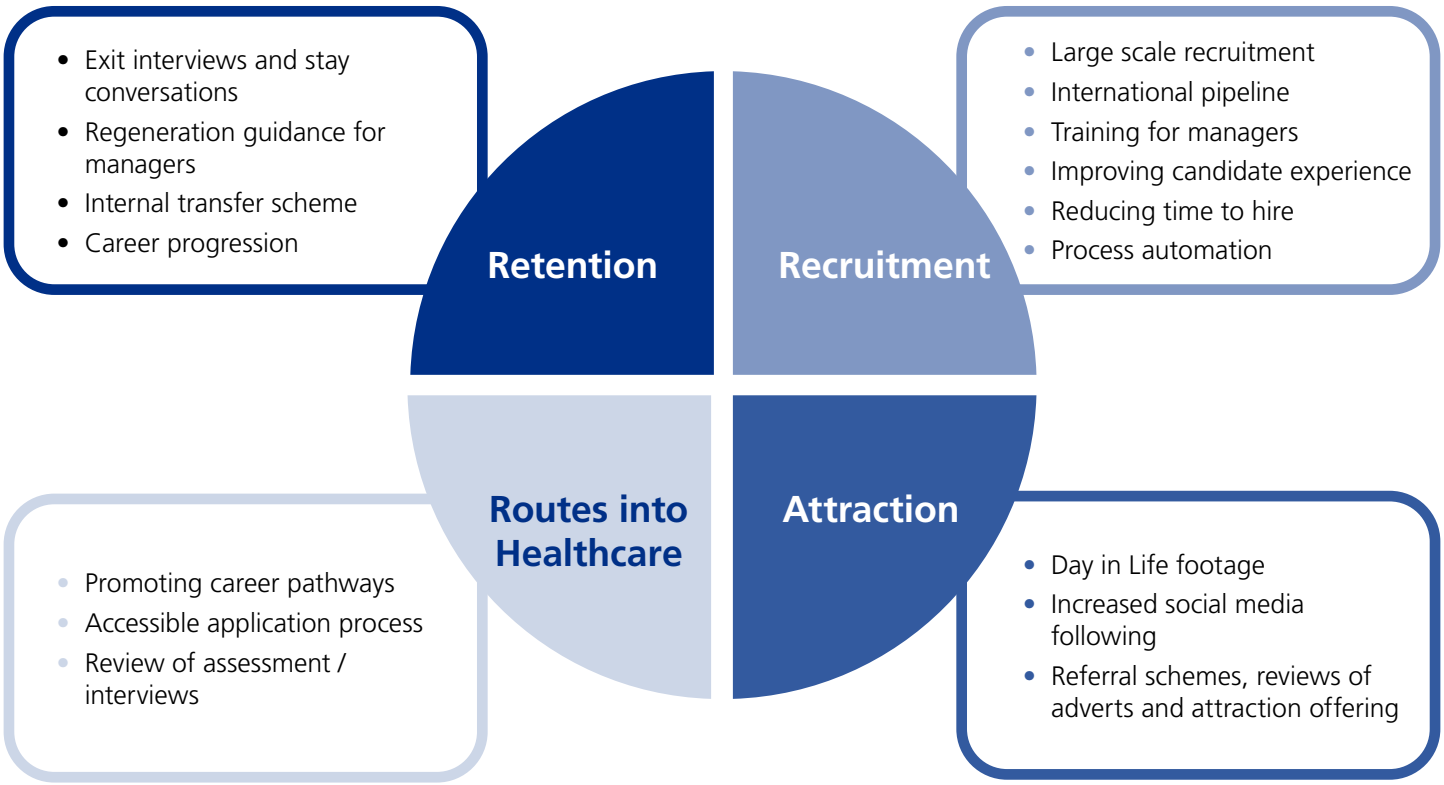
| Age Profile | Over 50 years of age | Over 55 years of age | Over 60 years of age |
|---|---|---|---|
| ED | 21.73% | 14.21% | 6.41% |
| Additional Clinical Services | 17.2% | 10.75% | 6.45% |
| Medical & Denta | 21.15% | 9.62% | 3.85% |
| Nursing & Midwifery | 18.35% | 8.86% | 3.16% |

### Recruitment, retention, attraction and routes into healthcare

In order to recruit, retain, attract and increase routes into healthcare MWL have developed a 'people strategy'[23] that commits to delivering 5-star patient care. As a people focussed organisation, MWL place their workforce at the centre of everything they do. Investing and valuing in their people enables their workforce to learn, grow and be able to provide sustained excellence in the delivery of patient care.

MWLs people strategy focuses on four key elements. The plan focuses on retention initiatives, career development and ensuring their recruitment processes are more user and candidate friendly, which will improve candidate experience and reduce time to hire. The image below summarises MWLs priorities:

[23] https://www.merseywestlancs.nhs.uk/media/.resources/65dcc11a5b5f59.61816661.pdf




In MWL, ongoing collaboration with higher learning institutions continues to strengthen the local health workforce. This includes a growing number of training programmes delivered in partnership with Edge Hill University, supporting a wide range of allied health professionals, nurses, and, more recently, medical students.

## 6.1.2. Key differences between co-location setting

Whilst the specific location for the co-located ED will not in itself change the ED workforce requirements, there will be implications for a number of other clinical services and workforce groups depending on the ultimate location for ED services across the Southport & Formby and Ormskirk District General Hospitals footprint.

The table below shows the number of services that are required to be co-located with an ED department that will be impacted depending on location, and the potential for requiring duplicated teams across sites or changes to the location where services are currently provided.

Option 1 – Co-location at Ormskirk District General Hospital
Option 2 – Co-location at Southport and Formby District General Hospital

Table 6

| Acute Service | Workforce | | Service relocation requirement (Y/N) | |
|---|---|---|---|---|
| | Option 1 (Ormskirk) | Option 2 (Southport) | Option 1 (Ormskirk) | Option 2 (Southport) |
| **Acute, general adult and care of the elderly wards** | Change in base location and potential duplication with additional staff needed | No impact | Yes | No |
| **Respiratory medicine & NIV** | Change in base location | No impact | Yes | No |
| **Medical gastroenterology** | Change in base location | No impact | Yes | No |
| **Acute general surgery** | Change in base location | No impact | Yes | No |
| **Trauma & orthopaedics** | Changes to ways of working | No impact | Yes | No |
| **Adult critical care** | Change in base location | No impact | Yes | No |
| **General anaesthetics** | Change in base location and changes to ways of working | Changes to ways of working | Some | Some |
| **Radiology services (x-ray, ultrasound, CT & MRI)** | Change in base location | No impact | No | No |
| **Pathology services** | Change in base location | No impact | Yes | No |
| **OT & physio** | Change in base location | No impact | No | No |
| **Psychiatric services** | Change in base location | No impact | Yes | No |
| **Gynaecology** | No impact | Change in base location and changes to ways of working | No | No |
| **Paediatrics** | No impact | Change in base location, disaggregation of paediatric and neonatal rotas with additional staff needed | No | Yes |
| **Children and Adolescence Mental Health Service (CAMHS)** | Changes to base location and changes to ways of working | No impact | No | Yes |

## 6.1.3. Workforce Review – Clinical services support ED

There are numerous clinical services that support the emergency department that are key to ensuring a smooth flow of a patients' pathway.

All of these services are currently provided to both Ormskirk and Southport ED departments. None have structural issues in terms of capacity or capability in terms of support for the services needed. We do not therefore expect a significant impact to the overall level of workforce required by co-locating services on a single site. However, the location of services may have an impact of the service configuration and location of where the team are located.

Below, we have listed the key services that support ED patients in their clinical pathway, and the main constraints we anticipate within a co-located ED.

| | Workforce | | Service Relocation | |
|---|---|---|---|---|
| | Option 1: Ormskirk | Option 2: Southport | Option 1: Ormskirk | Option 2: Southport |
| **Clinical psychology** | Change in base location/ways of working | No Impact | Additional space required within ED plan | No |
| **Pathology** | Change in base location | No impact | Yes | No |
| **Pharmacy** | Change in base location/ways of working | No impact | Some increase to footprint likely | No |
| **Radiology** | Change in base location/ways of working | No impact | Re-alignment of pathways – imaging equipment in place | No |
| **Therapy services** | Change in base location | No impact | No | No |

The estate requirements for service configuration has been considered in the overall estates impact and costs associated with increased or changes to footprint have been included within the estates review. The biggest single impact from these services would be a relocation of pathology services to Ormskirk District General Hospital (c900m2).

## 6.2. Estates, finance and deliverability modelling

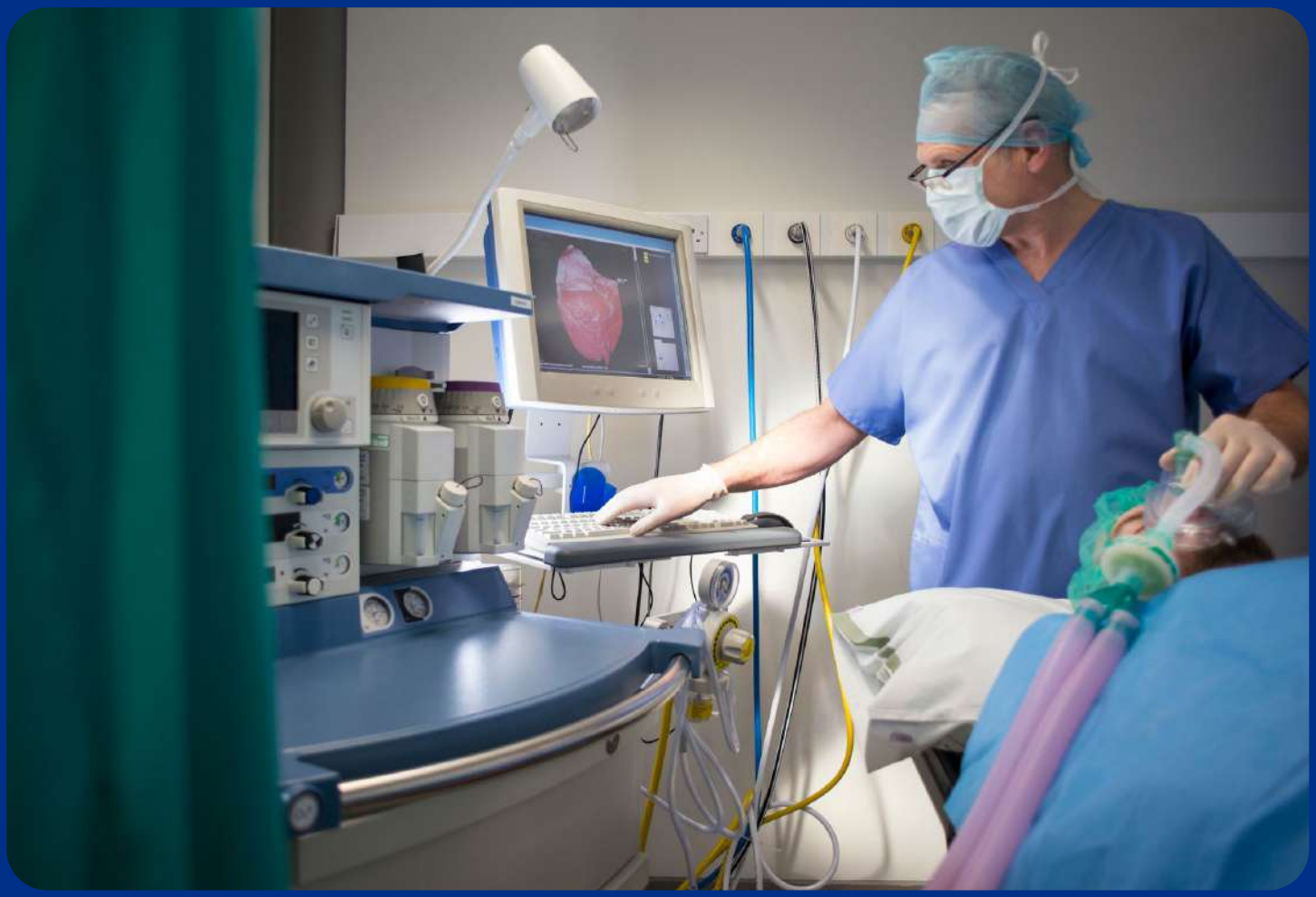
Southport & Formby and Ormskirk District General Hospitals present various opportunities to complement the SCT programme. To support the SCT programme, the condition of the hospitals and ongoing capital projects have been meticulously evaluated to ensure optimal use of public sector funds and available space. The challenges of executing major capital projects on active hospital sites have been duly considered.

In line with the options appraisal process, through reviewing the options for co-locating ED services onto a single site, three key variables have been assessed:

1. Potential location for ED services within the existing site
2. Impact on other clinical services that need to be co-located with an ED
3. Parking options to ensure sufficient capacity for increased patient flow

To support the trust in this programme, Ellis Williams Associates were commissioned as an independent firm of architects to review the existing estate configuration and provide an assessment of options for co-located services, along with the associated costs for delivering a co-located ED and time to deliver. The detailed report from Ellis Williams Associates is included as Appendix 8.

These three key variables have been used to determine the overall space requirements for a co-located ED at either hospital site and the likely cost of delivery, ensuring the necessary clinical adjacencies and parking to accommodate changes in patient flow.



## 6.2.1. ED co-location options

An initial review was conducted across both the Ormskirk and Southport and Formby District General Hospital sites to identify opportunities for refurbishing existing facilities or constructing new buildings that could provide the necessary square meterage to accommodate ED services for both adult and paediatric patients.

The working assumption for this review was that the existing service footprint would need to be consolidated onto a single site to effectively deliver a co-located ED. These initial reviews identified several areas for further exploration, as illustrated in the diagrams below.

Figure 12

2.6 Ormskirk Hospital Site Opportunities

NEW BUILD/REFURB OPPORTUNITIES

1. Development south east site area
   - Predominantly former ambulance parking or vehicle turning
   - Adjacent building used for ENT, Audiology and upper floor admin
   - Prominent front end location
   - Tree line provides barrier to residential
   - Limited parking loss/to be replaced
2. Demolish single storey admin block and construct 2 storey unit
   - Currently inefficient use of site space
   - Would suit standalone unit
   - Opportunity to widen road to eliminate single lane road
3. Develop former Workhouse buildings
   - Prominent site providing legible entrance
   - Would suit standalone unit
   - Opportunity to integrate historic structure with light internal refurbishment
4. Demolish single storey outpatient wing (Block 9) and construct new taller block as hospital 'front end'
   - Prominent site providing legible entrance
   - Could be constructed as standalone unit with limited connection to existing - entrance could be maintained
   - Bespoke new-build with ceiling height to suit modern ED
5. Internal refurbishment throughout main hospital block to suit proposed option
   - Would limit extent of external works
   - Working within existing footprint

New Build Opportunities

Refurbishment Opportunities

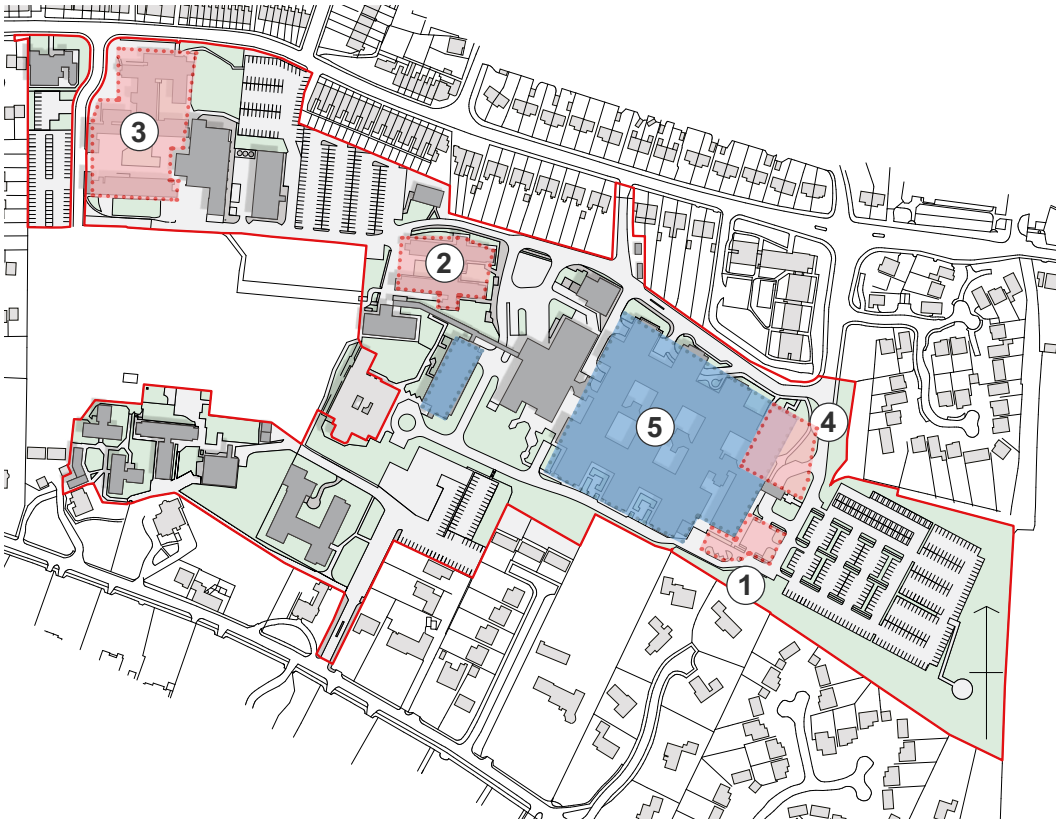
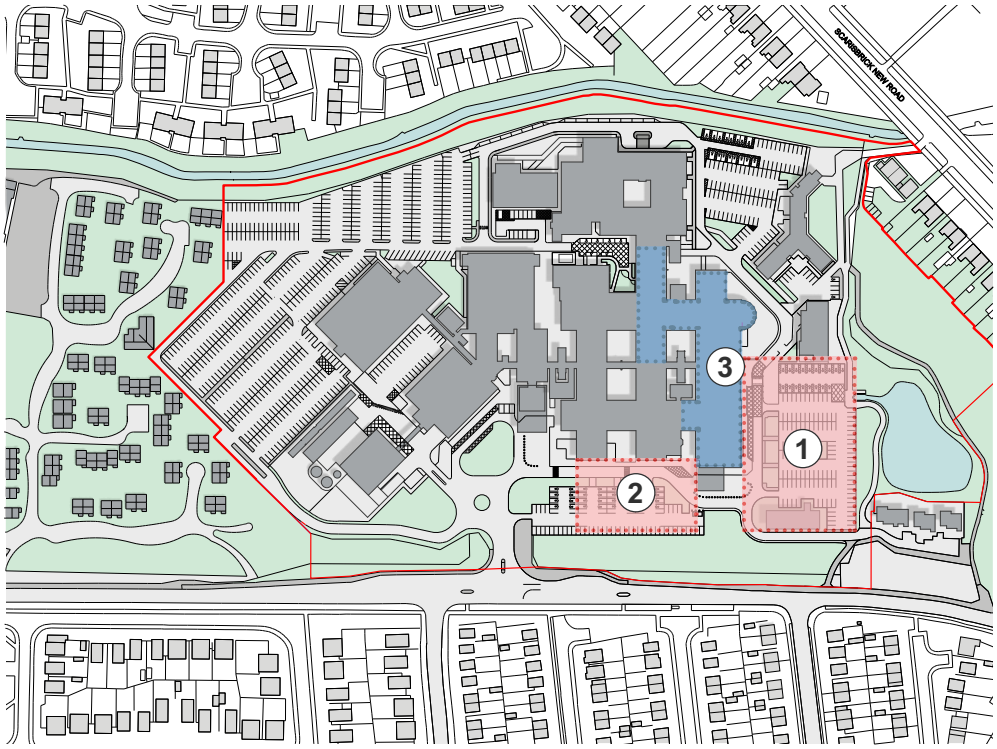


Figure 13

1.11 Southport Hospital Site Opportunities (1:1250)

NEW BUILD/REFURB OPPORTUNITIES

1. Development east site area
   - Predominantly at grade parking at present
   - Underutilised low level buildings with non-clinical function
   - Located close to existing ED
   - Substantial distance from residents with built precedent of existing buildings
   - Limited parking loss/to be replaced
2. Build on car park D
   - Prominent front site
   - Located adjacent to imaging and existing ED
   - Limited parking loss/to be replaced
3. Relocate existing outpatients and refurbish for UEC
   - Existing building
   - Direct road access
   - Within existing hospital
   - Located adjacent to imaging




New Building Opportunities

Refurbishment Opportunities

When evaluating the potential costs for new-build options, it became evident that, although preferable due to minimal disruption, the resources required to construct a new ED would be significantly greater than those needed to refurbish the existing estate. Consequently, the new-build option was discounted during the pre-hurdle criteria appraisal (see Section 5.3).

Refurbishing the existing estate aligns with the rationale and commitments outlined in the transaction business case to integrate Southport and Ormskirk District General Hospitals with St Helens and Knowsley Teaching Hospitals in the formation of MWL.

Should capital become available for a new-build option, the programme would reassess the available options.

## 6.2.2. Consideration of clinical co-dependencies

As outlined in section 4, several clinical services and departments would need to be relocated to support a co-located ED. The extent of these relocations varies significantly between the options. Based on the clinical co-dependency requirements from the national clinical senate recommendations, the table below details the number of services that are 'missing' from each site and would need to be either fully or partially relocated to support the ED. It also specifies the square meterage required on-site to provide the necessary ED support.

This information has been utilised in the subsequent sections to explore the total space required, estate configuration options, cost implications and time to deliver.

Table 7

Each of the codependencies has been categorised into 4 categories:
Must be located with ED
Service should come to patient - patient transfer not appropriate
Ideally on the same site
Does not need to be on the same site

| Codependencies for Emergency Departments | Missing from Southport | Missing from Ormskirk | Required Area - Southport ($m^2$) | Required Area - Ormskirk ($m^2$) |
|---|---|---|---|---|
| Acute and general medicine | | X | | 514 |
| Elderly medicine | | X | | 514 |
| Respiratory medicine | | X | | 798 |
| Medical Gastroenterology | | X | | 475 |
| General surgery | | | | |
| Trauma and Orthopaedics (separate) | | | | |
| Critical Care | | X | | 515 |
| General anaesthetics | | | | |
| X-ray and diag US / CT & MRI Scan | | | | |
| Urgent diag haem and biochem | | X | | 980 |
| Occupational therapy / physio therapy | | | | |
| Liaison psychiatry | | X | | See OPD |
| Gynaecology | X | | 770 | |
| Acute (non-specialised) Paediatrics and Paediatric Surgery | X | | 942 | |
| Endoscopy | | | | |
| Acute Cardiology | | X | | See OPD |
| Acute Oncology | | X | | See OPD |
| Palliative Care | | X | | 1690 |
| Clinical microbiology | | X | | 721 |
| Urology (in-patient) | | | | |
| Interventional Radiology (not 24/7) | | X | | Not required on same site |
| ENT (Outpatient) | | | | |
| Diabetes & Endocrinology (inpatient) | | X | | |
| Ophthalmology (outpatient) | | | | |
| SALT & Dietetics | | X | | See OPD |
| Neurology (Outpatient & in-reach) | | X | | Not required on same site |
| Dermatology (outpatient & in-reach) | | X | | See OPD |
| | | Total | 1,712$m^2$ | 7,242$m^2$ |

***Outpatient Department (OPD)**
For smaller codependencies, these have been combined into a single new Outpatient Department (OPD) to reflect the current scenario at Southport. This is sized at 1035m2.

## 6.2.3. Parking

Following feedback from our pre-consultation engagement listening events, a comprehensive review of existing parking facilities and vehicle flow across both hospital sites has been conducted.

Ormskirk District General Hospital offers a total of 714 parking spaces across four car parks. Southport and Formby District General Hospital provides a total of 926 parking spaces across six parking areas. When evaluating parking configuration opportunities, consideration has been given to the different user groups through a zonal system to determine the optimal locations for additional parking capacity. Given that both hospitals are situated in residential areas, opportunities for expanding parking capacity are limited. Consequently, adding a decked car park is likely to be the most effective solution to provide sufficient parking capacity.

### Ormskirk District General Hospital

For Ormskirk District General Hospital, the majority of patients utilise parking facilities in zone 1 of the diagram below, with ambulances and staff requiring access to the parking facilities in zone 2.

Figure 14

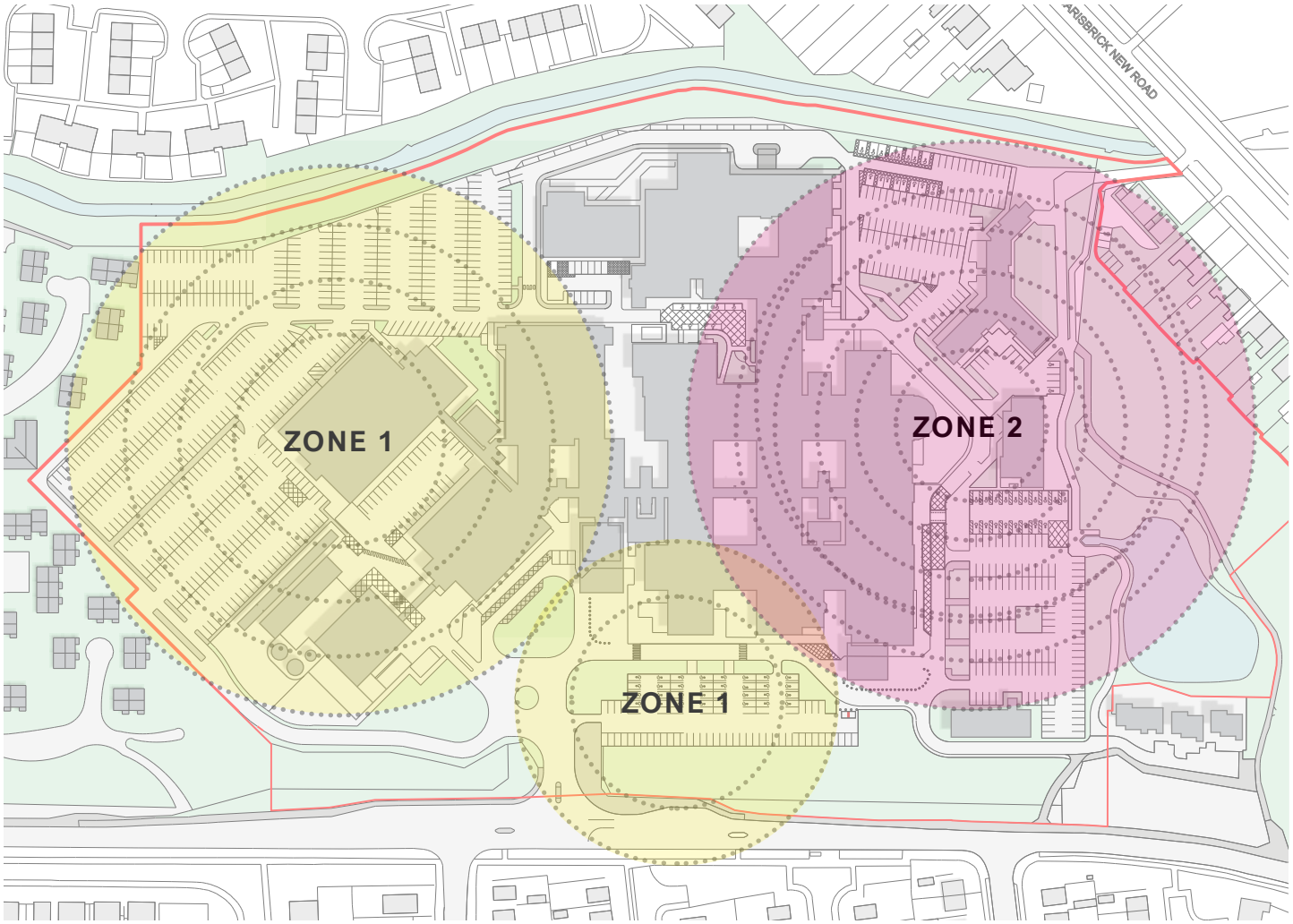

Zone 1 could provide enough space for a double deck car park with approximately 100 spaces per level, with a visual of what this could look like in the image below.

Figure 15

## Southport and Formby District General Hospital

At Southport and Formby District General Hospital, patients currently utilise a variety of parking facilities. The diagram below illustrates a proposed change, focusing on directing patients to access parking exclusively in Zone 1.

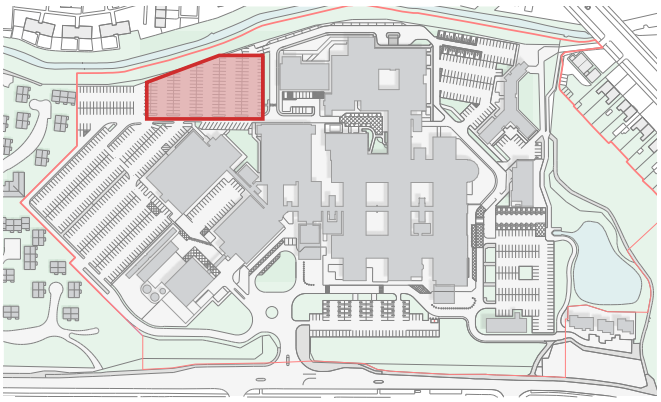
Figure 16

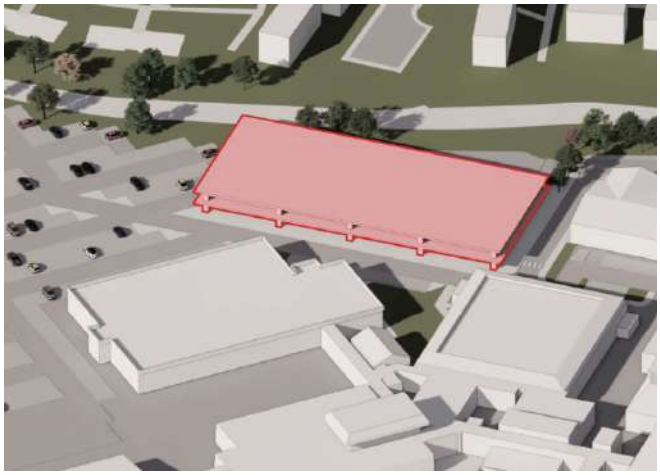



By focussing on zone 1, there would be two opportunities for additional decked car parking facilities as shown below with up to 266 additional parking spaces.

Figure 17

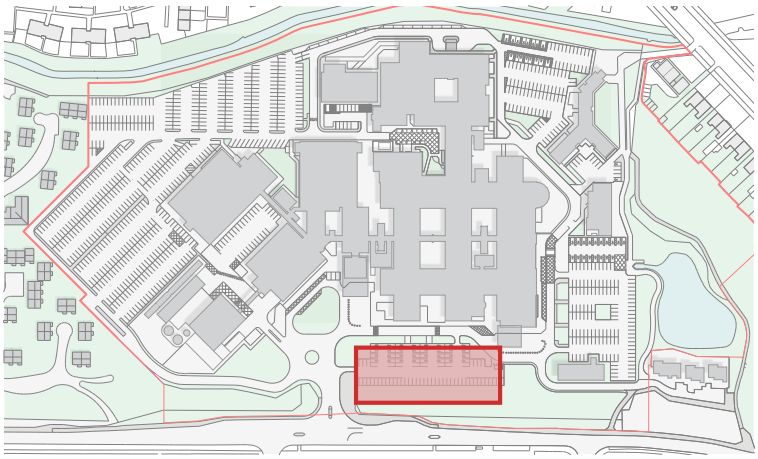
Scenario 2 MSCP - North Car Park Double Deck approx 100 spaces per level - 200 Total





Scenario 2 is to provide an additional 2 decks to the north car park to provide an additional 200 spaces of parking (approximately). This is located on the proposed public side of the site. This would be compatible with all proposed options for ED redevelopment/expansion.

Scenario 4 Surface Car Park - South Car Park - 153 spaces in total, 66 additional spaces from existing



Option 4 is to extend and replan the existing south car park that would provide additional 66 spaces. This is located on the front side of the site.

## 6.2.4. Estate configuration – Ormskirk District General Hospital option

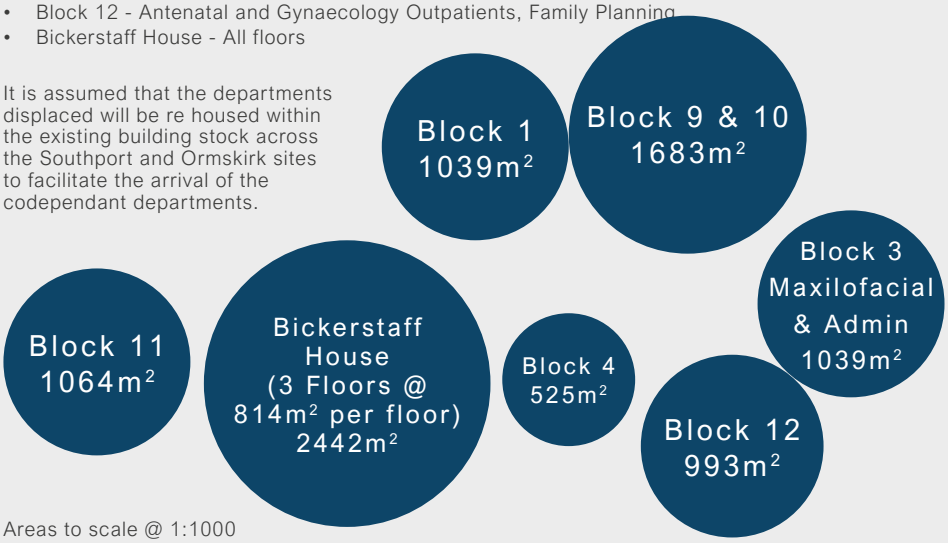
To co-locate the ED and the aforementioned co-dependent clinical services (Section 6.2.2), a total clinical area of 8,757m² would need to be constructed or refurbished. This would significantly impact the existing clinical service delivery across the site, with 1,500m² required for the adult ED and an additional 7,242m² to accommodate the relocation of the co-dependent clinical services. The refurbishment costs associated with this project are detailed in the next section. The graphic below illustrates the areas across the estate that would be displaced to support the necessary changes. In total, services across 8,785m² would be displaced to co-locate all required clinical services.

**Departments Displaced**

In order to locate as many codependencies as close to the new Adult ED as possible, the following departments are proposed to be displaced.

- Block 1 - Ward A + Ward B
- Block 3 - Maxilofacial and Admin
- Block 4 - Outpatients
- Block 9 and Block 10 - Outpatients, Essential Services Lab, Physio and Dermatology
- Block 11 - Treatment Centre & Endoscopy
- Block 12 - Antenatal and Gynaecology Outpatients, Family Planning
- Bickerstaff House - All floors

It is assumed that the departments displaced will be re housed within the existing building stock across the Southport and Ormskirk sites to facilitate the arrival of the codependant departments.




Areas to scale @ 1:1000

**Total Areas Displaced = 8,785m²**

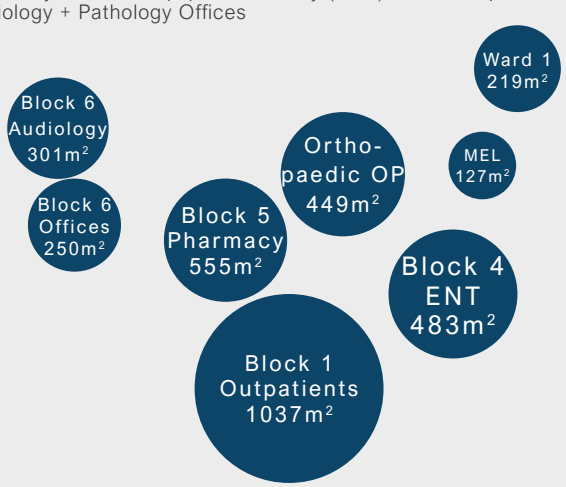
## 6.2.5. Estate configuration – Southport and Formby District General Hospital option

The co-location of the ED and additional codependent clinical services, as described in Section 6.2.2, requires a total clinical area of 3,501m² to be constructed or refurbished. Although still significant, the space required to support clinical dependencies is much lower than the Ormskirk option, resulting in less disruption to other clinical services (3,408m²).

**Departments Displaced**

In order to locate as many codependencies as close to the Adult ED as possible, the following departments are proposed to be displaced.

- Ward 1
- Block 1 - Outpatients
- Block 4 - ENT Outpatients
- Block 5 - Pharmacy, Medical Equipment Library (MEL) and Orthopaedic Outpatients
- Block 6 - Audiology + Pathology Offices




It is assumed that the departments displaced will be re housed within the existing building stock across the Southport and Ormskirk sites to facilitate the arrival of the co dependant departments.

Areas to scale @ 1:1000

**Total Areas Displaced = 3,408m²**

## 6.2.6. Deliverability

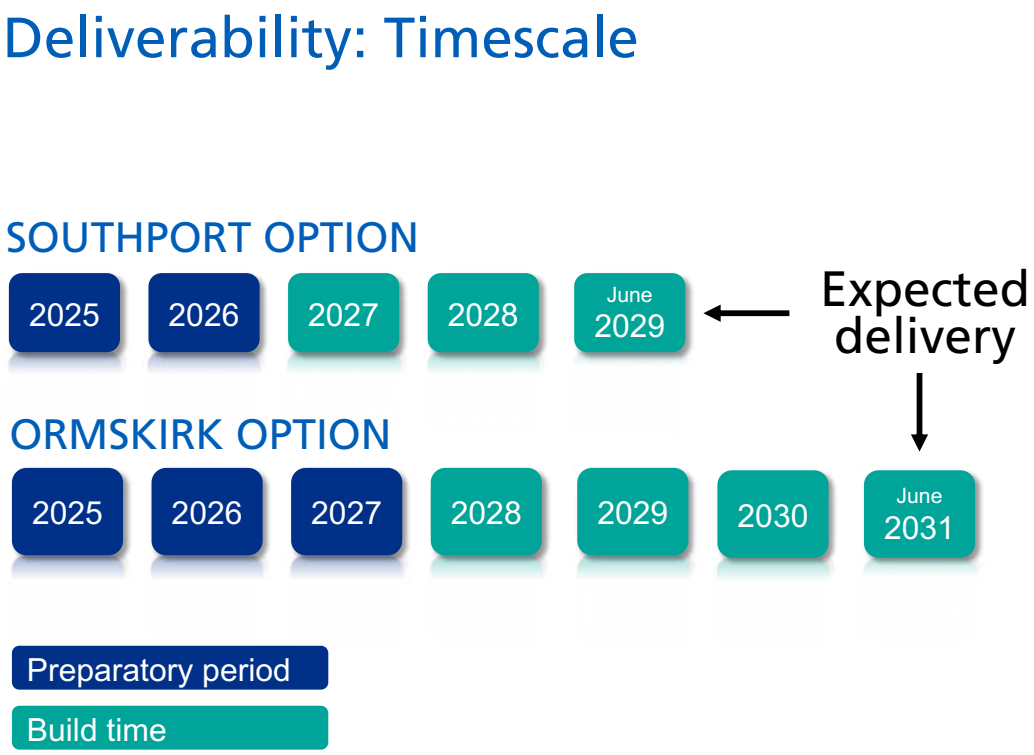
The space required for refurbishment and the number of co-dependent clinical services needing relocation vary significantly between the two co-location options. This discrepancy in costs will lead to considerably more disruption in clinical service provision under a co-location of EDs at Ormskirk District General Hospital compared to Southport and Formby District General Hospital and will take considerably longer to deliver.

In addition to changes in estate configuration, with a minimum of seven services needing to move to Ormskirk if EDs are co-located there, increased workforce consultation will be required to support changes in staff working locations. This includes assessments of clinical configuration options (e.g., single site or across site configuration) and potential consultations with commissioners and the public on changes to clinical services.

Co-location at Southport and Formby District General Hospital, although still requiring changes in both estate and clinical provision, is significantly less disruptive than the option to co-locate at Ormskirk District General Hospital.

Figure 18 describes the differences between the deliverability timeframes between the two options. Please note that this is an indication of deliverability for estates planning. The implementation plans for co-dependent services will also need to be reviewed which could likely extend timescales for plans that require significant movement of co dependencies.

Figure 18



## 6.2.7. Cost summary

The table below describes the cost of refurbishment of clinical areas and provision of additional parking facilities for the two options. They do not include costs to relocate displaced clinical services.

Table 8

| Description | Ormskirk District General Hospital ED co-location (£'000) | Southport and Formby District General Hospital ED co-location (£'000) |
|---|---|---|
| Refurbishment providing co-located ED services | £19,351 | £22,221 |
| Refurbishment for clinical co-dependency requirements | £62,731 | £12,463 |
| Additional car parking | £9,247 | £9,793 |
| **Total Cost** | **£91,329** | **£44,477** |

## 6.2.8. Finance summary

There are two key financial impacts from the co-location of ED services across the Southport & Formby and Ormskirk footprint.

Firstly, the consequential impact from this co-location and the resulting savings from improved workforce dynamics, as described in Section 6.1. Secondly, the capital implications from reconfiguring the hospital estate to support the co-location of adult and paediatric services.

### Revenue cost savings

By co-locating services and enhancing the working environment (both physically and structurally), the improved retention of staff, coupled with reduced reliance on agency or expensive short-term locum doctors, will result in an annual saving of approximately £1.5 million in the running of the co-located EDs compared to the current expenditure rate.

### Capital costs

The business case for the integration of Southport & Formby and Ormskirk District General Hospitals NHS Trust with St Helens and Knowsley Hospitals Teaching Hospitals NHS Trust into MWL included several key themes and assumptions that the options will support. Key drivers included optimising the use of existing facilities and improving the quality of estates across both hospital sites.

The business case committed to involving partners across the health economy in delivering sustainable services for the population and included the following:

> 'There is a need for robust agreements and resourcing by commissioners to establish adequate access to care for patients in the Southport, Formby and West Lancashire areas, compared to those in the Liverpool area. STHK have recognised that the new trust will need the support of key system stakeholders including the ICB and NHS England to deliver the reconfiguration changes that are required. There is also a recognition that capital investment will be required to deliver effective clinical reconfiguration for the new trust.'

The transaction business case had the full support of the system and outlined a vision for the reconfiguration of sustainable services. Providing co-located EDs will significantly contribute to ensuring that the clinical service model is sustainable from both a workforce and financial perspective.

It is clear from the analysis and commentary within this PCBC that the cost for co-located urgent care services that meet clinical requirements is significant. While the original SCT programme's circa £1 billion proposal for a new hospital development was not feasible, and the programme does require capital support to facilitate the changes across the footprint, the level of capital required to support the reconfiguration of clinical services, as described in this paper, is much lower than previous SCT programme proposals, at £44 million for co-location at Southport & Formby and £91 million for co-location at Ormskirk.

The route to funding will be through national funding via the SOC in line with national guidance. As described in NHS England[24] and HM Treasury[25] guidance, a SOC is the initial stage in the capital approval process. It establishes the need for change and the rationale behind the proposed intervention, before moving on to more detailed planning and analysis in subsequent stages of the business case development via the Outline Business Case (OBC) and Full Business Case (FBC).

Capital costs:

| High Level Cost Plan Summary | | |
|---|---|---|
| | *Description* | *Total Out-Turn Cost* |
| 001 A&E Development Scenarios | | |
| Southport Hospital - ED Relocation | Refurbish SDEC as Walk-in ED + relocate Paediatric ED and Inpatients from Ormskirk Hospital | £22,221,495 |
| | Refurbish areas for ED Codependencies | £12,463,483 |
| | Scenario 2 MSCP - North Car Park Double Deck approx 100 spaces per level - 200 Total | £8,141,602 |
| | Scenario 4 Surface Car Park - South Car Park - 153 spaces in total, 66 additional spaces from existing | £1,650,887 |
| Grand Total | | **£44,477,467** |

| High Level Cost Plan Summary | | |
|---|---|---|
| | *Description* | *Total Out-Turn Cost* |
| 001 A&E Development Scenarios | | |
| Ormskirk Hospital - ED Relocation | Light refresh of Paeds ED + ED relocated from Southport with new entrance extensions | £19,350,719 |
| | Refurbish areas for ED Codependencies | £62,731,022 |
| | Scenario 1 MSCP - East Car Park - Double Deck approx 100 spaces per level - Total 200 spaces | £9,247,227 |
| Grand Total | | **£91,328,968** |

Further information on key assumptions and exclusion, including percentage of risk and optimism bias can be found in Appendix 8.

[24] https://www.england.nhs.uk/wp-content/uploads/2018/03/B0595_addendum-to-planning-assuring-and-delivering-service-change-for-patients_may-2022.pdf
[25] https://assets.publishing.service.gov.uk/media/6645c709bd01f5ed32793cbc/Green_Book_2022__updated_links_.pdf

## 6.3. Activity models

Using 2023 activity data from Southport & Formby and Ormskirk District General Hospital EDs and ECDS data from patients registered with the five main CCG's covering the immediate area (Liverpool, Knowsley, South Sefton, Southport & Formby and West Lancashire) the anticipated activity levels at a co-located ED have been modelled in line with the options outlined in Section 5.

This section outlines the approach to the modelling and provides a high-level overview of the expected activity levels within co-located services at either Ormskirk or Southport and Formby Hospitals and impact on other local facilities.

### 6.3.1. Key modelling methodology and assumptions

Activity modelling has been completed based on profiling of market share data for Sefton and West Lancashire patients across Cheshire & Merseyside Emergency Care facilities. In addition, severity of injury/ illness (referred to as 'UTC rate') and Local Authority of residence have also been factored in.

In this context, market share refers to the proportion of total patients within a defined geographic area that a specific healthcare facility, such as an Accident & Emergency department, attracts relative to competing facilities. This concept adapts traditional business metrics to healthcare by treating emergency care demand as a 'market' and patient choices as analogous to consumer behaviour.

Market share models incorporate variables like proximity, hospital reputation, wait times, and service quality to predict patient distribution. These factors mirror consumer decision-making in commercial markets, enabling data-driven forecasts of patient flow.

The activity models were developed with reference to the clinical models of care (see Section 4) and the options appraisal process, incorporating support and input from colleagues across the health economy. Contributions from clinical teams at MWL and primary care, as well as colleagues from Alder Hey Children's Hospital NHS Trust, North West Ambulance Service NHS Trust and commissioners were invaluable in ensuring that the models received system-wide input.

Using current activity levels as the foundation, the initial review focused on modelling the additional activity likely within the paediatric service by re-opening on a 24/7 basis. Subsequently, two scenarios were developed for co-located EDs at either Ormskirk or Southport and Formby District General Hospitals.

Within the modelling, several assumptions have been applied to both co-location scenarios to ensure consistency in the approach. Individual aspects have been tailored according to location and population demographics (full details of all assumptions and modelling guide are available in Appendix 9a and 9b):

- All modelling uses calendar year 2023 data as the baseline for projections.
- Although 24/7 services across both sites are not being considered (as referenced within Section 5), modelling the opening of paediatric services on a 24/7 basis at Ormskirk was undertaken to provide a baseline for paediatric attendances in a 24/7 service.
- The attendance rates for patients at urgent care facilities (urgent treatment centres (UTCs) and walk-in centres (WICs)) during 2023 were used to determine likely behaviours for future years. Both co-location scenarios assume 24/7 access to both adult and paediatric EDs..
- Both scenarios assume that the vacated location will cease to provide emergency care services.
- A review of patient acuity was conducted to determine the proportion of patients that could, in theory, be seen within an UTC. Patients with low acuity are able to be seen within a UTC, but not all choose to do so ("UTC rate" as described in Appendix 9a SCT Attendance Modelling Guide).

Following the initial site-agnostic assumptions, activity was forecasted based on expected patient behaviours in each geographical area. Activity for all urgent care services across the patient population of Southport, Formby and West Lancashire was used in the modelling, along with key patient groups that attend services within the legacy Southport and Ormskirk District General Hospital catchment area.

Growth in activity has been applied in line with historic Trust averages: 1.5% for adult ED attendances, 2.7% for paediatric ED attendances, and 1.5% for UTC attendances. ONS population growth to 2027 estimates Sefton to be 1.1% and West Lancashire 1.1%, with 2032 projection in Sefton 2.4% and West Lancashire 1.9% (SHAPE Atlas[26]).

Consideration has been given to changes in populations across Sefton and West Lancashire with consultation of the Sefton Housing Strategy 2022-2027[27] and the West Lancashire Housing Strategy 2024-2029[28]. Also recognising that the Ministry of Housing, Communities and Local Government published guidelines in December 2024[29] for significant increases to local housing targets with Sefton increasing from 578 per annum to 1,466 (154%) and West Lancashire from 166 to 605 (264%). Once local councils allocate land for developments then consideration will be given to the impact on local ED services.


[26] https://shapeatlas.net/
[27] Sefton Housing Strategy 2022 ti 2027
[28] https://democracy.westlancs.gov.uk/documents/s36017/Appendix%20A%20-%20Housing%20Strategy%202024-2029%20MASTER%20-%20Draft%2011.1.24.pdf
[29] National Planning Policy Framework

## 6.3.2. Activity profiles

When modelling the activity for the co-location of ED services at Ormskirk or Southport, several variables were considered to determine changes in patient behaviour regarding which ED they are likely to attend. The baseline for these models is 2023 and activity data with forecast growth rate is shown in the table below.

Table 9

| Do nothing | | | |
|---|---|---|---|
| **Month** | **Southport ED** | **Ormskirk ED** | **Total** |
| **Year 1** | **56980** | **31548** | **88528** |
| **Year 2** | **57835** | **32400** | **90235** |
| **Year 3** | **58703** | **33274** | **91977** |

From this data, key demographic indicators such as age, sex, electoral ward, deprivation levels, and ethnicity were reviewed.

### 6.3.2.1. Co-located ED at Ormskirk District General Hospital

Co-location at Ormskirk necessitates an adjustment from the do nothing/business as usual scenario to account for changes in patient preferences regarding which ED they may choose to attend. A key factor in this is the geographic location of the services provided. In this scenario, patients from Southport will not have the option to attend a local UTC, as the nearest one is at Ormskirk. Consequently, a reduction in adult attendances by approximately 25% has been modelled, resulting in 42,000 attendances per year. A significant proportion of patients are likely to seek treatment at either Aintree Hospital or Royal Albert Edward Infirmary EDs.

Conversely, there would be a slight increase in paediatric attendances due to the availability of services on a 24/7 basis, with attendances increasing by 3% compared to current activity levels.

Table 10

| Option 1 – Co-location at Ormskirk breakdown | | | |
|---|---|---|---|
| **Month** | **Ormskirk ED – adult** | **Ormskirk ED - paeds** | **Ormskirk ED Total** |
| **Year 1** | **42,231** | **33, 032** | **75,263** |
| **Year 2** | **42,864** | **33,924** | **76,788** |
| **Year 3** | **43,507** | **34,840** | **78,347** |

Table 10 shows modelled activity for Option 1 – co-location at Ormskirk over the next 3 years, split by adult and paediatric attendances.

## 6.3.2.2. Co-located ED at Southport and Formby District General Hospital

In this option provision for both adult and paediatric services would be co-located at Southport. Adult attendances remain broadly unchanged from the do nothing/business as usual scenario. However, with a change in the clinical setting for paediatric services, paediatric activity has been reviewed through two main lenses:

1. Geographic location of the patient population
2. Acuity levels of patients, to determine the proportion of paediatric patients that could still be seen in a UTC rather than traveling to Southport and Formby District General Hospital's ED.

Table 11

| Option 2 - Co-location at Southport breakdown | | | |
|---|---|---|---|
| | Southport ED adult | Southport ED paeds | Southport ED modelled |
| Year 1 | 55,907 | 19,490 | 75,298 |
| Year 2 | 56,746 | 20,016 | 76,661 |
| Year 3 | 57,597 | 20,557 | 78,052 |

Table 11 shows modelled activity for scenario 3 – co-location at Southport over the next 3 years, split by adult and paediatric attendances.

## 6.3.2.3. Impact

### Impact on other trusts

As previously described, the location of the co-located ED will inevitably impact other EDs and urgent care facilities within the local health economy.

Co-location at Ormskirk will mean that patients living near Southport and Formby District General Hospital will not have access to urgent care services in their immediate vicinity. The two closest ED departments for these patients are likely to be Ormskirk District General Hospital or Aintree Hospital. The impact on other Trusts in this scenario will predominantly affect adult attendances, as the only change to paediatric services would be their accessibility on a 24/7 basis.

The location of the co-located services will also affect North West Ambulance Service (NWAS) NHS Trust services and the resources required to support patient transfers. The programme is collaborating with the ambulance trust to determine the likely impact of future service configurations.

NWAS provided a detailed report using their own bespoke modelling tool (Optima) to analyse the impact on the ambulance service for co-location at Ormskirk (Option 1) and co-location at Southport (Option 2). The following results were noted in Appendix 10 'NWAS Optima Simulation Report.'

In Option 1 (Ormskirk) an additional 2 hours 9 minutes per day is predicted to be spent on incidents which were altered for this scenario which translates to 2 hours and 54 minutes when looking at the impact on CM North and South Lancashire together.

Vehicles from Southport station are expected to be impacted the most in terms of additional travel distances which are predicted to travel an additional 116.8 miles per day with Formby and Preston doing an additional 45.2 and 37 miles respectively.

For Option 2 (Southport) an additional 42 minutes 14 seconds per day is expected to be spent on the altered activity by vehicles in this scenario. A minimal impact on travel distances is predicted in this scenario with South Lancs vehicles expected to travel an additional 15.4 miles per day when compared to the baseline

### Impact on primary care

Following engagement and input from primary care leads across Sefton and West Lancashire, there was a recognition that there would be an impact on primary care. Whilst efforts were made to understand this impact, due to the limited available primary care data, this impact could not be fully quantified at this stage. It was agreed with primary care partners and commissioning leads that an unknown and unintended impact to primary care would be acknowledged as part of the impact assessments (see Section 9).

### Co-location at Ormskirk District General Hospital impact

By extending the opening hours of the paediatric service at Ormskirk it will gain a small amount of paediatric activity from neighbouring ED departments which currently provide paediatric services out of hours, notably Alder Hey and Royal Albert Edward Infirmary.

The co-located ED may experience a significant decrease in adult attendances though as patients will need to travel to a different location than current. For some patients, alternative care settings could be more accessible. Consequently, there could be an increase in adult patients attending UTCs, WICs, and alternative ED departments – predominantly at Aintree Hospital, but also at the Royal Albert Edward Infirmary.

The adjacent map shows all emergency care facilities in the area, with a 5km radius of local catchment population.

With Southport removed it demonstrates the immediate competition Ormskirk has from services to the South and East (overlapping circles on the map). This is where competition from UTC's, WIC's and other ED's will come from.

It also shows how isolated the coastal population of South Sefton will become who could be drawn to Aintree.

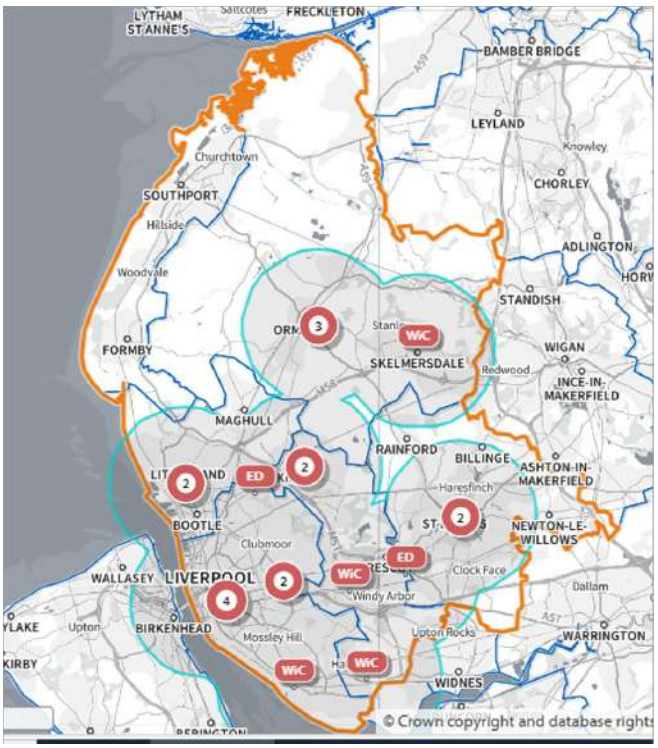


Table 12

| | Alder Hey 2023 | Alder Hey impact | Alder Hey impact (%) |
|---|---|---|---|
| **Total** | **61,099** | **-1,193** | **-2%** |

Table 12 shows actual ED attendances at Alder Hey (2023) from patients in our five core CCG's data set, with modelled reduction from patients switching to Ormskirk. This is approximately 2 patients per day. This activity is all from the current Ormskirk out of hours period (midnight to 8am), the impact on Alder Hey during this period is 21% of their overnight activity from our patient cohort.

Table 13

| | Royal Albert Edward Infirmary current | Royal Albert Edward Infirmary impact | Royal Albert Edward Infirmary impact (%) |
|---|---|---|---|
| **Total** | **4,858** | **2,846** | **59%** |

Table 13 shows actual ED attendances at the Royal Albert Edward Infirmary (2023) from patients in our five core CCG's data set, with impact for overall adult and paediatric patients modelled to attend there rather than Ormskirk. There would be a 67% increase in adult attendances (2,964 attendances or 8 per day), and a 29% decrease in paediatric attendances (-119 attendances or < 1 per day). Overall net increase of 2,846 attendances or 8 per day.

Table 14

| | Aintree 2023 | Aintree impact | Aintree impact (%) |
|---|---|---|---|
| **Total** | **89,570** | **6,450** | **7%** |

Table 14 shows actual ED attendances at Aintree (2023) from patients in our five core CCG's data set, with the modelled increase from patients who are assumed to choose to attend Aintree rather than travel to Ormskirk. This is approximately 18 patients per day.

## Co-location at Southport and Formby District General Hospital impact

The impact on attendances at neighbouring trusts due to co-location at Southport and Formby District General Hospital will be limited to paediatric activity, as there will be no change to the adult service provision.

Given the location and demographics of the population, co-locating services at Southport is expected to alter patient behaviours for a number of paediatric patients. As indicated in the tables above, while a proportion of patients are expected to attend the UTC at Ormskirk, there will be an underlying increase in patients choosing to attend the ED at Alder Hey Children's Hospital and Royal Albert Edward Infirmary in Wigan.

he adjacent map, again showing all local emergency care facilities with 5km radius catchment area shows how Southport is distinct in the region as it has no immediate competition (no overlapping circles).

It also demonstrates how isolated Southport is which means it is unable to draw in new markets of activity from the West.

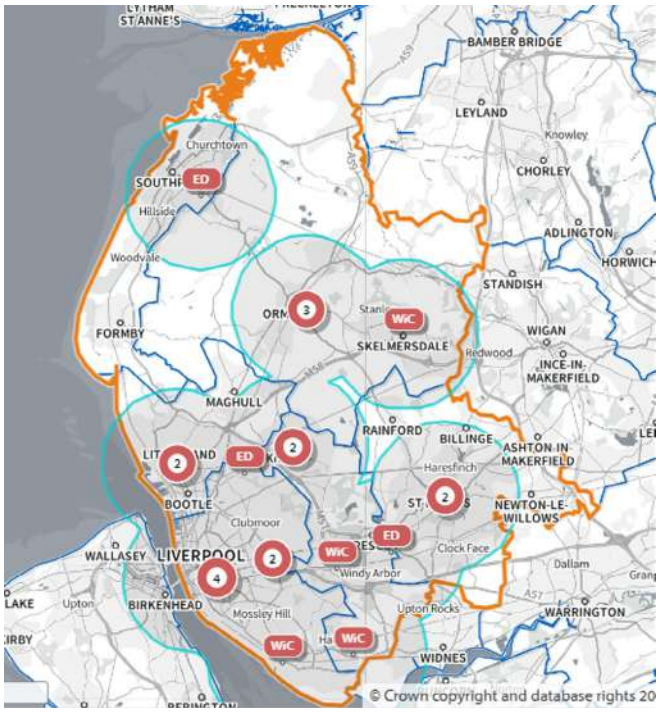



Table 15

| | Alder Hey current | Alder Hey additions | Alder Hey impact |
|---|---|---|---|
| **Total** | **61,099** | **594** | **0.97%** |

Table 15 shows actual Paediatric ED attendances at Alder Hey (2023) from patients in our five core CCG's data set, and the additional number modelled to attend Alder Hey rather than travel to Southport. This is approximately 1-2 patients per day.

Table 16

| | Royal Albert Edward current | Additional Royal Albert Edward Infirmary additions | Royal Albert Edward Infirmary impact (paeds) |
|---|---|---|---|
| **Total** | **4,858** | **448** | **0.7%** |

Table 16 shows actual ED attendances at Wigan (2023) from patients in our five core CCG's data set, and the additional number modelled to attend rather than travel to Southport. This is approximately 1-2 patients per day.

Table 17

| | Ormskirk UTC current | Ormskirk UTC additions | Ormskirk UTC impact |
|---|---|---|---|
| **Total** | **32,170** | **4,974** | **15.5%** |

Table 17 shows actual attendances at Ormskirk UTC (2023) from patients in our five core CCG's data set, and the additional number modelled to attend the UTC rather than travel to Southport. This is approximately 13-14 patients per day.

Table 18

| | Skelmersdale WIC current | Skelmersdale WIC additions | Skelmersdale WIC impact |
|---|---|---|---|
| **Total** | **18,143** | **2,269** | **12.5%** |

Table 18 shows actual attendances at Skelmersdale WIC (2023) from patients in our five core CCG's data set, and the additional number modelled to attend the WIC rather than travel to Southport. This is approximately 6 patients per day.

An area with potential positive impact, which has not yet been modelled, is the benefit of co-locating acute surgical services with a paediatric ED. This is likely to enhance the patient experience within the paediatric service, as patients can be treated on the same site where they are admitted, eliminating the need for relocation to a surgical site. This is expected to alleviate some inpatient burden from patients currently transferred to Alder Hey Children's Hospital.

## Key summary:

The modelling shows that the impact of co-locating services at Ormskirk District General Hospital would be more disruptive to both patients and the local health system than a co-located service at Southport and Formby District General Hospital due to a number of key factors:

- Patient population and activity for adult ED is predominantly from the Southport Coastal area
- Adult ED activity is significantly higher than paediatric activity

# 7. Stakeholder engagement

## 7.1. Stakeholders

Table 19 provides a list of key stakeholders from which the communications and engagement was planned; which was reviewed continuously and added to as and when new stakeholders were identified.

Table 19

| Type | Stakeholders |
|---|---|
| **Primary Care** | • Sefton GP Group<br>• West Lancashire GP Leadership |
| **Clinical** | • Primary care clinicians<br>• Secondary care clinicians<br>• Allied Health Professionals |
| **Councillors and local authority** | • Sefton Council<br>• Lancashire County Council<br>• West Lancashire Borough Council |
| **Media** | • Local and regional media outlets |
| **MPs** | • MPs representing constituents in Southport, Formby and West Lancashire |
| **Overview and scrutiny committees (local authority)** | • Lancashire HOSC<br>• Sefton HOSC |
| **Public** | • General public in Southport, Formby and West Lancashire<br>• Registered patients with GP Practices in Southport, Formby and West Lancashire |
| **PALS, Complaints and FOIs** | • NHS Cheshire and Merseyside ICB<br>• NHS Lancashire and South Cumbria ICB<br>• Mersey and West Lancashire Teaching Hospitals NHS Trust |
| **Regulators** | • NHS England |
| **Service users and carers** | • People accessing health and care services and their carers |
| **Staff** | • MWL and ICBs |
| **Trusts and other healthcare providers** | • MWL NHS Trust<br>• Mersey Care NHS Foundation Trust<br>• University Hospitals of Liverpool Group<br>• Alder Hey Children's NHS Foundation Trust<br>• North West Ambulance Service NHS Trust<br>• HCRG Care Group (provide UTC/ WIC provision as well as community service provider in West Lancashire)<br>• Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust |
| **Voluntary and third sector** | • Healthwatch<br>• ICB patient groups<br>• Local charity groups<br>• Community groups<br>• Campaign groups<br>• Local interest groups<br>• Sefton CVS<br>• West Lancashire CVS |

## 7.2. Approach

Stakeholder engagement is essential and one of the four tests set out by government guidance for service change. To ensure the programme met this requirement, a robust communications and engagement strategy was developed to support the programme. This can be found in Appendix 11. The pre-consultation engagement was carried out collaboratively by NHS Cheshire and Merseyside ICB, NHS Lancashire and South Cumbria ICB, and Mersey and West Lancashire Teaching Hospitals NHS Trust. All participating organisations gave full and conscientious consideration to the responses received.

## 7.3. Engagement: staff, local authorities, providers, patients and public

### Staff:

The MWL staff possess an intrinsic understanding of the NHS, frequently interacting with patients and shaping their experiences. This unique insight is further enriched by the fact that staff members are also part of the communities we serve and sometimes become patients themselves. The engagement provided invaluable perspectives on how we enhance urgent and emergency care services. Staff engagement activities included:

- **Trust Brief Live:** Regular all-staff briefing sessions with programme updates.
- **Online workshop:** A dedicated hour-long session for staff to ask questions and share their views.
- **Staff drop-in sessions:** Informal events held during lunch hours at the restaurant entrances of our Southport and Ormskirk sites, similar to our public roadshows, to raise awareness and engage staff in conversation.

### Local authorities:

The programme consistently engages with and provides updates to local Members of Parliament, councillors, and local authority officers. Additionally, the programme has periodically attended the HOSCs of both Sefton and Lancashire Councils providing an update of the programme, as well as agreeing that the proposed options constitute as substantial change. Maintaining these strategic relationships with elected representatives and appointed officials was crucial to the programme's success. See Section 10 for further information around engagement with HOSCs.

### Providers:

Given the potential impact on surrounding healthcare providers, the programme has maintained ongoing engagement with partner NHS organisations. These included:

- MWL clinicians
- MWL nursing leads
- MWL A&E staff
- MWL operational leads
- MWL executives
- NHS Cheshire and Merseyside ICB clinical leads (inc. primary care)
- NHS Cheshire and Merseyside ICB commissioning and operational leads
- NHS Cheshire and Merseyside ICB executives
- NHS Lancashire and South Cumbria ICB clinical leads
- NHS Lancashire and South Cumbria ICB commissioning and operational leads
- NHS Lancashire and South Cumbria ICB executives
- HCRG Care Group Ltd (Ormskirk UTC and Skelmersdale WIC provider)
- Merseycare NHS Foundation Trust
- Alder Hey Children's Hospital NHS Trust
- North West Ambulance Service NHS Trust
- University Hospitals of Liverpool Group
- NHS England Specialised Commissioning
- Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust

This included participation in the SCT Clinical UEC sub-group, involvement in the appraisal of options through hurdle and evaluation criteria workshops, and ad-hoc meetings with provider leads to update on programme progress.

**Primary care:**
General practitioners (GPs) across primary care in Sefton and West Lancashire have been engaged throughout the programme. This engagement has included involvement in programme workstreams, participation in the pre-consultation engagement and options appraisal process, as well as regular updates through GP bulletins, GP forums, and place urgent care boards where primary care is represented.

**Patients and public:**
A comprehensive plan of public engagement events was developed to ensure that any future redesign of services aligns with the needs of the communities we serve. This plan was designed to:

- **Listen** to concerns, views, perspectives, and ideas.
- **Inform** the public about the programme's scope, objectives, phasing, and ways to get involved.
- **Engage** through question and answer (Q&A) sessions, surveys, suggestion cards, and live conversations.
- **Record** views, suggestions, and lived experiences.

Recognising that different people engage in different ways, we tailored our events to include public meetings, online webinars, public roadshows, and focus groups to accommodate various preferences. Public events were held in various locations, including Ormskirk, Southport, Skelmersdale, Formby and Banks, and online through webinars. Specific events included:

- Public meetings: we hosted a series of four in-person public events in local community settings, offering attendees the chance to hear from, and put questions to, senior NHS leaders about the programme. These took place in Ormskirk, Southport, Formby and Banks.
- Public roadshows: we organised two drop-in sessions in busy public shopping centre areas in Skelmersdale and Southport, helping to inform, raise public awareness, gather views and encourage further participation. Events were publicised in advance, however, most conversations at these events were with people in-passing.
- Online webinars; We offered two online public meetings, catering for people who were unable to attend one of our in-person events.
- Focus groups: Targeted focus group discussions were arranged by invitation with staff, public and patients, and with community and voluntary sector groups.

We aimed to ensure not only the provision of engagement opportunities but also the facilitation of meaningful conversations. This required an effective and widespread communications campaign designed to reach all audiences. The engagement programme was promoted through local radio and newspaper advertising, social media, email marketing, and on posters, leaflets, and screens across Southport and Ormskirk District General Hospital sites.

Our network of voluntary and community groups played a crucial role in raising awareness and driving participation. Offline promotion included:

- Advertising screens and posters on hospital sites
- Local newspaper advertising
- Pharmacy bag advertising
- Leaflets available in main public areas across hospital sites.

Digital promotion included:

- Programme website
- Targeted social media advertising
- Newsletter updates
- Staff magazine and intranet
- Local media reporting

The key engagement metrics can be seen below:

| Digital | Offline | In-person |
|---|---|---|
| **Survey**<br>2,930 responses<br><br>**Website**<br>11,000+ visitors<br><br>**Social media ads**<br>101,600 reach<br>3,413 clicks<br><br>**Digital documents**<br>1,200+ downloads | **Radio ads Smooth NW**<br>800,000 reach<br><br>**Printed Case for Change**<br>1,000 distributed<br><br>**Pharmacy bag ads**<br>54,000 bags<br><br>**Newspaper ads**<br>Liverpool Echo & Ormskirk Advertiser | **Staff & public roadshows**<br>600+ live conversations<br><br>**Public meetings**<br>5 meetings<br>200+ attending<br><br>**Focus groups**<br>5 sessions with patients, staff and voluntary, community, faith and social enterprise groups |

In addition to this, Healthwatch Sefton, Healthwatch Lancashire, Sefton CVS and West Lancashire CVS have been engaged throughout the programme via the SCT Communication and Engagement Steering Group and SCT EPAG, as well as invitations to the public and online events and the options appraisal workshops.

A full report of the programmes engagement can be found in Appendix 12.

## 7.4. Key themes

Following the 10-week period of pre-consultation engagement, the following key themes were identified:

- Transport links are a barrier to access, especially in low car owning and more deprived areas.
- Future services needs to consider population change / new housing developments.
- People want A&E services close to where they live.
- Some people asked for a (24/7) walk-in-centre/ urgent treatment centre in their area.
- People said they often go to A&E because they can't get a GP appointment, and that primary care could do more to reduce the burden on A&E.
- Children's A&E should be 24 hours – Alder Hey should not be the closest overnight service.
- The programme must consider how to increase and retain the NHS workforce.
- People suggested that GPs may be referring non-emergency patients to A&E.
- The programme needs to communicate better and more widely (digitally and offline).
- Many people suggested collocating urgent and emergency services together on hospital sites.
- We need better provision of community services.
- Technology and artificial intelligence (AI) can harness improvements / efficiency gains.
- More joined up records and better systems integration would help improve efficiency and reduce waste.
- Ambulance services need further investment - current waiting times are putting patients at risk.
- Care for rural communities must be considered.


## 7.5. "You said, we did" table

All stakeholder feedback received, with the exception of survey responses, was recorded in our engagement log (see Appendix 13). This includes points noted, or submitted by comment cards, at our roadshows, public meetings and staff events, and all direct contact received either by post, email, phone or via the programme website.

We sometimes refer to the engagement log as our You said, we did tracker, because it not only shows the inputs received, but also indicates how the programme responded, and how contributions fed into the process of developing a long list of service options for appraisal. The types of input received can broadly be categorised as follows:

- Points relating to the engagement and pre-consultation process and in particular the extent to which the programme had been advertised in a way that allowed for broad participation. The log shows how, in many cases, the programme's communications activity was adapted to address stakeholder input received.
- Points relating to the current provision of UEC services, many of which will provide insight and guidance during the implementation phase. A number of these offered views on how services are managed and where improvements could be secured.
- Points regarding the accessibility of services and in particular the importance of considering transport when assessing the impact of possible service change on local populations.
- Points relating to the provision of NHS services other than UEC, which were responded to as 'out of programme scope' enquiries.

However, the greatest number of log entries offered views on how and where future UEC services should be offered. These were analysed alongside our qualitative survey response data. This analysis underpinned the development of the full list of possible service options which was subsequently appraised using agreed criteria at two workshop sessions in November 2024, as outlined in Section 5.

# 8. Government and NHS England five tests

NHS England's service configuration guidance outlines the Government's four tests for service change, along with an additional fifth test from NHS England, that all must be met to ensure that changes are in the best interests of patients and the public. These tests are:

1. **Strong public and patient engagement:** Proposals must demonstrate that there has been meaningful engagement with patients, the public, and local stakeholders. This ensures that the voices of those affected by the changes are heard and considered.
2. **Consistency with current and prospective need for patient choice:** The proposed changes should align with the need to offer patients choices about their care. This includes ensuring that any reconfiguration does not limit the options available to patients.
3. **Clear clinical evidence base:** Any proposed changes must be underpinned by a robust clinical evidence base. This means that the changes should be supported by clinical research and data demonstrating that they will improve patient outcomes.
4. **Support for proposals from clinical commissioners:** The proposals must have the backing of clinical commissioners, such as ICBs. This support is crucial as it indicates that those responsible for commissioning services believe the changes will benefit patients.
5. **Significant reduction in bed numbers:** The NHS England fifth test for major service change requires that any significant reduction in hospital beds must be justified by evidence of sufficient alternative services, reduced demand through new treatments, or improved bed efficiency.

These tests are designed to ensure that service reconfigurations are well-planned, evidence-based, and have the support of both the public and healthcare professionals.

## 8.1. Strong public and patient engagement

Under the NHS Act 2006[30], we are obligated to ensure the involvement of individuals who use, or may use, our services in the following areas:

- **Planning the Provision of Services:** Engaging with service users in the planning stages to ensure their needs and preferences are considered.
- **Developing and Considering Proposals for Service Changes:** Involving service users in the development and evaluation of proposals for changes to service delivery, particularly when such changes would impact the manner or range of services provided.
- **Decision-Making on Commissioning Arrangements:** Ensuring that decisions affecting commissioning arrangements, which may impact service delivery or the range of available services, involve input from service users.

Throughout the programme, robust public and patient engagement has been a priority. This engagement has included comprehensive pre-consultation engagement, supporting the development of hurdle and evaluation criteria, via by the SCT EPAG, and participation in options appraisal workshops. Further details on public and patient engagement can be found in Sections 5 and 7.

[30] Legislation.gov.uk (footnote 10)

## 8.2. Consistency with current and prospective need for patient choice

When a range of clinically appropriate and evidence-based treatments are available on the NHS, we have a duty to ensure that individuals can choose the care that best suits their needs, supported by information about the benefits and risks. For instance, patients can select any NHS organisation within England for their first outpatient appointment with a consultant or specialist. Additionally, in urgent and emergency care, patients have options such as choosing to visit an urgent care centre, walk-in centre or minor injuries unit for less severe issues, or an emergency department for life-threatening illnesses or accidents, and using the NHS 111 service to get advice on the most appropriate care. These requirements are outlined in the NHS Choice Framework[31].

In developing our potential options and proposed preferred option, we have consistently aimed to ensure that individuals will continue to have access to the right treatments, at the right place, and at the right time, with treatment choices offered as a standard practice, except where clinically inappropriate or unfeasible. However, choices may need to be constrained based on clinical safety or value for money or affordability, within the resources available to clinical commissioners in Southport, Formby, and West Lancashire. The SCT programme is committed to ensuring that residents in these areas have access to high-quality care within a financially sustainable healthcare system.

## 8.3. Clear, clinical evidence base

Clear, clinical evidence has been at the centre of the programme and is further detailed in Section 4. The reconfiguration is grounded in independent reviews (Deloitte, KPMG, and Clinical Senates) that identified workforce, safety, and financial challenges. The clinical models, developed in line with NHS England Emergency Care guidance, RCEM and RCPCH standards, NICE guidance, and CQC frameworks, align with national best practice. Through collaboration with ICBs and urgent care providers, the programme has established a clinically robust model, approved by key oversight groups to ensure evidence-based, high-quality emergency care.

To demonstrate compliance, the programme has conducted an evidence-based analysis in developing its models, has incorporated input from clinicians across primary care, secondary care, mental health, and community services in Southport, Formby, and West Lancashire. The PCBC highlights strong clinical leadership and engagement, outlining the impact of proposed changes on typical patients while identifying associated risks and benefits. The clinical models address critical service gaps, particularly the absence of 24/7 paediatric emergency care, by integrating adult and paediatric services. This enhances workforce resilience, reduces reliance on temporary staffing, and improves patient outcomes.

Oversight was provided by the SCT Clinical UEC Sub-group, which rigorously tested and validated the proposed clinical models. This group advises, informs, and approves clinical deliverables, offering guidance and direction to the programme. Further information on the clinical evidence base can be found in Section 4.4.

[31] https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

## 8.4. Support for proposals from clinical commissioners

NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB, as the clinical commissioners for Southport, Formby, and West Lancashire, have been actively involved throughout the SCT programme; with NHS Cheshire and Merseyside ICB as the lead commissioner. Their engagement has encompassed the development and review of clinical models and the Case for Change, support and participation in pre-consultation engagement, development of hurdle and evaluation criteria and collaboration in the development of the supporting information for the options appraisal process. Additionally, they have contributed to the development of the Quality Impact Assessment and Integrated Impact Assessment, and the review of the PCBC. Furthermore, a Joint Committee of NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB has been established for both ICBs to collectively make decisions relating to the SCT programme.

The ICBs for Cheshire and Merseyside and Lancashire & South Cumbria have been consistently engaged through regular updates, approval of key documentation, and representation at all levels of the SCT programme governance. Letters of support from NHS Cheshire and Merseyside ICB and Lancashire and South Cumbria ICB can be found in Appendix 14 and 15.

As the commissioners of the North West Spinal Cord Injuries Centre, currently located at Southport and Formby District General Hospital, NHS England North West Specialised Commissioning have also been engaged throughout the programme. This includes membership at the SCT Programme Board and participation as appraisers at the options appraisal evaluation criteria application workshop. Please see letter of support to the programme in Appendix 16.

### 8.4.1. Support from other providers

It is recognised that decisions made as part of the SCT programme may impact on neighbouring provider organisations; namely Alder Hey Children's Hospital NHS Trust, North West Ambulance Service NHS Trust, Mersey and West Lancashire Trust (including Whiston and St Helen's Knowsley Hospitals), Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust, University Hospitals of Liverpool Group, Merseycare NHS Foundation Trust and HCRG Care Group. In addition to the support received from the clinical commissioners, the programme has also sought support from these partner provider organisations. The providers have been engaged throughout the programme and more information can be found in Section 7.3.

Letters of support from providers that will be impacted from the changes can be found in Appendix 17, 18, 19, 20 and 21.

## 8.5. Bed closures

Effective from April 1, 2017, NHS England introduced a fifth test for proposals involving significant reductions in hospital bed numbers. Commissioners must provide evidence that they can meet one of the following conditions: ensuring sufficient alternative provisions, such as enhanced GP or community services, are in place alongside or ahead of bed closures with the necessary workforce to deliver them; demonstrating that new treatments or therapies, such as anti-coagulation drugs for stroke treatment, will reduce specific categories of admissions; or presenting a credible plan to improve hospital bed efficiency without compromising patient care, in line with the Getting it Right First Time programme. The SCT programme confirms that it does not plan to close any beds as part of the service reconfiguration, therefore this test is not applicable.

[23] https://www.gov.uk/government/publications/the-nhs-choice-framework/the-nhs-choice-framework-what-choices-are-available-to-me-in-the-nhs

# 9. Impact assessments

## 9.1. Quality Impact Assessment

The Quality Impact Assessment (QIA) was produced with the SCT Clinical UEC sub-group, which consists of clinical, operational and commissioning leads across MWL, NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB; as well as partner provider organisations.

The assessment highlights the potential benefits of improved patient safety, clinical effectiveness, and patient experience, while also noting the risks associated with increased travel times for some patients. Mitigations include providing a shuttle bus service and optimising urgent care centres.

The full detailed QIA can be found in Appendix 22.

## 9.2. Equalities and Inequalities Impact Assessment

The Equalities Impact Assessment (EIA) was completed in stages. Prior to the commencement of the pre-consultation engagement, a pre-EIA was completed to identify consultation issues linked with protected characteristics and identifies any potential indirect indiscrimination that decision makers need to be aware of. This can be found in Appendix 23.

An Equality and Inequality Impact Assessment (EIIA), derived from comprehensive research and analysis, is designed to ensure the SCT programme gives due consideration to risks affecting individuals with protected characteristics and localities. It also serves to inform the public, service users, staff, and stakeholders about our understanding of these risks. Additionally, it provides a reference point for any party to offer information and guidance if they believe our risk assessment is inadequate or incorrect.

In the context of service reconfiguration, the EIIA aims to identify existing inequalities, incorporate these findings into the design of new solutions, test these solutions to ensure they address any inequalities, and adapt them to mitigate potential risks. Decision-makers are required to give due regard to these risks and ensure, where possible, that they are mitigated.

The analysis process is continuous and begins once a change is deemed necessary. It involves several stages: evaluating the current service for inequalities, gathering insights from service users, staff, and stakeholders to avoid risks, testing and adapting solutions, consulting affected parties on potential risks, and post-implementation testing to ensure no unexpected negative impacts arise that require re-evaluation.

An interim EIIA analysis has been completed which outlines the ongoing EIIA for the SCT programme. Two potential reconfiguration options are under review to ensure equitable, sustainable, and integrated services. Key findings indicate accessibility challenges, particularly for deprived and rural communities, and concerns about travel, transport. The full interim report can be found in Appendix 24.

Furthermore, a full EIIA has been completed to assess the potential impacts of reconfiguring UEC services in Southport, Formby, and West Lancashire. This analysis ensures legal compliance, addresses health inequalities, and incorporates feedback from public, staff, and stakeholder engagements to guide future decision-making.

The EIIA identifies both opportunities and risks associated with the proposed reconfiguration, which involves co-locating both adult's and children's EDs at either Southport or Ormskirk Hospital, with the ED at the other site being closed.

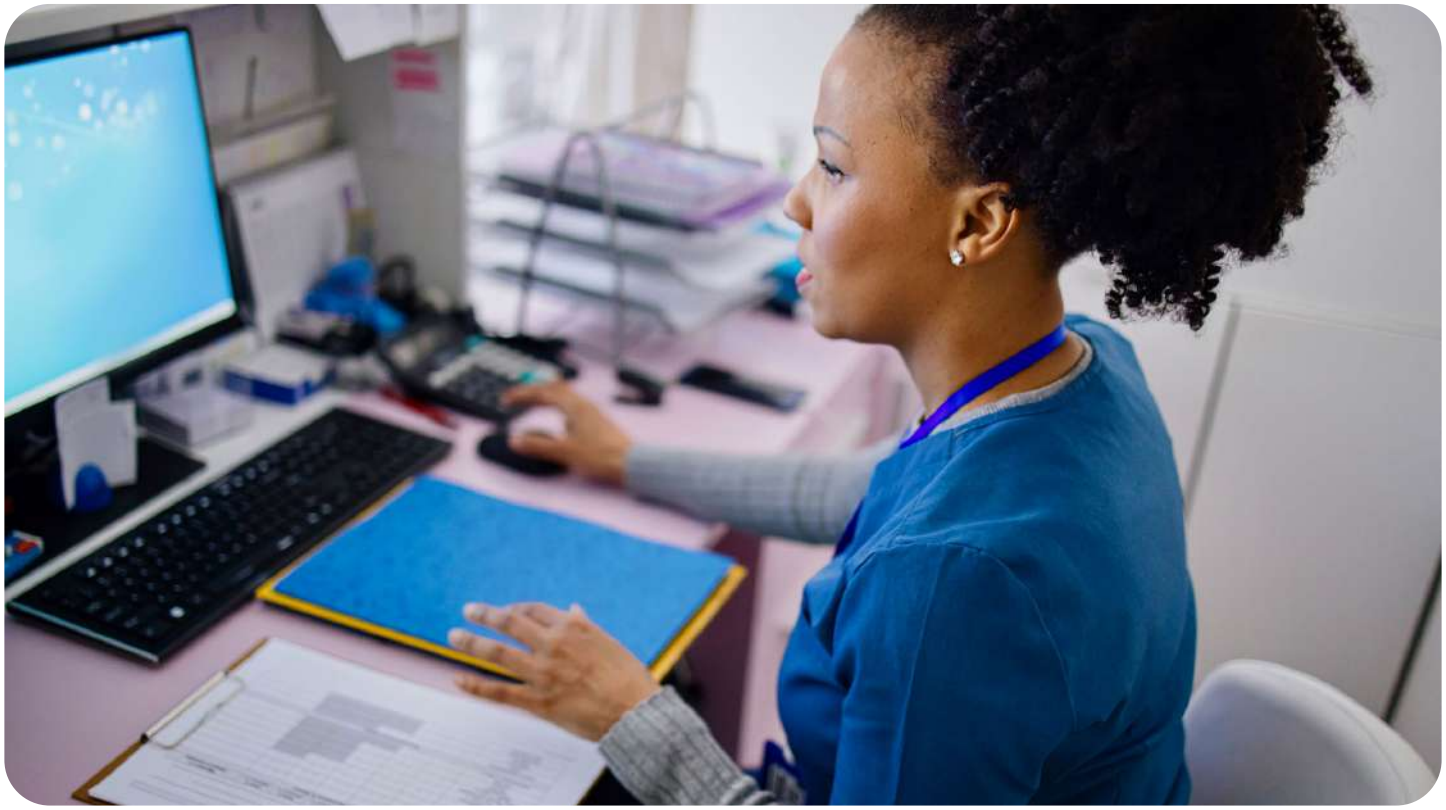
For patients, the most pressing concerns relate to accessibility and equity. Vulnerable groups—including the elderly, disabled individuals, carers, low-income households, and those without private transport—could face increased travel distances and financial burdens depending on the final location. These risks are especially pronounced in Skelmersdale and rural areas with limited public transport. There are also serious concerns about safety and wellbeing, particularly if children are required to share ED waiting areas with adults experiencing mental health crises or substance misuse. Issues such as congested facilities, inadequate parking, and site capacity limitations were frequently raised in engagement feedback.

On the other hand, the reconfiguration could bring positive impacts. Co-locating services has the potential to improve the integration, efficiency, and effectiveness of care, provided that infrastructure is upgraded accordingly. For either option, some patients and carers living closer to the selected site may benefit from reduced travel times and costs. The consistent availability of services for both adults and children could also support improved equity of access.

For staff, co-location could streamline operations by reducing the need to work across multiple sites, enhancing efficiency, and supporting professional development across both adult and paediatric emergency care. However, staff also flagged concerns about parking shortages, commuting difficulties, and site readiness, particularly if the transition is not supported by investment in facilities and transport infrastructure.

Overall, the EIIA underscores that while the proposed changes offer a route to more sustainable, integrated care, they also carry a risk of deepening existing inequalities unless mitigations—such as improved transport options, parking capacity, and accessible infrastructure—are defined and implemented. The full EIIA report can be found in Appendix 25.

This assessment is iterative and will continue to be reviewed and updated throughout the consultation and decision-making process. This approach ensures we meet our legal duties under the Equality Act 2010 and remain responsive to any new information or impacts identified through engagement with patients, carers, staff, and communities.



## 9.3. Travel Impact Assessment

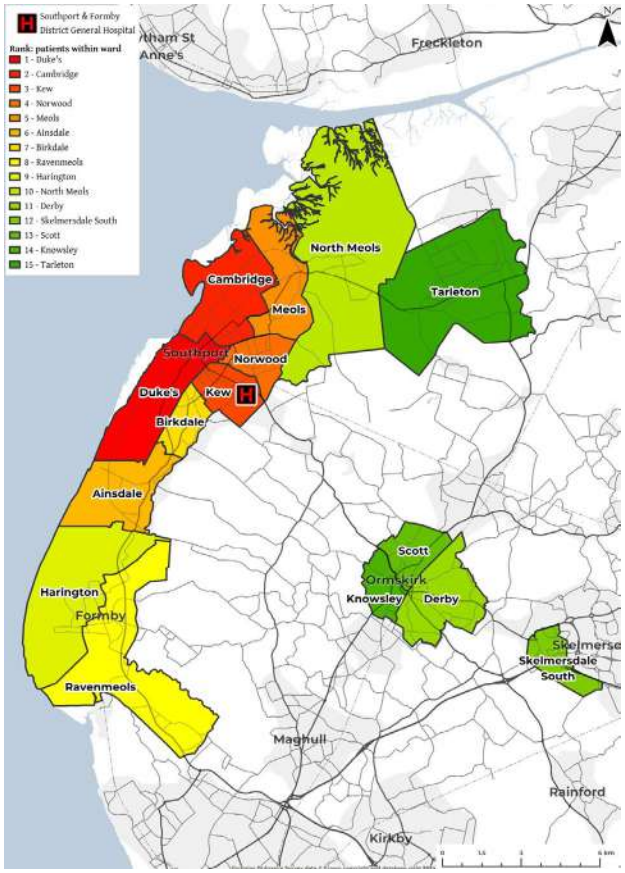
Analysis indicates that patients and staff generally live closer to Southport and Formby District General Hospital compared to Ormskirk District General Hospital. Although Ormskirk District General Hospital is better connected by road and public transport within an hour, connectivity from the Sefton Coast to Ormskirk is poor, lacking direct bus routes. With an ageing population on the Sefton Coast, investment in shuttle bus services will be essential if additional care services are located in Ormskirk.

Further analysis shows that many top patient wards are not served by another hospital within an hour's public transport journey, though drive time accessibility is better.

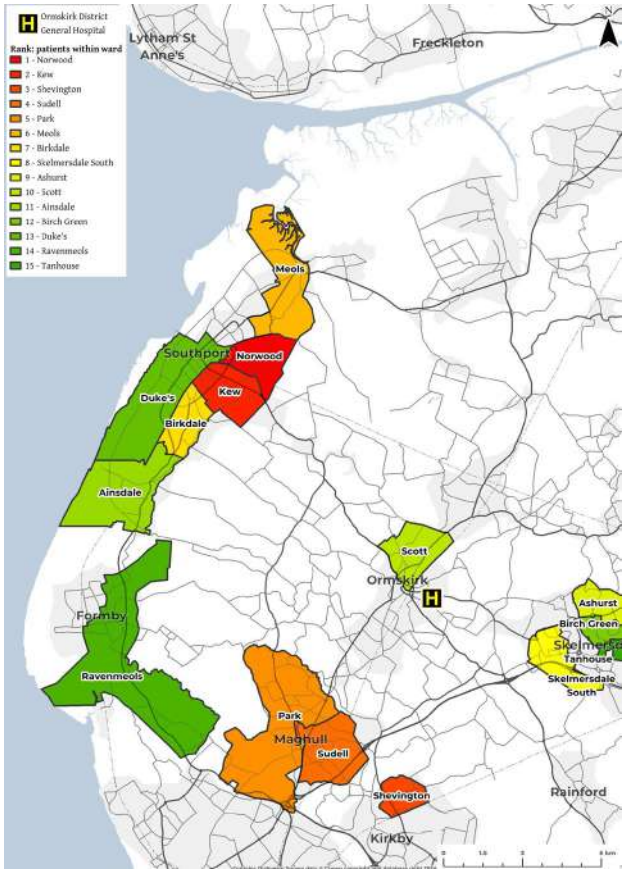
Detailed car journey analysis reveals shorter travel times to Southport and Formby District General Hospital, with significant increases if traveling to Ormskirk District General Hospital. The highest users of Southport and Formby District General Hospital's adult ED were from Dukes and Cambridge, both located within the Sefton area. Similarly, the highest users of Ormskirk District General Hospital's paediatric ED were from Norwood and Kew, which are also situated within the Sefton area (see Figure 19).

Figure 19

Top 15 patient wards for Southport & Formby Hospital mapped




Top 15 patient wards for Ormskirk District General Hospital mapped




Source: MWL ED data January 2023 to December 2023

Cost analysis highlights that bus travel is the cheapest per mile due to the £2 fare cap, but bus journeys are often 2-3 times longer than car or taxi trips. Time and cost are crucial factors in travel decisions for patients and staff. Improvements in public transport services and investment in new roads and junctions are needed to enhance access to both hospital sites.

The full travel impact assessment can be found in Appendix 26.

## 9.4. Environmental Impact Assessment

With national guidance outlining the NHS' duties in relation to climate change, an Environmental Impact Assessment was completed against the proposed options.

The impact assessment revealed that there is a greater opportunity to improve carbon impact with new materials, while there is little difference in terms of health and wellbeing impact, energy impact, transport, water, waste, and land use and ecology for both options.

The full detailed report can be found in Appendix 27.

## 9.5. Integrated Impact Assessment

An Integrated Impact Assessment was completed with the SCT Clinical UEC sub-group to understand the impact of the two options.

The Integrated Impact Assessment for the SCT programme evaluates the two options; co-location of adult and paediatric A&E services at Ormskirk District General Hospital or Southport and Formby District General Hospital.

**Option 1: Ormskirk District General Hospital co-location** Relocating adult A&E from Southport to Ormskirk would consolidate support services, potentially improving workforce flexibility, waiting times, and patient accessibility. However, it would require significant investment in infrastructure and co-dependent services, and could disrupt current service delivery. There are concerns about increased travel times and costs for patients from Southport and Formby, and the potential loss of the North West Spinal Cord Injuries Centre service.

**Option 2: Southport and Formby District General Hospital co-location** Relocating paediatric A&E to Southport would also consolidate services, improving clinical outcomes and workforce efficiency. However, it would necessitate relocating acute paediatrics, and could negatively impact patients from West Lancashire due to increased travel times. The assessment highlights the impact with other regional programmes, i.e. the maternity and regional neonatal programmes.

Both options aim to improve patient safety, clinical effectiveness, and patient experience, but each has its own set of challenges and potential impacts on health equity, workforce, and other providers.

The full impact assessment can be found in Appendix 28.

# 10. Assurance

## 10.1. NHSE assurance process

The NHS England major service change assurance process is a structured framework designed to guide and support commissioners and providers through substantial service changes. It ensures that proposals for service reconfiguration are evidence-based, align with national standards, and consider the government's four tests of service change. The process involves thorough planning, stakeholder engagement, and evaluation to ensure that changes are in the best interests of patients and can be implemented effectively.

The gateway assurance stages with NHS England include:

1. **Strategic sense check:** Initial review to ensure the proposal aligns with strategic priorities.
2. **Pre-Consultation Business Case:** Detailed case for change, including options appraisal and stakeholder engagement.
3. **Consultation:** Public consultation to gather feedback on the proposed changes.
4. **Decision-Making Business Case:** Final business case incorporating consultation feedback and detailed implementation plans.
5. **Implementation:** Monitoring and evaluation of the implementation process to ensure it meets the intended outcomes.

These stages ensure a rigorous and transparent process for major service changes, supporting the delivery of high-quality, sustainable healthcare services.

For the purpose of this document, the following assurance is provided:

- NHS England Stage 1 strategic sense check; the meeting took place on 3rd June 2024 with approval to proceed to stage. The letter can be found in Appendix 29.
- NHS England Stage 2 assurance checkpoint; the meeting took place on 18th March 2025.

## 10.2. Health Overview and Scrutiny Committee (HOSC)

HOSCs play a crucial role in NHS major service change by ensuring that proposed changes are in the best interests of the local population. They review and scrutinise the planning, development, and implementation of health services, providing a platform for public and patient engagement. HOSCs assess the impact of service changes on health outcomes and inequalities.

The programme has engaged both formally and informally with the Sefton HOSC and Lancashire HOSC since the programme was rescoped in October 2023 (see dates in Table 20).

Table 20

| Sefton HOSC | Lancashire HOSC |
|---|---|
| January 2024 | November 2023 |
| April 2024 | April 2024 |
| September 2024 | September 2024 |
| January 2025 | December 2024 |

The programme sought agreement of substantial variation with the Lancashire HOSC on 13th December 2024 and the Sefton HOSC on 7th January 2025. Minutes of these meetings can be found in Appendix 30 and Appendix 31. This agreement triggered the legal duties of HOSCs to form a Joint HOSC, as the programme covered two HOSC areas. The programme continues to engage with both HOSCs.

# 11. Plans for consultation

## 11.1. Consultation process

NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria ICBs are committed to ensuring that the proposed options outlined in the PCBC are subject to an open and transparent public consultation process in order to harness local people's views on the most appropriate way to address the challenges outlined.

The consultation will be informed by and reflect learning from the pre-consultation engagement process conducted in 2024.

A 13-week long public consultation process will therefore be held to:

- Ensure people in and around Southport, Formby and West Lancashire are aware of and understand the need to change and the proposed options for change
- Hear people's views on the proposed changes to the way urgent and emergency care is organised in Southport, Formby and West Lancashire
- Ensure the ICBs are made aware of any additional information which may help to inform the proposals and the decision-making process

During this period, commissioners will listen carefully to the views of all communities and local stakeholders who have an interest in health and social care. The consultation will also invite views on the criteria and considerations used to inform the ICBs' final decision to establish the importance of proposed evaluation domains to local people.

The consultation will be anchored in best practice, drawing upon the guidance below and informed by external critical advice

- Cabinet Office - Consultation Principles (revised January 2018)[32]
- NHS England – Planning, assuring and delivering service change for patients[33]
- NHS England – Planning for Participation[34]

No final decisions will be taken until after the consultation has closed and results have been collated and independently analysed.

[32] https://www.gov.uk/government/publications/consultation-principles-guidance
[33] NHS England (footnote 3)
[34] https://www.england.nhs.uk/wp-content/uploads/2014/03/bs-guide-princ-part.pdf

## 11.2. Stakeholders

The stakeholders identified for the consultation can be found in the table below.

Table 21

| Type | Stakeholders |
|---|---|
| **Primary care** | • Sefton GP Group<br>• West Lancashire GP Leadership |
| **Clinical** | • Primary care clinicians<br>• Secondary care clinicians<br>• Allied Health Professionals |
| **Councillors and local authority** | • Sefton Council<br>• Lancashire County Council<br>• West Lancashire Borough Council<br>• Maghull Town Council |
| **Health and wellbeing board** | • Sefton Health and Wellbeing Board<br>• Lancashire Health and Wellbeing Board |
| **Media** | • Local and regional media outlets |
| **MPs** | • MPs representing constituents in Southport, Formby and West Lancashire |
| **Overview and scrutiny committees (local authority)** | • Lancashire HOSC<br>• Sefton HOSC |
| **Public** | • General public in Southport, Formby and West Lancashire<br>• Registered patients with GP Practices in Southport, Formby and West Lancashire |
| **PALS, Complaints and FOIs** | • NHS Cheshire and Merseyside ICB<br>• NHS Lancashire and South Cumbria ICB<br>• Mersey and West Lancashire Teaching Hospitals NHS Trust |
| **Regulators** | • NHS England |
| **Service users and carers** | • People accessing health and care services and their carers |
| **Staff** | • MWL and ICBs<br>• Sefton Metropolitan Borough Council<br>• Lancashire County Council<br>• West Lancashire Borough Council |
| **Trusts and other healthcare providers** | • MWL NHS Trust<br>• Mersey Care NHS Foundation Trust<br>• University Hospitals of Liverpool Group<br>• Alder Hey Children's NHS Foundation Trust<br>• North West Ambulance Service NHS Trust<br>• HCRG Care Group<br>• Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust<br>• NHS Lancashire and South Cumbria Foundation Trust (LSCft) |
| **Voluntary and third sector** | • Healthwatch<br>• ICB patient groups<br>• Local charity groups<br>• Community groups<br>• Campaign groups<br>• Local interest groups<br>• Sefton CVS<br>• West Lancashire CVS |

## 11.3. Decision-making process

The NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria ICBs plan to make final decisions regarding the proposed changes in early 2026. These decisions will be presented to the Joint Committee of the ICBs, planned for Spring 2026.

The ICBs' decisions will consider the consultation outcomes, any variations arising from the consultation process, further clinical assurances, and the final accessibility and equalities impact assessment.

Before the ICBs finalise their decisions on the future of urgent and emergency care services in Southport, Formby, and West Lancashire, several key activities must be completed:

- **Consultation analysis:** Responses to the consultation will be independently analysed, and a report summarising the findings will be produced. This report will be provided to the Joint HOSC and made available to the public.
- **Updating the impact assessments:** The ICBs will continue to review and update the impact assessments in parallel with the consultation process, in line with their statutory responsibilities to ensure equality across protected characteristic groups, promote health, and reduce health inequalities. Input from local individuals, groups, and organisations will be crucial in identifying all potential impacts of the proposed service changes.
- **Ongoing business case development:** Elements of the PCBC will be further developed to ensure a comprehensive clinical and financial evaluation of the options, confirming workforce availability, affordability, and assessing relevant risks. This will involve additional clinical and non-clinical reviews of the proposed options, with external advice as necessary. Further clinical review will be particularly important for any alternative service models suggested. All additional information will be included in the final DMBC.
- **High-Level implementation and evaluation planning:** Although no changes will occur until the ICBs make their decision, preliminary implementation planning will take place. This planning will enable the program to mobilise the new service promptly and realise the anticipated health and efficiency benefits. Given the uncertainty of the consultation outcomes and the ICBs' final decisions, planning will accommodate the potential options, focusing on common features and measurable outcomes necessary to evaluate the success of the changes. Detailed implementation and evaluation planning will be completed once the consultation outcome is known and a decision is made.

## 11.4. Consultation timeline

A proposed* for the consultation period and subsequent DMBC and SOC development can be found below:

*subject to factors arising form the assurance process and approval by the ICB joint committee

Table 22

| Type | Stakeholders |
|---|---|
| **NHSE Stage 2 Clinical Senate Assurance** | 27th January 2025 |
| **Submission of NHSE Stage 2 assurance paper** | 13th February 2025 |
| **NHS England Stage 2 Assurance Check** | 18th March 2025 |
| **Local election pre-election period** | 21st March to 1st May 2025 |
| **PCBC to ICB Joint Committee for approval** | July 2025 |
| **Notification of consultation launch to Joint HOSC** | July 2025 |
| **Public consultation (13-week period)** | July to October 2025 |
| **Analysis of insights from the public consultation** | October to November 2025 |
| **Update to ICB Joint Committee with consultation insights and next steps** | November 2025 |
| **Engage with Joint HOSC (outcome of consultation and next steps)** | Winter 2025/26 |
| **Develop Decision-Making Business Case (DMBC) and Strategic Outline Case (SOC)** | Winter 2025/26 |
| **NHS England approval of the DMBC and SOC** | February 2026 |
| **JHOSC engagement (inform)** | Winter/Spring 2026 |
| **DMBC and SOC to Joint Committee for approval** | Spring 2026 |
| **Potential engagement with JHOSC** | Spring 2026 |

Please note: all the above milestones and dates align with SCT Programme Board governance.

# 12. Glossary of terms and abbreviations

| | |
|---|---|
| A&E | Accident and Emergency department |
| AHCH | Alder Hey Children's Hospital |
| AI | Artificial Intelligence |
| AMAU | Acute Medical Assessment Unit |
| AVS | Acute Visiting Service |
| CAMHS | Children and Adolescence Mental Health Service |
| CUES | Community Urgent Eyecare Services |
| DMBC | Decision-Making Business Case |
| ECDS | Emergency Care Data Set |
| ED | Emergency Department |
| EIA | Equality Impact Assessment |
| EIIA | Equality and Inequality Impact Assessment |
| ENT | Ear, Nose and Throat |
| GP | General Practitioner |
| GP OOH | GP Out of Hours |
| HOSC | Health Overview and Scrutiny Committee |
| ICB | Integrated Care Board |
| IUC | Integrated Urgent Care |
| IMD | Index of Multiple Deprivation |
| MWL | Mersey and West Lancashire Teaching Hospitals NHS Trust |
| NHS | National Health Service |
| NIV | Non-invasive ventilation |
| OPD | Outpatient Department |
| OT | Occupational Therapy |
| PCBC | Pre-Consultation Business Case |
| QIA | Quality Impact Assessment |
| SALT | Speech and Language Therapy |
| SAU | Surgical Assessment Unit |
| SCT | Shaping Care Together |
| SDEC | Same-day Emergency Care |
| UCR | Urgent Community Response |
| UEC | Urgent and Emergency Care |
| US | Ultrasound |
| UTC | Urgent Treatment Centre |
| WIC | Walk-in Centre |

# 13. Appendices

Appendix 1 - Strategic alignment

Appendix 2 - LSC Urgent and emergency care five-year strategy 2024 –2029

Appendix 3 - Case for Change

Appendix 4 - Clinical data and benchmarking analysis

Appendix 5 - SCT Hurdle criteria

Appendix 6 - SCT Evaluation criteria

Appendix 7 - SCT full list of options and SWOT analysis

Appendix 8 - Estates feasibility study

Appendix 9a - Activity modelling assumptions

Appendix 9b – SCT Activity Modelling guide

Appendix 10 - NWAS Optima Simulation Report

Appendix 11 - Communications and engagement strategy

Appendix 12 - Pre-consultation engagement final report

Appendix 13 - You Said, We Did log

Appendix 14 – NHS Cheshire and Merseyside ICB letter of support

Appendix 15 – NHS Lancashire and South Cumbria letter of support

Appendix 16 - NHS England North West Specialised Commissioning letter of support

Appendix 17 - Alder Hey Children's Hospital NHS Foundation Trust letter of support

Appendix 18 - North West Ambulance Service NHS Trust letter of support

Appendix 19 – Mersey and West Lancashire Teaching Hospitals NHS Trust letter of support

Appendix 20 - University Hospitals of Liverpool Group letter of support

Appendix 21 - Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust letter of support

Appendix 22 - Quality Impact Assessment

Appendix 23 - Equalities Impact Assessment – pre-engagement report

Appendix 24 - Interim EIIA analysis

Appendix 25 – SCT full EIIA report

Appendix 26 - Travel Impact Assessment

Appendix 27 - Environmental Impact Assessment

Appendix 28 - Integrated Impact Assessment

Appendix 29 - NHS England North West strategic sense check outcome letter

Appendix 30 - Lancashire Health and Adult Services Scrutiny Committee - mins 13.12.24

Appendix 31 - Sefton HOSC mins

NHS

# PUBLIC CONSULTATION

SHAPING CARE TOGETHER

## On proposals for **changes** to local **urgent** and **emergency care** services

In Southport, Formby, and West Lancashire

Have your say by
Friday 03 October 2025

**SHARE YOUR VIEWS. TAKE OUR SURVEY**

**www.bit.ly/sct09**

The Shaping Care Together programme is a partnership between Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria.

# Contents



**We are the NHS in Southport, Formby and West Lancashire.**

We're asking for people's views on proposals to change where and how we offer urgent and emergency care, affecting some of our services at Southport and Ormskirk hospitals.

# About this consultation

**The Shaping Care Together programme is actively seeking views on proposals for the future of urgent and emergency care services across Southport, Formby and West Lancashire.**

We are consulting on two sets of proposals designed to deliver a way of providing safe and excellent-quality urgent and emergency care services. We want to make sure we do this in a way that makes services available to everyone, all day, every day. And we want to find solutions that will help us in the long term so we do not have to keep changing things.

We know the way services are currently set up means we are not delivering this. For example, pressures on services mean our children's A&E at Ormskirk Hospital cannot be offered safely all day and night. That is why, in April 2020, we took the difficult decision to reduce opening times. Since that time there has been no dedicated children's A&E service at Ormskirk Hospital between midnight and 8am.

**Having children's and adult A&E services on different hospital sites comes with a number of challenges. At most hospitals across the rest of the NHS in England, children's and adult A&E services are on the same site.**

**This is the model underpinning both sets of proposals in the consultation.**

## What is a public consultation?

**A consultation is when public bodies, like the NHS, ask for feedback from the public on things like policy ideas or service changes.**

**It is a way of hearing opinions, concerns and suggestions before making decisions.**

**Doing this helps us to make better decisions and builds trust with the people we serve.**

## Our proposals for urgent and emergency care

**We are consulting on two options.**

**One is for locating children's and adult A&E services at Southport Hospital and the other is for services to be at Ormskirk Hospital.**

**The Southport site is our preferred option for reasons we explain later in this booklet.**

This booklet is designed to give you the information you need to get involved. Your views and contributions will help make sure proposals are co-designed with the people who use and rely on our services.

## No decisions have been taken yet

Based on the evidence, we feel the Southport option meets the programme goals better than Ormskirk. We explain why in the 'shaping proposals' section of this booklet.

Decisions will only be made, however, once we have heard a much wider range of views so we can be confident that proposals are based on all available evidence and reasoning.

## How you can help

We are looking for people to help us:

- Select the best option for meeting programme goals for the whole area.
- Make sure we have looked at and considered all relevant, available evidence.
- Understand the impacts of the proposals and what can be done to limit them.

There are lots of ways you can get involved.

**You can share your views by taking our survey and discover the latest news by signing up to our newsletter or visiting www.yoursayshapingcaretogether.co.uk**

We will bring the conversation to where you live through a series of public events and discussion groups.

And we will do all we can to help everyone take part and to make sure people have the information they need, in the way they need it. If you, or someone you know, has specific needs that we have not thought about, please let us know how we can help.

Find more detailed information on proposals in our pre-consultation business case (PCBC) and supporting documentation.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

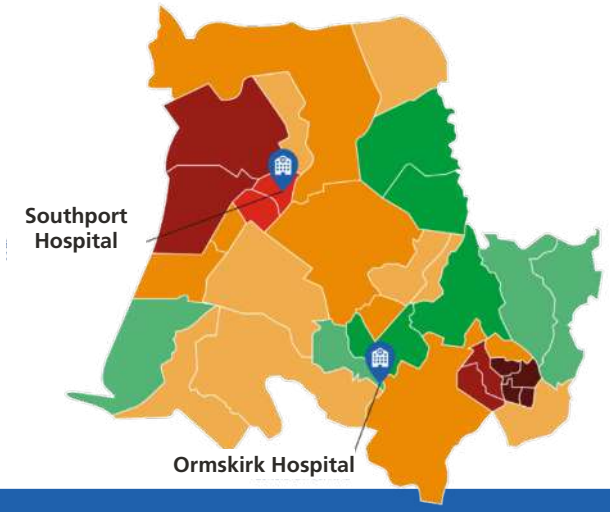
# Who we are and who we care for

## Who we are

We are the NHS in Southport, Formby and West Lancashire.

Our job is to help look after the health of our communities and people. That means making sure you can get the high-quality and safe care you need, when you need it.

This programme is a partnership between Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria.




**Southport, Formby and West Lancashire.**

The map is colour coded to show relative levels of deprivation in each area.

The dark red areas are the most deprived communities, and the dark green ones are the least deprived.

## Who we care for

This is about helping you, the people who live here, and the people who rely on our services.

We know where you live can have a big impact on how long you live, and how much you are likely to suffer from illness and disease. This is what we call health inequality.

**For example, in West Lancashire, people living in relatively deprived Birch Green are likely to die 10 years younger than people living in better off Tarleton.**

**And in Southport and Formby, the relatively affluent people in Ainsdale are expected to live between seven years (males) and nine years (females) longer than people living in the most deprived areas.**

As your local NHS, we have a responsibility to reduce health inequalities and to give everyone the chance of longer and healthier lives, wherever they live, and whatever their background.

### Life Expectancy

# Shaping the future of urgent and emergency care

When we started the Shaping Care Together programme, we identified seven service areas that needed to change. You can read about them in our Challenges and Opportunities booklet in the 'library' section of our website.

One of the service areas was urgent and emergency care. That is what we are looking at first and what this booklet is about.

## Getting people to the right place

The proposals in this consultation affect some services at Ormskirk Hospital in West Lancashire, where people aged under 16 went to A&E 32,457 times in 2023-24, as well as some services at Southport Hospital, where adults went to the emergency department 58,088 times over the same period.

We know many people who go to A&E could be assessed, cared for and treated somewhere else. This can lead to longer waiting times at A&E and can create additional pressures across our hospitals and wider NHS services.

**Our data shows almost four in 10 adults who went to Southport A&E last year could have been seen and treated elsewhere.**


**For people aged under 16 going to Ormskirk A&E, this rises to more than seven in 10.**


**Changing this pattern may not be easy, but it is necessary. With your help, we are confident we can do it.**

## Getting urgent and emergency care right helps the whole system flow better.

## That's why it's the first service we're looking at.

**As your local NHS, we need to work in the most effective and efficient way possible - providing a range of services to meet people's needs by making smart use of resources.**

As well as looking at congestion in our A&Es, we also need to improve the flow of patients through our hospitals, avoiding discharge delays wherever possible.

We are always working towards making sure more people get the treatment they need without being admitted to hospital by making best use of our same day emergency care unit (SDEC), our urgent treatment and walk-in centres, and our community-based services which help us provide care for some people more locally or in their homes.

When you need urgent or emergency care, we will help make sure you know the best place to go.

## Not sure if you need A&E?

It is not always easy to know if you need emergency care before you have been assessed by medical staff. If you are not sure where to go, **help is available from NHS111 by phone and online.**

They can check your symptoms and tell you what to do. They may suggest you go to one of our urgent treatment or walk-in centres or advise you to wait to see a GP or local pharmacist.

# Our vision for future services

**Our vision is to find a way to organise services that makes best use of NHS resources to provide safe and excellent quality care that can serve us well into the future.**

**Crucially, we have to make sure our urgent and emergency care services are there for everyone, all day, every day.**

To make that a reality, we will have to make some changes as we outlined in our case for change last year.

# Why change is needed

Five main factors are putting services under unsustainable pressure.

## Our population is getting older

Projections say the number of working-age people (under 65) will stay around the same over the next 20 years. But there will be a lot more people over 65. This means there will be more people to treat and more people needing urgent and emergency care.

## Having the staff we need

We need more healthcare assistants and senior doctors to do our job well. We often use temporary staff to fill the gaps. This is more expensive and less effective.

## Quality of care

Services must be safe and built around excellent-quality patient care. The last Southport and Ormskirk Hospital official inspection in 2019 said services 'require improvement'. We know things have got better since then, but we also know there is more to do.

## Buildings that are up to the job

We need to look after our buildings to make sure they are up to the job. We are not looking for quick fixes, as just doing the minimum can be more expensive and wasteful in the longer term.

It is about much more than just repairs. We need to have buildings that help us deliver high quality and safe services today and in the future.

We also have a duty to do that in a way that helps us protect the environment.

## Feeling the financial strain

The amount of funding the NHS receives is decided by the Government.

Having more money could help with some things but wouldn't solve all the challenges we face.

We need to find solutions that make the most of what we have. That may mean not doing the same things in different places if there is not a good reason for it.

## Why we are starting with urgent and emergency care

Urgent and emergency care services play a very important part in keeping us healthy. The NHS responds to more than 110 million urgent calls or visits every year, so it is crucial things run smoothly.

**Urgent and emergency care services can have a big impact on many other NHS services.** For example, trauma surgery, intensive care and high dependency units often sit alongside emergency care. When urgent and emergency care comes under pressure, these other services often feel it too.

That can make it harder for us to have the right staff in place to keep all these services running well. It can also mean more people leaving A&E and needing a hospital bed.

**When the pressures get too much, and we do not have the beds or staff we need, we sometimes have to cancel appointments for operations.**

The way we provide urgent care can also make a difference to how we care for and support people in their homes and communities.

**Getting urgent and emergency care right helps the whole system flow better.**

That is why it is the first service we are looking at.

## Why doing nothing is not an option

We need to make sure A&E is available for everyone all day, every day. However, the pressures we have outlined meant that four years ago, we had to take the very difficult decision to close Ormskirk Hospital children's A&E between midnight and 8am.

**To provide A&E services in a safe way, a lot of different, highly trained staff need to be there to support the emergency medical teams. In other parts of England, where children's A&E is at the same site as adult A&E, this support can be available in the wider workforce.**

Our case for change also explains why we feel that A&E services need to be organised in this way where we live. The many people who shared their views with us strongly supported this.

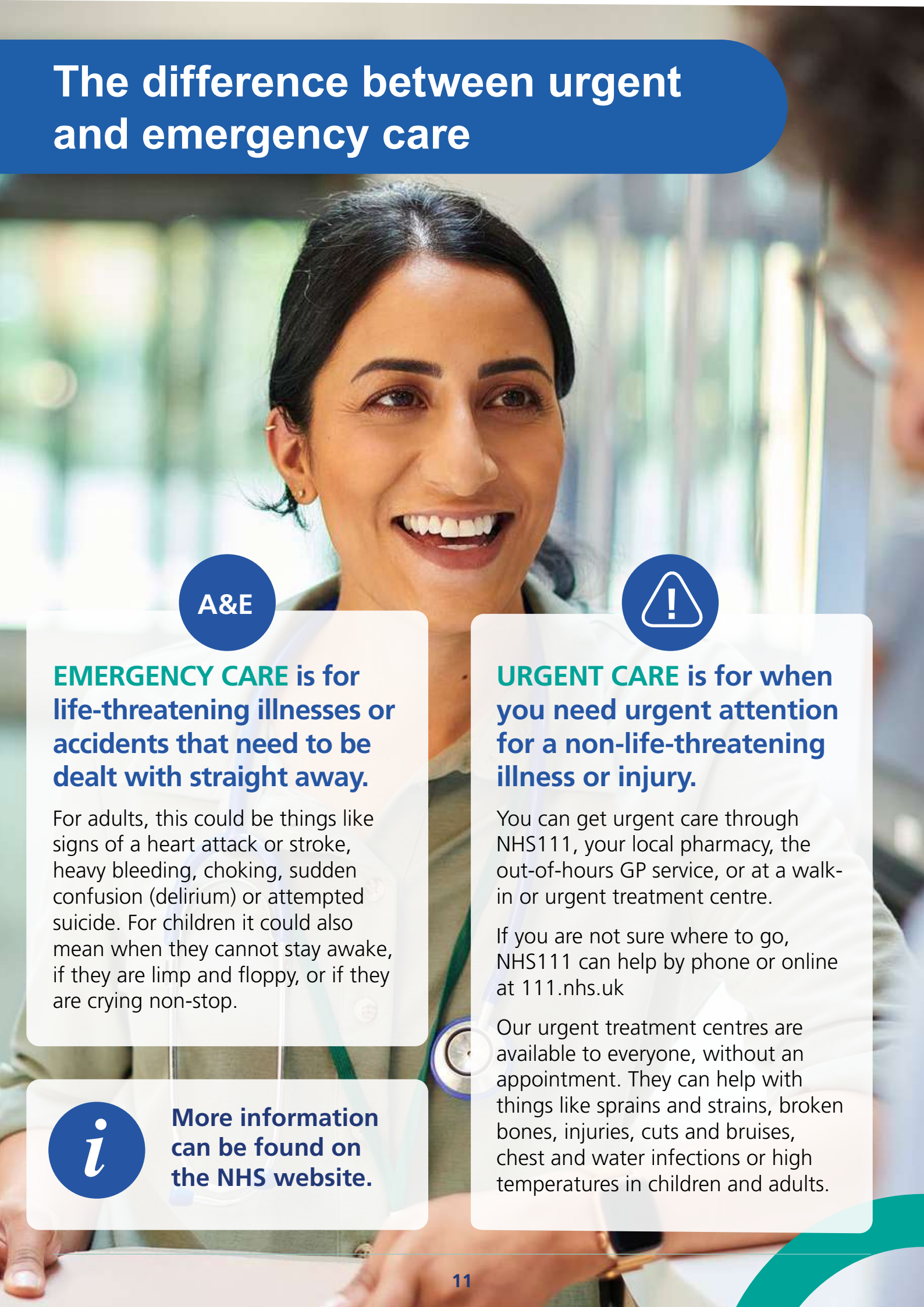
**If we do nothing, the pressures on services are only expected to get worse.**

**Achieving our goals may not be easy but, with your help, we are confident we can do it.**

Read more about service pressures and why change is needed in our case for change.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

# The difference between urgent and emergency care



A&E

## EMERGENCY CARE is for life-threatening illnesses or accidents that need to be dealt with straight away.

For adults, this could be things like signs of a heart attack or stroke, heavy bleeding, choking, sudden confusion (delirium) or attempted suicide. For children it could also mean when they cannot stay awake, if they are limp and floppy, or if they are crying non-stop.

## URGENT CARE is for when you need urgent attention for a non-life-threatening illness or injury.

You can get urgent care through NHS111, your local pharmacy, the out-of-hours GP service, or at a walk-in or urgent treatment centre.

If you are not sure where to go, NHS111 can help by phone or online at 111.nhs.uk

Our urgent treatment centres are available to everyone, without an appointment. They can help with things like sprains and strains, broken bones, injuries, cuts and bruises, chest and water infections or high temperatures in children and adults.

**More information can be found on the NHS website.**

# Why bringing our A&Es together makes sense

**Our children have specific needs which is why we make sure we give them emergency care in a dedicated, child-friendly environment where they can receive age-appropriate care.**

To do this we make sure the children's A&E has a dedicated entrance, waiting area and treatment areas. This allows for more tailored and effective care, ensuring young patients receive the best possible treatment in a safe and supportive environment.

If we locate the children's unit on the same site as the adult unit, however, there are many important benefits which can help us achieve our goals.

## Clinical benefits

There are a number of significant clinical benefits, including:

- Ensuring we have the workforce in place to offer round-the-clock emergency care to children.
- Providing better anaesthetics cover for paediatric emergencies.
- Allowing us to treat more cases of children needing trauma and orthopaedics and general surgery without requiring transfer to more specialist facilities.
- Better access to radiology services out of hours (meaning fewer journeys and delays for patients needing x-rays and scans).

It would also help ease the management of blood tests and transfusions in cases of emergencies for under-16s and offer better ways of working for our pharmacy services.

## Better service delivery

On top of the clinical benefits, we would also see better service delivery with improved rota management and more opportunities for staff supervision, training and workforce skills development.

**We would be better equipped to respond to critical situations and emergencies,** be able to move patients between services with less discomfort and risk and have better access to a broad range of key specialist skills such as pharmacy, radiology, pathology and microbiology, especially out of hours.

**And we would be better placed to manage peaks in demand for care,** with benefits coming through sharing resources across departments.

## We cannot keep going as we are today

Current pressures on services mean we cannot continue with services as they are today without a further deterioration in standards and patient outcomes.

We have a duty of care to the people and communities we serve and we are not going to allow that to happen. **We are confident that, with your help, we can find the solutions we need.**

Read more about the benefits in our pre-consultation business case (PCBC) and supporting documentation.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

# Our big conversation

In summer 2024, the programme started a big conversation to find out more about what people wanted and needed from urgent and emergency care and what their experiences were of using services today.

Many said they felt too many people went to A&E who could be treated somewhere else and this was causing problems such as long waiting times. Indeed A&E departments are meant to be for serious injuries and life-threatening emergencies.

**Our public survey, which received almost 3,000 responses**, helped us find out more about people's views on future services as well as their experience of services today.

**We were reassured to learn the programme's vision, principles and goals were supported by more than nine in 10 people who responded.**

## Survey question 3

**"Our priorities for redesigning urgent and emergency care services are that we provide everyone with safe and excellent care, today, and in the future. Do you feel these are the right priorities?"**

**88.3%** strongly or generally agree

## Survey question 4

**"In your opinion, how important is it that we set up urgent and emergency care services in a way that can help reduce waiting lists across our local NHS?"**

**90.8%** find this very or quite important

You can find out more about what people told us in our big conversation in our engagement report.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

# Our big conversation

## Survey question 5

"In your opinion, how important is it that urgent and emergency care is available for everyone, all day, every day?"

**97.7%** find this very or quite important

## Survey question 6

"In your opinion, how important is it that children and young people have the same access to emergency care as adults?"

**98.4%** find this very or quite important

The insights we gained into people's experiences of using services today helped us understand more about what they may need from future services as well as how they may be impacted by any changes and what can be done to manage those impacts.

Importantly, when we asked for ideas on how services should be organised, **there was a clear view that children's and adult A&E should be located together on the same hospital site**. This is how A&E services are organised at most general hospitals across the rest of the NHS in England.

You can find out more about what people told us in our big conversation in our engagement report.

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# Shaping proposals

We heard a wide range of ideas for how we might bring our A&Es together. We know some of them are not possible because we simply do not have the resources in the local NHS - staff, buildings and finances – or the proposals were out of scope. **This ruled out the six options below early on.**

## 2 x Proposals to maintain current A&E services and add new A&E services elsewhere.

- We do not have the resources to maintain services as they are today. We cannot increase that burden by introducing new services.
- For safety reasons, an A&E is always located at a hospital site and so a new A&E at a new location means building a new hospital. The Government's New Hospital Programme does not currently include plans for our area.

## 2 x Proposals that required building a new hospital.

- Previous studies have shown this to be unaffordable given the significant financial investment required.
- The same studies have shown a new hospital cannot be delivered within a reasonable timeframe.
- The Government's New Hospital Programme does not currently include plans for our area.

## 2 x Out-of-scope proposals.

- One proposal included making changes to planned care services. These are services that are scheduled in advance and include things like outpatient appointments, diagnostic tests, surgery or cancer treatments. The programme has not been asked to look at planned care.
- Another proposal required commissioning a new urgent treatment centre. New services are out of scope of the programme.

**The decision to remove these six options was unanimously supported by members of the assessment panel we invited to review the options. The panel included patients and members of the public.**

## Options for assessment

This left 10 options, all centred on our existing hospitals in Southport and Ormskirk. These were thoroughly assessed by review panels made up of NHS experts alongside members of the public and patients from across the Southport, Formby and West Lancashire area and local community and voluntary groups.

**The process removed eight of the options for the reasons explained below.**

### 3 x Options proposed doing nothing or keeping A&E units on two sites but with increased capacity or opening hours.

These were ruled out because:

- Current pressures mean we cannot continue as services are today without a further deterioration in standards and patient outcomes.
- These options do not make sure A&E is available for everyone, all day, every day.
- The options do not help address staffing, financial and infrastructural challenges or the need to maintain quality standards.
- Does not help us address growing demand.


### 5 x Options based on increasing the number of A&E units at Southport and Ormskirk

These were ruled out because:

- Pressures on services mean there are not the resources to safely carry on offering services as they are today.
- Adding more services will create more service duplication and stretch resources further.

**This left one option at Southport Hospital and another at Ormskirk Hospital. Both options proposed bringing all of our A&E units together on a single site - children's and adult.** These two options were then assessed in more detail to test whether they were both achievable and could help us reach our goals.

Reviewers were given an extensive evidence pack to help assess the remaining two options to see whether they could meet the programme goals.

## Doing things properly

NHS and government guidance was followed throughout to make sure the process was fair, open, and included a wide range of voices.

NHS England has made sure we are doing things properly. We also had advice from the North West Clinical Senate, which is made up of healthcare professionals and patient representatives

## Who was involved?

Members of the public were central to developing and assessing ideas for future services. Alongside them, a wide range of expert inputs helped shape the list of options.

The process was led by NHS clinical experts supported by:

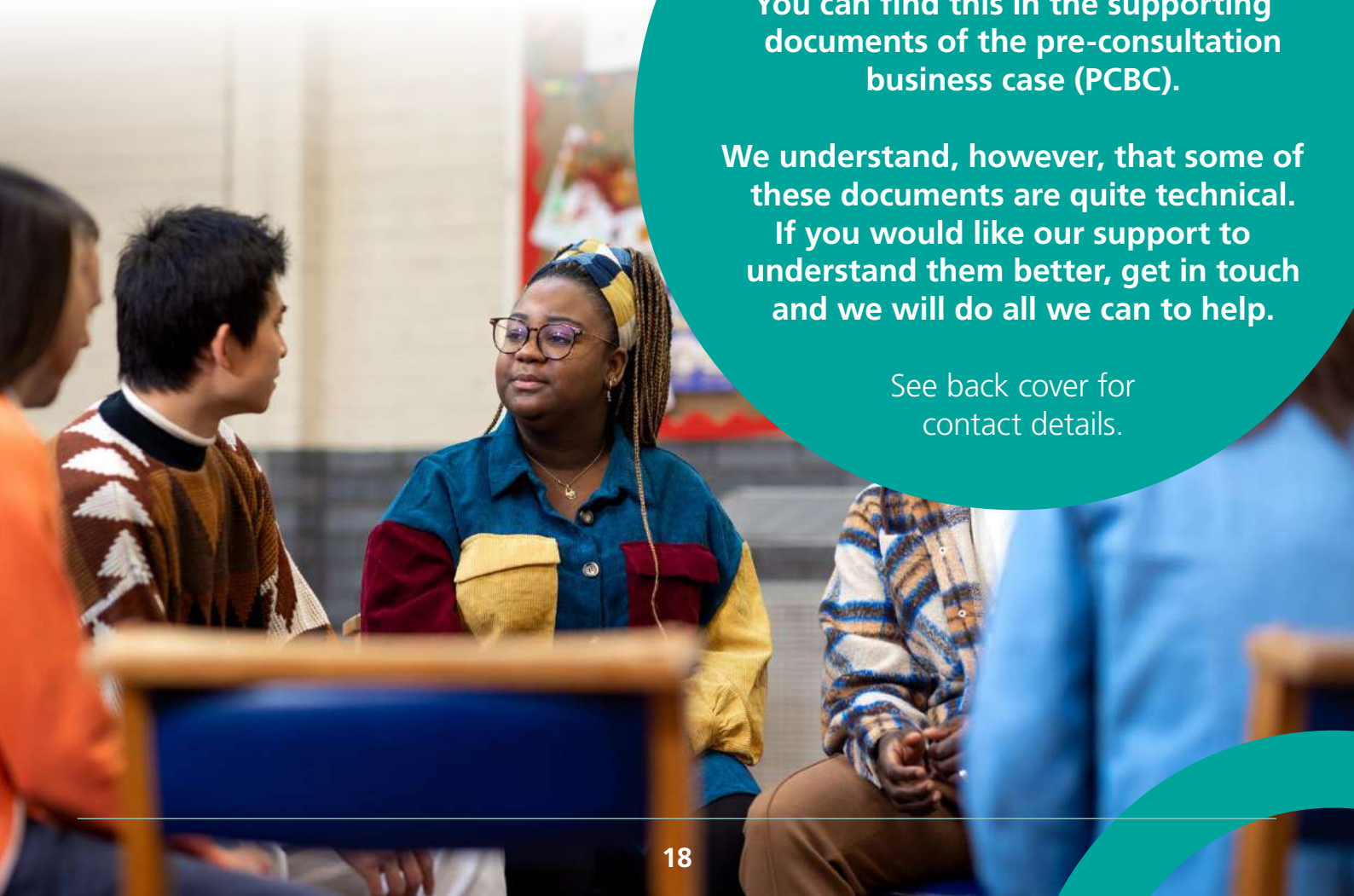
- NHS non-clinical experts including those working on estates, financial and workforce planning, management and development.
- NHS commissioners and staff from neighbouring trusts.
- Representatives from local Healthwatch groups and from the wider community and voluntary sector in our area.
- Local groups that represent patients and service users were also involved in the process.

## What evidence was used for assessment?

**You can find this in the supporting documents of the pre-consultation business case (PCBC).**

**We understand, however, that some of these documents are quite technical. If you would like our support to understand them better, get in touch and we will do all we can to help.**

See back cover for contact details.



# The assessment panel's view

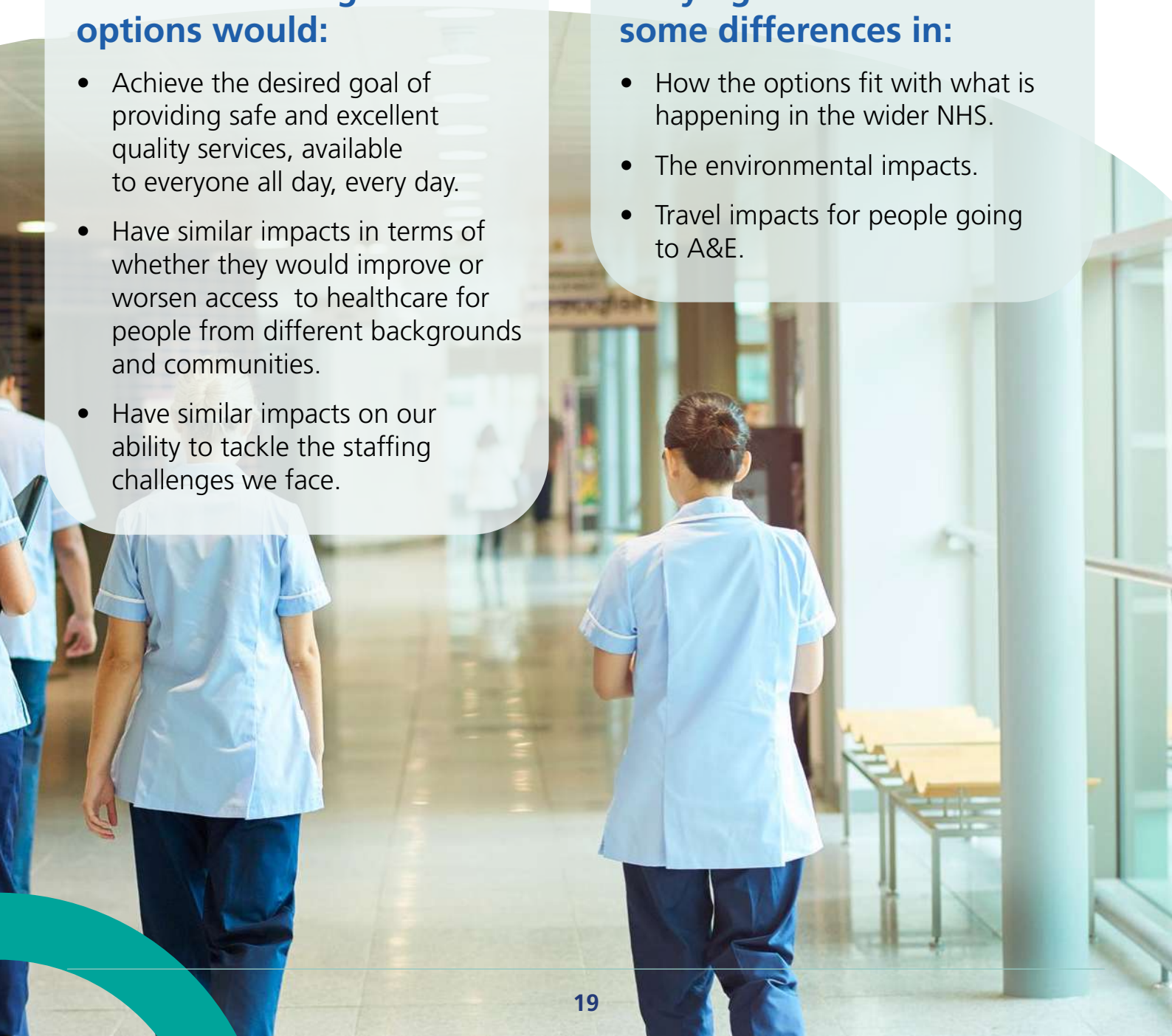
**Based on the available evidence the group's preferred option was Southport. Here's why.**

## Reviewers thought both options would:

- Achieve the desired goal of providing safe and excellent quality services, available to everyone all day, every day.
- Have similar impacts in terms of whether they would improve or worsen access to healthcare for people from different backgrounds and communities.
- Have similar impacts on our ability to tackle the staffing challenges we face.

## They agreed there were some differences in:

- How the options fit with what is happening in the wider NHS.
- The environmental impacts.
- Travel impacts for people going to A&E.



## Clear differences

When considering co-dependent services - those services that must be located alongside A&E so emergency care can be delivered safely - the group found clear differences between the options.

**The Southport option requires just one service to relocate (paediatric inpatients). The Ormskirk option, however, would mean seven services would have to be moved away from Southport** and another 10 services may be affected.

Service relocations could mean disruption to staff, patients and visitors across the wider hospital site.

**Importantly, the scale of relocation work has a significant impact on costs, time to deliver and space required for development.**

## With fewer service relocations needed, the Southport proposals would:

- Cost less than half the Ormskirk proposals (£44.5 million / £91.3 million).
- Be quicker to implement (five years rather than seven years for Ormskirk).
- Require less space for development (1,700m2 / 7,200m2).

### Southport option

**£44.5 million**

**5 years**

**1,700m²**

### Ormskirk option

**£91.3 million**

**7 years**

**7,200m²**

## Two options for consultation

The panel recommended a future public consultation should include **a preferred option for locating services in Southport**, as well as an alternative option for bringing services together at Ormskirk.

The NHS programme partners agreed with the group's recommendation. Final decisions will only be made, however, once proposals have been informed by a broad range of views captured during the consultation.


Read more about how options were developed and reviewed, and the evidence used by the panel in our pre-consultation business case (PCBC) and supporting documentation.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

# Our proposals and what the new A&E could look like

We are consulting on two different options we believe could deliver the solutions we need.

## Southport option

**One brings children's and adult A&E together on a single site at Southport Hospital,** relocating the children's A&E from Ormskirk Hospital and extending it to an all-day service (24 hours).

## Ormskirk option

**The other brings services together at Ormskirk Hospital,** relocating the adult A&E from Southport to Ormskirk and extending the current children's A&E to an all-day service (24 hours).

## Our preferred option is Southport.

Below is how urgent and emergency care could look under the new proposals.

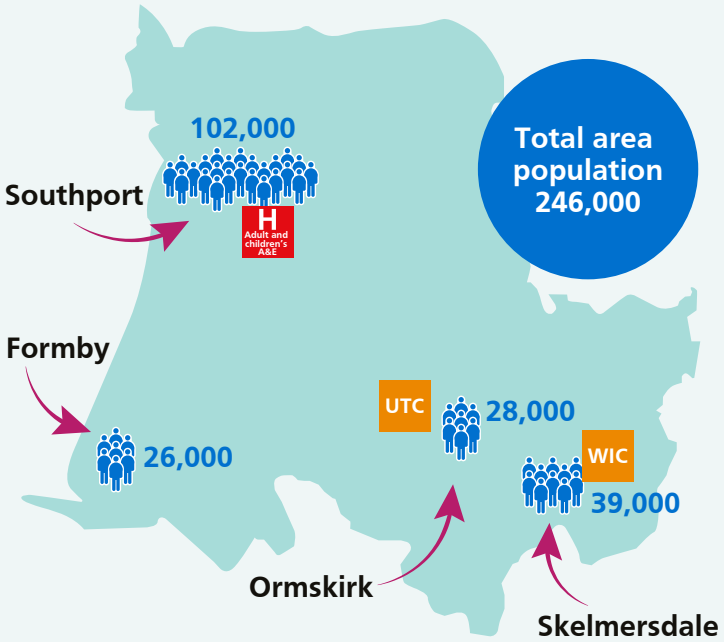
# Southport option (preferred)

## At our hospitals

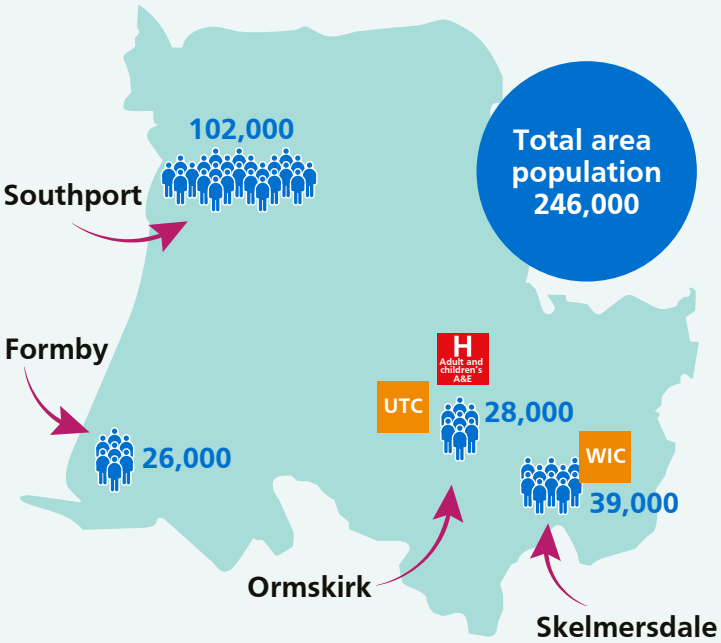
- Adult A&E in **SOUTHPORT**
- Children's A&E in **SOUTHPORT**
- Urgent treatment centre (UTC) in **ORMSKIRK**

## Community and closer to home

- Walk-in centre (WIC) in **SKELMERSDALE**
- Out-of-hours GP service for everyone
- NHS 111 by phone and online
- Local GP services for everyone
- Local pharmacy services for everyone




# Ormskirk option




## At our hospitals

- Adult A&E in **ORMSKIRK**
- Children's A&E in **ORMSKIRK**
- Urgent treatment centre (UTC) in **ORMSKIRK**

## Community and closer to home

- Walk-in centre (WIC) in **SKELMERSDALE**
- Out-of-hours GP service for everyone
- NHS 111 by phone and online
- Local GP services for everyone
- Local pharmacy services for everyone

# How would things look at the hospital?

## In both cases

- Plans allow for the current A&E units to remain in place and continue operating during construction.
- All refurbishment works needed at either site would be carried out to modern standards.
- We know parking can already be challenging at both sites.

NHS guidance is, where possible, for people to either be driven to A&E or to call 999 for an ambulance. So we must do our best to make sure parking is available if you come by car.

Both sets of proposals include expanded parking capacity to address this.

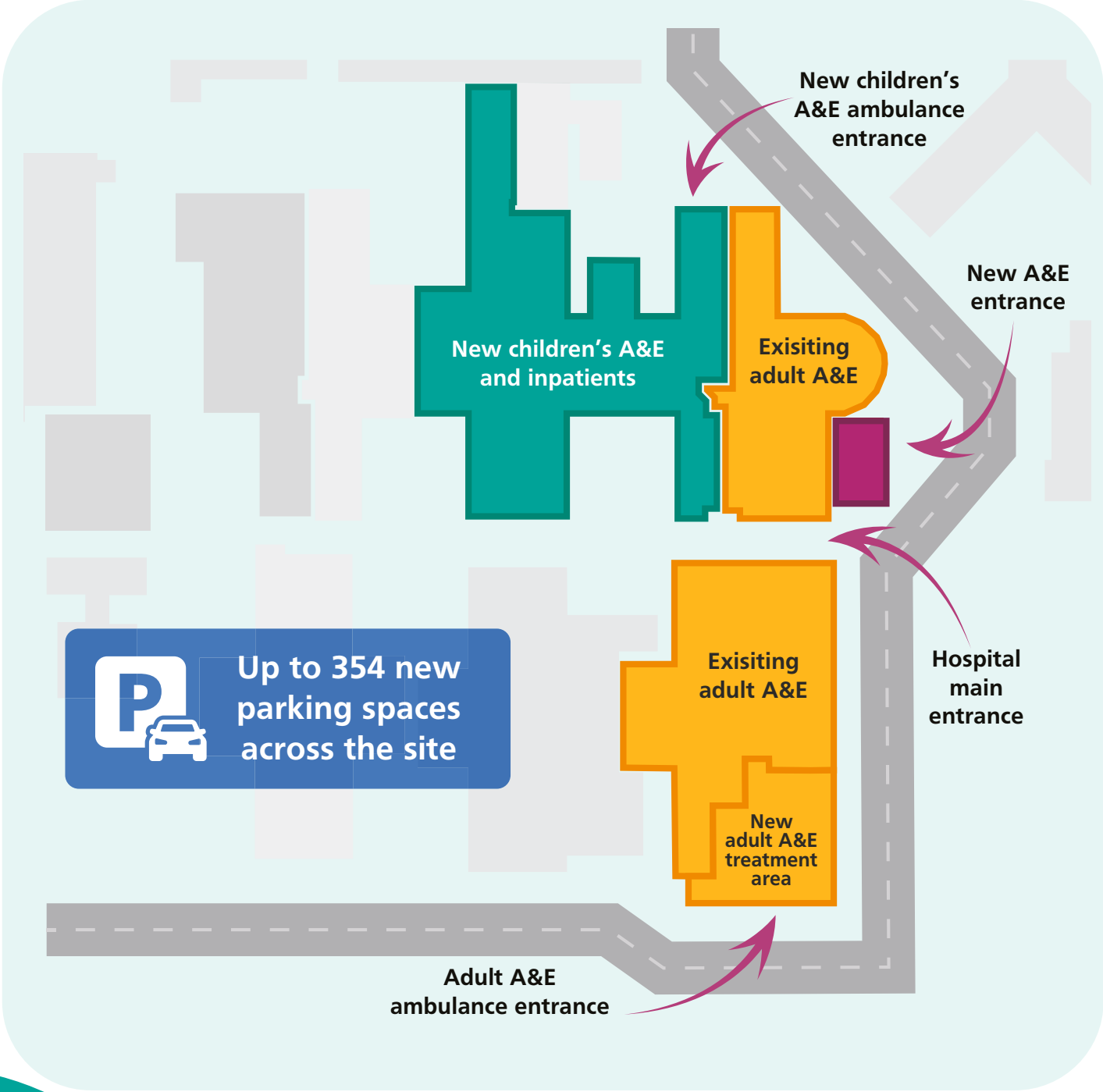
# What the Southport option includes

Today's adult A&E facility with 365m2 additional, newly refurbished treatment space.

A new ambulance entrance dedicated to children's A&E.

A newly refurbished children's A&E and inpatient facility of around the same size as the current unit at Ormskirk Hospital.

Up to 354 new parking spaces.



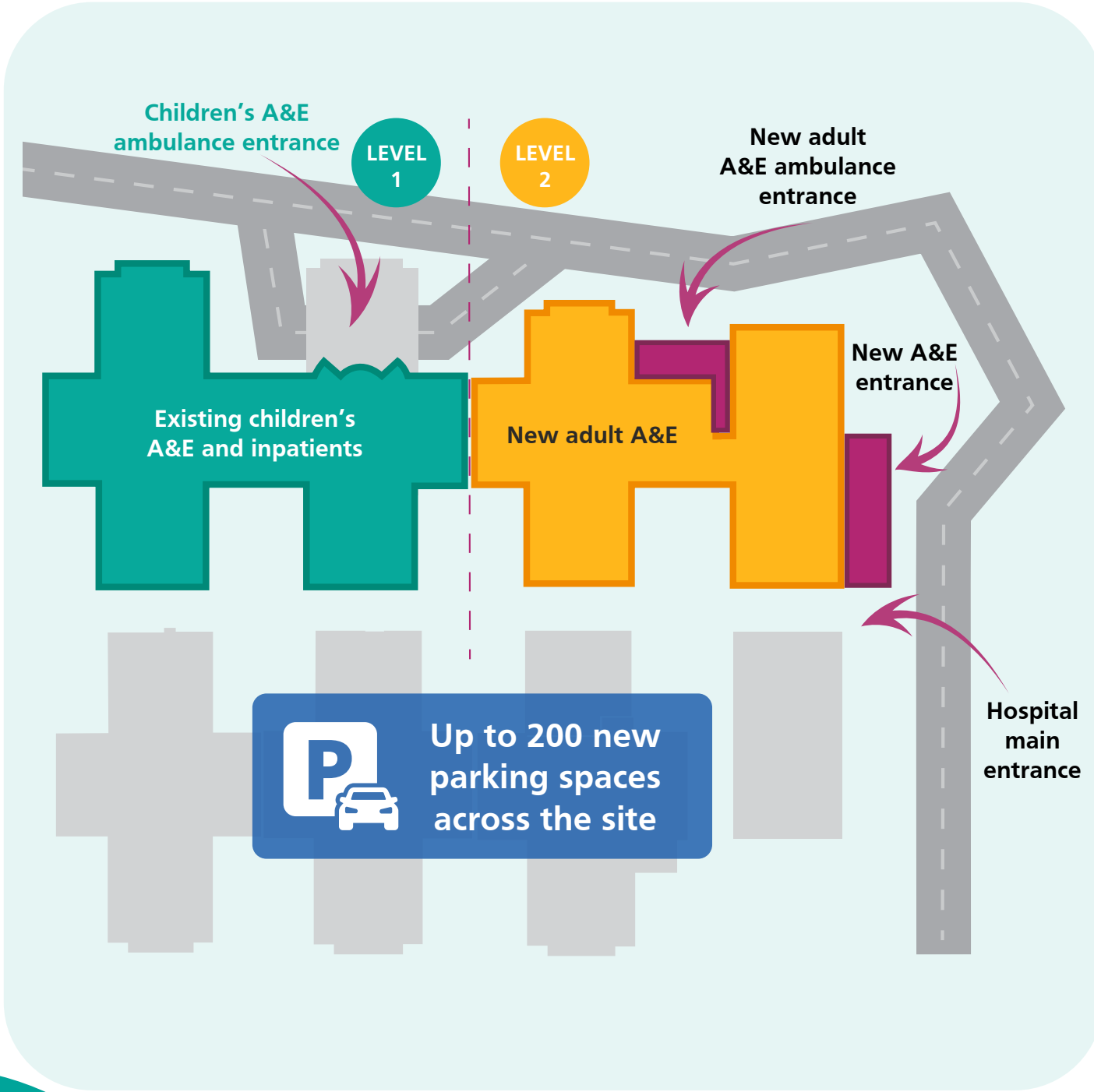
# What the Ormskirk option includes

A newly refurbished adult A&E with a 10 per cent larger floor area than the current Southport facility.

Today's children's A&E unit, which is in generally good condition.

A new ambulance entrance for adult A&E.

Up to 200 new parking spaces.



# No decisions have been taken at this stage

We have developed the plans outlined in this booklet to look at what could be done with each option. However, nothing has been fixed at this stage. **Our choices must be based on all the available facts and we will stay open to other ways to organise services if new evidence comes to light.**

Based on what we know today, however, we are asking people to consider which option can help us achieve our goals in the most efficient and effective way. It is only once we have heard from the people who use and rely on our services that a decision can be made.

As well as sharing views on which site is best for our A&Es, we also want people to let us know how they may be affected and what we could do about that. That will help us develop the best approach to implementing changes in the interests of our patients and public.

This is not just about bringing services together because of resourcing pressures. It is a chance to uncover smarter ways of working and to reflect on the things we already know could be better - aiming high and seizing the opportunities so we can build a smoother-running, more patient-focused, modern A&E.

Find more detailed information on proposals in our pre-consultation business case (PCBC) and supporting documentation.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

# Patient stories

## Olivia's story

Four-year-old Olivia has asthma and has been quite wheezy lately. The community respiratory nurse came to see her and made changes to her inhalers with a plan to check back the next day.

However, Olivia has woken up during the night with a high temperature, still struggling with her breathing. She has been admitted to hospital before, so mum Joanne thinks it is too risky to wait for the respiratory nurse in the morning. She could call 999 and wait for an ambulance, but decides it would be quicker to drive Olivia to Ormskirk. Joanne did not know Ormskirk children's A&E was closed overnight until she arrived. She starts to get concerned about wasting time as she now needs to drive another half an hour to get Olivia to Alder Hey.

**When adult and children's A&E are on the same site there will be no overnight closures. Joanne will know that if Olivia needs to be seen in an emergency, she can take her to the local A&E at any time of day or night.**

## Shav's story

Faisa is driving her eight-year-old daughter Shav home from a football tournament in Ainsdale when a lorry in front jackknifes and overturns. Cars are driving towards them at speed on the other side. Faisa brakes, the car slides and mounts the pavement. The windscreen shatters, causing some cuts to Faisa, who also complains of pains in her neck. Shav is conscious but quite distressed.

When the ambulance crew arrive, paramedics decide to take them both to A&E for further assessment. Faisa is taken to the adult A&E at Southport Hospital and Shav to the children's A&E at Ormskirk.

When dad Jalal finds out, he goes straight to see Shav in Ormskirk. It is a huge relief to hear his wife's injuries are not critical as he could not visit her without leaving his daughter.

**That is a tough choice that Jalal would not have to make if our A&Es were located on a single site, open all day, every day, for both adults and children.**

## George's story

George is 85 and lives alone. He has several long-term conditions, his health is deteriorating and he is under the care of the community respiratory team. As George is getting ready to go to a quiz at the community centre he gets quite dizzy and needs to sit down to catch his breath. He thinks about calling 999 but instead decides to call Nina, his community nurse.

Nina has been seeing George regularly for some time and thinks his symptoms could be better managed at home. She makes an initial assessment over the phone and arranges to admit George to a virtual ward, meaning he can get the care you might normally expect to only be available at a hospital while staying at home. George is happy to follow Nina's advice as he prefers to stay at home. To help the team monitor George's oxygen levels remotely, he is provided with a pulse oximeter, a device that measures the saturation of haemoglobin in the blood.

**We know people with long-term conditions like George can lose some of their independence when admitted to hospital meaning they may need to be discharged to a care facility before going home. Wherever A&E services are based in future, it is reassuring for George and many others to know we can also provide urgent care in the community.**

## Sarah's story

Fifteen-year-old Sarah is at the skatepark enjoying a summer evening with her friends. She tries a new trick for the first time but falls on the ramp. Sarah's friend Katie was right behind her catching the action on video. Katie cannot stop in time and her board hits Sarah hard in the head, knocking her unconscious.

The ambulance takes her to the children's A&E at Ormskirk Hospital. She is still very confused when she gets there. The doctor is worried she may have a severe head injury and so contacts the anaesthetist in case Sarah needs sedation. However, the anaesthetist is busy helping a pregnant woman and so the on-call anaesthetist must be called in from home.

Sarah's condition takes a sudden and rapid turn for the worst, but the anaesthetist still hasn't arrived. The A&E doctor knows that to keep Sarah safe she has to provide one-to-one bedside care for her until the anaesthetist is there.

**Emergency services rely on support from other specialties such as anaesthetics. When both A&Es are on one site, alongside critical care and emergency theatres, there will be more anaesthetists on hand to get to A&E patients much quicker when they need it.**

# The impacts and what we can do about them

## Who might this impact?

To continue to shape proposals we need to understand how any proposed changes might affect the people who use and rely on our services. To help us to do this we completed an **Equality and Inequality Impact Assessment (EIIA)** report. We did this by looking at available data as well as by speaking with service users about their experiences of using services and their specific needs.

That helped us identify some groups and communities who might be affected the most. It also showed us that we need to hear more from certain other groups for us to have a more complete picture. As we progress through consultation, we will update the assessment, ensuring that we take steps to engage with and capture the views of underrepresented groups.

Here is a summary of what we found.

### Age

Our population is getting older as people live longer while the birth rate is falling. **In Southport and Formby there is a large and growing community of people over 65**, many of whom live in the care homes community. They are more likely to need urgent and emergency care, so the location of A&E is of high concern for them.

This contrasts with communities of young adults with children living in Skelmersdale or the more deprived areas of Southport. Their priority is more likely to be about having urgent and emergency care as close to home as possible due to the costs involved with travelling further for care.

### Race - including ethnicity and nationality

**Our area is among the least diverse in England**, with Sefton being 95.8 per cent white and West Lancashire 96.9 per cent. This is reflected in the ethnic backgrounds of people going to A&E. We know that we have not heard from enough people from ethnic minority rounds to reflect this and that we need to do more. This is important because national data provides strong evidence that people from minority communities face greater health inequalities.

## Disability

**Disability rates in our area are generally above the UK-wide level of 17.7 per cent.** Rates are highest in North Meols at 23.1 per cent and lowest in Dalton at 13.5 per cent.

Two particular issues were raised by the people we heard from. Disabled people and their carers discussed accessibility and on-site facilities for people with mobility issues, particularly those who are wheelchair bound. Some other, unsupported disabled people reported struggling with access and in some cases communication, especially for those affected by hearing or speech issues.

Having listened to these concerns we feel our proposals should deliver an improvement on current arrangements. However, we also want to hear about any other concerns held by people with disabilities during consultation, as well as what can be done about them when developing proposals further.

## Carers

The 2021 Census found that there are 4.7 million people aged over five in England who are providing unpaid care for a family member or loved one. Carers must consider both the health of those they care for, as well as their own health. When the carer falls ill, they may fear for the person they care for. When the person they care for is ill, they are concerned about finding help for them.

The carers we heard from shared concerns about getting to A&E with the person they care for. Those who can go by car or taxi expressed concerns about getting from the car park or drop-off area to reception, more so if accompanying a disabled person and particularly a wheelchair bound person. Others said there is a need for additional support to get to A&E when ambulances are unavailable.

These concerns can affect the health and mental health of the carer which is why we want to hear from carers about how proposals can be developed to meet their needs.

## People from other backgrounds

We are also looking at how proposals could affect people of other backgrounds, including people suffering deprivation, people who are pregnant or who are caring for babies up to two years old (maternity care), members and former members of the armed forces, those who live in rural areas, those whose first language is not English and people of different sexes or genders.

**Understanding the impacts of proposals is important because we have a duty to ensure that everyone can receive the care they need.** Not everyone needs the same support, but some people have specific needs that we need to be aware of so that we can care for them as they need. Our work assessing the impacts is ongoing. Hearing from you about how to manage any possible negative impacts you might experience will help us develop proposals in a way that will lead to better patient outcomes.


# What people said matters most to them

Whatever the outcome of this consultation, we know some services will need to move from one site to another and some people or communities may feel they are losing out as a result.

Among the concerns we have already heard are:

**Travel impacts for people needing emergency care,** particularly for people living in areas with low car ownership or poor road access.

**The availability of onsite hospital parking,** especially for people with a disability. **Our proposals outline plans to increase parking capacity with up to 354 extra parking spaces at Southport or 200 extra spaces at Ormskirk.**

**Some aspects of how patients experience services onsite** and concerns about the impact of increased patient numbers.

**These concerns are real, we take them seriously and intend to do all we can to address them.** Hearing from people on how we can do that is an important part of this consultation.

The proposals outlined will address some of these concerns, with refurbished, modernised entranceways, ambulance drop-off areas, waiting and treatment areas and increased parking capacity.

## Travelling to A&E

Travel to hospital for emergency care has been raised as a significant factor in choosing the right site for services.

Wherever our A&E services are located in future we know that by putting them on the same site, it will take longer for some people to get to us in an emergency. Our travel impact analysis looks at all modes of transport, including bus, train, cycling and even walking.

The analysis provides an in-depth assessment of the impact our proposals could have on people travelling to A&E, as well as on staff travelling to work. It showed:

- Patients and staff across both hospitals combined live relatively closer to Southport than Ormskirk Hospital but Ormskirk is generally better connected to more places by both car and public transport.
- There are generally poor transport options between parts of the Sefton coast and Ormskirk as well as between Skelmersdale and Southport.

## Car journey times

NHS advice is for people to either be driven to A&E or to call 999. Both of these mean going by road which is why we are particularly interested in looking at who is using our A&E departments and how their car journey times could be affected.

The report looks at average car journey times for people living in the 15 areas that most used our adult A&E in Southport and our children's A&E in Ormskirk during 2023. The analysis includes average journey times at 9am, 11am and 5pm to reflect travel during typical busy periods.

### Car journey time for adults going to Southport Hospital A&E

The 15 local areas that use Southport A&E the most account for seven in every 10 adults who went there last year.

**For the large majority of those people (89 per cent) it is quicker, on average, to go to Southport by car than to Ormskirk.**

- The 4,400 people who came from Kew benefited the most by travelling to Southport (21 minutes quicker on average than going to Ormskirk).
- However, the 1,100 people coming from Skelmersdale South each needed 21 minutes more on average to travel to Southport than if services were available for them at Ormskirk.

### Car journey time for children going to Ormskirk Hospital A&E

The patient catchment for Ormskirk Hospital is much more diverse than for Southport. The top 15 areas that used Ormskirk A&E make up just four in every 10 of the under 16s who went there last year.

**For almost half the people living in these areas, driving to Ormskirk was quicker than going to Southport (43 per cent), based on average journey times.**

- The 716 people who came from Skelmersdale South benefited most by travelling to Ormskirk (22.5 minutes quicker on average than going to Southport)
- The 1,100 people coming from Kew, however, needed an extra 17 minutes on average to travel by car to Ormskirk than if services were available for them at Southport.

We realise people in some areas are less likely to own a car or have somebody they could ask to drive them to A&E. The impacts would be different for them as they would need to also consider the time spent waiting for an ambulance or the cost of a taxi to take them to A&E.

### What can we do?

- We are committed to working with local authorities and public transport providers to help make sure services are developed to reflect the needs of patients and staff to access our hospital sites.
- Wherever we locate A&E services, we have plans in place to provide a free-of-charge shuttle bus service between Southport and Ormskirk hospitals.
- We understand the significance of travel and how this can affect access to services. To help us better understand these impacts, and how they could be managed, we plan to set up a travel advisory group to include members of the public and patients.

## Ambulance journey times

North West Ambulance Service (NWAS) looked at impacts on ambulance journey times, using a specialist predictive tool, for both the Southport and the Ormskirk options. Predictions were based on the location of ambulance stations as they are today.

It predicted ambulances would have to spend more time on the road and travel further in both cases. However, there were some significant differences depending on where services were located.

### Most affected ambulance stations

Some ambulance stations in neighbouring areas would also be affected, depending on where services are located. The most affected stations would be:

**Ormskirk option**

- Southport
- Formby
- Preston
- Buckley
- Crosby

**Southport option**

- Preston
- Birkenhead
- Skelmersdale
- Anfield
- Burscough

## Ambulance impacts of Ormskirk option

- The predicted increase in ambulance travel time would be three times greater than if services were in Southport.
- In terms of increased miles travelled, the predicted impact would be more than four times higher than Southport.
- The most affected ambulance station would be Southport, where daily mileage is predicted to increase by 117 miles.

## Ambulance impacts of Southport option

- Ambulance travel time is predicted to rise by 42 minutes each day compared to 130 minutes for the Ormskirk option.
- With services at Southport, NWAS ambulances would travel a predicted 47 extra miles each day. This compares to 197 miles for the Ormskirk option.
- The most affected ambulance station would be Preston, where daily mileage is predicted to increase by 10 miles.

These findings are important when considering how long it could take people travelling by ambulance to get to A&E, but they are also relevant in terms of the impact each option could have on the environment.

# Impacts felt by patients at our hospitals

In our survey last year, we asked people to share with us their experiences of A&E services at both Southport and Ormskirk hospitals to build understanding of what we will need to think about when designing future services.

A number of people expressed concerns about the impact of increased patient numbers. These included the size, quality and accessibility of the waiting areas, particularly at Southport.

People also highlighted the importance of making sure we develop services with patient welfare in mind, especially for more vulnerable groups such as people with disabilities or frailty related conditions, those with specific sensory needs, and people suffering with poor mental health.

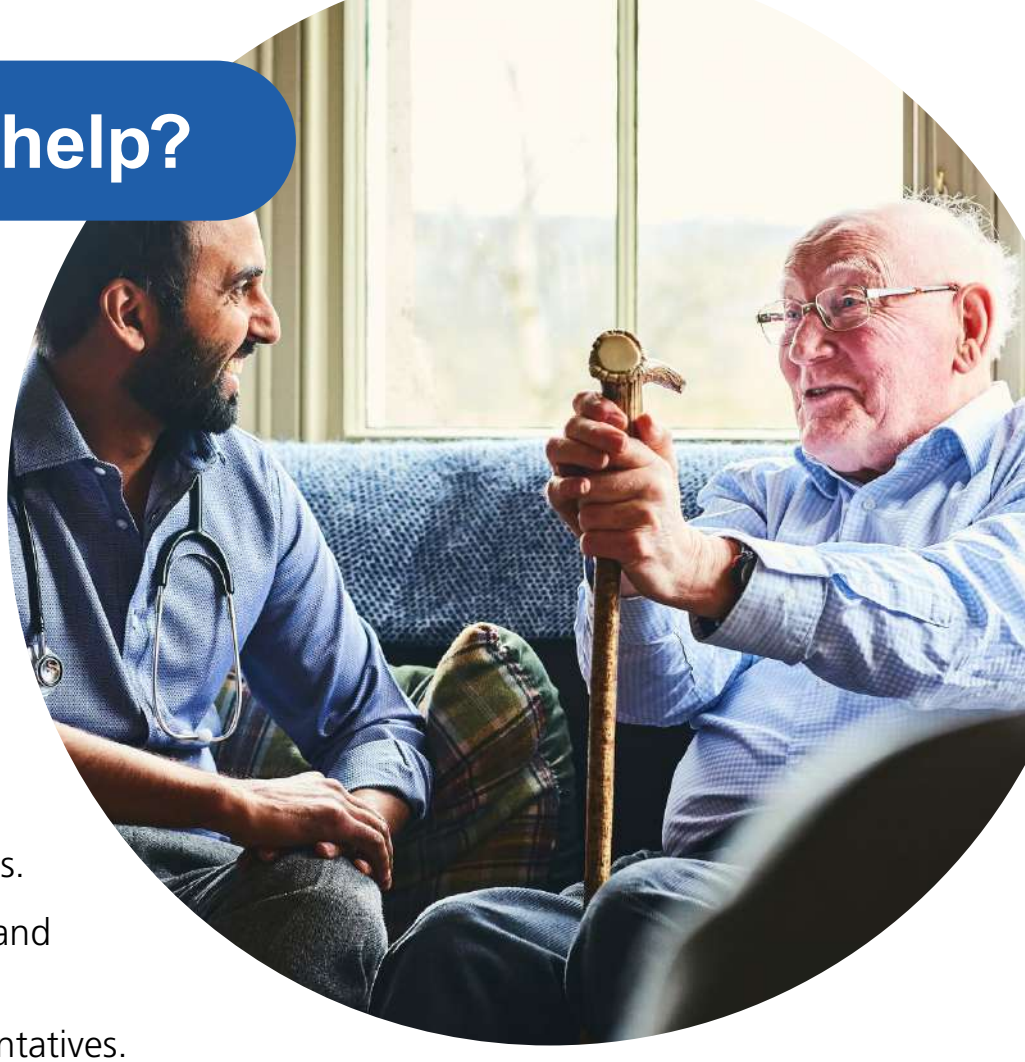
## What can we do?

- All redevelopment work will be carried out to modern standards of accessibility and with patient comfort and wellbeing prioritised.
- We will continue to work with our patient advice and liaison service (PALS) which helps us learn how to improve the patient experience at our hospitals through listening to concerns and suggestions from patients.
- We will continue working to reduce our reliance on hospital-based services by ensuring the availability of urgent care options closer to where people live, through services such as pharmacies, community-based services and local GPs.

Find more about the impacts of proposals in our pre-consultation business case, (PCBC) as well as our Equalities and Inequalities Impact Assessment.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

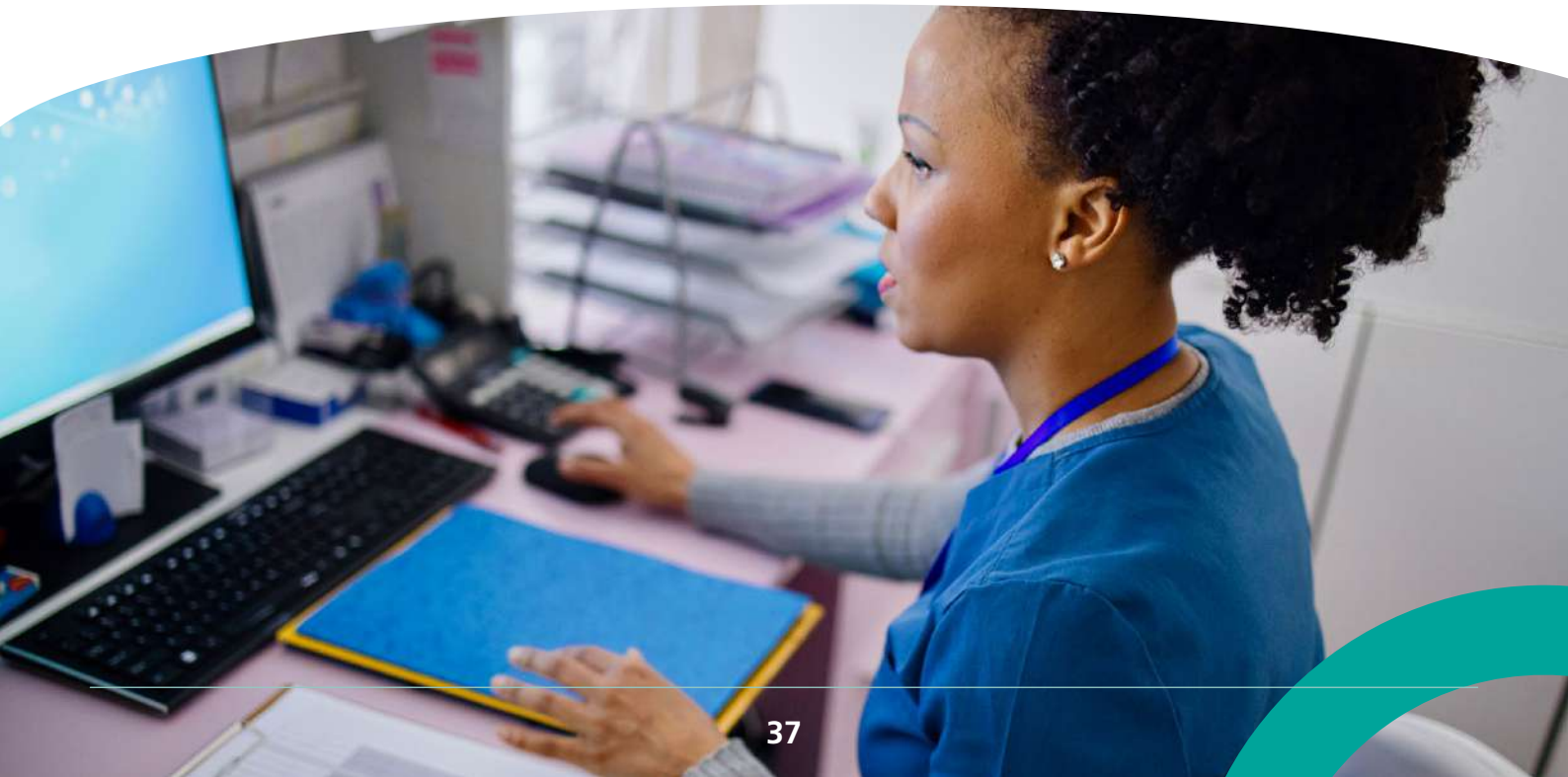
# How can you help?



## Who we want to hear from

The programme is consulting on the proposals between 04 July and 03 October 2025. **Anyone is welcome to contribute their views, but we especially want to hear from:**

- Patients, families and carers.
- Underrepresented groups and communities.
- Our staff and their representatives.
- People from protected characteristic backgrounds as defined in the Equalities Act 2010.
- Community, voluntary and faith groups.
- Organisations who work with or depend on the local NHS.
- People from neighbouring areas who may use and rely on NHS services here.



# What we already know

There are some things that are clear to us already, mainly because there are no alternatives open to us. Of course, if circumstances change and other ways become available, we will need to consider them.

**The evidence we have today, however, strongly supported by the views we heard from people when developing the options, means we are sure of three things.**

## 1 The need for change

Our case for change sets out clearly why we need to change the way some services are organised.

- Our population is getting older and demand for services will rise in the future.
- We are facing significant challenges getting the staff we need with the right skills.
- Many of our buildings were designed decades ago. Some need important maintenance work and others need investment to make sure they are right for us to operate to modern healthcare standards.
- Our finances are already stretched, and no new funding is currently available to us.

**All of these pressures combined are putting a strain on our ability to provide the safe and excellent care we aim for.**

## 2 Doing nothing is not an option

Our children's A&E at Ormskirk Hospital is currently not available all day, every day which means we have to change how we do things.

The pressures on services we have today are only expected to get worse if we do nothing which is why that is not an option we can consider.

## 3 Programme aims and objectives

The 2,930 people who completed our survey last year strongly supported our aims and ambitions for urgent and emergency care.

- Providing everyone with safe and excellent care today, and in the future. (88.3 per cent)
- Making urgent and emergency care available for everyone all day, every day (97.7 per cent)
- Giving children and young people the same access to emergency care as adults (98.4 per cent)

**Lastly, when we asked people to help find ways for us to achieve our goals there was a strong sense that this should be by having both adult and children's A&E on the same hospital site. We agree.**

# What we are asking

In the first place we want to hear people's views on which set of proposals they feel would make best use of local NHS resources to meet the challenges outlined and deliver our goal of providing safe and excellent quality services available to everyone, all day, every day.

**But we are not just asking people to choose between two options. We want to build on what we have learned already and find out more about how different people may be impacted and how we could reduce any negative impacts.**

Although we are confident we have looked at all the options, we know circumstances can change and new evidence can come to light that we would need to consider.

We welcome all views, thoughts and contributions, but especially those which help:

- Select the best proposals for meeting programme goals for the whole area.
- Make sure all relevant, available evidence has been considered.
- Build understanding of the negative impacts of proposals and what we can do to limit them.
- Make sure that the voices of people who use and rely on our services are heard and accounted for in decision-making.

**We want people to think about what is best for the whole area of Southport, Formby and West Lancashire as we have a responsibility to all people and communities we serve.**

Find out how to take our survey, submit your views and get involved in our consultation events on the programme website.

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help. See back cover for details.

# After the consultation

## What will happen with your views?

Once the consultation has finished, we will thoroughly analyse all responses and feedback received.

We will look carefully at where responses came from to consider whether we have received views from a representative and balanced section of the people and communities we serve.

Our reporting will demonstrate we have both heard, understood and fully considered the views of respondents.

Finally, we will update our proposals considering what we have learned during the consultation as part of what is known as our decision-making business case (DMBC).

The DMBC will need to show how the proposed changes are achievable and sustainable in service, economic, environmental and financial terms.

At this stage we will also review and update the underlying evidence and assessments used to develop proposals considering the feedback received during consultation.

At that point we will be able to move towards decisions being taken about implementing plans.

## Who makes the decisions?

Once everyone has had the chance to share their views during the consultation, the NHS organisations involved will be asked to make some final decisions about what to include in the DMBC. Local councils will also have a say.

There are three NHS partners involved.

Mersey and West Lancashire Teaching Hospitals NHS Trust, which provides the services at the hospitals in Southport and Ormskirk. NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria make the decisions about which services should be offered, and where.

# Our promises to you

1

**We promise to give you the facts you need, the way you need them.**

We all have different needs. If you need help to find or understand information, or to know how you can join in, let us know and we will support you however we can.

2

**We promise to listen, try to understand, and to always get back to you.**

We cannot promise to do everything you suggest. But when we can't, we will let you know why. And when we can, we will show you how.

3

**We promise not to hide anything. We will be open and honest.**

Nobody wants to hear things that do not feel sincere. We will always do our best to say it like it is, to provide you with the facts and to be fair and balanced in everything we do.

Finding the best solutions will take time and effort. We will work as hard as we can to make it happen but we cannot do it without you.

**By working together with our patients, our dedicated healthcare professionals, and our partners, we are sure we can get this right.**

# Get involved

We are consulting on the proposals between **04 July and 03 October 2025.**

## There are lots of ways to get involved.

Some are online, such as the website where you can share your views by taking the survey and discover the latest news.

We will also bring the conversation to where you live through a series of public events and discussion groups.

We will do all we can to help everyone take part and to make sure people have the information they need, in the way they need it. If you, or someone you know, has specific needs we have not thought about, please let us know how we can help.

We know not everyone can get online. If you would like a printed copy of our consultation summary booklet, please let us know. We will also send you a survey with a postage paid, pre-addressed envelope.

And please help spread the word. Share this booklet with any people or groups you think may want to get involved or let us know so we can get in touch.

### Want to know more?

**Find out about events in your area on our website or get in touch for more details (see back cover)**

SHAPING CARE TOGETHER

**We are committed to giving you the information you need, the way you need it.**

Can't get online or you need documents in a format that suits you better? Get in touch and let us know how we can help.

A summary version of this booklet is also available.

**SHARE YOUR VIEWS. TAKE OUR SURVEY**

www.bit.ly/sct09

## Get in touch

To learn more about the programme, stay up to date with latest news and developments and discover ways to get involved and have your say, visit the Shaping Care Together website, or contact us directly.


www.yoursayshapingcaretogether.co.uk

Leave us a message on 0151 478 7929

sct.getinvolved@merseywestlancs.nhs.uk

Shaping Care Together, Communications Dept., Whiston Hospital, Warrington Rd, Rainhill, Prescot L35 5DR

# Shaping Care Together

## NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria Joint Committee

Rob Cooper, Chief Executive and SCT SRO, MWL

Halima Sadia, Programme Director, SCT

Friday, 4th July 2025

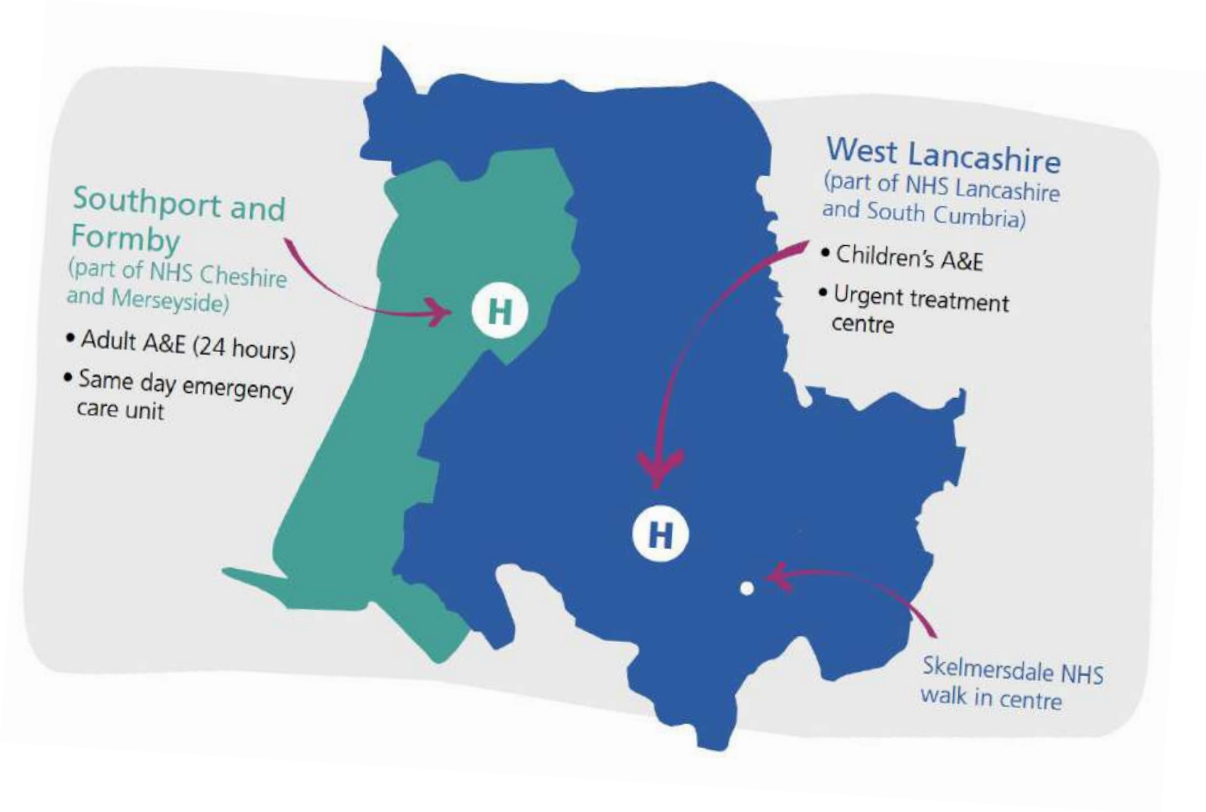
# Contents

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

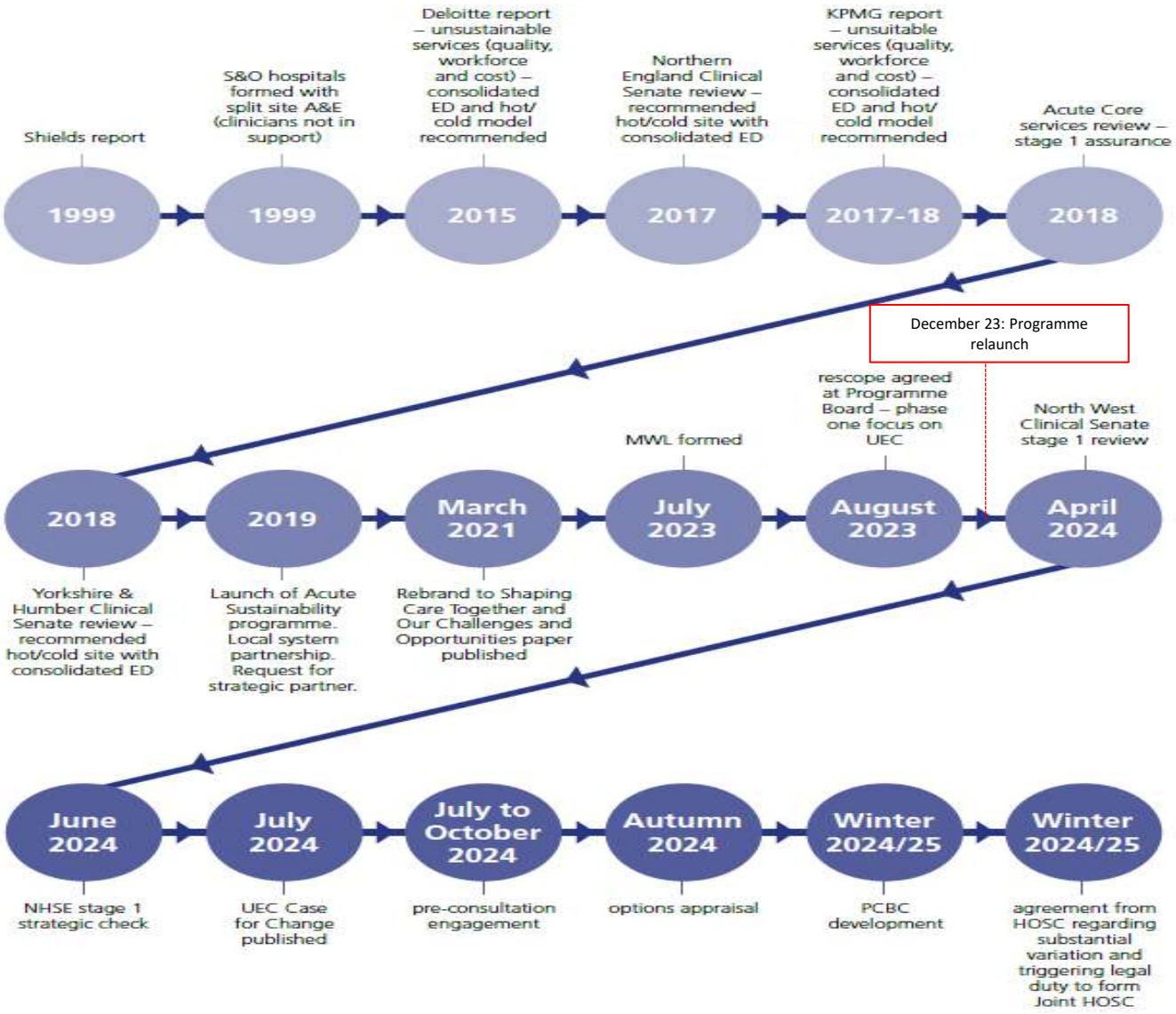
# Background and Context

# Three NHS partners

- Deciding which services to offer, and where (commissioning)
  - NHS Cheshire and Merseyside ICB
  - NHS Lancashire and South Cumbria ICB
- Providing the services
  - Mersey and West Lancashire teaching Hospitals NHS Trust



# Background – our journey so far

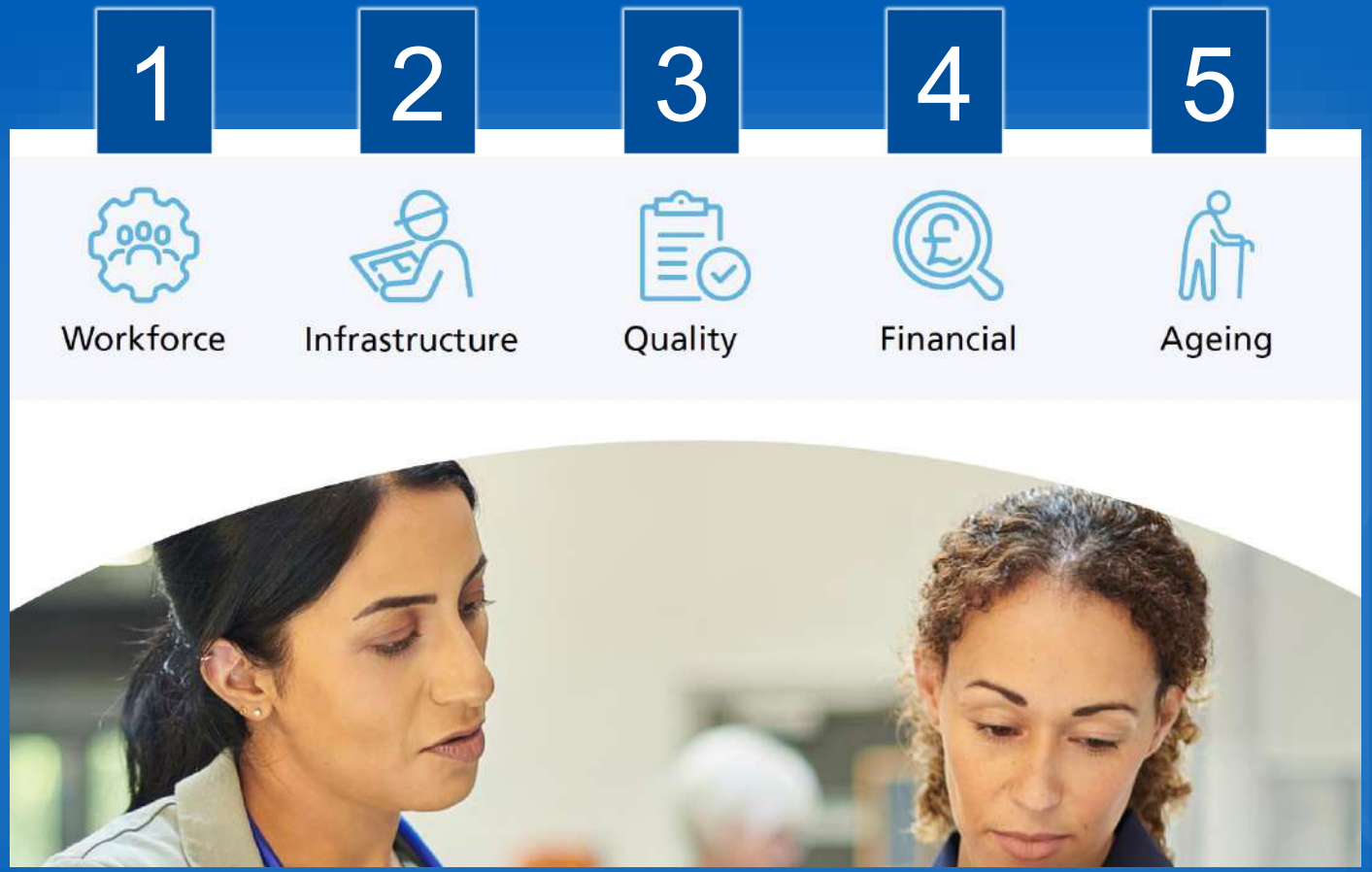


# Our focus

## Seven fragile service areas


- Programme scope was very broad
- Not sensible to tackle everything at once
- Started with UEC
- So what will we focus on next...

Maternity services




# The need for change

## Five core drivers

# Clinical Benefits

- Improved Rota Management
- Enhanced Supervision and Training
- Development of Workforce Skills
- Increased Consultant Input
- Staffing Flexibility
- Emergency Response
- Continuity of care
- Specialist availability
- Resource Sharing
- Flow management and escalation

# Strategic Alignment

# Strategic Fit

## What we are working towards

- Address immediate issues of current ED configuration through major service change
- Make more efficient and effective use of available resources to provide better care and better value
- Ensure that resources are used in a way to help improve patient flow and safety
- Strategic alignment between place-based work and this programme to ensure cohesion

# Strategic Fit

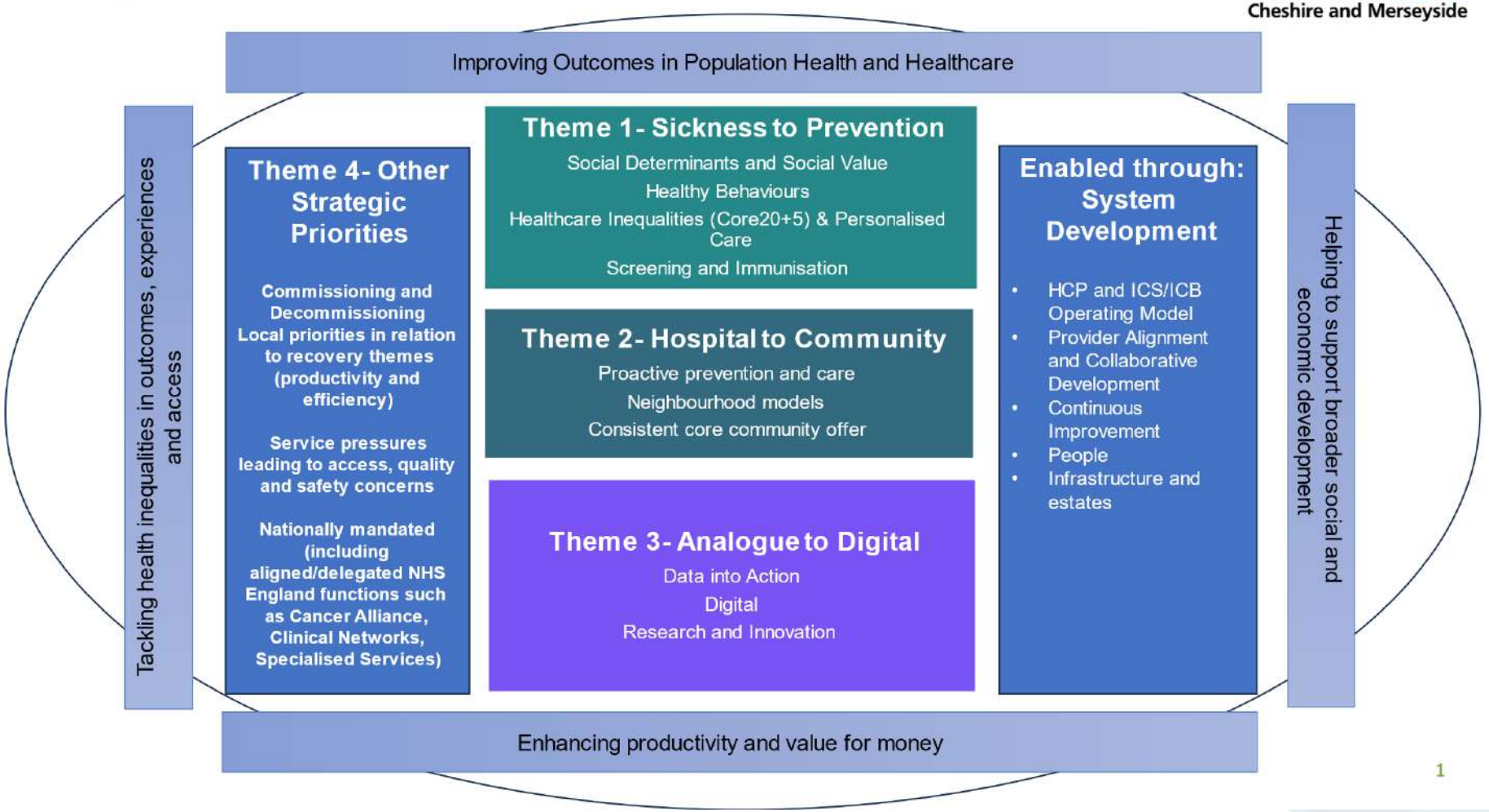
- Wider system UEC plans in place which deliver transformation across the full UEC end to end pathway
- System plans align with 3 shifts ambitions due to be set out in 10-year plan
- SCT connects to the wider system plans to ensure strategic alignment


- L&SC ICB UEC 5  Year Strategy
- L&SC IUC Redesign
- C&M MWL UEC Recovery
  - Admission Avoidance Schemes;
  - Discharge Schemes;
  - Acute Length of Stay Schemes;
  - In Hospital transformation
- C&M Better @ Home - Sefton
- Self Care
- Enhanced neighbourhood health models (i.e. integrated care including primary care, community services, VCS, wider partners)
- Primary care access
- EPR Transformation

# C&M Strategic fit

## Priority themes for our intentions

NHS
Cheshire and Merseyside




1

# SCT UEC Strategic Alignment

UEC Journey

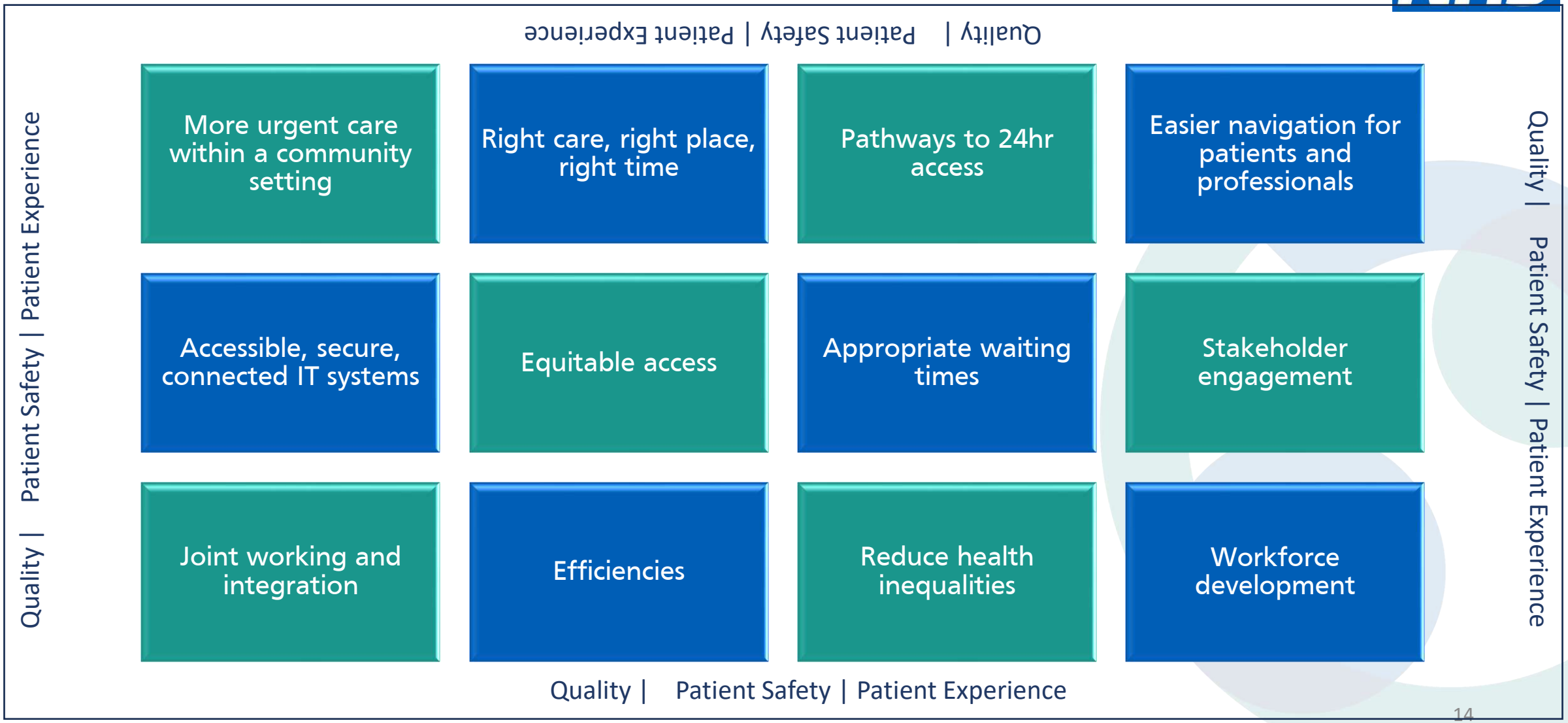
| Self-Care | Pre-Hospital community | Pre-Hospital Urgent/ Sub Acute | Front door Hospital | In Hospital (Flow) | Post Hospital |
|---|---|---|---|---|---|
| • Self care - NHS Cheshire and Merseyside<br>• LSC Integrated Care Board :: Self care (icb.nhs.uk) | • Integrated Neighbourhood Teams<br>• Virtual Wards<br>• Future care planning<br>• Enhanced Care home Offer<br>• Domiciliary Care Offer<br>• Community Pharmacy<br>• 111/OOH<br>• Primary Care<br>• Better @ Home | • Urgent Treatment Centre/ WIC<br>• UCR<br>• Intermediate Care (Step up)<br>• Supporting & Specialist Palliative Care<br>• OOH Care/ advice<br>• IV/OPAT admission avoidance<br>• UEC Single Point of Contact development | • Emergency Department<br>• Hot Clinics<br>• SDEC<br>• 24/7<br>• Rapid Triage<br>• Frailty Assessment | • Emergency Surgery<br>• Critical Care<br>• Assessment and Short Stay Unit<br>• Board round improvement initiative | • Intermediate care – Step Down<br>• Virtual Wards<br>• Palliative care (specialist)<br>• Home First (recover, reablement & rehab at home)<br>• Chase Heys Test of Change<br>• Transfer of Care Hub<br>• Joint health & social brokerage development<br>• Better @ Home |

Red text: In scope for SCT

Enablers

| | |
|---|---|
| Digital innovation (analogue to digital) | Acute to Community (left Shift) |
| Illness to Prevention | Workforce, Estates and Finance |

# L&SC Strategic Fit



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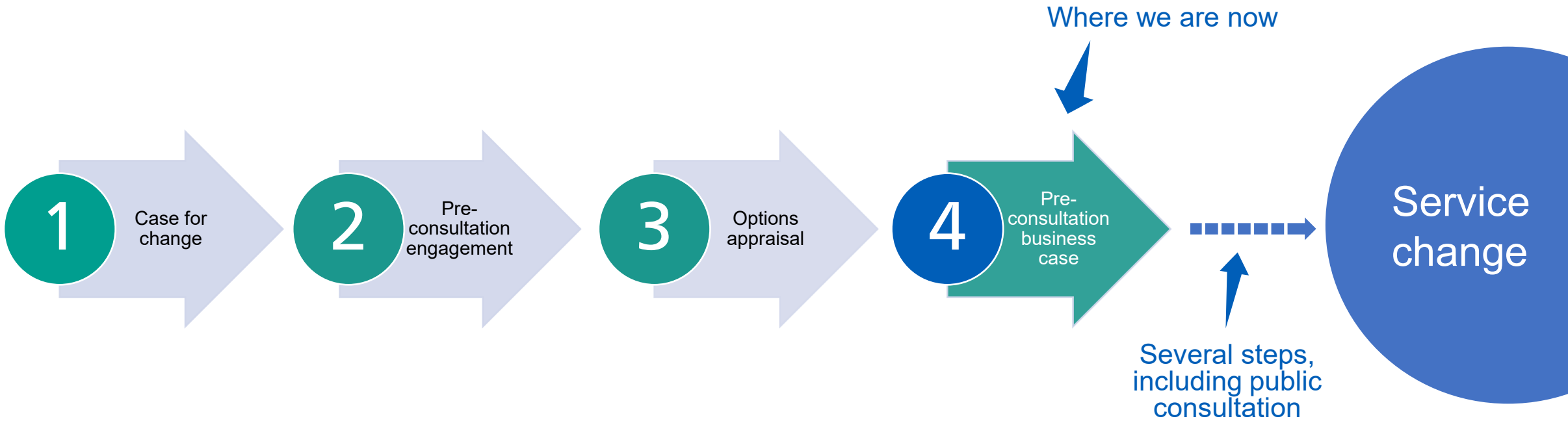
# PCBC and Consultation Document Development

# Getting to consultation




- Process set out in law and informed by NHS guidance
- We must be very thorough in respecting the process

# A Pre consultation Business Case: NHSE guidance

A Pre-Consultation Business Case (PCBC) is the business case on which the commissioner decides to consult. Contains information about case for change, clinical model and review, options appraisal, evidence of pre-consultation engagement, evidence of how proposals meet the governments and NHSE's 5 tests.

This document forms the basis of further business cases and will be the document that local government scrutinises.

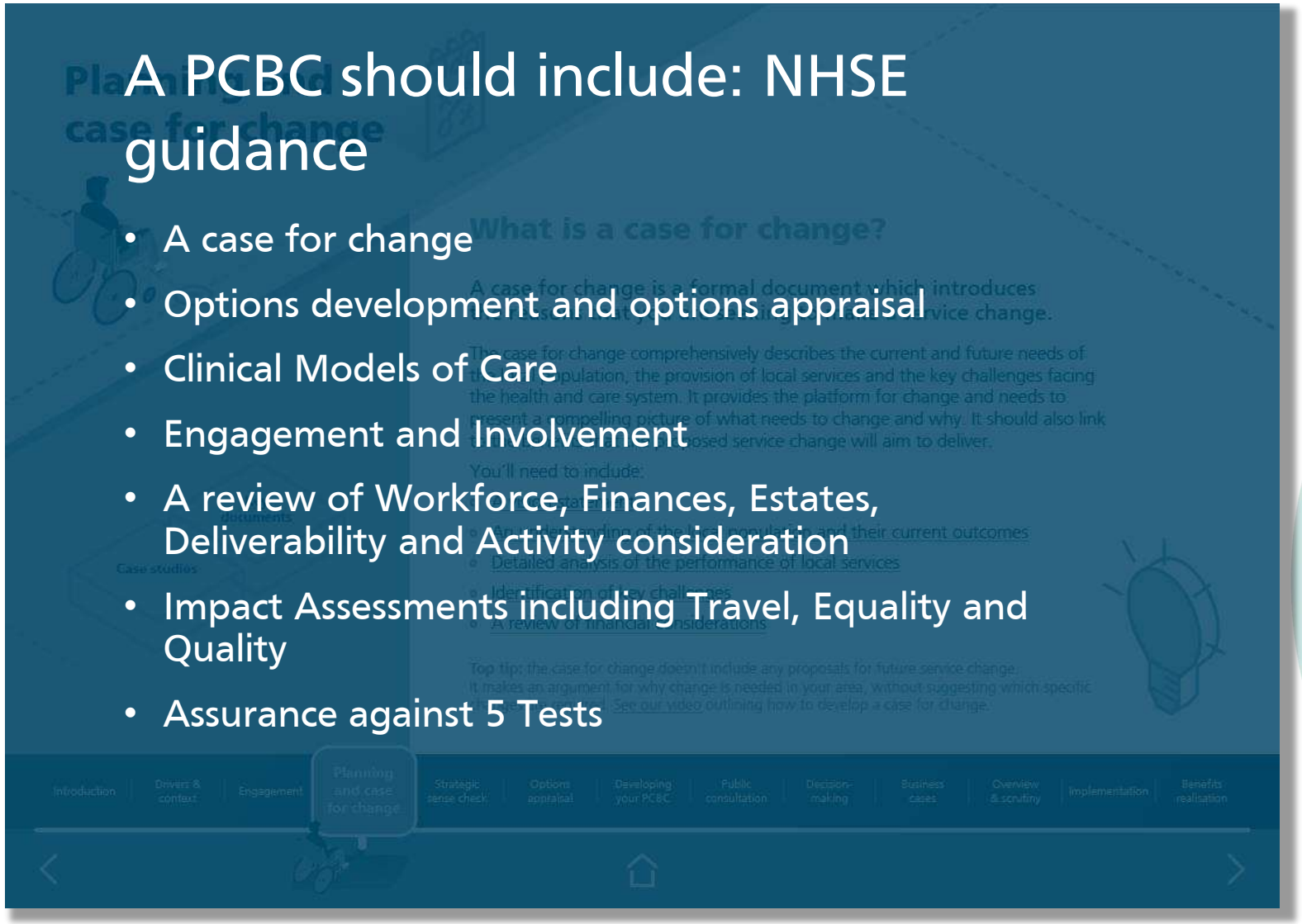
## The core elements

A PCBC is not a decision-making document.

No decisions have been made yet.

# A PCBC should include: NHSE guidance

- A case for change
- Options development and options appraisal
- Clinical Models of Care
- Engagement and Involvement
- A review of Workforce, Finances, Estates, Deliverability and Activity consideration
- Impact Assessments including Travel, Equality and Quality
- Assurance against 5 Tests




## The core elements

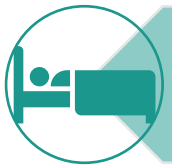
# Government and NHSE five tests

1. Strong public and patient engagement

2. Consistency with current and prospective need for patient choice

3. Clear, clinical evidence base

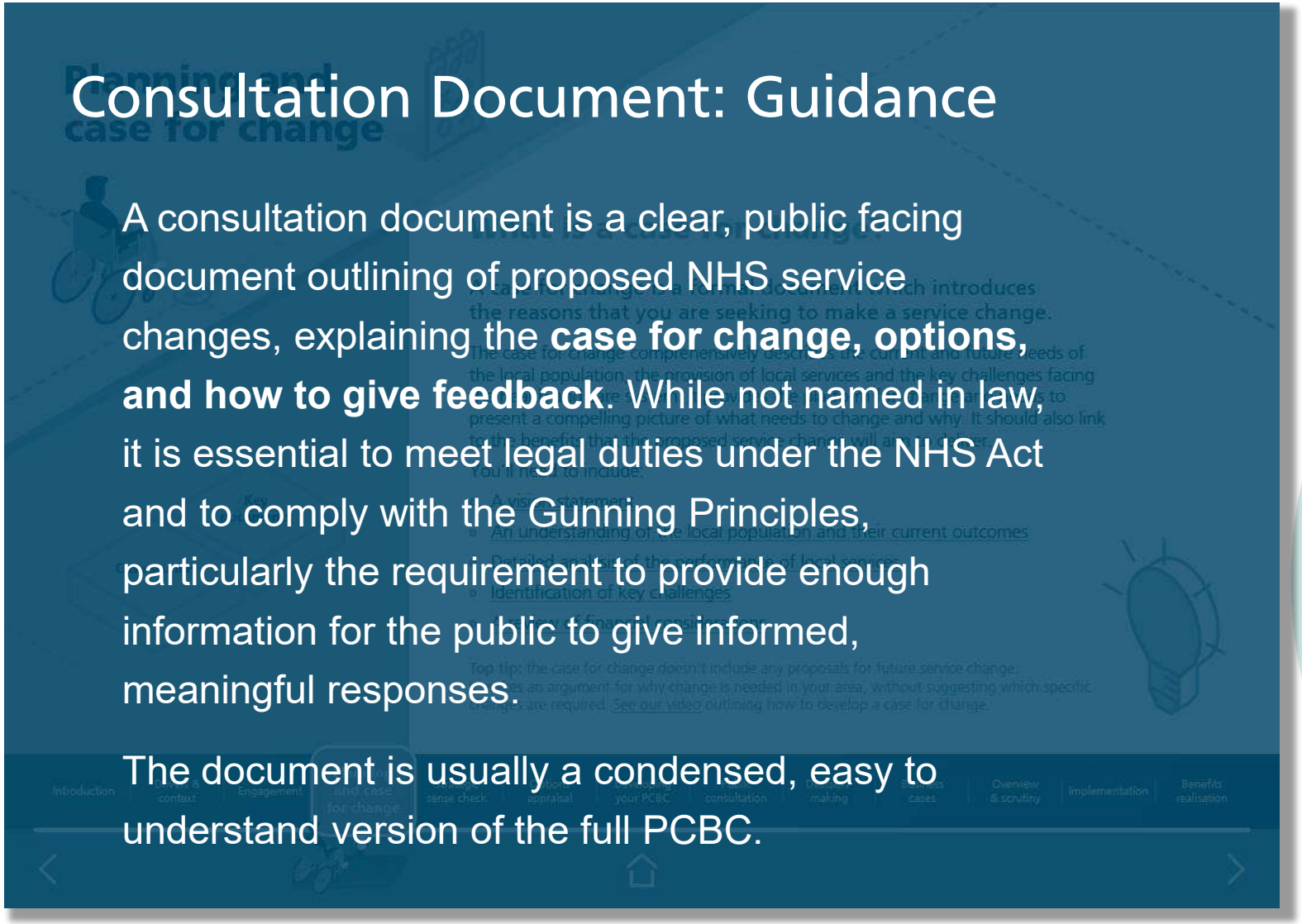
4. Support for proposals from clinical commissioners



5. Significant reduction in hospital bed numbers

The programme does not propose to reduce the number of hospital beds

# Consultation Document: Guidance



A consultation document is a clear, public facing document outlining of proposed NHS service changes, explaining the **case for change, options, and how to give feedback**. While not named in law, it is essential to meet legal duties under the NHS Act and to comply with the Gunning Principles, particularly the requirement to provide enough information for the public to give informed, meaningful responses.

The document is usually a condensed, easy to understand version of the full PCBC.

NHS Guidance

# Our approach

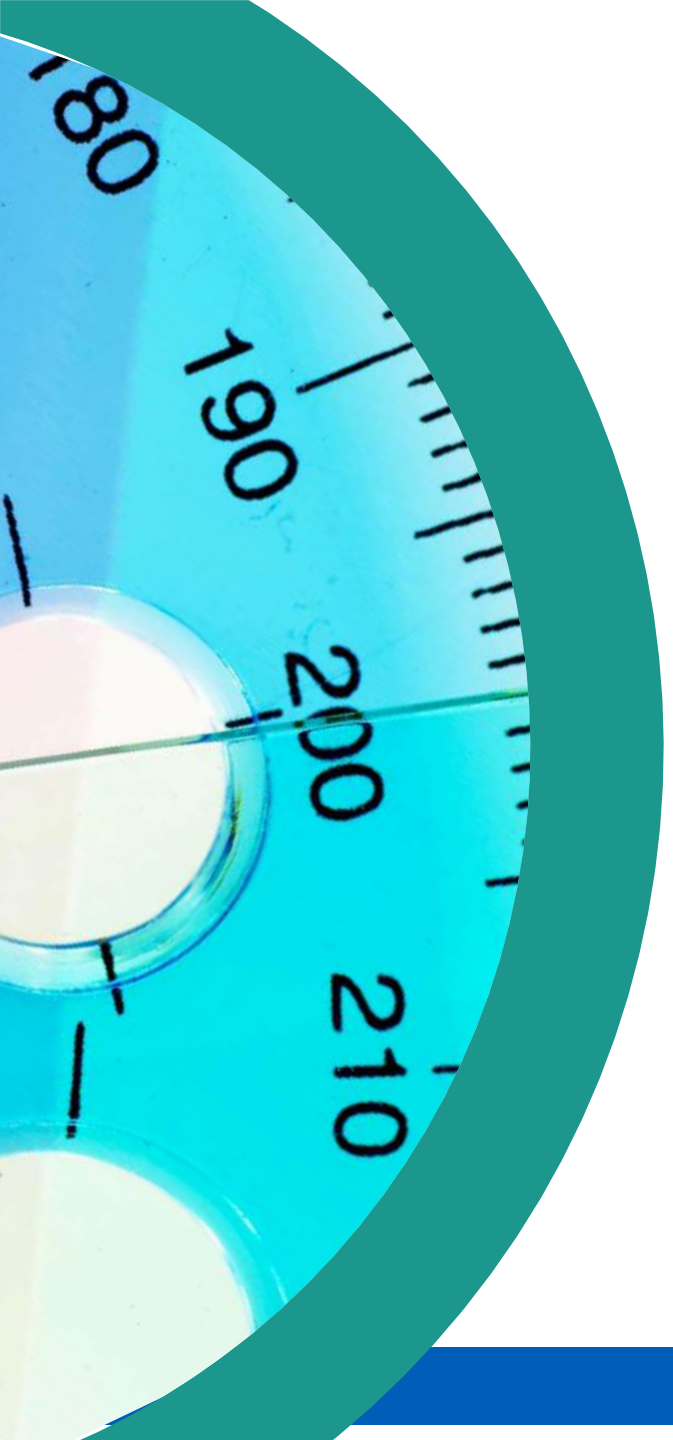
BASED ON EXISTING DOCUMENTATION (PCBC, CASE FOR CHANGE, AGREED NARRATIVE)

MEETS THE GUNNING 2 PRINCIPLE OF MAKING SURE INFORMATION IS CLEAR, RELEVANT, AND ACCESSIBLE TO ENABLE PEOPLE TO UNDERSTAND PROPOSALS AND PROVIDE AN INFORMED RESPONSE.

EASY READ AND BSL VERSIONS WILL ALSO BE MADE AVAILABLE AND SUMMARY VERSION

CLEAR AROUND PATIENT AND PUBLIC INVOLVEMENT AND HOW TO GET INVOLVED

# Pre-Consultation Engagement and Options Appraisal Process



# Pre-consultation engagement

## Digital

Survey
2,930 responses

Website
11K+ visitors

Social media ads
101.6K+ reach
3,413 clicks

Digital documents
1200+ downloads

## Offline

Radio ads Smooth NW
800K reach

Printed case for change
1000 distributed

Pharmacy bag ads
54K bags

Newspaper ads
Liverpool Echo, Ormskirk Advertiser

## In person

Staff & public roadshows
600+ live conversations

Public meetings
5 meetings
200+ attending

Focus groups
5 session with patients, staff and VCFSE groups

300+ direct stakeholder contributions logged (in addition to survey responses)

# Developing the list of options

- Over 3.5K stakeholder inputs analysed, including:
  - All qualitative survey responses
  - All points recorded at public meetings
  - All points recorded during focus groups
  - All points raised and noted at public road shows
  - All other qualitative input received
- Produced a list of 10 core options for appraisal

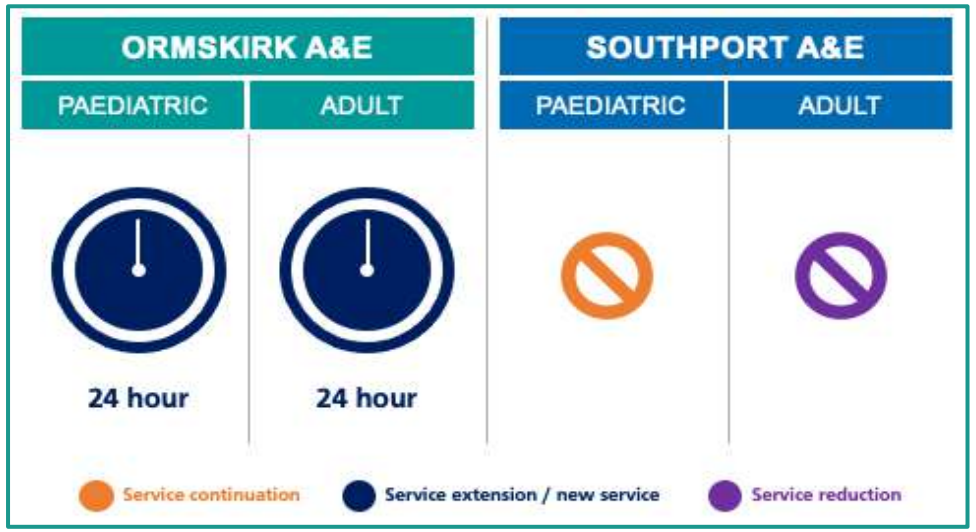
# Out of scope options

- Our analysis of engagement insights provided a further six options
- Following pre-appraisal assessment each was adjudged to **clearly not meet the hurdle criteria** for one of the following reasons:
  - Required substantial financial investment which cannot be secured at present
  - Required **significantly longer** than 3-5 years as specified by the 'implementation' criteria
  - Required substantive change to out-of-scope services, such as planned care
  - Required commissioning of wholly new services
- If new evidence is put forward, or if circumstances change, new, or previously discounted options, may be brought back into consideration

# Options

## Option 1

### Co-location Ormskirk




## In summary

Relocate paediatric A&E from Ormskirk to Southport and extend to a 24-hour service, collocated with 24-hour adult A&E

## Option 2

### Co-location Southport


## In summary

Relocate 24-hour adult A&E from Southport to Ormskirk and return the paediatric A&E to a 24-hour service.

Preferred Option

# How have people been involved?

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

| | Providers | MPs / Councillors | Commissioners | Patients, Public and Representatives | Staff |
|---|---|---|---|---|---|
| Who | NWAS<br>Alder Hey<br>University Hospitals Groups Liverpool<br>MerseyCare<br>WWL<br>MWL<br>General Practitioners<br>HCRG Care Group Ltd (provider of UTC/WIC in West Lancs) | Patrick Hurley (MP for Southport)<br>Ashley Dalton (MP for West Lancashire)<br>Bill Esterton (MP for Formby)<br>Councillors for Sefton<br>Councillors for West Lancashire<br>Councillors for Lancashire | C&M ICB<br>L&SC ICB<br>NHS England NW Spec Comm | Patients, public and carers for Southport, Formby, West Lancashire and surrounding areas<br>Healthwatch Sefton<br>Healthwatch Lancashire<br>Sefton CVS<br>CVS West Lancashire<br>EPAG:<br>• Hesketh Community Bank, Change Grow Live, Community Champions, Galloways, People First, Age UK, Southport Access for Everyone, Myeloma Support Group, Sefton Cancer Support, Breathe Easy North Sefton | MWL Clinicians<br>MWL Nursing staff<br>MWL A&E staff<br>MWL Operational staff<br>MWL executives |
| How | 1:1 meetings<br>UEC sub-group<br>Options appraisal process<br>Pre-consultation engagement events<br>Newsletters<br>GP forums | 1:1 meetings<br>Councillor meetings<br>HOSC<br>Newsletters<br>Pre-consultation engagement events | SCT Programme Board<br>Options appraisal process<br>1:1 meetings<br>Pre-consultation engagement events | EPAG meetings<br>C&E Steering Group<br>Options appraisal<br>Newsletters<br>Focus groups<br>Pre-consultation engagement events<br>Newsletters | UEC sub-group<br>Trust Brief Live<br>CEO Blog<br>MWL News<br>Staff Facebook group<br>Focus groups<br>Options appraisal<br>Pre-consultation engagement events |

# NHSE Service Reconfiguration: Assurance Self Assessment

NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

External legal assurance of process

External expert review of the process

We conducted a risk assessment workshop prior to consultation

# Finances

# Finances

NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

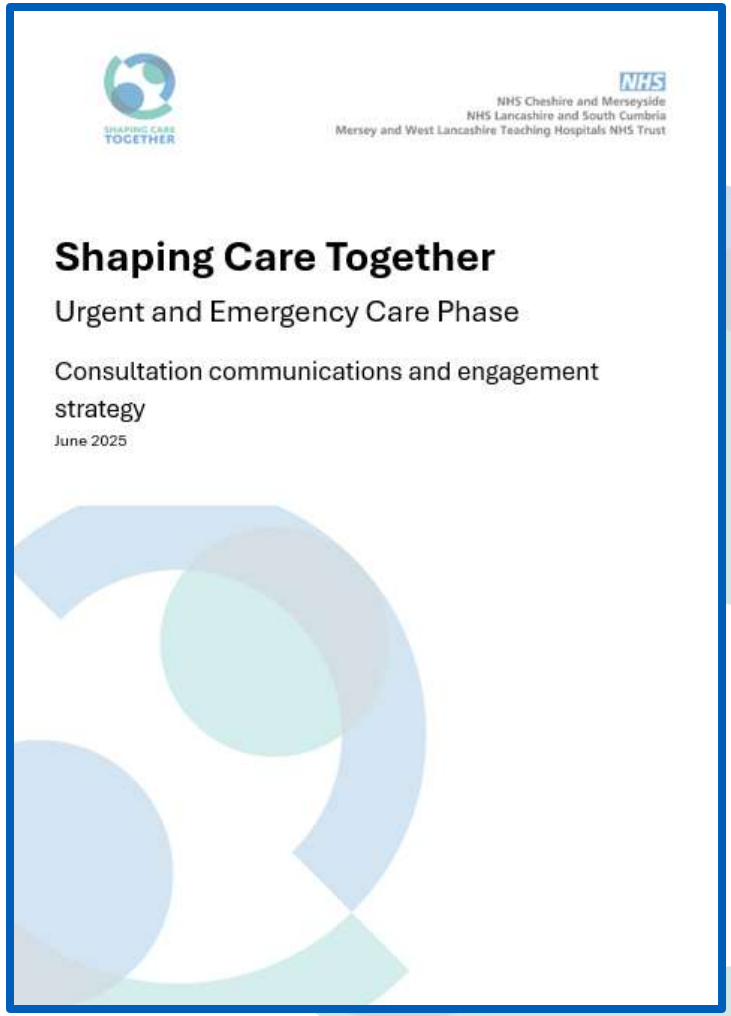
- Routes to funding = national funding (via SOC process)
- Currently have some funding allocated for SCT service reconfiguration from the transaction
- Will require additional capital support for the preferred option, through the SOC process
- Productivity: c£1.5m reduction in premium, increased opening times (back to 24/7)
- Risk assessment to funding undertaken

# Consultation Plans

# Consultation Plans

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- A communications and engagement strategy has been developed for the consultation. This includes:
  - Externalities and contingencies
  - Stakeholder list and mapping
  - Engagement approach (inc. methods and channels of engagement, phasing and timelines)
  - Communications plan (inc. targeted MP engagement)
  - Risks and mitigations
  - Plans for evaluation and monitoring
- The strategy will be revised as necessary before and during the consultation period



# Consultation Plans

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

| | |
|---|---|
| Mobile engagement | In-person<br>2 sessions |
| Community workshops | In-person<br>2 sessions |
| Public Meeting (In Person) | In-person<br>6 sessions |
| Public Meeting (Online) | Online<br>2 sessions |
| Focus groups / Targeted sessions | In person<br>2 sessions |
| Focus groups / Targeted sessions | Online<br>6 sessions |
| Trust Brief Live takeover | Online<br>2 sessions |
| Staff workshops | Online<br>2 sessions |
| Staff drop-in | In person<br>4 sessions |

# Ask of Joint Committee

# Ask of Joint Committee

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Approve PCBC and Consultation Document
- Agree to start a public consultation for a 13-week period

# Thank you

To: Sam Profitt, Interim CEO
Lancashire & South Cumbria
Integrated Care Board

Cathy Elliott, CEO
Cheshire & Merseyside Integrated
Care Board

Louise Shepherd
North West Region
4th Floor
3 Piccadilly Place
Manchester
M1 3BN

louise.shepherd17@nhs.net

23 June 2025

Dear Sam and Cathy,

**NHS England Stage Two assurance of proposals for service transformation in Merseyside and West Lancashire: Shaping Care Together – Phase 1: Urgent and Emergency Care Services (UEC)**

Following our previous correspondence of 16th June 2025, and the Stage Two assurance meeting held on 18th March 2025, I am writing to confirm NHS England's **full assurance** of your proposals for the transformation of UEC services in Merseyside and West Lancashire as part of the Shaping Care Together (SCT) programme.

**Assurance outcome**

As you will recall, the panel previously provided partial assurance, pending additional information and alignment in two key areas: the communications and engagement consultation strategy, and the Equality and Quality Impact Assessment (EQIA).

We have reviewed the updated documentation, submitted on 18th June 2025, and can confirm that relevant panel members are now satisfied that these documents address the requirements set out in our previous letter (16th June 2025).

With reference to the EQIA in particular, clearly there has been substantial time and work invested in this document; in identifying the main components and areas for further enquiry, discovery and engagement. There is clearer recognition of the specific requirements, with a broader understanding of patients, residents and employee needs and the potential positive benefits. We welcome the comprehensive plan of action, to address and mitigate any pre-identified potential adverse impacts. This is greatly appreciated.

We hope that this letter provides you with the support required to proceed to public consultation in early July, as planned.

**Next Steps**

Given the strategic importance of this programme in the region, we would welcome early sight of your Decision-Making Business Case (DMBC), prior to final decision-making post-consultation. If there is any major deviation from the original proposals, or any change to the clinical or financial viability of the proposed scheme, we may wish to further review. I suggest that you continue to work with Jo Stringer, NHSE NW's Head of ICS Development, as you develop the DMBC and then any issues can be identified and addressed, should they emerge.

If you have any queries about the content of this letter, please do not hesitate to contact Clare Duggan, Regional Director of Strategy and Transformation, or Jo Stringer.

Thank you once again to you and your team for the significant amount of work to date on these proposals.

Yours sincerely,

**Louise Shepherd CBE**
Regional Director (North West)

Cc Clare Duggan, Regional Director Strategy & Transformation, NHS England
Rob Cooper, Chief Executive, Mersey and West Lancashire Teaching Hospitals NHS Trust
Steve Rumbelow, Chair, Mersey and West Lancashire Teaching Hospitals NHS Trust
Halima Sadia, Programme Director
Clare Watson, Assistant Chief Executive, C&M ICB
Sarah O'Brien, Chief Nurse, LSC ICB

NHS Lancashire and South Cumbria

NHS Cheshire and Merseyside

# Meeting of the Shaping Care Together Joint Committee

**04 July 2025**

## Shaping Care Together – Programme Timelines

**Agenda Item No:** SCT/25/07/08

NHS Lancashire and South Cumbria

NHS Cheshire and Merseyside

# Shaping Care Together – Programme Timelines

## 1. Purpose of the Report

1.1 The purpose of the paper is to outline the Timelines of the Shaping Care Together Programme including significant milestones which require this board to meet.

## 2. Executive Summary

2.1 The programme timelines can be found in Appendix 1. The timelines include critical milestones such as NHSE Assurance checks, dates for proposed consultation and future business cases.

## 3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

- Note the programme timeline for the Shaping Care Together Programme.

## 4. Reasons for Recommendations

4.1 Informs the committee of the programme timelines that are currently in place and alignment to this committee.

## 5. Background

5.1 This timeline has gone through the following governance routes:

- SCT Programme Board: 5th March 25, 4th June 25
- NHSE Stage 2 Gateway Assurance 18th March 25

## 6. Officer contact details for more information

Rob Cooper – Managing Director, Mersey and West Lancashire Teaching Hospitals NHS Trust (rob.cooper@merseywestlancs.nhs.uk)

Halima Sadia – Programme Director – Shaping Care Together, Mersey and West Lancashire Teaching Hospitals NHS Trust (halima.sadia@merseywestlancs.nhs.uk)

## 7. Appendices

**Appendix One:** Shaping Care Together Programme Timelines

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

SHAPING CARE TOGETHER

# Shaping Care Together Programme Timeline

# Programme Timeline

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

| Milestone | Date |
|---|---|
| NHSE Stage 2 Clinical Senate Assurance | 27th January 2025 |
| Submission of NHSE Stage 2 assurance paper | 13th February 2025 |
| NHS England Stage 2 Assurance Check | 18th March 2025 |
| Local election pre-election period | 21st March to 1st May 2025 |
| PCBC to ICB Joint Committee for approval | July 2025 |
| Notification of consultation launch to Joint HOSC | July 2025 |
| Public consultation (13-week period) | July to October 2025 |
| Analysis of insights from the public consultation | October to November 2025 |
| Update to ICB Joint Committee with consultation insights and next steps | November 2025 |
| Engage with Joint HOSC (outcome of consultation and next steps) | Winter 2025/26 |
| Develop Decision-Making Business Case (DMBC) and Strategic Outline Case (SOC) | Winter 2025/26 |
| NHS England approval of the DMBC and SOC | February 2026 |
| JHOSC engagement (inform) | Winter/Spring 2026 |
| DMBC and SOC to Joint Committee for approval | Spring 2026 |
| Potential engagement with JHOSC | Spring 2026 |

# Shaping Care Together Joint Committee

## Terms of Reference

**Version 0.6**

| Date | Version | Revision | Comment | Author / Editor |
|---|---|---|---|---|
| 04.10.24 | 0.5 | Update to section 2, section 5 and section 7 | Updated to reflect agreements between ICBs | Matthew Cunningham, Debra Atkinson, Halima Sadia |
| 28.10.24 | 0.6 | Update to section 2 | Removed reference to oversight of finances in the roles and responsibility section | Debra Atkinson, Halima Sadia |
| | | | | |
| | | | | |

**Review due:**

**V0.6 approved by the:** Board of NHS Cheshire and Merseyside ICB, 28 November 2024
Board of NHS Lancashire and South Cumbria ICB, 13 November 2024

## Partner Organisations

| Organisation Name | Address | Lead Contact Officer | Website |
|---|---|---|---|
| **NHS Cheshire and Merseyside ICB** | No1 Lakeside, Centre Park, Warrington, WA1 1QY | Clare Watson | www.cheshireandmerseyside.nhs.uk |
| **NHS Lancashire and South Cumbria ICB** | Level 3, Christ Church Precinct, County Hall, Fishergate Hill, Preston, PR1 8XB | Sarah O'Brien | www.lancashireandsouthcumbria.icb.nhs.uk |

## Document control

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## 1. Introduction and purpose

1.1. Shaping Care Together (SCT) is a health and care transformation programme operating across Southport, Formby and West Lancashire. This partnership programme is supported by Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), NHS Cheshire and Merseyside Integrated Care Board (ICB) and NHS Lancashire and South Cumbria ICB. Its aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money and buildings to maximum effect, and it is starting with Urgent and Emergency Care as phase one.

1.2. Pursuant to section 65Z5 of the National Health Service Act 2006 as amended ('the NHS Act') NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB have agreed to establish a Joint Committee, which will be known as the **Shaping Care Together Joint Committee** (referred to as 'Joint Committee' for the purposes of this Terms of References). In accordance with Section 65Z5 of the NHS Act, ICBs can establish and maintain joint working arrangements, overseen by the Joint Committee, to jointly exercise their commissioning functions.

1.3. The Joint Committee will be responsible for the key programme decisions for the Shaping Care Together programme, supporting the Partners to collaboratively make decisions on the planning and delivery of the Programme.

1.4. These terms of reference set out the role, responsibilities, membership, decision-making powers, and reporting arrangements of the Joint Committee in accordance with the statutory duties of an ICB. These Terms of Reference will be published on the website of each Joint Committee partner organisation.

## 2. Role and responsibilities of the Joint Committee

2.1 The Joint Committee will safely, effectively, efficiently and economically discharge the joint functions in scope of the Shaping Care Together Programme and as delegated to the Committee by both ICBs through the following key responsibilities:

- determining the appropriate structure of the Joint Committee and programme governance arrangements;
- oversee the development, implementation, performance and review of the Shaping care Together Programme;
- making joint decisions in relation to the planning and commissioning of services, and any associated commissioning or statutory functions, within the scope of the Shaping Care Together programme, for the population of Southport, Formby and West Lancashire
- have due regard to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources in all decision-making;
- having due regard and assuring against NHS Planning, assuring and delivering service change for patient's guidance including assurance for each NHSE gateway assurance checkpoints and 5 tests (public and patient engagement, patient choice (and EIA), clinical evidence, support from GP commissioners, NHSE Bed closure test (if applicable) and Finance)
- ensuring the Joint Committee has access to appropriate clinical advice and leadership, including through Clinical Senates

- ensuring that, prior to a decision being made by the Joint Committee in relation to the services areas in scope of the Shaping Care Together Programme, that proposals for future delivery of these services are clinically led, informed by clinical evidence, research, and intelligence, and can demonstrate that they meet the needs of the population who access them;
- Consider longer-term planning of services within scope of the Shaping Care Together Programme, including the opportunities for transformation and integration of the services and functions;
- ensuring that there are effective engagement arrangements in place, and that there is meaningful involvement of the public, patients, carers, and stakeholders in the development of proposals;
- ensuring that relevant Oversight and Scrutiny Committees and appropriate local, regional and national bodies are engaged and that the ICBs and other partners comply with statutory and regulatory requirements, in particular the duties of consultation should any major service reconfiguration be recommended;
- ensure that all significant proposals undertake all relevant integrated impact assessments so that their impact can be assessed against the objectives of the Shaping Care Together Programme;
- make recommendations to the Boards of each ICB on any changes to the mandate of and scope of the services within the Shaping Care Together programme which impact on any functions, statutory duties, quality and safety of services and financial implications;

2.2 For the avoidance of doubt, in the event of any dispute when making any decisions or recommendations, the Standing Orders, Standing Financial Instructions and the Schemes of Reservation and Delegation of each ICB will prevail over these Terms of Reference.

## 3. Accountability and reporting

3.1 As a Joint Committee of the two ICBs, the Joint Committee is ultimately accountable to the respective Boards of NHS Cheshire and Merseyside ICB and NHS Lancashire and South Cumbria ICB.

3.2 The Joint Committee will report separately and consistently to each of the two ICBs. Highlight reports and confirmed minutes of meetings of the Joint Committee will be published within the papers of ICB Board meetings held in public.

## 4. Authority

4.1 The Joint Committee is authorised to:

- receive and approve on behalf of both ICBs, any case for change for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs, any Pre-consultation business cases and any associated capital strategic outline case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs any Outline Business Case or Full Business Case for services within scope of the Shaping Care Together programme
- receive and approve on behalf of both ICBs the associated materials involved with and the initiation of any engagement or formal consultations with the

public, patients, carers and stakeholders, , in respect of the services within the scope of the Shaping Care Together Programme
- receive, consider and decide on any further next steps after receiving the outcomes of any engagement or formal consultations with the public, patients, carers and stakeholders, in respect of the services within the scope of the Shaping Care Together Programme
- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the two ICBs (who are directed to co-operate with any request made by the committee) within its remit as outlined in these terms of reference
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the committee must follow any procedures put in place by the partner ICBs for obtaining legal or professional advice.

## 5. Membership

5.1 **Members.** The Committee shall draw its membership from the two Partner ICBs. The two Partner ICBs will each identify three individuals to sit on the Joint Committee as a member. For each ICB, one member will be drawn from its ICB Executive Officers, and one will be drawn from its ICB Non-Executive Members. Each ICB has the discretion to identify who its additional member will be.

5.2 In being a named member of the Joint Committee, each member, regardless of which organisation they are drawn from, are there as a member on the Committee representing the two ICBs and are undertaking Committee duties and making binding decisions on behalf of and in the interests of both ICBs.

5.3 **Member Deputies**. Each ICB will need to identify named Deputies to attend meetings of the Joint Committee if their named Members are unavailable or if they are unable to attend or participate in the decision-making because they are conflicted. The named deputies will undertake the duties of and have the authority of their respective members at these Committee meetings when attending on their behalf. Members of the Committee must ensure that any such named deputy(s) are suitably briefed and qualified to act in that capacity.

5.4 **Chair and Deputy Chair(s).** At the first meeting of the Joint Committee in each financial year, the Membership shall select a Chair, and its Deputy Chair. The Chair and Deputy Chair must be selected from the non-executive members drawn from each ICB. The Chair and Deputy Chair may not be appointed from the same organisation

5.5 The incumbent(s) in the role / position of Chair and Deputy Chair shall hold office until such time as an individual is formally confirmed at the first meeting of the Joint Committee in the next subsequent financial year. At the first scheduled Joint Committee meeting after the expiry of the Chair's / Deputy Chairs term of office, the Committee Membership will select a Chair, and Deputy Chair(s), who will assume office at that meeting and for the ensuing term.

5.6 The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference.

5.7 **Regular Participants.** The Joint Committee may invite regular participants or observers at its meeting in order to inform its decision-making and the discharge of its functions as it sees fit. These regular participant / observers will not form part of any formal decision making arrangements as outlined within Section 7 of these Terms of Reference.

5.8 Participants will receive advance copies of the notice, agenda and papers for Committee meetings. They may be invited to attend any or all of the Committee meetings, or part(s) of a meeting. Any such person may be invited, at the discretion of the Chair presiding over the meeting to ask questions and address the meeting but will not partake in any decision making.

5.9 The following may be invited to be regular participants to the Committee:

- representatives from Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL)
- other Officers of the two Partner ICBs
- representatives of Shaping Care Together Programme Team
- representatives of NHS England
- representatives from Provider Collaboratives
- representatives of Clinical or Research networks
- representatives from Local Government
- any other person that the Chair considers can contribute to the matters under discussion.

5.10 The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.11 **Membership lists.**The Joint Committee shall ensure that there is a prepared and up-to-date list of the members and regular participants of the Committee and that this list is made available to the Partners.

5.12 **Quorum.** A Joint Committee meeting is quorate if at least the following members are in attendance:

- the Chair, or Deputy Chair
- an Executive Officer (or deputy) from both ICBs.

## 6. Meeting arrangements

6.1 The Joint Committee shall meet at least two times per year. Meetings may occur more frequently in line with any key decision milestones

6.2 At its first meeting (and at the first meeting following each subsequent anniversary of that meeting) the Joint Committee shall prepare a schedule of meetings for the forthcoming year (“the Schedule”).

6.3 The Chair (or in the absence of a Chair, the Deputy Chair) shall see that the Schedule is notified to the members.

6.4 The two partner ICBs (individually or collectively) may call for a special meeting of the Joint Committee outside of the Schedule as they see fit, by giving notice of their

request to the Chair and Deputy Chair. The Chair may, following consultation with the two partner ICBs, confirm the date on which the special meeting is to be held and then issue a notice giving not less than one weeks' notice of the special meeting.

6.5 Use of video, telephone or other electronic communication means to conduct meetings of the Joint Committee is permissible with prior agreement of the Chair of the meeting. The Chair of the meeting will take into account the difficulties that might be posed to ensure proper access by members and attendees to the meeting should it, on occasion, be necessary to hold remote meetings and will make adjustments where possible.

6.6 The Joint Committee is not subject to the Public Bodies (Admissions to Meetings) Act 1960. Admission to meetings of the Joint Committee is at the discretion of the Partners. All members in attendance at a Joint Committee are required to give due consideration to the possibility that the material presented to the meeting, and the content of any discussions, may be confidential or commercially sensitive, and to not disclose information or the content of deliberations outside of the meeting's membership, without the prior agreement of the Partners.

6.7 Meetings of the Joint Committee will be held in public where there is the agreement between the Partner ICBs and where it is deemed in the public interest to do so in relation to the decisions required to be undertaken by the Committee.

## 7. Decisions making arrangements

7.1 The aim of the Joint Committee will be to achieve consensus decision-making by its members wherever possible, and decisions made by the Joint Committee will be consistent with the powers provided to it within these terms of reference and in line with the Constitutions and Schemes of Reservation and Delegation of each ICB.

7.2 The Partner ICBs must ensure that matters requiring a decision are anticipated and that sufficient time is allowed prior to Joint Committee meetings for discussions and negotiations to take place, however this may not always be possible for urgent issues.

7.3 Where it has not been possible, despite the best efforts of the Committee, to come to a consensus decision on any matter before the Joint Committee, the Chair, in agreement with all members present, may defer the matter for further consideration at a future meeting of the Committee or require the decision to be put to a vote in accordance with the following provisions:

- each Committee member will have one vote
- a vote will be passed with a simple majority
- there is no recourse for abstention.

7.4 In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.

7.5 In no circumstances may a member, or nominated deputy contribute to the business of the committee meeting or decision-making by proxy.

7.6 Decisions undertaken by the Joint Committee are binding on the two ICBs.

## 8. Dispute Resolution

8.1 Where helpful, the Joint Committee may draw on third-party support to assist them in resolving any disputes, such as peer review or support from NHS England.

## 9. Administrative Support

9.1 The partner ICBs shall provide sufficient resources, administration and secretarial support to ensure the proper organisation and functioning of the Joint Committee.

9.2 The Joint Committee shall be supported with a secretariat function which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair and Deputy Chair with the support of the relevant officer lead to the Committee
- records of conflicts of interest members' appointments and renewal dates. Provide prompts to renew membership and identify new members where necessary
- good quality minutes are taken and agreed with the Chair. Keep a record of matters arising, action points and issues to be carried forward. Minutes of the meeting will be circulated to all Committee members within 10 working days of the meeting, highlighting actions by individual members
- the Chair is supported to prepare and deliver reports to the Boards of each partner ICB
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

## 10. Publication of notices, minutes and papers

10.1 The Chair (or in the absence of a Chair, the ICBs themselves) shall see that notices of meetings of the Joint Committee, together with an agenda listing the business to be conducted and supporting documentation, is issued to the Partners one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

10.2 The proceedings and decisions taken by the Joint Committee shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The Joint Committee shall confirm those minutes at its next meeting.

## 11. Conduct and conflicts of interest

11.1 Members of the Joint Committee will be expected to act consistently with existing statutory guidance, NHS Standards of Business Conduct and any other relevant organisational policies.

11.2 Members should act in accordance with the Nolan Principles (the Seven Principles of Public Life).

11.3 Members should refer to and act consistently with the NHS England guidance: Managing Conflicts of Interest in the NHS: Guidance for staff and organisations.

11.4 Where any member of the Joint Committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, either by participating in discussion or by voting. An ICB whose Committee Member is conflicted in this way may secure that their appointed substitute attend the meeting (or part of meeting) in the place of that member.

11.4 Members of, and those attending, the Committee shall behave in accordance with the Constitution, Standing Orders, and Standards of Business Conduct Policy of each of the partner ICBs.

11.5 Members must demonstrably consider the equality, diversity, and inclusion implications of decisions they make.

## 12. Review

12.1 The Committee will review its effectiveness at least annually.

12.2 These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board of each ICB for approval.