Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 10 October 2016

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Tuesday, 18 October 2016**
Time: **3.30 pm**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Joint Health Overview and Scrutiny Committee

Gerald Dakin (Co-Chair)	Andy Burford (Co-Chair)
John Cadwallader	Veronica Fletcher
Heather Kidd	Rob Sloan
David Beechey (Co-optee)	To be confirmed (Co-optee)
Ian Hulme (Co-optee)	Rajash Mehta (Co-optee)
Mandy Thorn (Co-optee)	Dag Saunders (Co-optee)

Your Officers are:

Amanda Holyoak Committee Officer
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AGENDA

1 Apologies for Absence

2 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes (Pages 1 - 16)

To confirm the minutes of the meeting held on 5 July 2016, attached marked: 3

4 Joint HOSC Visit to Widnes and Runcorn Urgent Care Centres and Responses to Interim Questions (Pages 17 - 34)

To receive a report on the key findings from the Joint HOSC visit to Widnes and Runcorn Urgent Care Centres and also the responses from the NHS provided to questions submitted from the Joint HOSC Chairs on the Future Fit Programme following the last meeting on 5 July 2016, all attached marked: 4

5 Future Fit and Sustainability and Transformation Plan (STP) (Pages 35 - 42)

Dave Evans (Chief Officer Telford and Wrekin CCG and Future Fit Programme Accountable Officer), a representative of Shropshire CCG and Simon Wright (Chief Executive of the Shrewsbury and Telford NHS Hospitals Trust and Chair of the STP Board) will update the Committee on the progress of the Future Fit Programme and the STP and respond to the questions, attached marked: **5**. Representatives from the Shropshire Community Health Trust and the Local Authorities will also attend for this item.

6 Consultation Programme for the Future Fit Programme (Pages 43 - 56)

Dave Evans (Chief Officer Telford and Wrekin CCG and Future Fit Programme Accountable Officer) to present the report on the consultation process for the Future Fit Programme.

7 Next Steps for Joint HOSC

The Joint HOSC will consider further information required and work that members of the Committee will undertake before the consultation on the Future Fit Programme begins in December 2016.

8 Joint HOSC Work Programme

To consider the work programme for the Joint HOSC.

9 Chairs' Update

Role of the Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee

Purpose of the Joint Health Overview and Scrutiny (Joint HOSC) Committee Meeting on the 18th October 2016

The Joint HOSC has had an on-going role in scrutinising the development of the proposals for the Future Fit Programme and the continued safety of hospital services. The purpose of the Joint HOSC Committee meeting on the 18th October will be to continue to investigate the issues that the Committee has identified which include:

- Risks for Current Services
- Deficit Reduction / Sustainability and Transformation Plan
- Clinical Model and Work Force Planning
- Activity and Capacity
- Equipment and Information Technology
- Governance and Timescales
- Leadership and Capacity
- Consultation

The Committee will carry out its statutory function to scrutinise and respond to the proposals agreed by the Telford and Wrekin and Shropshire Clinical Commissioning Groups during the formal period of public consultation which will start in December 2017.

Background Information:

The Centre for Public Scrutiny promotes 4 principles of good scrutiny. Local Authority Scrutiny Committees should:

- provide a constructive 'critical friend' challenge
- amplifies the voices and concerns of the public
- be led by independent people who take responsibility for their role
- drive improvement in public services

Statutory Role of the Joint Health Overview and Scrutiny Committee (Joint HOSC)

The Joint HOSC has a statutory role to review and scrutinise matters relating to the planning, provision and operation of the health services in the area. (Guidance to support local authorities and their partners to deliver effective health scrutiny: Department of Health, 2014)

Under the legislation the Committee has the power to:

- Require information to be provided by certain NHS bodies
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions
- Make reports and recommendation to certain NHS bodies

In addition to this the NHS must consult the Joint HOSC on proposals for any substantial variation or development in service in the local authority areas. The Joint HOSC does not have the power to make decisions about local NHS services.

SHROPSHIRE AND TELFORD & WREKIN JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee held on 5th July 11.00am in Quaker Meeting Room, Meeting Point House, Town Centre, Telford, TF3 4HS

Present: Councillors: A. Burford (Chair), G. Dakin, V. Fletcher, H. Kidd, R. Sloan and

Co-optees: D. Beechey, I. Hulme, R. Mehta.

Also Present: A. Begley, Director of Adult Services, Shropshire Council (J HOSC 5); D. Evans, Chief Officer Telford and Wrekin Clinical Commissioning Group and Accountable Officer, Shropshire Clinical Commissioning Group (J HOSC 5); J. France, Head of Nursing for Children & Families, Shropshire Community Health Trust (J HOSC 5); Steve Gregory, Executive Director of Nursing & Operations, Shropshire Community Health Trust (J HOSC 5); A. Hammond, Deputy Executive for Commissioning and Planning (Integrated Care) Telford and Wrekin CCG (J HOSC 6); D. Vogler, Future Fit Programme Manager (J HOSC 5); S. Wright, Chief Executive Shrewsbury and Telford Hospitals NHS Trust (J HOSC 5)

In Attendance: F. Bottrill, Scrutiny Specialist, Telford & Wrekin Council (minutes); A. Holyoak, Democratic Service Officer, Shropshire Council; D. Moseley, Democratic Services & Scrutiny Team Leader.

J HOSC-1 Apologies for Absence

Apologies were received from Cllr. J. Cadwallader and Co-optees: B. Parnaby, D. Saunders and M. Thorn.

J HOSC- 2 Declarations of Interest

B. Parnaby declared an interest in Item 5 as a director of HealthwatchTelford and Wrekin.

J HOSC- 3 Minutes

A member asked for clarification about the National Symposium on rural issues. It was confirmed that this would be held in February 2017.

RESOLVED that the minutes of the meeting of the Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee held on the 2nd March be confirmed and signed by the Chairman.

J HOSC - 4 Review of the Terms of Reference for the Shropshire and Telford & Wrekin Joint Health Overview and Scrutiny Committee

The Scrutiny Group Specialist informed the Committee that it was good practice that the terms of reference was reviewed annually, and confirmed that there were no proposed amendments so the terms of reference considered by the Committee were the same as last year.

RESOLVED that draft terms of reference be endorsed.

J HOSC – 5 Progress of the Future Fit Programme and Submission of the NHS Sustainability and Transformation Plan.

Before taking the report on the Future Fit Programme and Sustainability and Transformation Plan the Chair informed the Committee he was aware that the issue regarding stroke services was of concern to members and that this was not included on the agenda as a specific item. He informed the Committee that this would be covered under the Chair's update and he would ask the Chief Executive of SaTH to provide some assurance to the Committee.

The Chair welcomed the officers to the meeting and provided some background to this item. The Chair recognised that there is continued public interest in the Future Fit Programme and he confirmed that the role of the Joint Health Overview and Scrutiny Committee was to be an independent body, which does not represent the views of either local authority or a particular political party. The role of the Committee was to hold NHS Commissioners and providers to account and ensure that sufficient information is provided to enable the Committee to carry out this role. The Chair clarified that at previous meetings the Committee had supported the direction of travel

for the Future Fit Programme, but there had been a number of caveats where members had said that additional work was needed. The Chair recognised that some of this work was still in progress and the Committee would continue to scrutinise these issues which included ensuring that hospital services are sustainable and that demand for community and primary care services in the clinical model could be managed. The Committee would not come to a formal view on the proposals until after the formal consultation period.

The Chair informed the Committee that after the last Committee meeting the Chairs had met with the Chief Executives at the Shrewsbury and Telford Hospitals NHS Trust (SaTH) and the Chief Officer / Accountable Officer for the CCGs. Following these meetings the Committee had agreed some questions which had been sent to the NHS on the 26th May. The response to these questions was received on the 8th June. The Committee met informally to consider the response and had requested clarification on a number of issues. The initial response and clarification had been circulated with the agenda for this meeting.

Members of the Committee had also received a submission from Shropshire, Telford and Wrekin Defend Our NHS. The Chair has spoken to the representative who had sent the letter and explained that questions from the public would not be taken at the meeting. However, some of the points raised may inform the future work of the Committee.

Prior to the meeting the Committee had agreed 4 main lines of inquiry which broadly cover the response from the NHS. The Chair confirmed that the Committee would consider these 4 issues rather than go through the response point by point.

First line of inquiry: Safety
The Chair said that there had been articles in the press which questioned the safety of the current A&E service at SaTH. The Committee asked for assurance that the A&E services provided are safe.

The Chief Executive of SaTH explained that the Trust is assured about the safety of services through a number of mechanisms and this is not carried out in isolation. Assurance is provided through the commissioning and contracting process which involves detailed discussions with clinicians, and with other external organisations including the Care Quality Commission and Healthwatch in Shropshire and Telford and Wrekin and the Community Health Council in Wales. The Committee was informed that all these organisations are aware of the frailty of the A&E service and that last week there had been external validation of the service when the West Midlands Ambulance Service validation process did not raise any concerns about either hospital site. However, the Chief Executive said that the Committee was right to ask questions about the frailty of the service as the staffing levels were only just

adequate and that the reduction in the number of junior grade doctors who will join in the August rotation was an additional risk. There were a significant number of gaps in the rotation for the Deanery which needed to be filled. Maintaining the safety of the service required constant vigilance.

A member asked how the Trust can maintain the service with low staff levels when other areas had closed the A&E department with higher staffing levels.

The Chief Executive from SaTH responded that the safety of the A&E department was also dependent on other services e.g. respiratory, gastroenterology and stroke. The role of the extended nurse practitioners also had to be taken into account. It was explained that it is important not just to look at the speciality but to take a team focus and this allowed the A&E to remain open. The decision has been made that the change to A&E services must be made in a planned way and it was important to find ways of keeping both A&Es open until then. The Chief Executive said he could not speak for other areas but in some cases the decision to close an A&E may have been taken without due diligence.

A member asked about the consequences of delaying the Future Fit Programme particularly on the Trust's ability to retain A&E staff. The Chief Executive of SaTH said that staff were aware of the implementation timetable and that once a decision is made it will take several years to implement. Staff had confidence that a decision would be taken and once the decision has been made other staff will join the Trust. If there were a delay the level of frustration for A&E staff would increase and the Trust could not afford to lose consultant staff without consequences.

Second Line of Inquiry: Activity and Capacity
A member asked how confident the Chief Executive was that 69% of current A&E attendances would be seen at an Urgent Care Centre and how the figures in the locality table which showed an average of 47% compared with the 69% previously quoted.

The CCG Chief Officer / Accountable Officer responded that the table related to walk-in activity.

The Chief Executive of SaTH said that the figures for the proportion of people who could be seen at a UCC were robust and based on modelling over a number of years. He explained that this would require the correct staffing and required commitment from the whole system. Another important aspect is the confidence of the public in the service. Where the system has not worked in other areas they have not got near 69% e.g. where the UCC is not on a hospital site and the risk appetite is lower. The Chief Executive of SaTH was confident that 69% of front door urgent care activity could be managed at Urgent Care Centres if there is work with Primary Care and the public

have confidence in the service. He also confirmed that in the Future Fit Model patients would not have 'walk in' access to the Emergency Department.

The CCG Chief Officer / Accountable Officer added that currently 20% of people who attend A&E can self-manage and the GP at PRH has shown that 27-26% of patients can be treated in primary care. When these figures are added together it makes the total of 69% more realistic.

A member also questioned the figure that 109,000 patients attend A&E per year which would mean that on average there were 298 per day. It was confirmed that the figures were correct.

A member highlighted that the figure of 69% urgent care patients being treated at a UCC seemed high considering the continued high number of patients attending A&E at RSH after the Walk In Centre/Urgent Care Centre had moved there from its previous location in Monkmoor.

The Chief Executive of SaTH said that this is based on a different model. When asked how long it would take to implement the new model for Urgent Care he responded that, based on the experience of the UCCs at Runcorn and Widnes, it could be done within 1 year and would need to be planned and implemented with the West Midlands Ambulance Service (WMAS) and other partners.

Members recognised that it would take time to train and recruit staff with the correct skill set. The Chief Executive of SaTH explained that some A&E staff would transfer and that having links between points of access would make it easier to attract staff. Staff working at the UCCs would have exposure to lower risk work and also have the opportunity to rotate through other services which will help to develop their career and retain staff. It was explained that for this to work the Emergency Department must not be isolated from the UCCs, and the UCCs must not be isolated from other settings.

A member asked about the additional work load that the Future Fit Model will place on GPs in primary care based on the figure that 40% of current attendances at A&E could be treated in Primary Care. What plans are in place to ensure that GPs will be able to cope as they are already under pressure, what funding will be available for additional staff and services in primary care and what outcomes will be expected?

The CCG Chief Officer / Accountable Officer responded that 35-40% of A&E patients could be seen and treated in primary care and this would be a challenge. It was clarified that that primary care included other professionals e.g. Advance Nurse Practitioners. The Neighbourhood work identified in the Sustainability and Transformation Plan (STP) included building resilient teams and improving access. It was confirmed that funding for the additional work in primary care has been built into

the plans.
A member asked how it was ensured that all the parts of the health and social care system would work together so that they plans did not fall down if one link was missing? It was recognised that it was particularly important to engage GPs in this work.

The CCG Chief Officer / Accountable Officer replied that the STP which was submitted the previous week would bring the different parts of the system together. The STP will enable the NHS to access funding and allow some double running of services. The CCGs were working with the GPs in the Shropshire localities and the Telford GP forum. Discussions were taking place about a different model for primary care and an expanded care offer.

A member expressed reservations that the GPs and primary care would be able to cope.

The CCG Chief Officer / Accountable Officer said that there are some reservations, but that if changes are not made the system will collapse. The concern for GPs is the additional work and how this is paid for. He explained that the additional resource in primary care could be staff or funding e.g. the staff and equipment to manage outpatient appointments in primary care.

A member asked about the figure of £6million in the plan to be invested in new primary community care and social care capacity and asked for confirmation if this was dependent on savings made in the system.

The CCG Chief Officer / Accountable Officer responded that the £6 million was built into the STP which includes the transformation money.

In response to a comment that the STP money needed to be used in many ways the CCG Chief Officer / Accountable Officer said that there are some nationally mandated areas of work e.g. 7 day working in primary care.

The Chief Executive of SaTH said that there was a joint narrative that was owned by all the boards in the county. He explained that it is not a simple process but that there are pockets of excellence. It was recognised that GPs are under pressure and to attract GPs to the area will require a different model. GPs will have to engage but they still question if it will work. As the prototypes develop they can then see how it will work and this will help to arrest their anxiety.

A member confirmed that the Committee understood that it is a complex process and asked for clarification on the number of staff that would be required in the acute hospital, in the UCCs and in primary care.

The CCG Chief Officer / Accountable Officer replied that staff employed by the hospital trust could work in or support colleagues in primary care. The example was given of respiratory patients. Follow up appointments could be held at a local level where either staff from secondary care would come out to provide this service or provide support using video conferencing. Each speciality will look at how it can work.

The Chief Executive of SaTH gave the example of stroke service. The early support discharge team supports patients at home rather than prolonging their stay in hospital. The Trust has a large work force and the staff do not have to work in fixed buildings. He explained that some models of care are unaffordable and that the funding for some services does not relate to the cost to provide it. There is a lot of duplication e.g. families receive visits from health visitors and other health professionals. It would be more efficient to have fewer visits which provide a wider range of services. The hospital must focus on improving wellbeing and the moment the services focus on diagnosis and treatment.

A member asked when the details of the new pathways will be available.

The CCG Chief Officer / Accountable Officer responded that within the next year there will be prototypes.

The Chief Executive of SaTH said that the work force plans need to be different from the current model. Some workers will still be needed in the long term but there are opportunities for local people to do things differently e.g. Assistant Practitioner roles.

Members questioned the predicted reduction in A&E attendances of 24% based on the preventative work on high risk factors e.g. smoking, high cholesterol and high blood pressure. Members were concerned that this was very optimistic.

The CCG Chief Officer / Accountable Officer responded that some preventative work will produce a change in the long term e.g. smoking. However, addressing other health issues such as blood pressure and diabetes has a much shorter lead in time and can have immediate results. He explained that the preventative work was broader than the usual public health messages and included issues such as reducing falls for older people.

A member asked about the 4072 patients that would be seen and treated through the rural urgent care service. It was highlighted that across the 5 areas this did not seem a high number. The Member asked if the money for this service would be better spent on prevention?

The Chief Executive at SaTH responded that the effect of preventative work will be cumulative and that there is good evidence from other areas that where there is a focus on the wellbeing agenda this had a direct impact on health and money can be invested in other preventative areas.

The Executive Director of Nursing & Operations from Shropshire Community Health Trust added that the basis of the STP is to join up health and social care. He said that Shropshire and Telford and Wrekin was starting from a relatively low base on wellbeing and so the plans were prudent. Where people are treated as individuals this saves money.

The Chair said that the Committee has not questioned the principles of improved prevention or the principles of the STP. The Committee was trying to make sense of a difficult and complex programme, and wanted to know if this would work given the resources available and the speed that was necessary to meet the timescales. He recognised that some of the processes are enormously difficult to achieve in a short space of time. The concerns expressed by the Committee do not dispute the objectives but question can it be achieved?

The CCG Chief Officer / Accountable Officer responded that the local health economy was currently spending money it did not have. He added that it could be argued that the current funding is not enough but that the local organisations believe that the change set out in the Future Fit Programme is the right change and that this must be financially and clinically sustainable.

The Chief Executive of SaTH said that the programme is achievable and that organisations must stop doing things that do not contribute to this agenda. Part of this must be to reduce the number of meetings and bring in experts to provide support if needed. He explained that it is incumbent on a chief officer to take the difficult problems and work with the community to provide solutions. He gave the example of recruitment of medical staff where a married couple are both qualified medics and how both clinicians in primary care and the acute hospital could be employed to work in the area. He added that there is the determination to make this work and that it was the first time that all the Chief Executives had accepted that this is the one agenda.

A member asked about rural areas as the discussion focussed on urban areas. The information on the travel times was not accurate and concerns were also raised about treatment by a paramedic as the ambulance response times were so poor. The point was made that health services need to improve for everyone. Further information on the work in other rural areas was requested and also reassurance that the role of the West Midlands Ambulance Service (WMAS) is included in the planning for future services.

The Chief Executive of SaTH said that it was a fair point that the roles of the WMAS and mental health services were not recognised in the STP submission and that this would be amended. He added that the Board will want to see a level of evidence, but that it is important not to spend too much time analysing data and work should start where there is evidence that things work

A member commented that the issues faced by rural communities were much broader, for example, housing and infrastructure cost much more in rural areas.

The Chief Executive of SaTH said that he recognised the higher cost of delivering services in rural areas and that changing services does not always mean that it will be cheaper, but the decision should be made because it is the right thing to do.

Third line of inquiry: Interdependencies with other programmes
The Chair said he wanted to move the discussion on to the issue of the interdependencies between the Future Fit Programme, Community Fit and Rural Urgent Care Centres. He explained that the Committee's concern for some time has been that other areas of work had not been as advanced as members would have liked and that this had been recognised by the local NHS organisations. The written response to the Committee's questions had been that a prototype was being developed but the question remained that if this shift in activity does not happen what are the implications for the acute sector? The Committee was being asked to hope that the Community Fit Programme and Rural Urgent Care services will take the pressure off. The worry for the Committee was that if this does not happen that the UCCs and Emergency Department would become overwhelmed.

The Chief Executive of SaTH said that focus of work had been on Future Fit, but that 75% of the STP focussed on resourcing and architecture for neighbourhoods. He explained that it is not difficult to design hospital services but the support and infrastructure for community services more challenging. What he heard the community saying is that there is a lot of good work and this must be brought together in a single narrative and should not be separate projects.

The Chair said he understood that Telford and Wrekin Council had made progress with the neighbourhood work, however his concern remained the timeframes and the amount of work that needed to be achieved in a relatively short space of time.

The Executive Director of Nursing & Operations said that clinical design meetings had taken place which included the WMAS and Shrop Doc. He agreed that it was important to get Community Fit right and then the hospital services must follow. He explained that one size does not fit all and that it is important to map out the services that are currently available.

The CCG Chief Officer / Accountable Officer said that 6 different pathways were being developed with GPs and public health. This work was being done at pace and should be available in the next 3 months.

The Chief Executive of SaTH said that he was not able to turn back the clock and that the hospital does not have time for another delay to the Future Fit Programme. If there is a delay the hospital would not be there. He explained that there is the determination to continue the work and the public want a decision to be made.

The Chair asked if the work on Community Fit and the other related programmes would be included in the Future Fit consultation.

The Chief Executive of SaTH confirmed this information would be included in the consultation.

The CCG Chief Officer / Accountable Officer said that Primary Care colleagues had made it clear that resources must follow the services that will be required in primary care. This message has been sent clearly to the CCGs.

A member asked how the wider message about health improvement was communicated to the public.

The Chief Executive of SaTH replied that more can be done by the NHS to influence the choices that people make that affect their health. He said that communities are resilient, some rural communities have had to be, but not all areas are at the same level. Diabetes, mental health and falls for older people are all areas where people can be helped to help themselves.

Fourth line of inquiry: Finance

The Chair said that the final area the Committee wanted to explore was finance and how the deficit was going to be addressed. He asked how robust the figures for the Future Fit Programme and the STP are and if the programme is aspirational or achievable?

The Chief Executive of SaTH responded that if you do not believe that it is achievable it will fail. He added that the honest answer was that he did not know, but that there is currently duplication and complexity which cost the Trust. The current staffing and rotas means that the Trust is not an attractive place to work. He said that there is a good evidence base that what is in the plan can be achieved and that using technology can reduce waste. The Trust can learn from primary care about how to reduce the amount of paper used. He said that if what is planned is not enough he did not know what more could be done.

A member asked about the added pressure on carers and family if patients have to go out of county to receive care.

The Chief Executive of SaTH gave the example that patients from Telford and Wrekin and Shropshire can go to Stoke to have a procedure that is carried out by a consultant from SaTH. The patient is then seen as an outpatient at SaTH. He explained that where it is sensible services should be provided in county and some service could be brought back.

A member asked about the health economy's ability to make savings. There were a lot of assumptions in the responses given to the Committee about savings but the Trust had not delivered the Quality Innovation Productivity and Prevention (QIPP) savings.

The Chief Executive of SaTH responded that the Trust had saved £50 million and that the local authority had also saved a huge amount. If an organisation is only making cuts this makes people anxious, but if the savings can be made by removing waste and variation this provides more confidence. There is a collective view on the way forward and there is good external scrutiny of the programme. He explained that it is a hard process and that in 18 months' time the Committee would be able to see if it had been successful.

A member commented that making changes to influence choices people make that affect their health requires political will and gave the example of the reduction in smoking since the smoking ban in public places.

The Chief Executive of SaTH responded that there are changes that can be made at a local level e.g. removing the sugary drinks vending machine in the paediatric department at the hospital. It has also been recognised that Council's licencing function has a role e.g. take-aways near schools. He said it is important to support families and that changing attitudes takes time but it can be done.

In response to a question about the implications of Brexit, the Chief Executive of SaTH replied that it did not help to become frightened about things that local organisations have no control over. The Future Fit Plan and the STP is the starting point and if local organisations are doing the right thing then this will determine the cost.

The Chair concluded the discussion and said that the Committee would continue to look at the issues of safety, activity and capacity, interdependencies with other programmes and funding for the Future Fit Programme. He recognised that the views of the Clinical Senate and the outcome of the non-financial option appraisal would be key stages in this work. He informed the Committee that enquiries were being made

regarding a visit to the Urgent Care Centres at Runcorn and Widnes to inform the Committees work.

RESOLVED that:

a) **the progress of the Future Fit Programme and the submission of the Sustainability Plan be noted**
b) **arrangement be made for Committee members to visit the Urgent Care Centres at Runcorn and Widnes**
c) **the Committee agree further questions to scrutinse the progress of the Future Fit Programme**

HACSC- 6 Update on the consultation and engagement if the procurement of the Child and Adolescent Mental Health Services for Telford and Wrekin and Shropshire

The Chair invited the Deputy Executive for Commissioning and Planning (Integrated Care) at Telford and Wrekin CCG to present the report on the procurement of the Child and Adolescent Mental Health Services.

The Committee was informed that the CCG had worked with Experienced Led Commissioning (ELC) to get the views of children, young people and their families and carers, professionals, community groups and organisations. This had provided valuable information which will inform the commissioning of the Emotional Health and Wellbeing Service.

The report set out the 10 high impact actions that had been developed through the commissioner challenge process with ELC.

A member said that she remained concerned that the service was not cohesive and that there were long delays. As a school governor she was concerned that if children were not self-harming they were not seen as a priority.

The Executive Director of Nursing & Operations, Shropshire Community Health Trust, said that children and young people were waiting an unacceptable length of time and he recognised that the uncertainty during this period affects the child or young person and their family.

There was a discussion about the referral process and it was confirmed that in Shropshire referrals should be made through Compass. An example was given by a

member where the referral process had not worked. The Executive Director of Nursing & Operations from Shropshire Community Health Trust said he would look at the details of this case outside of the meeting.

A member asked about referrals to the service made by schools, particularly smaller schools that do not have specialist staff.

The Deputy Executive for Commissioning and Planning informed the Committee that schools have a responsibility for pupils with mental health issues. The question for the NHS is how the new service will work with schools so they can deliver what they should and how the school interfaces with NHS services. She clarified that the new service will not take on the responsibility for services that are the responsibility of schools. Smaller schools that do not have specialist staff can buy in support as a traded service.

The Head of Nursing for Children & Families from Shropshire Community Health Trust said that there is an example of a school buying in the services of a school nurse which helps to support the emotional health and wellbeing of pupils.

A member commented that a larger primary school may have the budget to do this but smaller schools would not have the resources. The Head of Nursing for Children & Families responded that smaller schools could work together to buy in this service.

The Chair said that the Committee had been very impressed with the level of engagement in the development of this service. He asked how the people who had given their views would be informed about the service as the procurement process continued.

The Deputy Executive for Commissioning and Planning replied that letters had been sent to people who had attended the engagement sessions and that a group of young people had been asked to design the questions for the Invitation to Tender process for providers.

The Chair said that young people need to see a change in the service. He was concerned that the resources may not be sufficient to meet the level of demand. He added that the process outlined showed that the CCG was doing all it could to get the views of young people. He asked when the service specification would be available for the Committee.

The Deputy Executive for Commissioning and Planning said that the final edit on the service specification would be made the following week, the 4 organisations involved would sign off the service specification on the 18th July and the invitation to tender would be issued on the 8th August.

The Chair said that due to the tight timescales it would not be possible for the Committee to meet to consider the draft service specification. He requested that the Chairs of the committee receive a copy to make any comments before the 18th July.

The Deputy Executive for Commissioning and Planning confirmed that the draft service specification would be sent to the Chairs for comment.

RESOLVED that:

a) **the Committee note the progress on the procurement of the Emotional Health and Wellbeing Service for Telford and Wrekin and Shropshire**
b) **the Committee chairs consider the draft service specification**

HACSC- 7 Chair's Update

The Chair informed the Committee that there had been media reports of the relocation of stroke services from the Royal Shrewsbury Hospital. He informed the Committee that he had received a letter from the Chief Executive of SaTH explaining that the change had been made quickly due to two consultants leaving unexpectedly and that this was the reason the Committee has not been informed. He invited the Committee's co-chair to comment.

The co-Chair said that he had also received the letter and he had accepted that the Trust was a difficult situation and that replacement staff were being sought. He recognised that this was more of an issue for patients in Shropshire and the Chief Executive of SaTH had been asked to keep Shropshire's Health and Adult Care Scrutiny Committee informed of progress.

The Chief Executive of SaTH said that he was meeting a candidate the following week and if appointed the consultant role would be filled in 3 months. He confirmed that the relocation of the stroke rehabilitation services was temporary and that the service would move back to Shrewsbury. He recognised the effect of the move for patients' families who have to travel the extra distance to the Princess Royal Hospital. The Chief Executive of SaTH had been asked at a meeting of the Trust Board about the process through which he and the Board had been informed about the decision to relocate the service. He informed the Committee that this was being investigated. He apologised that the Committee chairs' had been informed of the relocation of the service on the Thursday before the move had taken place.

The Scrutiny Specialist said that a copy of the letter to the Joint HOSC chairs had been sent to members of the Committee and paper copies were circulated at the meeting.

RESOLVED that the Chair's update be noted.

The Meeting ended at 12.57am

Chairman: .....

Date: .....

Key Findings from Visit to Widnes and Runcorn Urgent Care Centres

Friday 9th September 2016

Present: Cllrs. A. Burford (Joint Chair), G. Dakin (Joint Chair), J. Cadwallader, R. Sloan,

Co-optees: D. Beechey, B. Parnaby

In attendance: K. Subramanian, R. Thomson, D. Moseley, F. Bottrill

The model for the Urgent Care Centres at Widnes and Runcorn were developed:

- In response to the increase in attendance at the 2 A&E departments which were located outside the local area
- To provide access to urgent care services closer to home
- To respond to identified need and to improve the wellbeing of the local community through the Healthy Town programme.

It had been recognised that attending an A&E department was not always necessary – and that there could be better ways of meeting patients' needs. The example was given of frail elderly patients. Where these attend A&E many are admitted. When discharged 30% would have improved, 30% would be about the same as before admission and 40% could be worse from a functional perspective.

The Urgent Care Centres opened in 2015 and while they both work to the same service model the setting is different. Previously there had been a Minor Injuries Unit at Runcorn and a Walk In Centre at Widnes.

- **Widnes UCC**: Based in a community setting in the same building at 3 GP practices and the GP out of hours service. The service is commissioned by Halton CCG and provided through the Community health provider, Bridgewater Community Healthcare NHS Foundation Trust
- **Runcorn UCC:** Based in a hospital setting and is provided by an Acute Trust, Warrington and Halton Hospitals NHS Foundation Trust.

Both UCCS are open from 8.00am – 10.00pm and provide diagnostic services. If a patient needs to be seen by a specialist they are referred directly to that department so they do not have to go through A&E.

The medical and nursing teams working at the UCCs are

Band	WTE Runcorn	WTE Widnes
Doctor		
Nurse Manager Band 8a	1.0	1.0
Nurse Clinician Band 8a	2.0	2.0
Nurse Co-ordinator Band 7	5.0	5.0
Clinical Nurse Band 6	7.0	7.0
Clinical Nurse RSCN Band 6	3.5	3.5
Clinical Nurse Development Band 5	3.5	3.5
Health Care Assistant Band 3	3.5	3.5
Administration Staff Band 3	7.0	7.0

The target is to initially clinically assess patients on arrival within 15 minutes using the Manchester Triage guidelines. Patients are triaged as Green (seen in 4 hours) Yellow (seen in 1 hour) Orange (seen in 10 minutes) Red patients – the UCCs do not see many Red patients but are trained to identify patients who require immediate acute care. The example was given at Runcorn UCC where a patient with vascular issues was transferred by helicopter to the acute service. 85% -95 % of patients at Widnes are triaged within the 15 minutes. It was discussed that when the service is quiet that a full triage may not seem necessary. Patients may be seen and treated during the initial assessment.

It was recognised that seeing all patients in 15 minutes provides reassurance for the patients and complies with clinical safety when the waiting time is longer. The average time from booking in to discharge is currently 54 minutes at Runcorn and 58 minutes at Widnes.

The service works to the A&E target that patients should be seen, treated and discharged / admitted within 4 hours. The target is to see 95% of patients within 4 hours. It was reported at Widnes that 99.2% of patients were seen within 4 hours. At Widnes 2.9 – 3.1% of patients are referred from the UCC to the acute hospital. It was commented that this is the same rate of transfer as the previous minor injuries unit – but many of these patients would have been referred for x-ray which can now be provided at the UCC. The type of patient now referred to the hospital are more acute.

Both sites have the equipment and staff to take x-rays and blood samples. Some blood samples are taxied to the pathology service and the result returned within 90 minutes of receipt. There are some Point of Care testing available on site.

Both sites have observational bays where adults or children can be observed for up to 4 hours. Runcorn UCC has a separate paediatric area with a waiting area and 2 observation bays. The aim of the observation bays is to ensure that a patient's condition does not deteriorate and if it does an appropriate referral can be made. This has reduced the number of zero hour admissions at A&E.

Neither site has direct access to bed provision. Intermediate care referrals are made through the Local Authority RARS process and referrals to hospital services are made through existing pathways.

The UCCs do not provide obstetrics or gynaecology services on site – patients would be referred on. However, there is a pathway for women who have a bleed early in their pregnancy who come to the UCC. If a woman went into labour at the UCC the ambulance would be called and the patient would be transferred or the paramedics are trained in delivery.

The UCCs work with mental health services. An assessment may be carried out over the phone with the mental health provider, this relies on the skill of the UCC staff. In some cases an assessment can be carried out at the UCC. (The service developed by the Police and CPN team has reduced the number of people sectioned by the Police and who receive a criminal record. The CPNs are in the patrol car with the police and respond to incidents. (This service is jointly funded with the police)

The service closes at 10.00pm so there is a close down procedure. If the service is busy toward the end of the day or patients arrive close to 10.00pm they may be advised to come back in the morning, see the out of hours primary care service or directed to A&E (however this referral route is not used unless necessary)

The decision to close the service at 10.00 was discussed. This was on the basis of the current patterns of the services used and that the existing A&E and Out of Hours services would continue. Providing a night time service also presents issues regarding patients who have consumed alcohol which would be difficult to manage in a small stand-alone unit at Widnes or Runcorn.

There is a recognisable pattern to the attendance at the UCCs. E.g. an increase in sports related injuries for 11-14 year olds in the morning at weekends.

Where a patient from requires transport from the UCC to A&E this would be provided if necessary but where patients could provide their own transport this was encouraged.

There are plans to use the UCCs to train other GPs and nurses in urgent care. This can help them develop a portfolio career and fits with the role of the GP Federation in developing GP providers.

IT

The UCC IT system at the Runcorn site is linked with the A&E/hospital system (Lorenzo) so information can be shared. Whilst System One is used at Widnes. Although GP's use a different IT system, EMIS, electronic discharges have been introduced which enables GPs to have as close to real time access to information about their patients who access the UCC or who are referred there. GPs do not have to wait several weeks for a letter from the hospital to know if the patient required further treatment and if this needs to be followed up in Primary Care.

It is the intention to introduce the same system; EMIS, used by GPs in Halton into both the UCCs.

Impact of UCC on A&E Attendance

A&E attendance has reduced by 8% during the time that the UCCS have been in operation. This is compared to the continued increase in A&E attendance in other areas. While it is difficult in a complex system to directly attribute the reduction in A&E attendance to the UCCs it is noticeable that the reduction in the use of A&E correlates with the increase in attendance at the UCCs.

There have been occasions where the A&E department has been particularly busy and non-emergency patients have been transferred from the A&E to the UCC. This demonstrates the confidence that the A&E staff have in the UCCs.

How the Model of the UCCs was Developed

The model for the UCCs was developed locally by clinicians – it was important the CCG did not develop a service specification and present this to the providers. 11 different organisations were involved in developing the UCCs. The model used to develop the UCCs allowed the clinicians to take ownership of the design and delivery of the model. An example was given of the DVT pathway which previously excluded many patients in the community based facility – under the UCC model the only patients who cannot be assessed are pregnant women.

Staff from the Local Authority and the CCG were co-located. There had been good partnership working before but working at the same site improved this. Both organisations had to recognise that doing things differently did not just apply to the other organisations and that there had to be compromise on both parts. It was important that the public saw that the NHS and local authority were united behind the proposals (see comments later about compromise with public) Developing the service is a difficult process that requires commitment from all the partners. It could fall at a number of stages but once the vision has been agreed it is important that organisations continue to work together and deliver this. It is important that there are the right staff with the right skills to support the development of the service and leadership must be provided right at the top. Local communities put faith in elected members – it is important that they understand and can articulate how and why the service is being developed.

Timescales can be contentious – it can be problematic if the timetable slips.

It was seen that the development of the UCCs would be an opportunity to improve the wider health, wellbeing and resilience of the local communities. It is important to understand where patients go to access services – local geography and community identity is important and needs to be taken into account. When people are referred from Widnes UCC to an A&E they have a clear preference on where they want to go depending on where they live. Both A&Es are about the same distance from the UCC.

The clinical pathway reference group continues to meet bi-monthly to review the data on attendance and patient flow and acuity, the current pathways, clinical skills, new pathways that can be developed.

It was discussed that it was essential to involve the ambulance service in the development of the service model and the pathways of the UCCs.

The UCCs are ‘kite marked’ with the Ambulance Service so paramedics will bring patients who are triaged as Green or Amber. The Ambulance staff would often phone the UCC staff and discuss the case with them to see if it can be managed at the UCC.

It was discussed that the model of General Practice in Primary Care is changing. Individual practices have their own pressures – but how can GPs work together for the whole health and wellbeing of

population. There was a discussion about the role of the GP Federations. All GP practices currently have a wellbeing offer which includes volunteering.

Estate is an enabler for change. It is recognised as part of the Sustainable Transformation Plan. The feedback from many GPs is that they do not want to own buildings and there is an opportunity to bring GPs together with other services.

Finance - Behind the work on the clinical model there is a lot of 'behind the scenes activity'. In developing the UCCs resources were not taken away from A&E. Finances were found from within the system. There was an additional investment of £ 1.2 – 1.3 million.

The view was that patients who attend the UCC needed health care. While some of them could have been seen in primary care it was reported that this was not an issue that needed to be pursued. GPs would have access to the advice, treatment, tests or referral that their patient would have been given. This highlighted the point that the UCC had to be 'primary care facing' as well as facing the A&E departments.

Work has started in developing a guide to developing a UCC – this may be available towards the end of the year.

Staffing

It has been difficult to recruit staff with the right skills for the UCCs. When recruiting nursing staff the requirements were:

- Clinical experience
- Diagnostic skills
- Prescribing (Desirable)
- Paediatrics (These skills are in very short supply)

The services have 'grown their own' staff who have completed further qualifications in Urgent Care, Minor Injuries and Masters qualifications in paediatrics and adult assessment and management.

It has been difficult for the Community Service to recruit GPs for the UCC – the posts have gone out to advert 3 times. The GPs currently providing the services are employed through an agency.

The new Job Description for the GPs at the UCC involves rotation with the Emergency department as well as working within the UCC.

One of the difficulties in 'growing your own staff' is that this takes time and when qualified they are very sought after and may move to another job.

Public consultation, engagement and view of the service

The UCC services have not been formally launched – there has not been a public opening ceremony. The use of the centre has been through word of mouth and the reputation of the service. Information is available on line and supported with posters, radio adverts etc. It was felt that it was important not to raise expectations about the service too much when it started.

It was recognised that for patients the distance to an A&E was important – in Shropshire this would be up to 35 miles. This means that as well as the model for the urban urgent care centres it is important for Telford and Shropshire to consider rural urgent care centres / services as well.

There is a high rate of satisfaction from patients who use the UCCs. Healthwatch has done a user satisfaction report on both UCCs. (see attached)

As well as responding to the concerns of patients and the public it was also important to help them to understand that some compromises would have to be made to achieve a viable service.

The feedback from patients was that a doctor had to be at the UCCs. It was reported that while approximately 5% of patients need to see a GP it was essential that a GP was there and that the diagnostic services were available so that people had confidence in the service. It was very important that people understood that they would not be seen at the UCC and just referred to the A&E.

From a patient perspective they were not particularly interested in the detail of the pathways. They wanted to know: is the service credible and does the treatment help me and make it easier for me to access the care I need.

The local history of the health services was important. When Halton hospital had opened it was anticipated that an A&E department would be provided as a later date on this site. This had not happened and it became clear that this was not going to happen. When people were asked what they wanted from a UCC they were clear that there had to be a doctor on site – if there was no doctor they would go to A&E. It was recognised that while Runcorn and Widnes does not have a rural population the issue of equity between communities is important. There was some resistance to the development of the UCC – change can always be unsettling. Initially one of the issues was that the service was developed at Widnes and people felt that there was nothing at Runcorn. It was stressed that it is important to listen to want the local population are saying and respond to the issues that are important to them.

Parking became a very important issue for the UCCs. There was a commitment to providing free car parking for people accessing the UCCs. This meant that as:

> Runcorn: The hospital operates an automated registration recognition system. Patients going to the UCC here give their registration at reception and this is inputted in the system so not charge is made.
>
> Widnes: There was limited parking on the UCC site. It was a very important issue for local people. The Borough Council had a policy that no parking charges would be made in the town centre and this means that the CCG could not generate income from charging for parking. To respond to these concerns the CCG changed its constitution to that it could hold a lease on land and a car park was then developed. Income has been generated from the

electricity substation and the walls around the car park are being used to promote healthy messages through a mural.

Parking can be an issue for local residents – this concern is passed on to ward members.

It was recognised that 'you can never tell people enough'. It is important that the message about the service and why it is being developed is repeated. Local organisations need to be involved.

The consultation must be as transparent as possible with the public and staff. Where staff are involved in developing a service they take pride in it. Doctors, nurses and ambulance staff can all help get the message across to patients.

Other documents

Report by Durrow (2010) – Providing Acute Care Locally

Healthwatch Reports

Response to Joint HOSC Questions

Question	Lead	Response
RISK		
Since the Joint HOSC meeting on the 5th July has there been any change in the level of risk for services which either significantly change the safety of the services provided by SaTH?	Julia Clarke	The risk in Critical Care remains unchanged and is risk-rated 20. The risk in ED is slightly reduced from 20 to 16 as the Consultant on sabbatical has returned to post. Also the Trust has agreed to step outside the national capped Agency rate to pay more to two locum consultants in order to retain them and prevent further fragility. However the Trust still only has 6 substantive consultants compared to 30 at Stoke (who have agreed to support us by providing some consultant support on a Monday). Although not currently on the Risk Register there may be a problem with middle grade medical cover at ED. there has also been a problem maintaining the Stroke service across two sites due to medical manpower shortages, which should be resolved in September, but the
CLINICAL MODEL		
What progress has been made in agreeing the process for the clinical senate review of the proposed options? Is there any feedback from the clinical Senate that can be given to the Joint HOSC to inform the discussion during the visit to the UCCs in Runcorn and Widnes?	Debbie Vogler	The Senate review has been provisionally scheduled in for 17th-21st October. This timeline is based on their position of a need to have a preferred option to review and that the option appraisal on 23rd and CCG Board meetings on 11th and 12th October to receive the recommendation need to take place prior to the review. Documentary evidence in line with a senate checklist will be forwarded early
What progress has been made to develop the patient pathways for specific illnesses e.g. respiratory illnesses? Please give examples of the pathways that have been agreed. What services will be provided in primary care, what in community care, UCC, RUCC and ED? How are these plans being developed with and communicated to colleagues in Primary Care, social services and community services?	Emma Pyrah	6 pathways have been chosen for pathway development: COPD, Frailty, Diabetes, Heart Failure, Renal and MSK (focus on falls and fractured neck of femur). The Future fit/Community Fit team are supporting the co-ordination of multi-stakeholder groups to develop the pathways over the next 4/5 weeks. Diabetes and Renal have now met and dates are (or are being) scheduled for the others. A set of guiding principles has been agreed by the overarching Community Fit Clinical Design Group to inform pathway development. The pathway development work is at too early a stage to give examples of what services will be provided where and by whom but the groups task is to define this within each of the pathways as well as the activity and workforce assumptions. Membership of the pathway development groups includes primary care, public health, community and acute clinicians and patient reps. Once the pathways are drafted and signed off by the
DEFICIT REDUCTION/STP		
Please provide details of the Deficit Reduction Plan for STP area, including details of any substantial variation or development in service resulting from this plan.	Neil Nisbet	Please see attached paper

Please provide details of the Medium Term Financial Plan for Shropshire CCG which show how the Shropshire CCG deficit reduction plan will be eliminated, including details of any substantial variation or development in service resulting from this plan.	Andrew Nash/Ilse Newsome	Whilst the CCG is in dialogue with NHS England in respect of the measures required to deliver the Medium Term Financial Plan, including any potential service variation, it must consider the wider implications of taking necessary actions including the protection and safety of the patients it serves . The agreement and approval of the Medium Term Financial Plan is scheduled for the late summer period and will be link in with the STP system wide deficit recovery plan . The Plan will be shared with all stakeholders after formal adoption and sign off
What progress has been made to develop the locality / neighbourhood working as set out in the STP? How are these plans being developed with and communicated to colleagues in Primary Care, social services and community services?	Andy Layzell	Please see attached paper
URBAN URGENT CARE CENTRES		
What progress has been made to determine the services that will be available at the Urban Urgent Cares? How are these plans being developed with and communicated to colleagues in Primary Care, social care and community services?	Kate Shaw	The services available at the Urban Urgent Care Centre are based on the algorithm developed by the clinical teams in Future Fit. The Future Fit Clinical Groups of which Primary Care were involved agreed which injures and illnesses could be seen in an UCC and what would need to be seen in the ED. This was based on a set of indictors such as what diagnostics are required. This then determined what the service would look like. Following the initial work undertaken by FF, SSP has worked with the clinical teams to agree a draft service specification for UUCC which has been shared with Future Fit. The role of the UUCC is being discussed as part of our on-going programme of engagement with GP practices
RURAL URGENT CARE CENTRES		
What progress has been made to develop the rural urgent care service prototype for Bridgnorth? How are these plans being developed with and communicated to colleagues in Primary Care, social care and community services?	Emma Pyrah	A small working group has been established to define a preliminary proposal for the scope of the rural urgent care prototype offer for Bridgnorth. This group includes CCG commissioner, 2 GPs, Shropcom Executive lead and the Community Hospital Manager. Following the next working group meeting on 17th August the plan is to widen the membership of the group to include wider stakeholder partners including patient representatives to further refine and agree the prototype model. The primary focus for the prototype will be related to frailty and admission avoidance.
GOVERNANCE AND TIMESCALES		

What is the process to sign off the Future Fit proposals for consultation? What has been the process for continued engagement with GPs? What is the process and timescales to seek endorsement for the preferred option from the Local Medical Committee? What is the timescale for both CCG Boards to agree the preferred option for consultation?	Debbie Vogler	The Communications team are currently setting out an engagement plan to gain feedback on the content of the consultation plan and approach. The draft consultation plan will go to Programme Board for approval in November and on to the CCG November Board meetings (currently 8th and 9th November). The start date in December is yet to be confirmed. The period of consultation needs to take account of Xmas/New year holidays and purdah. GP engagement continues through the pathway development work. 6 end to end pathways are being developed initially to demonstrate how a more integrated delivery model would work that supports the shift from acute to community provision and the assumptions within the SOC. Within the STP the work around locality provision is being progressed through the Neighbourhoods work streams. GPs are engaged in both these pieces of work. During September and October presentations to GP locality Boards and the Telford Forum will take place. The Clinical reference Group will also meet on 7th September to receive and further develop
What other service reconfigurations are taking place across the West Midlands and Wales that may impact on the Future Fit proposals? How are these plans being taken into account as part of the Future Fit Programme?	Debbie Vogler	The Programme Team have regular conference calls with Powys LHB and Betsi Cadwallader UHB. A link with the Programme Director for the Mid Wales Collaborative and their plans around the single integrated change programme, has also been made through this route. For example, the acute Trust have been involved in discussions around networked specialist services to Bronglais Hospital. We are aware of the business case for the Sub regional neonatal intensive care at Glan Clwyd Hospital. The access modelling which forms part of the appraisal and IIA process will show any potential impact on other providers through choice or ambulance journey times . Through our ongoing engagement with Wales, Wrexham Maelor have requested access data on the options and are particularly interested in urgent care and obstetrics services impact of the options on them as a provider. Powys LHB and NHSE are represented on the Programme Board and any plans for

Deficit Reduction Plan

1. Methodology

In establishing a financial plan for the Shropshire Health Economy, the community has committed to ensuring that each of the predominant health bodies operating within the system, are through the actions taken, able to record by the year 2020/21 a balanced financial position. In making this commitment the system also recognises the need to respond appropriately to the challenges also being experienced by local authority colleagues, and will do so in ultimately finalising its plans for the years 2016/17 – 2020/21.

The scale of financial challenge is significant. Collectively the two clinical commissioning groups responsible for commissioning healthcare for the populations of Telford and Wrekin and Shropshire enter the 2016/17 financial year with a sizeable financial deficit amounting to circa £19.9 million. Provider organisations within the community similarly take into the planning period a structural financial position that will require important decisions to be made to ensure that the provision of services can be sustainable into the future. The size of structural deficit within providers is calculated as amounting to £21.5 million.

Over the period 2016/17 to 2020/21 the collective level of resource available to commission healthcare is planned to increase by £119 million, such that by the year 2020/21 the level of resource available amounts to £884 million. Contained within this, exists a dedicated sum amounting to £33 million available to support the health economy in delivering its transformation plans. Despite receiving this level of increase the combination of demographic growth and inflationary pressures across commissioning spending results in a shortfall that will need to be recovered through new more efficient ways of working. The level of shortfall is estimated to amount to £16.7 million.

Collectively the three provider organisations identified within the Shropshire system and transformation footprint, The Shrewsbury and Telford Hospital NHS Trust, Robert Jones and Agnes Hunt Foundation Trust and Shropshire Community Trust estimate increased pay and non-pay costs will introduce a further £65.8 million cost pressure over the years 2016/17 to 2020/21.

Accordingly allowing for the need to address opening structural financial problems and spending growth in response to inflation and demography, sets a recurrent financial challenge for the health system amounting to £123.5 million.

	Commissioners	Providers	Total
	£millions	£millions	£millions
Structural deficit	19.5	21.5	41.0
Inflation / Demographic cost pressures	16.7	65.8	82.5
	36.2	87.3	123.5

In responding to this scale of financial challenge provider organisations have committed to delivering internal efficiencies within their respective organisations. For The Shrewsbury and Telford Hospital NHS Trust and Robert Jones and Agnes Hunt Foundation Trust this is assumed to be equivalent 2 per cent per annum, the average level of efficiency saving to be delivered by Shropshire Community NHS Trust amounts to 3.6 per cent per annum. Delivering this level of savings generates cost reduction amounting to £53.7 million. In addition to these internal efficiencies, the Carter Review highlights further cost reductions , particularly in respect of Agency premiums of medical and nursing staff, improved workforce management and benefits from greater consolidation of back office functions. These are estimated to introduce additional cost savings amounting to £8.8 million.

Beyond activities associated with internal efficiencies, the local health system has identified a series of important transformational activities to reduce the scale of financial gap and restore financial balance. These transformational activities are summarised in the table below.

	£millions
Repatriation of Income	12.0
Rebasing of Orthopaedic spending – as per right place benchmarking	4.5
Community service reconfiguration	6.0
Reconfiguration of hospital services	22.0
Rationalisation of Acute services	3.0
Consolidation of provider organisations	1.0
Utilisation of Transformation funds	10.5
Other – transferred to Health bodies outside of STP	9.0
Total Transformation savings	68.0

- Repatriation of Income – The two local commissioners are presently commissioning activity from NHS provider bodies operating outside of the local health economy. A detailed review is being undertaken to determine the opportunity to re-establish such spending locally. It is estimated that doing so would generate a financial benefit to the health system of £12.0 million.
- Rebasing orthopaedic spending – The right place benchmarking programme has identified that Shropshire County CCG is an outlier in respect of spending in relation to orthopaedic services. Commissioning at levels consistent with benchmarked CCG's reduces spending by £4.5 million.
- Community service reconfiguration – providers and commissioners within the health and social care system are presently working to develop new integrated pathways of care structured around definable neighbourhoods. It is envisaged that these new models of care will lead to cost reduction of circa £6 million per annum.
- Rationalisation of Acute services – Secondary and Tertiary care services are presently provided within the health system through three hospital facilities located in Shrewsbury, Telford and Oswestry. A programme of work has commenced to determine the level of savings possible though a rationalisation of the services provided on these three sites. It is estimated that this can be expected to generate savings amounting to £3 – 5 million per year.

- Consolidation of provider organisations – Three provider organisations and two clinical commissioning groups presently exist within the Shrewsbury and Telford heath system. In taking forward the transformation programme it is intended to review opportunity to consolidate these various organisations.
- Reconfiguration of hospital services – In response to significant operational service challenges The Shrewsbury and Telford Hospital NHS Trust has developed a case for reconfiguring the delivery of its hospital services between the existing Shrewsbury and Telford hospital sites. The intention being to establish a Hot and Warm secondary care clinical model. In order to take forward this change requires availability of £300 million capital resource. Consolidation of clinical services is expected to generate cost savings amounting to £22 million as a consequence of reduced levels of service duplication, revised working practices and improved efficiency in the utilisation of the facilities.
- Utilisation of Transformation Funds – The financial plan for the health system has been set to enable the provider organisations and commissioners to deliver a financial surplus consistent with Business Rules. The level of Transformation Funds required amounts to £6.5 million.

The financial position for the health economy can then be summarised as follows:

	Commissioners	Providers	Total
	£millions	£millions	£millions
Structural deficit	19.5	21.5	41.0
Inflation / Demography cost pressures	16.7	65.8	82.5
Local Health system deficit	**36.2**	**87.3**	**123.5**
Provider Trust efficiency programme		(53.7)	(53.7)
Carter Review savings		(8.8)	(8.8)
Transformation savings required	**36.2**	**24.8**	**61.0**
Transformation savings	(40.9)	(27.1)	(68.0)
Health economy surplus	**4.7**	**2.3**	**7.0**

2. Use of Transformation funds

By 2020/21 the Local health Economy will receive recurrent Transformation Funds amounting to £33 million. Over the years 2016/17 – 2020/21 these Transformation Funds will be released progressively and the Local Health System Plan intends to use these funds on a non-recurrent basis to underpin the transformation changes.

The recurrent use of the funds however is still to be determined. This financial plan presently assumes that £6.5 million of this sum is used to enable the Local Health Economy to achieve a surplus position. The residual £26.5 million is then intended to be used to take forward:

- Extended GP access
- Recommendations contained within the Mental Health Taskforce, Cancer Taskforce strategy, National Maternity Review
- Increasing Child and Adolescent Mental Health service capacity,
- Delivery of seven day urgent and emergency care in hospitals,
- Investment in Prevention programmes, particularly childhood obesity and diabetes care,

- Implementing paperless technology.
- Supporting Local Authority Adult and Children service cost pressures.

Joint HOSC Progress Report on Neighbourhood Working – August 2016

Good progress has been made in developing the Neighbourhood models of care for Telford and Wrekin and for Shropshire. These programmes are led by the Chief Executives of the respective local authorities, working with Public Health, social care, Shropshire Community Services and the respective CCG. The two programmes are different (reflecting their different histories and local circumstances) but have the following common elements:

- A focus on community resilience – which aims to support local people to stay healthy and which is independent of the main statutory agencies
- Local health promotion initiatives
- Joint working with the local voluntary sector
- GP practices increasingly working together and becoming the building blocks for community based teams
- Care services and community services working with General Practice to provide a consistent level of non-hospital based services.
- The identification of some services that, for reasons of scale, would need to be available across a number groupings of practices
- Secondary care clinicians providing support to out of hospital services

Both models identify community resilience as a key element of their work. This recognises that Statutory agencies need to change their approach to maintaining wellbeing in the community by valuing community centred approaches and the work of local groups and the third sector. Statutory agencies have a role in facilitating and occasionally leading change.

Both models also build on collaborative work between GP practices to create Neighbourhood Care Teams (the description varies slightly between Shropshire and Telford), which bring together health and social care; physical and mental health professionals; and statutory and non-statutory services. These teams have a prime aim of preventing unnecessary hospital admissions and facilitating discharge – particularly amongst the frail elderly. Both models also help meet the needs of people at the end of life and the increasing number of people with long term conditions, such as diabetes.

The development of neighbourhood working is time consuming but essential if the assumptions that lie behind the Future Fit hospital reconfiguration are to be met.

Questions from Joint HOSC for Committee Meeting on 18th October

1 Risk for Current Services	
1a) Please clarify the level of risk for Emergency Services at SaTH. While it was reported in August that the consultant cover has improved – what is the level of Middle Grade medical cover and what risks does this present for the sustainability of the ED service?	Sustainability of the current A&E services at SaTH remains a challenge especially with regards to medical staffing. Failure to recruit to middle grade doctors means that consultants act down on a frequent basis. The Trust is working with UHNM to progress the provision of consultant support to both A&Es
1b) Current risks to other services: • What other services are identified as fragile? • What plans are in place to mitigate this? • Are the services currently being provided safe?	Critical Care fragility is mitigated through the use of locum consultants and agency nurses. The safety of patients is of paramount importance to the Trust and so the filling of workforce vacancies through external agencies continues alongside the commitment of staff to keep patients and services safe.
2) Deficit Reduction / STP	
2a) What planned in year savings from reducing duplication of services have been built into the budgets for 2015/16? What are these savings and what services will be affected?	There were no planned savings from reducing duplication costs built into the budgets for 2015/16.
2b) Are there any proposed changes to services in the Deficit Reduction Plan that involve a substantial variation or development in service? What are the timescales for these proposed changes? What consultation will be carried out and how / when will the Joint HOSC be consulted? What are the risks of dis-investing from these services? Please provide details on the equality impact assessment that has been carried out on these decisions?	The Deficit Reduction Plan is currently being revised. However, the largest savings result from a 2% efficiency levied annually from each provider (this has been accepted practice for the last five years); from the savings that result from the reconfiguration of acute services (£16m); and from repatriation of patients that are currently treated outside of the Shropshire border (£12m)
2c) How have the Local Authorities been involved in the development of the Deficit Reduction Plan and the Disinvestment programme?	Not explicitly, although Local Authority Chief Executives are part of the STP Partnership Board
3)Clinical Model and Work Force Planning	
3a) Information on recruitment to existing A&E / proposed ED and UCCs – What practical immediate difference would approval of the Future Fit Programme make to recruitment? Is there comparative information from a similar hospital (previous comparisons have been with Stoke which is a	Due to the progression of the programme and the approval of the SOC, we have already seen an improved recruitment position into Unscheduled care for medical staff. Once the preferred option is known, more detail of the programme and its timelines will form part of all recruitment packs for

Major Trauma Centre?)	registered professionals inviting them to be part of the development for services at the Trust. This worked well in the recruitment of staff for the W&C reconfiguration. Advanced practitioner training is currently underway with expectation that 50 wte will be in place to support a reconfigured service. A workforce transformation plan will form part of the OBC and investment has also been identified for the creation of new roles (double running, back fill etc) and the management of change.
3b) Work force planning for Future Fit. What consultation will be carried out consultation with staff re: change of roles, location, and salary.	Significant engagement has been completed already in determining the workforce requirements identified within the plan. This work culminated with senior leadership sign off on numbers, role developments, staff movement etc. A full engagement and communication plan will be instrumental in ensuring successful delivery as we move forward and we will be adhering to our management of change policy with appropriate formal staff consultations, informal group sessions. New role developments will be driven forward with health education colleagues, the clinical body and staff side colleagues.
3c) What consultation has taken place with care providers regarding the work force needed to support the Future Fit model and /or the tele-health and tele-care systems that will need to be in place? What investment will be available for this work?	The STP workforce workstream is a cross cutting enabler and as such will develop new ways of working ensuring that focus is placed where it supports the clinical model within Future fit and IT requirements. This is aligning with the internal piece on SSP and the work with Channel 3 (external IT consultancy)
3d) What will be the staffing arrangements at the UCCs and what training opportunities will there be for staff? How will staff rotate between the UCC and ED?	On the Emergency Site the UCC will be staffed by Advanced Practitioners, GPs and Doctors in Training. In the UCC on the Planned Care Site staff the Advanced Practitioners will be supported by a GP. Training is underway for advanced practitioners. The staff will be expected to rotate through the UCC and ED on both the Emergency and Planned Care Sites to ensure the maintained and development of skills. Social Services and Mental Health Teams will also support services on both sites.
3e) How will GPs be recruited to the UCCs? Will they be employed by the Trust, working in partnership with Shrop Doc / GP Federation or will an agency be used?	This is still being explored although the Trust has made provision to employ GPs directly into the UCCs

3f) What training opportunities would there be for GPs and primary care staff in the UCCs?	As above. This will also form part of the workforce transformation plan.
3g) How are / will existing staff at the Trusts be supported to undertake training so the necessary skills are available for the proposed UCCs? From the visit to the UCCs at Runcorn and Widnes it was noted that there was a shortage of nursing staff with paediatric skills and that it takes time to train staff to the necessary levels e.g. to Masters level.	Staff at both A&E's currently see and treat the patients that will be transferring to the UCC. These staff will be rotating through the ED and UCC in the future to develop and maintain skills.
3h) What is the view of NHS England, national clinical bodies and regulators on the safe percentage of patients who can be treated at a UCC?	Not explicitly, although Local Authority Chief Executives are part of the STP Partnership Board
3i) What will the triage process for patients who attend the UCC be and what will be the target timescales?	Streaming of patients will take place upon arrival to the UCC by an experienced clinician. Pathways of care and capacity has been planned on the basis that patients will be seen and treated and discharged within 2 hours of arrival in line with NHSE guidance (Transforming Urgent and Emergency Care Services in England, August 2015)
3j) What proportion of urgent care / trauma patients currently go out of county? (can this be broken down to show the medical condition or reason for specialist service e.g. heart attack or road traffic accident)	Data is being validated but for 15/16 emergency spells at either Wolverhampton Hospital or Royal Stoke accounted for approximately 2% of all emergency spells. These figures do not differentiate between "normal" and tertiary activity. For RTAs data suggests about 10% go to Stoke or Wolverhampton.
3k) What advice has the CCGs received about the location of the ED Department and the Women's and Children's Service?	The CCGs have commissioned an independent review by the Manchester Transformation Unit of what is referred to as Option C2 where the W&C Centre would be located on the planned care site at Telford with the Emergency Centre on the Shrewsbury site. It has been the view of local clinicians that this option will be extremely challenging to deliver. The report from the review has been included in the non-financial appraisal.
3l) How will the Future Fit Clinical Model include end of life pathways?	The clinical model will support the delivery of End of Life care being provided within the home through development of the community pathways as part of the Neighbourhood workstreams.
3m) How will the Future Fit Clinical Model help to reduce health inequalities?	There was clear and repeated recognition throughout the clinical design process that the biggest single factor which will determine success or failure of the programme over the next twenty years is the degree to which the prevention and wellbeing agenda is addressed. The general health of the

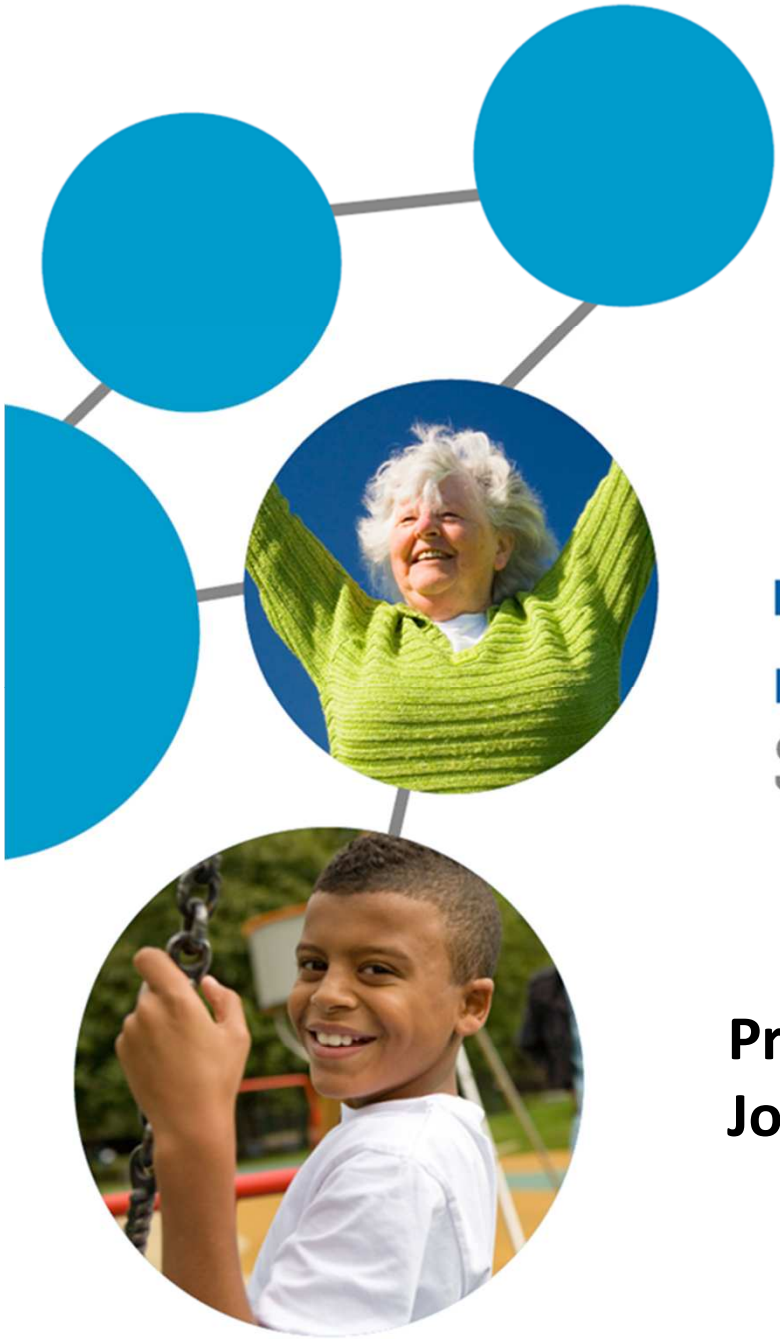
	population and the years they live without disease ('disease free life years') will be the primary determinant of the 'disease burden', the size of which will determine whether or not health and social care is effective and sustainable in the future. Whilst targeted prevention is effective in social and health care settings, and will continue to be embedded in the health and social care system, this will largely benefit people known to be at risk or who already have disease. There is an absolute requirement for an enhanced and integrated education and prevention programme addressing the wider determinants of health of the whole population, driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim, without which the sustainability and quality of services in the future will be seriously threatened. There is currently confusion between the delivery of targeted prevention activities and the wider wellbeing agenda relevant to the whole population. To resolve this, it is proposed that the nomenclature for targeted prevention aimed at those 'at risk' is prevention, whilst addressing the wider determinants of health through social change is wellbeing. This will enable clarity in planning and in determining roles and responsibilities for the prevention agenda as distinct from the wellbeing agenda. The Community response to Future Fit is a work in progress. The community response, encompasses rural urgent care, end to end pathway redesign and the innovative Neighbourhoods approach; all being developed in harmony to improve health and wellbeing and reduce health inequalities.
3n) How will the Future Fit Clinical Model ensure that the mental health needs of patients (including dementia) are met in an acute / urgent care setting?	As part of the development of the UCC and ED service, pathways and facilities have been developed with specific consideration of this patient group. Specifically the provision of dedicated rooms where patients with mental health needs can wait, be assessed and/ or treated within an appropriate setting in line with NICE guidance. New ward environments will be designed to be dementia friendly and anti-ligature rooms will also be created in high risk areas.

4) Activity and Capacity	
4a) Details on activity and capacity work – who has been involved and how many meetings?	The acute activity and capacity sub group met on 7 occasions to february 2014. Membership included SaTH clinicians, Shropshire CCG , T&W CCG, Shropshire Community Trust , GP leads, ambulance services and patient representation
4b) Assumptions on reduction in activity for A&E prior to implementation of Future Fit –Can you confirm the accuracy of figures and if these are correct – are they realistic? E.g. reduction of 32% in admissions for people with frailty or LTC, 15 – 20% reduction in admissions related to smoking, 20 – 50% fall in alcohol related admissions* and 20% reduction in admissions for falls.	The OBC describes a reduction in activity that's relates to a reduction of 4200 admissions over the next 5 years. With a further reduction of 27000 Outpatients over the same time period. The alternatives to acute hospital care are in development within the Neighbourhood workstreams. Mitigation for non delivery of the activity shift will be described in the OBC.
4c) Please clarify the figures below for Anticipated Emergency Department Attendances (current A&E attendances at both A&Es 120,000): • Future Fit Phase 2 modelling assumption 31% of front door urgent care activity will go to ED – 68,000 ED attendances (based on projected 110,628 A&E attendances in 2018/19) • Sustainable Services Activity modelling 35% urgent care to ED – 40,690 attendances (based on 1157712 A&E attendances)	The Trust has seen a year on year increase in A&E activity of 5%. The OBC will describe levels of activity in the UCCs and ED that reflect the 2015/16 actual activity. Using 15/16 activity data as a baseline of the 121,096 patients that attended A&E, through application of the Future Fit algorithm, 64% of patients will be treated in the UCC and 36% in the ED.
4d) What evidence is there nationally of the number of patients who go to a UCC who will be transferred to an A&E / ED? What modelling has been done to look at how the age and frailty of a patient increased the risk of transfer from a UCC to the ED?	Through the development of patient pathways and the model of care of a single site for admission, patients will be triaged to the right site. Discussions with the ambulance services are underway to develop pathways of care in partnership to ensure the safe transfer of patients. Development of the Ambulatory Emergency Care Unit and the Frailty Assessment Unit on the Emergency Site will ensure that frail patients are cared for in an appropriate setting without delay to minimise the need for admission.
4e) How have the assumptions that have been made about activity and capacity been 'future proofed' so that the services will be sustainable for the long term? E.g. projected demographic changes.	Demographic growth has been included in activity assumptions within the OBC. Changes in population size and age profile were derived from the Office for national Statistics (ONS) sub national population projections. For A&E activity projections are based on 5% PA which reflects the average growth seen over the last 2 years.
4f) From the visit to the UCCs at Widnes and Runcorn it was recognised that some patients who attended the UCC could have been seen in primary care. The UCCs in this model were strongly connected with	Currently there are no plans to incorporate primary care activity within the UCCs. However, joint and integrated working between Primary, Secondary and Community Care is essential to the success of a reconfigured health system.

Primary Care and this transfer of activity was not seen as an issue and may help to create capacity in Primary Care. This was also supported by the IT system which enabled GPs and A&E staff to access the records of patients who attended the UCC. How will these issues be addressed in the Future Fit Model for the UCCs?	
4g) Who engaged has the West midlands Ambulance Service been in the activity and capacity work and the managing the implications for this service?	A dedicated meeting has taken place with WMAS and an engagement plan has been agreed. This will include members of SaTH shadowing a crew to understand pathway challenges, WMAS attendance at pathway and architectural development groups. WMAS are supportive of the clinical model. Quarterly meetings are being planned for SaTH, WMAS, Welsh Ambulance Service and the Air Ambulance. A commissioner led Task and Finish Group has been agreed to coordinate the activity and contract elements of the change.
5) Equipment and Information Technology	
5a) Will the IT systems will be in place to enable both Primary Care and staff at the Acute Trust to access records of patients who attend the UCC?	Yes that is anticipated. The Digital Strategy Group is taking forward a number of key objectives that will support Future fit and the wider STP. For example paper free at the point of care by 2020 and ; digital enabled self care;
5b) What diagnostic equipment will be available at both UCCs and what diagnostic services will be available remotely?	UCCs will have access to a full range of diagnostics, however, should a patient require what is considered complex investigations such as CT, they would become an ED patient by definition. Discussions are underway with regards to the rural urgent care services, which are also being progressed through the Neighbourhood Workstreams. Investigations are likely to point of care testing, plain film x-ray and ultra-sound.
6) Governance and Timescales	
6a) How will the Future Fit model engage with emergency planning policies and procedures for both local authority areas?	A joint approach will continue as now
6b) How are social care providers engaged in the development and testing of the Future Fit model?	Through the Clinical Design Group and the Clinical Reference Group.
6c) Are there any other proposed changes to services e.g. orthopaedic services? (STP report commissioned from 3 sites and at level beyond peer group.) Do any of the proposed changes involve a substantial variation or development in service?	We know that Shropshire CCG appears to have a disproportionately high spend on orthopaedic services. Musculo-skeletal and orthopaedic services are currently provided by Telford, Shrewsbury and Robert Jones hospitals and by the community. The review is a clinical review to determine whether or not

	we currently have the best configuration of services and to recommend any changes that need to be made
7) Leadership and Capacity	
7a) Learning from the visit to Widnes and Runcorn UCCs we heard how important it was that all organisations had a shared vision and provided leadership to deliver the UCCs and that there were the skills and capacity in the organisations to deliver it. Can you confirm that the Future Fit Programme and the Hospital Transformation Programme have united leadership and that this vision is jointly owned by clinicians in Primary Care?	The STP Partnership Board and the governance arrangements we have put in place for our supporting value streams and enabling workstreams provides an ability for all organisations and professional groups involved in delivering health and care to take forward our shared vision for services. We have a unified vision and agreed priorities which include reconfiguration of our hospitals and developing neighbourhood care models that prevent unnecessary unplanned admissions and proactively support effective discharge from hospital. All organisations within health and social care have agreed to work together to implement the STP plan of which Future fit is one part.
8) Consultation	
8a) At each stage of the discussion on the development of the Future Fit Programme the Committee has stressed the importance of the links between the UCCs / A&E and primary and community care. What level of detail will be included in the consultation document regarding the Community Fit programme and the pathways being developed, Rural Urgent Care Centres / Services and Primary Care – including the timescales for this work and the funding available and the consultation that will be carried out on these proposals?	This work is being progressed through the value streams within the Sustainability and Transformation Plan (STP). The Neighbourhoods work is developing models for supporting communities to become more resilient, supporting people to stay health and developing neighbourhood care models. It is anticipated that whilst this work will not be completed we will be able to present high level models of care and early examples at the point we consult on the acute service reconfiguration options in December. More detailed work will be completed over the next 3-6 months and prior to the OBC approvals process.
8b) How has the NHS responded to issues / concerns raised during pre-consultation phase? How will this be demonstrated in consultation document?	The NHS Future Fit communications and engagement team has collected hundreds of comments during the pre-engagement period. These comments have been collated and analysed to help inform the basis of the consultation plan. A key piece of work is currently underway to get feedback on the methods used during a consultation to ensure that the needs of local people are met as far as resources will allow. We have added people to our mailing list when they have requested to do so. They have then been sent regular news bulletins, which have included press releases and regular e-bulletins. Where people have provided us with their views and suggestions they have been read and considered by programme board members, responded to and

	given feedback as to how their views will be taken into consideration. Their views have been used to shape services, an example being where we have held 'Rural Urgent care workshops', understanding the key issues that local people were facing and their concerns. All pre-engagement evidence will be included in the consultation document.
8c) Learning from the visit to the UCCs at Widnes and Runcorn the Committee recognises that the services at the UCCs will develop once they are established e.g. refining patient pathways and developing new ones. This needs to be balanced with a commitment to provide a minimum level of service provision at the UCCs – how will this be demonstrated in the consultation document?	The description of what will be provided in the UCCs has been widely shared and the relevant internal pathways and workforce model developed. Whilst the UCCs may evolve over time in response to changes in activity, the key elements of the UCCs at RSH and PRH have been identified for this stage of the process.
8d) Will the consultation document set out how the existing community hospitals, including the Minor Injuries Units, will be utilised in the Future Fit model and how this capacity be better used and publicised?	This information will not specifically form part of the consultation. However work is being progressed through the Neighbourhood value streams within the Sustainability and Transformation Plan (STP) to shape services locally. The Neighbourhoods work is developing models for supporting communities to become more resilient, supporting people to stay health and developing neighbourhood care models. It is anticipated that whilst this work will not be completed we will be able to present high level proposed models of care and early examples.
8e) Will the CCG Boards form a Joint Committee / Committee in Common as the decision making body for the Future Fit Programme? If formed, how will the membership and the terms of reference for this Committee be determined?	The two CCGs have agreed to form a Joint Committee to receive the recommendations on the preferred option from the Future Fit Programme Board. Draft terms of reference will be considered by their respective Boards in October
8f) Will the consultation document include the measures against which the CCGs will commission and assess the effectiveness of the Future Fit model?	The options have been put through a weighted appraisal process, both financial and non-financial. This process will be evidenced in the consultation document and made publically available.



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Presentation to
Joint HOSC Shropshire Telford and Wrekin
2016

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Programme overview

The Future Fit programme has developed proposals for reconfiguring acute hospital services in Shropshire and Telford & Wrekin (also serving parts of Powys).

- Proposals build on an overarching, whole-system clinical model.
- Model subject to Stage 1 Review in Spring 2014.
- Report made to Senate Council in September 2015 to initiate Stage 2.
    - Confirmed Case for Change
    - Highlighted critical workforce challenges
    - Set out delivery solutions for 3 options
- Emergence of deficit position prevented delivery solutions being progressed

Since September -

    - Revised and more affordable delivery solutions have been developed
    - STP processes are addressing wider system deficit
- Appraisal of revised delivery solutions under way
- Evidence being compiled in line with draft Senate Checklist
- Seeking to complete Stage 2 Assurance processes in November
- Consultation from December (otherwise May due to local elections)

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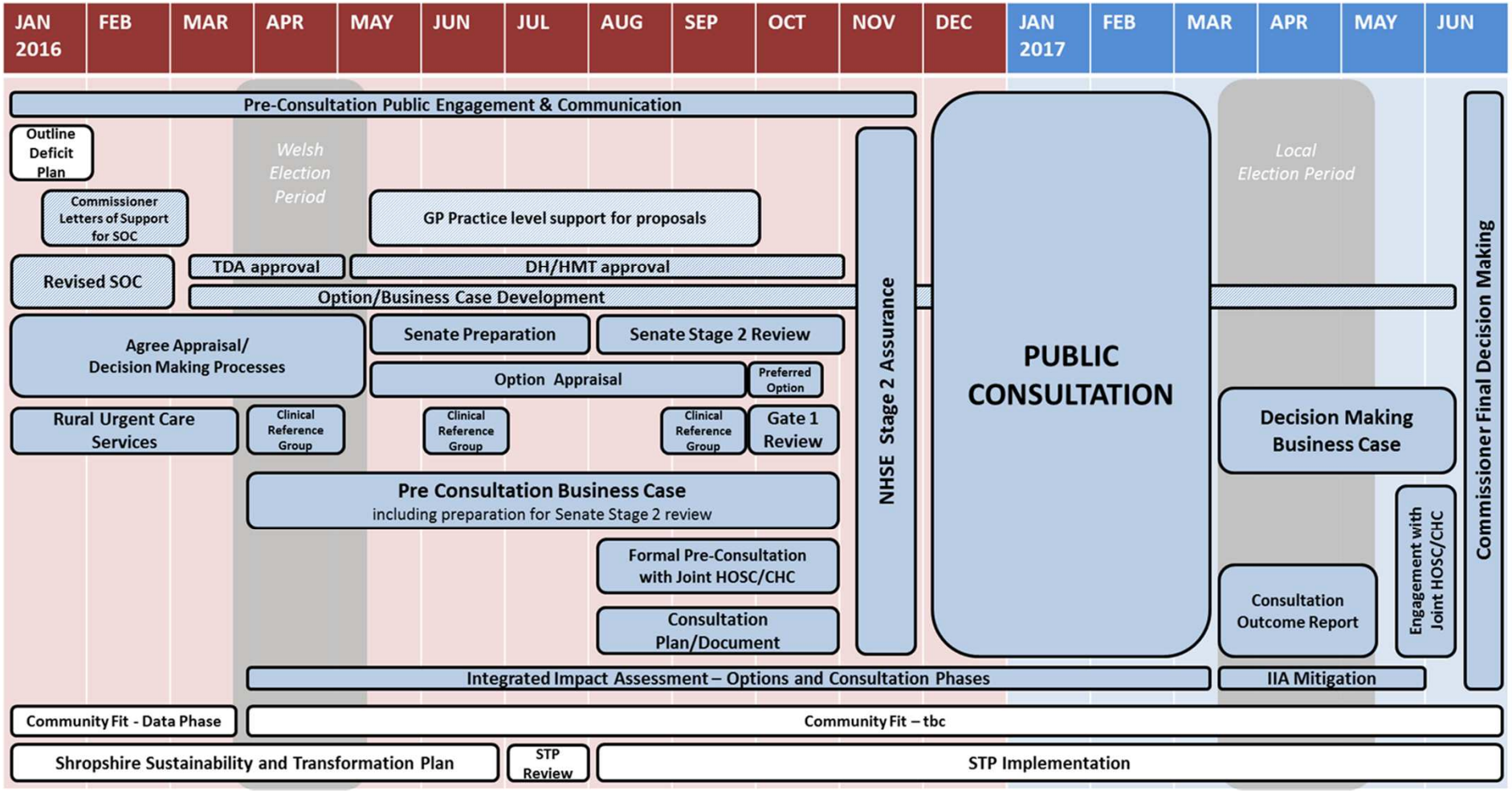
Timetable



NHS Future Fit: Communications and Engagement Plan on a Page Date of Update: 01/09/2016

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Programme Monitoring:

RAG Rating:

Progress since last review:
- *Confirmed key messages*
- *Confirmed priorities for next three months*
- *Initiation of consultation planning.*

Immediate issues of concern:
- GP engagement
- Political acceptance / Support
- Production of consultation materials
- Public input to option development
- Comms & engagement input to the Appraisal process

Stakeholder Groups
Note stakeholder map & P&I grid:

Patients, Service Users: Case for change and comms on delivery models with feedback and involvement required to inform option development as well as feedback on consultation planning.

Members, Public, Communities
As above.

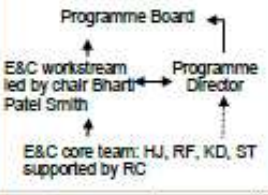
Media
Promote case for change and key principles of programme. Fair and balanced reporting with evidence scrutinised. Explore possibility of communications partners during the consultation

Workforce & key partners
Ambassadors for plans and key advocates for case for change; Involvement includes feedback in option development and consultation planning.

Decision makers
Engagement throughout to ensure case for change and options for consultation are understood. Feedback to be iterative element of engagement journey and key learnings to be gathered around gateway reviews and assurance

Political
Highly sensitive group that need to be kept informed and engaged upon key milestones. Councillors key for community outreach meanwhile MPs for decision making and FBC stage.

Programme Arrangements being finalised however at present:



Key Messages

- NHS Future Fit will transform acute hospital services that serve patients in Shropshire, Telford & Wrekin and Mid Wales, making them fit for at least the next 20 years.
- It is a key component of the local health and care plan (ie STP). Other workstreams will transform community services and rural urgent care services and will dovetail with NHS Future Fit.
- Future Fit will change the way acute hospital services are provided and ensure they are sustainable based around the area's two acute hospitals – PRH and RSH. It will equip them better to deal with the area's growing and ageing population, with more people living with long-term conditions.
- Future Fit is designing services that will attract NHS professionals to work in with the aspiration that this will deal with current retention and recruitment issues, particularly among staff with key skills.
- The programme has been led by local clinicians drawn from across the health economy, along, with key input from patient groups and local authorities.
- A key principal of Future Fit is that key specialisms should be brought together onto one site, and should not be split (as many currently are). This will include having one Emergency Centre.
- Evidence nationally and internationally shows the above approach improves outcomes for patients. Local evidence, such as the creation of specialist stroke and trauma centres, also shows this is has worked for patients.
- While there will only be one Emergency Centre, dealing with the most serious cases, an Urgent Care Centre (UCC) will be developed at each site. These two UCCs will deal with the majority of people who are currently seen at A&E. So for the majority of patients nothing will change.
- Future Fit will modernise and transform the way our hospital services interact with GP services and social care services to support more patients to live at home.
- Harnessing new technologies also forms a key part of Future Fit's work, helping more people to maintain contact with their specialist medical services without the need for frequent time consuming hospital appointments.

Key C & E Outcomes

1. Secure a public understanding of the case for change recognising not everyone will like it
2. Evidence public feedback and involvement in option development
3. Support to IIA workstream to deliver the EIA and liaise with gatekeepers to groups with protected characteristics
4. Successfully plan and run a consultation process that adheres to Gunning Principles, Brown principles and related legislation and guidance on consultation and engagement in both England and Wales.

- Consultation should occur when proposals are at a formative stage;
- Consultations should give sufficient reasons for any proposal to permit intelligent consideration;
- Consultations should allow adequate time for consideration and response;
- The product of consultation must be conscientiously taken into account

Key Risks	L	C	LxC	Mitigation
Failure to gain and sustain support from clinicians to be visibly leading the programme; thus dwindling clinical and public support, and undue burden on small number of leaders.	5	4	20	Work with most senior clinicians in each sponsoring organisation to help identify and develop emerging spokespeople
Failure to comply with Gunning Principles & Brown principles and related legislation & guidance on consultation and engagement in England and Wales	5	4	20	Programme Board to approve consultation plan which complies with specified requirements.
Failure to agree a process when diverging off plan. Risk includes inability to implement a timely plan to meet best practice standards with no subsequent ownership	5	4	20	To implement the Engagement and Communication Strategy and subsequent plans. Additional focus includes creation and maintenance of risk register.

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Pre-Consultation Engagement & Communication: Longlist to Shortlist	*Pre-Consultation Engagement & Communication: Short-list to Preferred Option*	*The Consultation*	*Post -Consultation Engagement & Communication: Impact and Analysis*	*Post -Consultation Engagement & Communication: Decision and Impact*
Ongoing: Communicate case for change messages and engage public on option development. ***Refer to Integrated plan for detail.***	**Ongoing: gather feedback from public and stakeholders on the preferred option. Work alongside IIA for EIA ensuring it meets best practise and statutory obligations.** ***Refer to Integrated plan for detail.***	**Please refer to the draft consultation plan (currently being taken to the workstream then to all stakeholders) for initial feedback**	**Ongoing: communicate key dates and pause (public facing) for period of reflection and analysis. Finalise stakeholder and public communications plan on decision making.** ***Refer to post consultation plan for detail.***	**Ongoing: communicate with public on what future services will look like and the impact/changes for them. Engage on option implementation and how best to communicate any changes with communities and public.** ***Refer to post consultation plan for detail.***
1.Decision to Review; Service Provision Review • Analysis of usage of current provision (who, why, when) & population's needs • Research of intended users' knowledge and perceptions of current provision/ needs • Review of current system; pros & cons, • Costs and Risks to address. 2. Decision to Change; pre-consultation: • Clarification of change objectives • OSC and Healthwatch involvement • Press briefings and engagement • Stakeholder analysis& engagement • Strategy document development 3. Decision to consultation; Strategy & Scope: • Objectives of consultation; Info only or collecting opinions • Decide on how to present options put	4. Agree Consultation Scope; Develop Document: • Draft Consultation Document and plan • Review Document and plan with all key stakeholders (including OSC) and improve • Test Document and plan with intended audience and improve. 5.Produce Draft Document/ plan; Final Preparations: • Gain sign off of Document / plan from CCGs, NHS England and OSC • Publish Document • Formulate media strategy • Create online materials (e.g. feedback survey).	6. Commence Consultation; Consultation • Ensure accessibility of document • Produce summary document for easy access • Publish consultation plan tactics ie promote how public can feedback and on what • Extensive stakeholder engagement • Extensive public engagement (varying tactics—see the proposed consultation plan) • Confirm mid-review and adjust plans as necessary • Manage Press and campaign groups	7. End of Consultation Period; Reporting • Analysis and Report production • Prepare report to OSC • Prepare to provide feedback to stakeholders. Assist the IIA workstream with equalities analysis and feedback	8. Decision Re: Future Provision; Communicate Decision • Signoff with CCGs, OSC and LMC • Stakeholder engagement *Communication to staff and patients* • Manage Press.
Sept 2014 to Sept 2016	*Sept 2016 to Nov 2016*	*Dec 2016 to Mar 2017*	*Mar 2017 to May 2017*	*Jun 2017 to Sept 2017*

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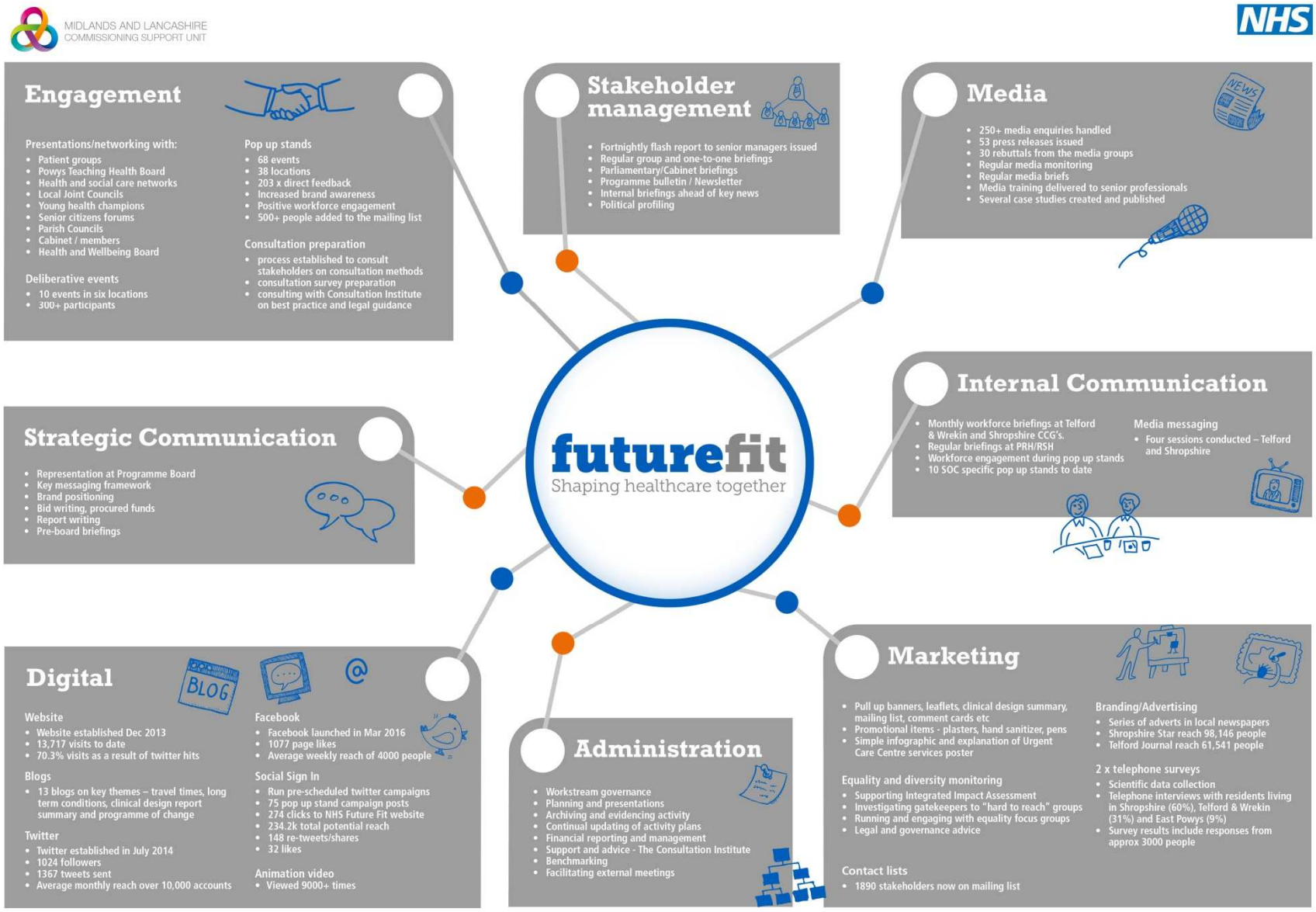
Pre Consultation Engagement



July 2014 – September 2016

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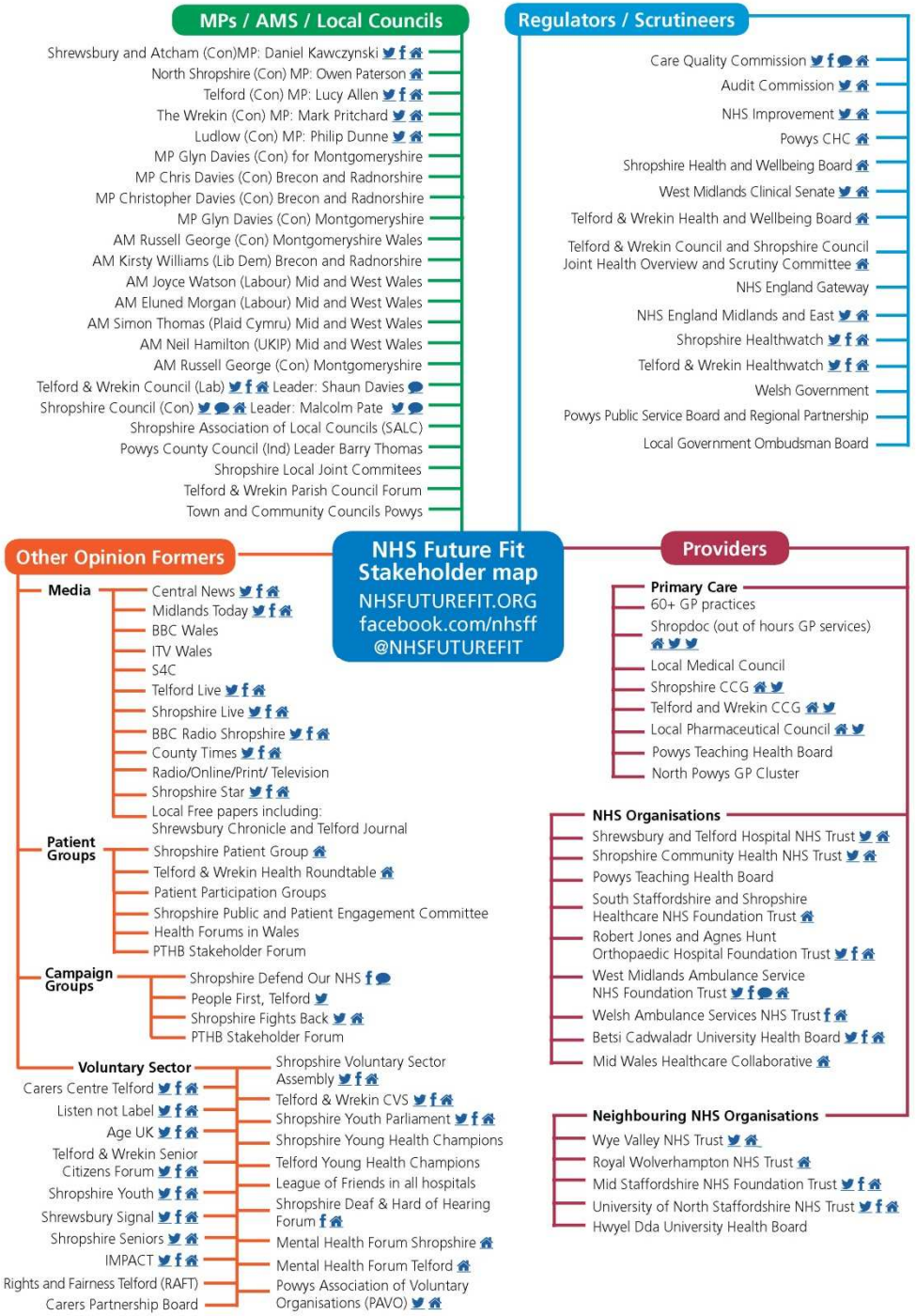
Stakeholder map



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Our approach to consultation

- To build on pre engagement activity – listening to our stakeholders and the public
- Working with our partners and key stakeholders to develop our consultation methodology
- Making the best use of shared resources
- Following legal guidance and best practice
- Following expert advice from the Consultation Institute

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Aims and objectives of the consultation

Working with the Consultation Institute our aim is to deliver a best practice consultation which we will achieve with the following objectives:

- To ensure that the consultation is transparent and that that it meets its statutory requirements through sufficient inclusiveness, breadth, and depth
- To create a significant and meaningful amount of engagement with local stakeholders, and to provide evidence of this

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Methodologies

Using a range of communication methods, channels and platforms including but not limited to:

- Face to face – pop up events, public workshops, engaging with groups, boards and forums
- Digital – online surveys, social media, website, online advertising
- Local media – newspapers, radio, local bloggers – utilising as a conduit for response
- Partners and stakeholders – word of mouth, workforce, use of their established channels, e.g. parish newsletters, websites, mailshots

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Final document and plan

- Survey with a mix of quantitative and qualitative data
- Approach inputted by and signed off by all key stakeholders
- Comprehensive schedule to implemented over 12 week period with one extra week as minimum to pause, reflect and adapt if necessary
- Process supported and led by programme and clinical leads

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Next steps on completion

- Full and detailed analysis of responses
- A comprehensive report to be presented to the programme board who in turn present to CCGs with a recommendation for their due consideration
- Providing the full results of the consultation for a set period of time to all who want to see them
- Keeping all stakeholders informed of result and consequent commencement of works

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Risk register

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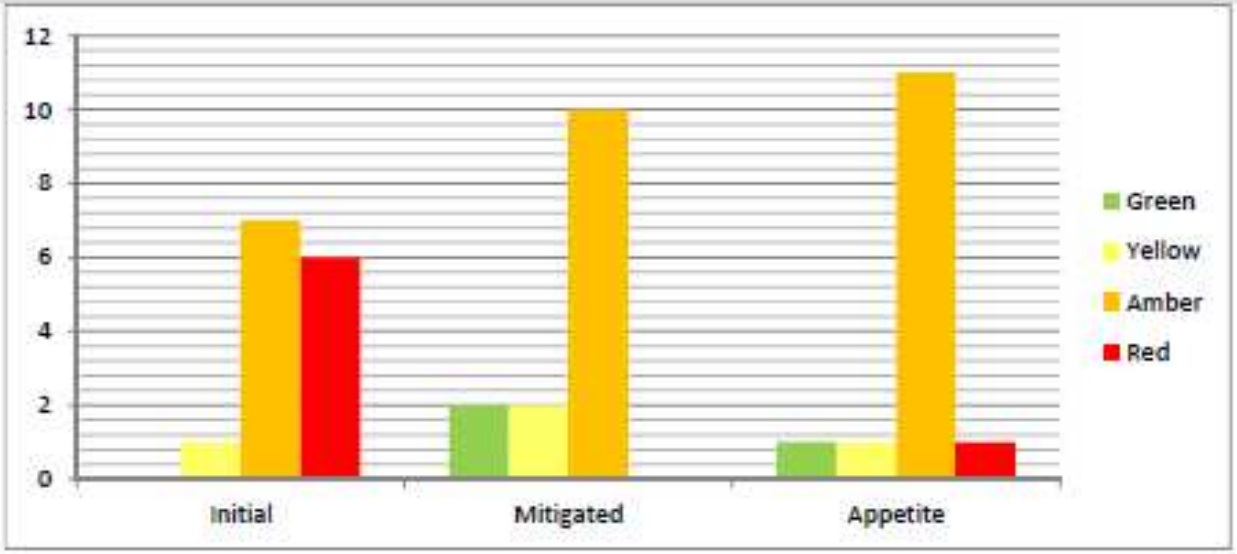
The NHS Future Fit Engagement and Communications workstream has developed this register which, in line with best practice, sets out the areas which could adversely impact the development and/or implementation of workstream/programme proposals. This uses qualitative and quantitative measures to calculate the overall level of risk according to likelihood of occurrence and potential impact.

Each risk is given an initial Red/Amber/Green rating, and a summary of how the risk is being mitigated by the workstream/programme is also provided. Where further action is needed, this is also set out. The Risk Register is formally reviewed and updated on a regular basis by the workstream. Risks rated 'red' (either before or after mitigation) will be reported to the Programme Team as appropriate.



	Initial	Mitigated	Appetite
Green	0	2	1
Yellow	1	2	1
Amber	7	10	11
Red	6	0	1
Totals	**14**	**14**	**14**

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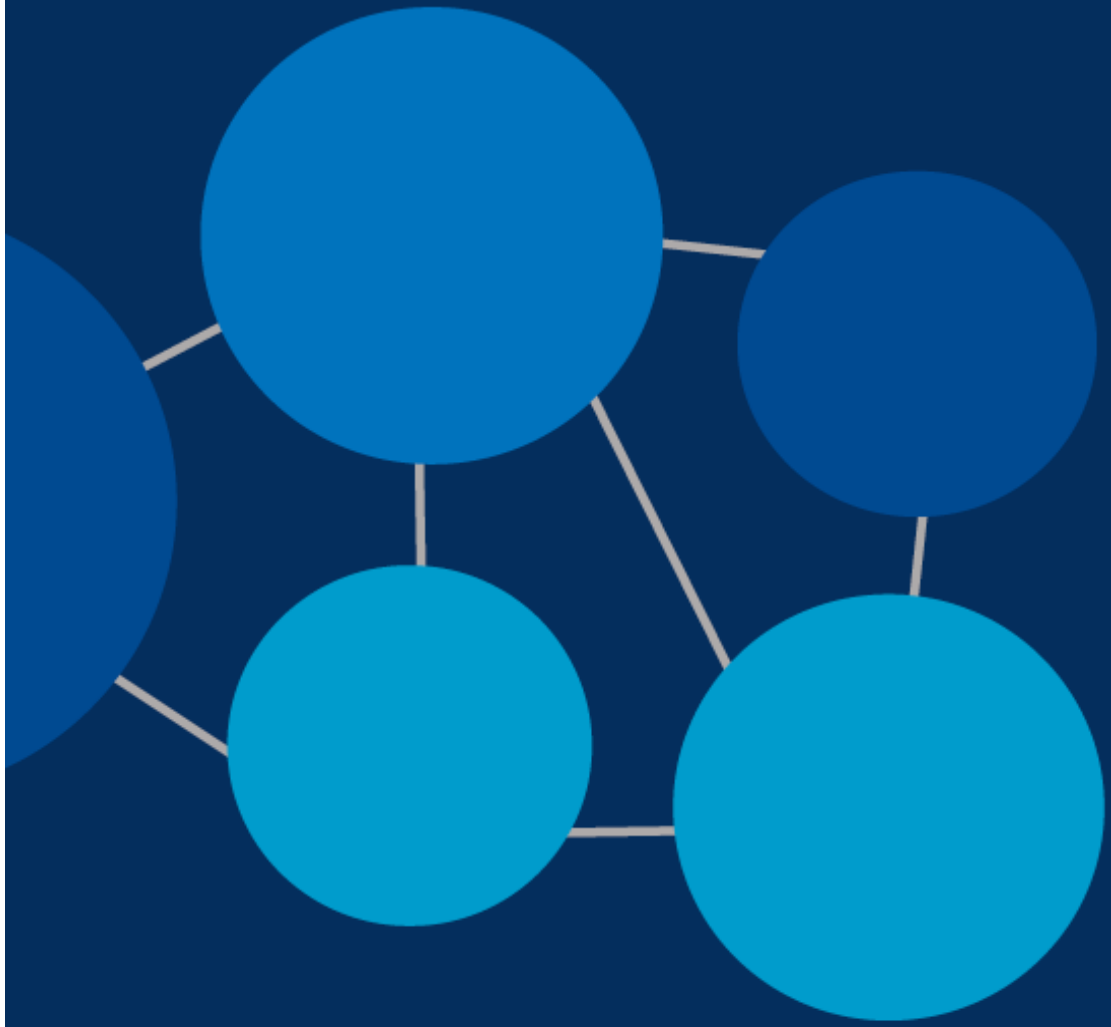

Any questions?