Telford & Wrekin COUNCIL

Shropshire Council

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

Date:	**Friday, 11 January 2019**	Time	**2.00pm**
Venue	**Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND**		

Enquiries Regarding this Agenda:

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Committee Membership:

Telford & Wrekin	Shropshire
Councillor Andy Burford (TWC Health Scrutiny Chair)	Councillor Karen Calder (SC Health Scrutiny Chair)
Councillor Stephen Burrell	Councillor Heather Kidd
Councillor Rob Sloan	Councillor Madge Shineton
Mrs Hilary Knight (Co-optee)	Mr David Beechey (Co-optee)
Ms Carolyn Henniker (Co-optee)	Mr Ian Hulme (Co-optee)
Mr Dag Saunders (Co-optee)	Mr Paul Cronin (Co-optee)

AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**

3. **Minutes** — Appendix **A1** and **A2** To Follow
To confirm the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 3 December 2018 and 17 December 2018.

4. **Proposed Reconfiguration of Ophthalmology Services** — Appendix **B**
To consider a report on the engagement plan to support The Shrewsbury and Telford Hospital NHS Trust seek the views of Eye Department service users, interested parties and staff on the proposed reconfiguration of ophthalmology services. Report attached.

Mr Tony Fox, Vascular Surgeon / Deputy Medical Director for Transformation will be at the meeting to present the paper and answer questions.

5. **Community Learning Disabilities Health Services in Shropshire, Telford and Wrekin**

To receive a verbal progress update from Francis Sutherland, Head of Commissioning, Mental Health and Learning Disability, Telford and Wrekin CCG.

6. **Urgent Treatment Centres** — Appendix **C** To Follow

To receive a briefing on Urgent Treatment Centres – a nationally mandated service that need to be in place by December 2019, and on the Joint Project Group set up by Shropshire CCG and Telford & Wrekin CCG to procure UTCs in Shrewsbury and Telford.

Jon Hart, Senior Project Manager (Secondary Care) Telford and Wrekin CCG will be at the meeting to present the paper and answer questions.

7. **Maternity Learning** — Appendix **D** To Follow

To receive a presentation on Maternity Learning from Adam Gornall, Clinical Director of the Maternity Services, Shrewsbury and Telford Hospital Trust

8. **Future Fit** — Appendix **E** To Follow

The response made by the Joint HOSC to the CCGs is attached for information

9. **Joint HOSC Work Programme**

10. **Co-Chairs Update**

A1

SHROPSHIRE COUNCIL,TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on Monday 3 December 2018 10.00 am – 1.27 pm in the Shrewsbury Room, Shirehall, Shrewsbury

Members Present:

Shropshire Councillors: Karen Calder (Co-Chair), Heather Kidd, Madge Shineton
Telford and Wrekin Councillors: Andy Burford, Stephen Burrell, Rob Sloan
Shropshire Co-optees: David Beechey, Ian Hulme
Telford and Wrekin Co-optees: Carolyn Henniker, Hilary Knight, Dag Saunders

Others Present:
Tom Dodds, Statutory Scrutiny Officer, Shropshire Council
David Evans, Senior Responsible Officer - Future Fit and Chief Officer Telford and Wrekin CCG
Fiona Ellis, Commissioning Lead, Women and Children, Shropshire
Simon Freeman, Senior Responsible Officer - Future Fit and Accountable Officer Shropshire CCG
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Jessica Sokolov, Deputy Clinical Chair, Shropshire CCG
Francis Sutherland, Head of Commissioning Mental Health and Learning Disability, Telford & Wrekin CCG
Pam Schreier, STP Communications and Engagement Lead
Rod Thomson, Director of Public Health, Shropshire Council
Debbie Vogler, Associate Director, Future Fit
Andrea Webster, Senior Programme Manager, Future Fit
Stacey Worthington, Senior Democratic and Scrutiny Services Officer, Telford & Wrekin Council

1. Apologies for Absence

Apologies were received from Paul Cronin, Shropshire Co-optee.

2. Disposable Pecuniary Interests

Members were reminded that they must not participate in the discussion or voting on any matters in which they had a disclosable pecuniary interest and should leave the room prior to the commencement of the debate. Councillor Madge Shineton declared a connection with the Health Concern Wyre Forest Group.

3. Minutes of the last Meeting

It was noted that the minutes of the meeting held on 26 November 2018 would be presented at the 17 December 2018 meeting for approval.

4. Midwifery Led Services

The Chair welcomed Dr Jessica Sokolov, Deputy Clinical Chair, Shropshire CCG and Fiona Ellis, Commissioning Lead, Women and Children, Shropshire CCG to the meeting.

They provided a presentation updating the Committee on the Shropshire, Telford and Wrekin Midwife Led Unit Review. This covered: options development and appraisal; Identification of hub sites; the NHS England Assurance process; Feedback received from a stakeholder feedback event held on 24 October and next steps. The critical path diagram indicated Joint HOSC input on three occasions in 2019. A copy of the presentation is attached to the signed minutes.

It was confirmed that the 12 week consultation period but this would not take place until after the the Borough of Telford and Wrekin elections in May 2019. It was hoped the consultation would be as early as possible but could be as late as the summer holiday period.

During discussion, Members made observations and asked tquestions:

- SATH has recently agreed to extend closure of MLUs for a further year – how will that impact on proposals?
- What will the public consultation look like?
- Was it envisaged that there would be a preferred option set out in the consultation?
- The number of hubs was likely to be a key issue of debate with rural Shropshire and high levels of need in some Telford areas with critical issues around maternity.
- Was data was likely to be skewed on use of Consultant Led Units (CLU) and Midwife Led Units (MLU) as many had not booked in to a MLU due to availability being unreliable?
- The list of services to be offered from hubs included areas covered by Public Health funding, for example, obesity and smoking cessation. What will be consulted on if public health funding no longer covered these areas? Could there be long term risks to health safety and welfare if proposed cuts to the Public Health budget took place?
- To what extent would Independent investigations into Maternity Services influence thinking?
- Clarity of the role of General Practitioners would be required
- Would the public consultation fall within the summer holiday period. Were there any lessons to learn from the timing of the Future Fit consultation?

In response, CCG officers clarified that:

- Closure of the MLUs on safety grounds did not impact directly on the review which was a distinct process. However, the inability to staff the current model had been a driver for the review. The MLUs did not currently births and postnatal stays but were open to provide other services.

- Advice on the consultation was being sought from the STP Communications and Engagement Team and the intention was to conduct as exhaustive a consultation as possible. The consultation plan would be presented to the Joint HOSC for its input. A preferred option would be identified but all clinically and financially viable options would be included.

- It was hoped that discussion around hub locations would not be divisive, the review area was all part of the same system within the STP footprint. A huge amount of information had been collected for over 10 years on trends for birth preferences, before temporary closures had become necessary and also on the level of need in Telford and Wrekin and Shropshire. All recommendations would be evidence based. It was also pointed out that the current configuration was inequitable.

- Public health funding was a key concern for CCGs in keeping women and babies health and well, particularly in relation to smoking and obesity. It was not clear yet how this would be resourced but there was a joint programme and care would be taken to ensure there was no duplication. All of these issues would be considered together. The Chair reported that Shropshire's Health and Adult Social Care Overview and Scrutiny Committee had requested impact assessments on the proposed public health budget cuts.

- The reporting date for the Ockenden review had been moved back several times already as the investigation had expanded. It had been decided not to delay the CCG's MLU review to await an outcome but if any changes were subsequently needed then they would be addressed at that time.

- Patients were saying that they wanted GPs to be more involved in maternity care and they had been identified as having a key role in co-ordinating health and liaising with services on behalf of mother and baby patients. In recent years there had been a shift in maternity care being provided exclusively by midwives and this had led to GPs not being as confident in delivering these services. Although it was not envisaged that GPs would be located in hubs, better communication was envisaged. A key message had been that there was now too much emphasis on the birth plan and not enough on becoming a family.

Dr Sokolov added that nowhere else in the country had five midwife led units for a population the size of Shropshire's and there were many other ways of delivering services. The review would outline a case that would be sustainable and delivered good outcomes.

The Chair thanked Dr Sokolov and Ms Ellis for the update. She asked that responses to questions raised at the 24 October stakeholder meeting be made available for Joint HOSC members. The Committee looked forward to receiving the draft consultation plan at a future meeting.

5. Community Learning Disabilities Health Services in Shropshire, Telford and Wrekin

The Chair welcomed Frances Sutherland, Head of Commissioning Mental Health and Learning Disability, Telford and Wrekin CCG. She presented a paper to members (copy attached to signed minutes) which outlined the learning disabilities services locally, the proposed process to move to a new model and the impact that would have on a cohort of individuals who accessed Oak House for carer respite.

The new model would involve closure of the Oak House bedded unit and the money being reinvested in an intensive health outreach service. This would support a more comprehensive and effective community service, reasonable adjustments for people with Learning Disabilities in GP practices, acute hospitals, and alternative respite provision. Support for carers of people with mental health needs would be part of the new model.

Proposals going forward included each Oak House individual and their carer/s having a face to face assessment to consider the impact of any closure. This would include access to day care, respite options including the amount and impact of that respite and any financial implications. This information would be reviewed and a forward plan developed for each individual. Key principles for these plans were set out in the report.

It was agreed that the plan could be made available to the JHOSC prior to any decision to close Oak House. Individuals would also have another face to face meeting to discuss their plans and implementation phase of the plans prior to any closure. Members noted that the service had been under review for at least 16 years and it did not fit the idea of living an ordinary life.

The Chair referred to the recommendation in the report and clarified that the role for the Committee lay in consideration of the consultation process and that the CCG Boards would make any decisions. She referred to the key principle identified that individuals would not be penalised financially and questioned how long this protection would remain in place for. Members also welcomed the principle of living a normal life but did not want to see elderly carers suddenly losing respite opportunities and were concerned that work on capacity was undertaken before any beds were taken out of the system. Ms Sutherland explained that alternative bedded provision would likely be in a bedded unit such as a care or nursing home specially trained to support those individuals. There would be more flexibility in the new model.

Members asked if it was intended that the £1m saved in maintenance costs would be directly invested in the service. Mr Evans emphasised that this was not a cost saving exercise, but one of finding more focused solutions for a small but important and vulnerable group of individuals. Both CCGs would be very sympathetic when looking at budgets in the future and would ensure there was no simple cost transference.

The Committee agreed that plans to date appeared to be fair and proportionate and asked Ms Sutherland to return to the Committee with an update once the next stage was complete. In response to a question about the timeframe, she said that NHS clinicians and social workers would talk to individuals and until that had been done it would be difficult to provide a timescale.

Members looked forward to an update as soon as possible, and asked for as much information as possible, bearing in mind the need to anonymise any information presented to the Committee.

Ms Sutherland was thanked for attending meeting.

6. Future Fit

Simon Freeman, David Evans, Debbie Vogler, Pam Schreier and Andrea Webster were welcomed to the meeting for the Future Fit item. A presentation was made to Members (a copy is attached to the signed minutes). The Committee asked that any future presentations be made available prior to the day of the meeting.

It was agreed to structure discussion under the headings of each of the papers before members. The comments and questions of members of the Committee are set out in italics below.

Consultation Findings Report

How will the product of consultation be conscientiously taken into account when finalising the decision, when 65% of respondents had disagreed with the preferred option. Would the response be related to mitigation and assurances only or be more open minded.

Mr Evans said that it had always been made very clear that only clinically sustainable and financially viable options would be consulted on. Other viable options could have been identified through the consultation but none had been.

Members had heard that some alternative options had been proposed through the consultation.

Mr Evans said that options raised through the consultation, for example a new hospital between Shrewsbury and Telford, and proposals based on the Northumbria model had been raised and responded to previously. He reminded members that over 40 options had been considered in 2014, some of which had related to a single centre but none of them had been affordable. The Northumbria model had been raised and subject to a report commissioned by SATH. Other suggestions raised through the consultation were related to tweaking or modification of the options suggested, and more community care and outreach

Will there be a response made to substantial responses made to the consultation, for example, that submitted by Shropshire Save Our NHS.

There had been 34 large submissions made, including that from Shropshire Save Our NHS, and those contributing them had been approached for permission to share those responses publicly. These would be added to the Future Fit website and would form an appendix to the full decision making business case.

Was there confidence that capital money from the Treasury was still secure?

There was confidence that the Treasury had underwritten the capital money.

What is the definition of Shropshire used in the 'demographic highlights' slide of the presentation – was there confidence that this was the right definition and right approach? Some Telford and Wrekin postcodes would be outside the Telford and Wrekin Unitary Authority.

Mr Freeman said that the term Shropshire in this slide referred to the Unitary authority of Shropshire and all those resident in it, including Shifnal and not just those in the hospital catchment. Future Fit was about looking at how to best meet the needs of the whole population through a whole system.

There were lots of comments in relation to telemedicine – did this mean the Future Fit model was now out date?

Why was the word 'however' used only in relation to the Telford and Wrekin population, what was this intended to convey? (pages 22, 23, 40)

Mr Freeman said that the report was authored by Participate who were completely independent of both CCGs. *The Committee requested that a response to this question be brought to the 17th December meeting*.

What assurances did the CCGs ask of Participate to ensure their report was an accurate reflection to the responses provided.

Participate were an independent company, and had been involved in numerous similar consultation exercises previously. Clear terms of reference had been set and both CCGs had confidence that the report accurately reflected the responses received. There had not been any surprises and the main themes including travel and transport were the ones which were expected to have emerged. Ms Schreier confirmed that she personally had looked at all of the responses.

Two separate reports had been written by the Programme Team on large responses and any comments received that had not been submitted on a survey form had been summarised in a separate report.

It was confirmed that details of mitigations would be available for the meeting on the 17th December. Drafts would be considered by CCG Boards in the next week but they would be updated during the implementation period.

The Co-Chair said nothwithstanding the emphasis that the consultation did not represent a vote or referendum, was there any feedback on the weight of the response rejecting the preferred option,or was this simply seen as a need for mitigation.

Mr Freeman commented that moving services would always be unpopular and if the position was reversed, the same level of objection would have come from elsewhere. It was not a vote, but about clinical evidence supporting the right services and clinical outcomes for patients.

Mr Evans said it had been made very clear before, during and after the consultation that what was important was understanding of the impact on individuals, families, work colleagues and communities and the consultation had clearly asked what the impact would be, whichever the preferred option. Ms Vogler reiterated that the model needed to improve services for the whole population and the equalities impact work had shown that this would happen, although there would be a need to provide mitigation for smaller groups.

Would the Future Fit Team agree that there had been a communications problem around the consultation

Ms Vogler said that every effort had been made to articulate the difference between Urgent Care and Emergency Care and that some people felt this had not been done effectively in some cases. Mr Evans said more work could be done on explaining the range of conditions.

Some members stated that population growth and deprivation were not just urban issues and that a balanced approach was needed.

Mr Freeman referred to the national deprivation definition. The Director of Public Health drew attention to a March 2017 LGA and Public Health England publication which identified that the government underestimated levels of and the effect of poverty and deprivation in rural areas. It was agreed to circulate the link to this publication after the meeting.

The presence of clinicians at some Future Fit events had helped those present to understand the background to the consultation. Whilst noting the pressure on clinicians, the Committee felt it would be very useful to have clinicians present for the next Joint HOSC meeting

The Women and Children's unit had only opened four years at a cost of £28m. How would issues related to its move be mitigated

Mr Freeman said the relative capital costs of the two builds was not the basis of the decision. The issue option appraisal was based 50% on cost and 50% on non-financial assessment and an Independent Review had said this was a robust process. This would not be revisited. The Unit was a modular building and could be used for other purposes. Ms Vogler said mitigation plans would be put in place where there was a differential impact.

People of working age had not participated as much in the consultation and had been prohibited from doing this in the day time.

It was acknowledged that people of this demographic could be difficult to reach but a number of evening meetings had been held to accommodate people of working age and information had been handed out at train stations at the suggestion of a member of the JHOSC.

The Chair said the Committee would need to comment on whether the consultation process had been fair, and reached as many people as possible. At the halfway stage the Committee had felt that this was being done well, the list of people and

groups the Team had conversed with and pop up meetings was extensive. She was of the opinion that no more could have been done and from what she had seen this had been an example of a good consultation to date.

Summary of Key Stakeholder Organisation responses

Bullet point summaries were set out in the paper but it was confirmed that these responses would go forward in their full format as an appendix to the decision making business case.

Summary of Individual Responses to Future Fit Consultation

This section provided information on the detailed letters and e-mails received from individuals. The report would feed into the conscientious consideration phase and provide CCG Boards with overview of feedback from individuals, main themes of feedback and a document to support a discussion on any potential material issues for consideration and any mitigation required.

Members referred to comments that centralisation of stroke services had not been a success.

Mr Evans said the national evidence base showed that centralised services resulted in better outcomes for patients. Stroke services were already centralised and did not appear to have been improved as much as they should have done. Reasons for this would be brought to the 17 December meeting but were likely to do with equipment not being fit for purpose and lack of a seven day service.

Draft Equalities Impact Assessment Report

The Draft Equality Impact Assessment examined if any protected characteristic group or other vulnerable group were likely to experience any disproportionate impact from the proposals, and paid particular attention to the nine protected characteristics under the Equality Act 2010 and four additional groups: people living in rural areas; people living in areas of deprivation; carers and Welsh speakers, as a first language. The document would be taken to the December Board meetings of the CCGs and form part of the decision making case, and be considered by the Joint committee of the two CCGs early in 2019. An element of realism would be required as not all circumstances could be fully mitigated but reduced to some extent.

A member requested that the full EIA be provided to the Joint HOSC for consideration.

Ms Vogler confirmed that the EIA was an ongoing piece of work, and was a lengthy document containing much data. It was confirmed that both Joint HOSC Chairs had seen the full version and also the Directors of Public Health of both Local Authorities. It was currently an aspirational document and talked about how mitigation work could be undertaken and how. If mitigation action was to be taken it would have to be affordable, practical and sustainable.

Concern was expressed that over time some of this work might get diluted or lost and that mitigations might not be strong enough, especially where addressing small parts of what were big problems, eg those related to transport.

Had the four recommendations for inclusion in mitigation plans set out on page 16 been fully accepted?

This would be a decision for the Programme Board and then the Joint Committee. The Chair observed that the STP would need to get to grips with addressing some of these issues.

Travel and Transport Draft Mitigation Plan

Members considered proposed solutions to travel and transport issues identified through a variety of means, including the Participate Report on the consultation.

Why had the threshold for eligibility for non-emergency transport changed?

Mr Freeman agreed that more information on non-emergency passenger transport and eligibility criteria would be brought to the meeting on 17th December. He understood that the criteria had not been changed but was now enforced properly. He reported that the current service was commissioned by the CCGs but from next April the contract would be managed by the Trust.

It was also agreed that details of how to access help towards the cost of travel would be brought to the meeting, especially as this was currently underclaimed.

It would be important not to rely on the Voluntary Sector for transport - volunteers were ageing themselves and new volunteers were not coming forward. Many areas did not have a voluntary car scheme. It was also important to remember that people travelling often needed a carer with them.

Mr Evans said that mitigations would be put in place to address change to the way services were delivered but not in response to the general challenge of transport already faced in Shropshire.

A travel and transport set of proposals to mitigate the effect of changes should have been in place for the consultation as it was known that this would be of public concern from the outset. Issues regarding border issues and concessionary fares should be taken into account.

Mr Freeman said that the impact was surprisingly small. Attempts had been made to engage the wider community in terms of wider transport issues but this had only been partially successful.

Telford and Wrekin Neighbourhood Working Programme

The Chair commented that this was a useful and easy to read document which described what was going on well.

The Co-Chair reported that the Telford Health Scrutiny Committee had recognised how valuable some of this work had been in Telford and Wrekin and applauded the direction of travel. However, it had identified some sceptism, including from GPs, about how much impact it could have and also some structural issues which would need to be addressed across organisations. There also appeared to be some gaps in staff, particularly as those undertaking projects often had day jobs. The extent of the impact assumed in the Future Fit model of this work had not been seen so far.

Mr Evans acknowledged the significant challenge at hand. He referred to a recent pilot programme in Telford whereby a paramedic with rapid response team had helped prevent 60 ambulance journeys to hospital over a four week period. Small scale wins through admission avoidance would help to make the incremental steps needed to achieve the vision. He acknowledged that there was a long way to go over the next 5 years but he was also confident it could be done and that necessary resources would be available. He also referred to evidence that investing in the third sector could often provide more value.

Shropshire Care Closer to Home Transformation Programme Update

The Chair commented that the Telford and Wrekin document had been much easier to read. The Shropshire update contained lots of figures and assumptions in terms of reductions. The Chair also felt that the Telford document reflected a feeling that 'we' referred to both Telford and Wrekin Council and CCG but this was not reflected in Shropshire.

Why had there been difficulties engaging stakeholders in the phase 3 design sessions, referred to in the 'corrective actions' section and why was progress behind the timeline?

Dr Sokolov explained that there had been difficulties with this phase of the work due to work on the Winter Plan. She also explained that the data had been provided in order to help allay fears about a bed gap. Mr Freeman said that the Shropshire Out of Hospital Programme faced challenges that Telford and Wrekin did not, including ageing infrastructure, and delivery over a vast area.

Reference was made to the use of an independent health consultant by Shropshire Council and Shropshire CCG to facilitate working together.

Dr Sokolov also reported that the Shropshire closer to Home Programme Board included representatives of the Acute Trust, Mental Health Trust, Acute Trust, Public Health, voluntary organisations, Local Authority and patients. Work over the last three years had included introduction of Community and Care Co-ordinators into every GP practice, and social prescribing pilots across the county. These were all ongoing and the local authority led on social prescribing.

She reported on three phases in the closer to home work – fraility front door, rapid response in the community using skills from the secondary sector, and social prescribing.

A member expressed concern that officers working on social prescribing at Shropshire Council had recently been issued with redundancy notices.

It was agreed that the more public facing document be presented to the meeting on the 17th.

Questions from Members of the Public

The Chair asked if any members of the public wished to ask questions.

Questions and comments were made in relation to paperwork that had been available at the recent Programme Board meeting, and whether those present had been given full access to full copies of responses to the consultation.

Ms Vogler confirmed that access had been available to all of the documents and these would be added to the website once those had submitted them had given permission.

Another member of the public expressed the view that people living in rural areas were routinely discriminated against when services were reconfigured.

In response, officers said there would be impacts in terms of travelling but the gains would be better outcomes.

Another member of the public felt that the consultation should have also covered maternity, community and mental health services as well as acute services, and another felt that there as a lack of imagination in proposed solutions to transport and travel problems.

The Chair observed that the Committee was able to comment and ask questions about the consultation process, whether it had been fair and equitable and whether people had been able to access it.

NHS officers reminded all present of the Assurance process that the Programme had travelled through to date, including that set out by NHS England and the West Midlands Clinical Senate.

The Chair encouraged anyone with outstanding questions to contact her and the Co-Chair ahead of the next meeting on 17 December 2018. She thanked all committee members, officers and members of the public for attending.

The meeting concluded at 1.27 pm.

NHS
The Shrewsbury and
Telford Hospital
NHS Trust

ENGAGEMENT PLAN

PROPOSED RECONFIGURATION OF OPHTHALMOLOGY SERVICES

1 INTRODUCTION

This is an engagement plan to support The Shrewsbury and Telford Hospital NHS Trust to seek the views of Eye Department services users, interested parties and staff on the proposed reconfiguration of ophthalmology services.

This plan will outline the engagement and communication events that have happened to date and outline the next steps.

The engagement period will run for 6 weeks and during that time will seek the views of Eye Department service users from the current sites through a programme of targeted engagement, which include a stakeholder event in order to seek views from representative groups such as HealthWatch, Commissioners, Macular Society, Royal National Institute for the Blind etc.

The results of the engagement period will be analysed and presented to the Trust Board alongside associated recommendations in a public Board meeting in February 2019

2 CONTEXT AND OVERVIEW

For many years Ophthalmology Hospital Eye Services provided at Shrewsbury and Telford Hospital NHS Trust have been considered as a “fragile” service and has had many challenges.

The Ophthalmology department has had service reviews and recommendations from the Royal College of Ophthalmology, Macular Society, Healthwatch and others who all identified shortfalls and recommended that improvements were required. In addition to these reviews, Health Education West Midlands (HEWM) reviewed the service in July 2017. HEWM are responsible for the training and education of junior doctors. The visit was arranged following concerns that deanery trainees highlighted the lack of cataract surgery training opportunities as a major concern.

The Trust and Commissioners also recognised these shortfalls and a Risk Review meeting chaired by NHS England took place in October 2016. At the meeting the Trust presented its review of the service and the areas which needed addressing to ensure the provision of a safe and sustainable service for the long term in the County and Mid Wales.

One of the areas outlined for improvement was the Substandard and Fragmented Accommodation. The department strives to provide a high quality, safe service to patients and recognises that the patient accommodation forms an essential part.

3 HISTORICAL ACCOMMODATION OVERVIEW

Ophthalmology provides services from 3 sites; RSH, PRH and Euston House in Telford, as well as from peripheral units throughout the locality. The increasing demands on the service means that the Ophthalmology department accommodation is not fit for purpose. This view is supported by the afore mentioned external bodies, who deemed that the facilities at RSH clinic 10 were no longer suitable for Ophthalmology patients.

As a result the Trust supported a capital investment to redevelop space within the Copthorne building on the RSH site to build an ophthalmology patient friendly facility to relocate Clinic 10. The new facility opened to adult patients on the 26th June 2017 and to paediatric patients in October 2017.

These new facilities provide excellent provision of outpatient services for patients with sight conditions. The new facility and service as a whole was inspected by Healthwatch in November 2017 as well as the Getting It right First Time (GIRFT) assessment in August 2017. Both reports recognised the improvements the department has made but also indicated that further improvements need to be made.

4 CURRENT ACCOMMODATION OVERVIEW

Ophthalmology currently provides services from 3 sites; RSH, PRH and Euston House in Telford, as well as from peripheral units throughout the locality.

Site	Outpatients	Surgery
RSH	**Adult** & **Paediatric** All sub-specialisms and Urgent Eye Clinic	**Adult** General Anaesthetic and Local Anaesthetic sub-specialisms, complex and "simple". Emergency Operating.
PRH	**Adult** & **Paediatric** All sub-specialisms **Excluding** the following: Urgent Eye Clinic Injections for Medical Retina related conditions Cornea Cataract assessment	**Paediatric** General Anaesthetic and Local Anaesthetic **Adult** Oculoplasty surgery.
ICAT	**Adult** The following services only: Cataract assessments, non-specialised ophthalmology and the ability to deliver lasers. .	**Adult** The following services only: Local Anaesthetic "simple" Cataract and Injections

Activity at each site is summarised in the below two tables and is split by Adults and Paediatrics:

Adults

Financial Year	RSH		PRH		Euston House	
	Outpatients	Surgery	Outpatients	Surgery	Outpatients	Surgery
2015-2016	29115	1884	6208	64	10114	1323
2016-2017	27486	1657	12920	58	7516	1134
2017-2018	34891	2693**	6488	58	3901	924
2018-2019*	37332	2110	4529	38	2602	1694

*2018-2019 is predicted full year effect based on activity levels April-August 2018.
** in 2017-2018 SaTH commissioned Nuffield Health to provide 115 surgical cases which are included within the RSH figures.

Paediatrics

Financial Year	RSH		PRH		Euston House	
	Outpatients	Surgery	Outpatients	Surgery	Outpatients	Surgery
2015-2016	3726	10	4973	149	13	0
2016-2017	3434	3	4864	66	17	0
2017-2018	2734	1	5748	54	3	0
2018-2019*	4781	7	4303	91	2	0

*2018-2019 is predicted full year effect based on activity levels April-August 2018.

5 CONCERNS WITH CURRENT SITE CONFIGURATION

The Trust outlined its challenges within the risk review meeting in October 2016, stakeholder engagement sessions and the Trust Board April 2017. A summary of the challenges identified were as follows:

- Substandard and fragmented accommodation;
- On-going serious untoward incidents;
- Workforce gaps and Team dynamics
- The inability to see patients within the past maximum wait standard, and demand exceeding capacity.

All 4 challenges are interlinked and in particular substandard and fragmented accommodation affects the others in the following ways:

Workforce Gaps: The department has had some significant challenges in recruitment and retention of medical staff for a number of years. This has resulted in the department employing agency clinicians who put an additional strain on finances and whilst bolstering the quantity of staff the commitment to improving the department may not be their priority. Following the investment into accommodation at RSH SaTH has managed to recruit to most vacancies and reduce its reliance on agency staff. Investing in an improved environment with reduced travelling requirements would encourage persons

currently in post to remain and improve the chances of employment into vacancies. Reducing the number of sites would allow travel time to be put back into clinical activity.

The department has also been subject to sickness absences, whilst we recognise that this is unpredictable having more staff at a reduced number of sites would potentially mean appointments would not need to be cancelled due to sickness.

The Trust supports junior doctor training and has 5 junior doctors who are in training allocated to the Trust. Health Education West Midlands who manage the trainees have advised that we risk losing our right to be trainers if we cannot provide sufficient access and training opportunities with theatres specifically Cataract operating. At Euston House we are unable to train juniors within the theatre set up due to lack of adequate space.

Team dynamics**:** Having clinicians spread too thinly across sites affects the ability to work as a team and this also impacts on patients who need to be seen by more than one professional. Having staff working alongside each other enables many patients to have all of their eye needs considered in one appointment rather than multiple trips.

Inability to see patients within the Past Maximum Waiting time standard, and demand exceeding capacity: Across the whole ophthalmology service demand is outstripping capacity.

The long waiting times in Ophthalmology can be categorised into two main areas; patients on a referral to treatment (RTT) pathway awaiting first outpatient appointment and those waiting for follow up appointments (PMW).

RTT- referral to treatment time

RTT performance within Ophthalmology has achieved since January 2018 having failed for the previous 3 quarters. Performance against RTT is affected by available capacity and new referral demand. The workforce issues identified within the "Workforce Gaps and Team dynamics" sections impact on the capacity to deliver RTT performance. The department actively flexes available capacity to meet the urgent clinical demand which means routine conditions may wait longer. RTT performance has mainly been affected by increases in demand specifically and significantly for referrals for consideration for cataract surgery. Productivity at Euston House within the cataract theatre is limited due to the design of the unit. Activity suggests that 6 patients are treated per list. Moving activity to a new purpose built theatre would increase productivity in line with clinical guidelines and in line with GIRFT review recommendations of 8 patients per list.

PMW- Past Maximum Waiting Time for follow up appointment

There was a significant issue within Ophthalmology with a large number of patients waiting longer than clinically recommended for follow up appointments. In January 2016 there were just under 3300 patients waiting longer than they should. This issue has been on-going for a number of years and since January 2016 these numbers have significantly reduced and at 3rd August 2018 it was 689 patients with the lowest recorded at 252 on 27th October 2017.
Following the risk review meeting in October 2016 one of the interventions the commissioners and SaTH jointly agreed to suspend new referrals for general, glaucoma and adult squint surgery. This closure was implemented to reduce the PMW numbers. Following the improvements within the

accommodation and workforce the Trust and Commissioners agreed to reopen SaTH service to new referrals for General and Glaucoma from the 1st April and following a period of clinician training Adult Squint Surgery is planned to commence in 2019-20.

Ongoing Serious Untoward incidents

The department had a number of serious incidents over a number of years which related to two themes:

- Individual clinicial issues and poor practice.
- Incidents relating to patients waiting longer than clinically recommended

The department recognised this and realigned its governance structures and as part of this Mr Sagili (Consultant Ophthalmologist) was appointed as the departments Consultant Governance Lead. Harm pro-formas completed by the clinicians for patients that has waited longer than clinically determined and concerns are investigated at the patient safety meeting. Monthly department patient safety meetings take place to review incidents. Relevant trends and outcomes of investigations carried out by the patient safety representatives are reported at the monthly Governence meeting to aid learning and to support the delivery of the action plans. Any serious incidents and those causing harm are investigated in line with Trust policies and procedures.

To specifically address the 2 themes identified above:

- “Individual clinicial issues and poor practice” the department has been supported by the Trust in taking action around the individuals that undertook poor clinical practice which has meant that members of staff no longer work for the Trust and others have been supported with retraining.
- “incidents relating to patients waiting longer than clinically recommended” as waiting times remain an concern it presents a risk.

6 ENGAGEMENT OVERVIEW (TO DATE)

The Trust and Department recognise the importance of service user engagement and involvement with patients in considering changes in service provision. Since the October 2016 risk review meeting the Trust has completed two stakeholder engagement sessions the first was held on Tuesday 21st March 2017. Attendees were asked to consider the options to reconfigure Ophthalmology services provided at Sath. Representatives were invited and attended from Telford and Wrekin and Shropshire CCGs, Healthwatch, RNIB, Macular Society, patients and SaTH. Unfortunately members of the Welsh HB were invited however were not in attendance.

The outcome of the stakeholder are summarised below:

- The familiarity and confidence in the surroundings and floor plan was essential element and there was a very strong preference for one site where all tests and treatment could be offered in one appointment. Having all services at the same site was more important than any travel issues that might arise however representatives recognised that for some patients this would be challenging. There was concern from Telford and Wrekin Healthwatch that changes should not be made ahead of decision surrounding the Sustainable Services Plan

however they did accept that further delay within a challenged service could harm patient users and also result in continued decline of the service. Telford and Wrekin commissioner agreed with the principle of centralisation but stated clearly that preference would be given to provide local care for their own population of patients.

- Opportunity exists to establish Centre of Excellence and develop services that mitigate risks that the Trust raised at the October 2016 risk review meeting chaired by NHS England. The outcome of the meeting was that a consensus agreement preferred the option of a single County Ophthalmology unit with centralisation of services.

7 TRUST BOARD VIEW

Following the feedback from the Stakeholder Engagement event the outcome was shared within a paper to Sath's open Trust Board meeting in April 2017 and a summary of the official minutes is provided below:

Mr Fox presented the following options to enable reconfiguration of the Ophthalmology service to address its substandard and fragmented accommodation; these opportunities would also support a reduction in workforce gaps and an improvement in team dynamics which are fundamental to the delivery of a sustainable service for the population of Shropshire, Telford and Wrekin and mid-Wales.

- Option 1 – Relocation of Clinic 10 into the Copthorne Building at RSH – this option has already been approved
- Option 2 – Reduce to two sites by closing Euston House with cataract surgery reprovided in Theatres 10 & 11 at RSH and all paediatrics relocated to MTX (portacabin) Building at PRH
- Option 3 – Reduce to two sites by closing Euston House with cataract surgery reprovided in Theatres within the Copthorne Building and all paediatrics relocated to the MTX (portacabin) Building at PRH
- Option 4 – Reduce to one site working at RSH with all adult services provided in the Copthorne Building and Paediatric Outpatient department within Copthorne and all paediatric surgery continuing at PRH
- Option 5 – Reduce to one site working at RSH with all adult services provided in the Copthorne Building and paediatric outpatient department with all paediatric surgery continuing at PRH
- Option 6 – Reduce to one site working at PRH

The Service Users identified that one site was crucial for service users because of the following:
- Familiarity and confidence in the surroundings and floor plan is essential;
- Very strong preference for one site where all tests and treatment could be offered in one appointment;
- Having all services at one site was more important to patients than travel issues that may arise as a result.

It was reported that Euston House do not fulfil the requirements for Health Education West Midlands cataract training; the suggested proposal would mean that cataracts would all be provided in the Copthorne Building in a purpose built daycase facility which would allow greater throughput and much improved and safer one-stop services. It would mean that around 22 patients per week from Telford ICAT (half of whom are Telford residents) would receive their cataract treatment at Copthorne and all children from Shropshire would continue to receive their surgery at PRH, as at present. There is also a real opportunity to recruit and retain a high calibre workforce.

Mr Deadman (NED) queried if the organisation is 'slow to change or does it only change when a crisis is upon us'. He was informed that this is not specific to Ophthalmology; a change to a service takes time due to involving and engaging with the public. The FD reported that from his experience of working within the Trust over the past six years, he has found that there is an element of crisis management, however the Trust is moving to an improved vision.

The CEO commended the report stating it meets all safeguarding requirements, etc, and agreed that the organisation will go forward with the joint HoSC (Health Overview Scrutiny Committee).

Following discussion, the Trust Board APPROVED the following recommendations:

Phase 1:

- The relocation of Paediatric Ophthalmology Outpatients from Clinic 10 RSH to the Copthorne building (Ward 16) **and** as interim measure to move all paediatrics to MTX, PRH from 26th May 2017 for an interim period of 12 weeks;
- To relocate adult outpatient services from ICAT back to the respective main hospital sites
- To relocate cataract surgery from ICAT to Copthorne building

Phase 2:

- Following Purdah, to consider engaging with the public and relevant stakeholders to fully consult on the single site options identified, fully exploring cost and geographical location to implement a decision on these services but this would not preclude any decision arising from the Future Fit process.

Since the Trust Board approval in April 2017 Phase 1 (first bullet point) has been completed and Paediatric Ophthalmology Outpatients has been re-provided at RSH and PRH.

The department has been working on Phase 1 bullet points 2 and 3 and this paper outlines the engagement plan to seek a view on whether to proceed with:

- relocating adult outpatient services from ICAT back to the respective main hospital sites
- relocating cataract surgery from ICAT to Copthorne building

This engagement plan will **NOT** consider Phase 2 and will await the outcome of the future fit consultation.

8 ENGAGEMENT PLAN

This document outlines the engagement and communication plan. It is proposed that a 6 week period of engagement would commence in September 2018. This period will involve Eye Department services users, interested parties and staff. These persons will be asked to consider the options of Ophthalmology provision within the Trust particularly considering the option of reconfiguring services from 3 sites to 2 sites.

The Options; we are seeking the views of our local communities on the following two options below.

- Option 1: No change.
- Option 2: To relocate adult outpatient services from ICAT back to the respective main hospital sites and relocate cataract surgery from ICAT to Copthorne building.

Supporting Option 2 will result in the following changes. Those moved from ICAT are indicated in red type/italics.

Site	Outpatients	Surgery

RSH	**Adult** & **Paediatric** All sub-specialisms and Urgent Eye Clinic *Those outpatient services previously delivered at ICAT Adult.*	**Adult** General Anaesthetic and Local Anaesthetic sub-specialisms, complex and "simple". *Local Anaesthetic "simple" Cataract and Injections previously delivered at ICAT.* Emergency Operating.
PRH	**Adult** & **Paediatric** All sub-specialisms *Those outpatient services previously delivered at ICAT Adult.* **Excluding** the following: Urgent Eye Clinic Injections for Medical Retina related conditions Cornea Cataract assessment	**Paediatric** General Anaesthetic and Local Anaesthetic **Adult** Oculoplasty surgery.

We are seeking people's views via a questionnaire which can be accessed on the XXX section of our website or via [url to be inserted]. We will also be undertaking a programme of targeted engagement with patients using our eye department services across the current site configuration and we will be liaising with representative groups such as HealthWatch.

The engagement period will run for 4 weeks November/December 2018, and we would like to encourage people with an interest in Hospital Eye Services delivered at Sath to review the engagement document and complete the questionnaire.

The result of the engagement period will be analysed and will be presented to our Trust Board alongside associated recommendations regarding future temporary suspensions in a public Board meeting in January/February 2019.

9 ENGAGEMENT PROGRAMME OVERVIEW

The process
The engagement period will run for 6 weeks and during that time will seek the views of:

- local communities through a questionnaire, available online and in hard copy from the eye departments at PRH, Euston House and RSH
- Patients using Eye Departments through a programme of targeted engagement, which includes discussion groups. At these sessions attendees will be taken through the engagement document and asked to complete the questionnaire
- representative groups such as HealthWatch.

The result of the engagement period will be analysed and be presented to our Trust Board alongside associated recommendations regarding future temporary suspensions in a public Board meeting in January/February 2019.

The engagement document

At the core of the programme will be an engagement document which will clearly set out the basis on which we are engaging. It will set out: the purpose of the engagement programme and the dates of when it will start and finish; the operational pressures the service is under; the proposed future options for accommodation reconfiguration including the implications of no change, as well as what the results of change would look like in terms of benefits to patients and families and potential disadvantages; information about the engagement programme, and including how to respond.

The engagement document will be accessible, clear, concise and written in plain English. It will also be available in large font to aid those patients with sight impairments.

In addition to the engagement document, frequently asked questions will be produced during the engagement period. These will be used to provide answers to common issues and questions and respond to any issues that have arisen.

The questionnaire will be available on the Trust website and hard copies can be requested from the Care Group should anyone not have access to the internet. Hard copies will also be available across the Trust's Eye Departments.

Raising awareness and encouraging involvement

We would like to hear from local people and particularly patients and their families using our Hospital Eye Services to understand how we can best meet their needs. We are therefore proposing to raise awareness of the engagement period in the following ways:

- an initial announcement which will include a media release, letters to staff and stakeholders and social media content
- posters will be put up within our 3 Eye Departments as well as being provided on the information screens within the eye department at RSH
- eye department staff will be supported to talk to patients and families using the service to raise awareness and encourage involvement
- information will be available on the eye departments section of the website, and we will invite key partner organisations to signpost to it

Media approach

Our media approach will be proactive during the engagement period (as well as reacting, of course, to any enquiries or issues that arise). Across the county, the local media continues to be important in influencing public perception and reaction to all aspects of health and care changes and we will work with them and communicate key messages for the engagement through the channels they provide.

During the engagement programme we will adhere to the following key principles:

- Ensure we can provide clinical spokespeople wherever possible to explain the need for change, the options and next steps, and to support them appropriately in this role
- Work closely with local journalists and ensure they are fully briefed on the need for change, the options and next steps
- Respond to all media enquiries in a timely and helpful manner
- Regularly monitor the media and ensure that inaccurate information about the engagement programme is rebutted where necessary

- Evaluate all media coverage to assess its effectiveness, and the inclusion of our key messages, adapting our approach as appropriate.

Discussion groups

Stakeholder discussion groups will be held where patient representatives, staff, commissioners and other interested parties will be invited to attend. These discussion groups will use the engagement document to fully explain and discuss the current operational issues, the proposed options for consideration and to answer any questions. Participants will then be invited to complete the questionnaire.

We will aim to include those identified by the Equality Impact Assessment in discussion groups.

Questionnaire

Our questionnaire will be used to ask people for their feedback on the three proposed options, and to gather views and feedback on issues and concerns so that these can be understood, and taken account of, including mitigating where possible, in terms of decision-making and implementation of that decision. The engagement will also provide an opportunity to seek additional insight and ideas that may not have been considered so far.

We will send out the link to our questionnaire by email to a wide range of stakeholders and will also make hard copies available through our maternity services, and particularly our midwives. People will also be able to access the questionnaire via the Trust website and from our social media feeds.

Mechanisms for response

People will be able to respond to respond via a hard copy or online questionnaire.

Analysis of Engagement responses

The responses to the engagement will be analysed and a summary report will be presented to the Trust Board.

10 DIRECT ENGAGEMENT

Group	How	Aim
Eye Department Staff – clinical and non-clinical	• Face to face briefing sessions • Emailed information • Updated as necessary throughout engagement period through internal communication channels – via managers and matrons etc.	• To ensure staff are equipped to communicate about the engagement and answer questions from service users • To encourage eye department staff to be involved as appropriate • Ensure all staff are aware of how to signpost service users who would like to

		have their say – discussion groups, online etc.
Stakeholder Engagement Discussion Groups	• Dedicated stakeholder engagement groups will be arranged and will include presentation of current situation, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and the distinction between this and the forthcoming CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure the group is aware of how to signpost service users who would like to have their say – meetings, online etc.
Health Watch / Community Health Council	• Attendance at specific meeting including presentation of current situation, hard copies of the survey made available, signposting to FAQs on website and online survey	• Well briefed on the current position and able to communicate the facts to service users • Ensure the group is clear on the remit of the engagement programme and the distinction between this and the forthcoming CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost service users who would like to have their say – discussion groups, online etc.
Joint Health Overview and Scrutiny Committee	• Attendance at specific meeting including presentation of current situation, detailed programme of engagement and hard copies of the survey to be made available, signposting to FAQs on website and online survey	• To provide an opportunity for the committee to scrutinise the plans of engagement in line with our duty to consult and their role in reviewing and scrutinising matters relating to the provision

		and operation of local health services • Well briefed on the current position and able to communicate the facts • Ensure the committee is clear on the remit of the engagement programme and the distinction between this and the CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost service users who would like to have their say – meetings, online etc.
MPs	• Face to face or telephone briefing to include update on current situation, overview of engagement and to raise their awareness of FAQs and online survey	• Well briefed on the current position and able to communicate the facts • Ensure they are clear on the remit of the engagement programme and the distinction between this and the CCG consultation • Ensure opportunities for dialogue and feedback have been made available • Ensure aware of how to signpost women who would like to have their say – discussion groups, online etc.

11 REVIEW AND EVALUATION

The questionnaires will be analysed and a summary report will be used to inform a paper for the public Trust Board meeting in January/February 2019. It is intended that papers will be published as part of this decision-making process.

SHROPSHIRE AND TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 11/01/2019

Urgent Treatment Centre Joint Project Group Briefing Paper

REPORT OF THE T&W NHS CCG SENIOR PROJECT MANAGER

1.0 PURPOSE

1.1 To brief the Scrutiny Committee on Shropshire and Telford & Wrekin CCGs' plan to procure the nationally mandated Urgent Treatment Centres including the CCGs' related plans for communication and engagement activity.

2.0 RECOMMENDATIONS

2.1 That the Committee note the contents of the report and confirm JHOSC support for the level of planned communication and engagement activity associated with this service development.

3.0 INTRODUCTION

3.1 Urgent Treatment Centres (appendix 1)

NHSE published 'Urgent Treatment Centres – Principles and Standards' guidance (appendix 1) in July 2017. The delivery of Urgent Treatment Centres form one element of the "Next Steps on the NHS Five Year Forward View (5YFV)" that was published in March 2017 with the intention of improving A&E performance, a stated national service improvement priority. The national requirement is that UTCs are in place by December 2019.

4.0 KEY INFORMATION

4.1 Current related service provision

There are two Accident and Emergency Centres within Shropshire. One is located at Royal Shrewsbury Hospital (Shrewsbury) and the other at Princess Royal Hospital in Telford.

Each A&E has an adjacent GP led walk-in/GP streaming service which treats patients assessed as not clinically requiring the specialist acute service of the Emergency Department according to local criteria. Each service currently operates to a different specification.

Both current contracts for the existing walk-in/GP streaming service come to an end in 2019 with no option for further extension and therefore the CCGs have agreed that they will be replaced with the nationally mandated Urgent Treatment Centres. This will also end the service inconsistency on each site through a joint procurement under one service specification, one contract and, in line with national policy, with one name.

4.2 National Standards for Urgent Treatment Centres

The CCGs will ensure that the UTC's conform to the following minimum national standards:

1) Open for at least 12 hours a day seven days a week, including bank holidays.
2) GP Led, supported by an appropriately trained multidisciplinary clinical workforce.
3) The scope of practice will include minor illness and minor injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.
4) Provide both pre-booked same day and "walk-in" appointments; however patients and the public will be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.
5) Support patients to self-care and use community pharmacy whenever it is appropriate to do so.
6) For patients who require an appointment in the urgent treatment centre this will be booked by a single phone call to NHS 111 or via the Ambulance Service; locally patients will be encouraged to use NHS 111 as the primary route to access an appointment at an urgent treatment centre.
7) Patients who "walk-in" to an urgent treatment centre will receive a rapid initial clinical assessment within 15 minutes of arrival.
8) Following clinical assessment, walk-in patients will be given an appointment slot, which will not be more than two hours after the time of arrival.
9) Patients who have a pre-booked appointment made by NHS 111 will be seen and treated within 30 minutes of their appointment time.
10) Protocols in place to manage critically ill and injured adults and children who arrive at an urgent treatment centre unexpectedly.
11) Access to appropriate investigations to enable safe, effective, high quality clinical assessment and treatment.
12) Be able to issue prescriptions, including e-prescriptions and emergency contraception.
13) Direct access to local mental health advice and services.

4.3 Existing GP Streaming/Walk-In service offer compared to New UTC Service

The UTC Service will offer a similar but enhanced delivery model to the current service offer on both acute hospital sites. There will be no diminution of service offer available to the public as a consequence of procuring an UTC on each acute hospital site (to replace the existing walk-in service/GP streaming service).

The enhancements to the service offer relate to the introduction of some new elements when compared to the current service. The most notable are:

- Increase in opening hours of PRH service (from 11 hours to 12 hours)
- Increased access to diagnostics

- Increased scope of minor injuries to be seen within the UTC
- Pre-bookable appointments through 111/WMAS which means patients can remain at home rather than waiting in A&E (seen and treated within 30 minutes of appointment time rather than potentially waiting for two hours as a self-presentation).
- Provides an appointment being allocated for self-presenting walk in patients within 2 hours of being streamed to the UTC
- UTC patients with a pre-booked appointment will be seen within 30 minutes of their appointment time.

Note: the opening hours at PRH are currently 1100 – 2200. The proposed 12 hour time slot for the UTC will be 0800 – 2000. This is to tie in with OOH and assist A&E with peak patient footfall.

4.4 Expected Outcomes

- More consistent and better quality rapid initial clinical assessment on arrival (streaming)
- Improved patient experience with appointment slots and defined waiting times standard
- More patients managed through the UTC relieving pressure on ED contributing to improved A&E performance
- Provides a consistent service offer on both acute sites
- More integrated and seamless working between acute and GP led service
- Provides a strong base on which the Future Fit model can build when Future Fit moves into operational delivery.

4.5 Relationship to Future Fit Proposals

The CCGs recognise the importance of including in this JHOSC briefing a description of the relationship of this procurement exercise to the Future Fit Transformation Programme and its published service offer proposal of an Urgent Care Centre on both acute sites.

This service development is not aiming to implement the Future Fit model. It is wholly in response to the need to implement nationally mandated policy in 2019 and to replace two contracts which expire (in 2019) to ensure essential service continuity. That said, the CCGs recognise the need to ensure that this procurement exercise delivers an interim solution which provides a sound foundation on which the CCGs can transition to the final Future Fit model when approved. The service specification will specifically reference that the Provider is expected to be open to future innovation and service development as set out in the Future Fit Transformation Programme for Acute Hospitals and focus on offering their own

solutions to further develop and refine the service model in light of that.

NHSE National Guidance on urgent treatment centres is explicit in the nomenclature (Urgent Treatment Centre) to be used for services that meet the core set of standards as described in the NHSE Guidance.

The UTC contract duration to be offered will allow flexibility to enable the transition to the Future Fit agreed model.

4.6 Communication and Engagement Plan

The CCGs propose to undertake communication and engagement activity as part of this procurement exercise. To-date, there has been patient input to the project through the patient reps (from both T&W and Shropshire) who are members of the project group and have been active in the development of the service specification from the outset and there will have been public and patient input at a national level in design of the national UTC principles and standards.

Prior to formal publication of the Invitation to Tender, patient views will further be sought by talking with service users in A&E and the adjoining GP led walk-in/GP streaming service.

Given this is nationally mandated policy, and as there is no diminution to the current service offer through the introduction of Urgent Treatment Centres, the CCGs do not propose to undertake formal consultation but will aim to undertake communication and engagement activity which:

- Explains the nature of the new service offer
- The rationale for doing this ahead of Future Fit
- To involve staff, patient and public representatives and other stakeholders in the development and implementation of Urgent Treatment Centres in Shropshire and Telford and Wrekin
- To inform and engage local stakeholders ensuring they have the opportunity to feedback on UTC proposals

During the communication and engagement activity, the service the CCGs are procuring and seeking views on will be referred to as an 'Urgent Treatment Centre'. This will allow differentiation with the Future Fit nomenclature (Urgent Care Centre) on which the public have recently been consulted.

The level of communication and engagement has been determined following discussions with both CCGs Communication and Engagement Teams, the Future Fit Comms Team, and the Joint Project Group membership (which includes patient representation).

The proposed level of engagement/involvement with the public is:

- patient representative members on the weekly Joint Project Group

- development of a suite of information resources, including briefings and Q & As, which can be used across numerous communication channels including web sites

and social media. These would also be shared with partners and stakeholders to increase reach and accessibility.

- seek the views of existing service users at A&E and GP Streaming/Walk-in services, supported by tailored resources which would not only explain why the service is being changed and its potential benefits but also capture feedback
- Assuring Involvement Committee (sign-off – Telford only)
- Telford Patients First Group (collect feedback)
- Shropshire Patients’ Group to be briefed and proposal shared
- Liaise with Healthwatch and seek their input into the planned communications and engagement work with a view to increasing the opportunity for local people to become engaged and informed

4.6 Timeline

The key milestone dates for the procurement are contract award in summer 2019 with new contract start date of 1st October 2019.

5.0 FINANCIAL/VALUE FOR MONEY IMPACT

Both CCGs are currently in the process of working out the financial envelopes for each CCG and the payment mechanism on which the contract will operate.

6.0 LEGAL ISSUES

6.1 Procurement

A procurement exercise is required as current contracts for the delivery of this service (with IMH and Shropdoc) expire next year, and there is no option to further extend. Our Procurement Team have advised that there is sufficient market interest to warrant an open tender exercise and that the risk (of legal challenge) to the CCGs would be significant if they were to directly award the contract to a provider instead of going out to the market.

Report prepared by Jon Hart, Senior Project Manager (T&W CCG) and Emma Pyrah, Head of In-Hospital (SCCG)

Urgent Treatment Centres – Principles and Standards

July 2017

NHS England INFORMATION READER BOX		
Directorate		
Medical	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**06861**
Document Purpose	Guidance
Document Name	Urgent Treatment Centres – Principles and Standards
Author	NHS England
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Target Audience	CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs , NHS England Regional Directors, Emergency Care Leads, NHS Trust CEs
Additional Circulation List	NHS England Directors of Commissioning Operations
Description	This document sets out the principles and standards which Sustainability and Transformation Partnerships and local commissioners should achieve when establishing Urgent Treatment Centres as part of their local integrated urgent and emergency care system.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Urgent and Emergency Care Review Team NHS England Quarry House Leeds LS2 7UE england.urgentcarereview@nhs.net

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Urgent Treatment Centres

Principles and Standards

Version number: 1.0

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Prepared by: NHS England

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact england.urgentcarereview@nhs.net

What change are we looking to see?

1. The *"Next Steps on the NHS Five Year Forward View (5YFV)"* was published on 31 March 2017. This plan explains how the 5YFV's goals will be implemented over the next two years. Urgent and Emergency Care (UEC) is one of the NHS' main national service improvement priorities, with focus on improving national A&E performance whilst making access to services clearer for patients.

2. One element of the UEC section of the FYFV is *"Roll-out of standardised new 'Urgent Treatment Centres'".* This document sets out the standards that we want to see implemented by Sustainability and Transformation Partnerships and local commissioners.

3. From the outset of our review of urgent treatment services in the NHS[1], our patients and the public told us of the confusing mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service. Within and between these services, there is a confusing variation in opening times, in the types of staff present and what diagnostics may be available.

4. To end this confusion, we have set out a core set of standards for urgent treatment centres (UTC) to establish as much commonality as possible. By December 2019 patients and the public will:
    a. Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.
    b. Have a consistent route to access urgent appointments offered within 4hrs and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.
    c. Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.
    d. Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

5. We expect reduced attendance at, and conveyance to, A&E as a result of this standardisation and simplified access, as well as improved patient convenience as patients will no longer feel the need to travel and queue at A&E. Attendances at urgent treatment centres will count towards the four hour access and waiting times standard.

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[1] NHS England (2013) Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report

6. In addition, commissioners will wish to consider if, and how, clinicians working in urgent treatment centres can also provide wider clinical assessment services to patients calling NHS 111.

Alignment with primary care and other urgent care services

7. It is the function of the system to:
   a. guide the patient to the correct level of care and treatment.
   b. provide clarity as to which services are provided where, along with providing pathways to access these services reliably 24/7.

   NHS 111 should be that guiding service for most urgent care needs, in addition to provision of treatment through the clinical assessment service.

8. Wherever a patient contacts the healthcare system they will have consistent access to all services and will, if necessary, be referred on to necessary services through a process of direct booking whenever possible. Urgent treatment centres will operate as part of a networked model of urgent care, with referral pathways into emergency departments and specialist services as required. Commissioners should make sure that all services form part of ambulance services referral pathways as an alternative to conveyance to A&E where appropriate.

9. The General Practice Forward View set out a plan for investment of a further £2.4 billion a year by 2020/21, designed to promote sustainability in general practice, improve patient care and access, and invest in new ways of providing primary care. CCGs are already beginning to commission extra capacity to ensure that, by March 2019, everyone has access to GP services, including sufficient pre-bookable and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care.

10. There is an opportunity for commissioning of a genuine integrated urgent care service, aligning NHS 111, urgent treatment centres, GP out-of-hours and routine and urgent GP appointments with face to face urgent care. Commissioners should align thinking for urgent treatment centres with the core requirements for extended access[2], as well as opportunities with the clinical assessment service that supports NHS 111. There are many opportunities to integrate wider primary care with urgent care, to rationalise the service offer, reduce duplication and flex the workforce to provide urgent and primary care services which meet the needs of the local population.

What are we asking of STPs and local commissioners?

11. There will inevitably be variation in what each urgent treatment centre may provide as the needs will be different for different populations and geographies. But in the future, all facilities must have in common the offer of booked urgent appointments, accessed through NHS111, General Practice

[2] Set out in the NHS Planning Guidance 2017-19.

and the ambulance service. Commissioners will need to consider local activity, demand management, and patient flow and throughput in the final specification of commissioned services. This will ensure that patients are directed to the most convenient service available that can provide the treatment they need, that there is consistency of access and that investment is targeted to meet demand.

12. We know that there will be some exceptions where there will be justification for offering a service that does not meet these standards, most likely in more rural or sparsely populated areas. These exceptions should be agreed on a case by case basis working with NHS England and NHS Improvement regional teams.

13. Commissioners, supported by NHS England, should review current provision, impact and local health needs assessments against the below standards and make a plan for each existing facility, alongside current provision and plans for extended GP access, subject to local consultation and following proper procurement process where appropriate. We know that many services will already offer, or be close to offering, this level of service, and others will need local investment to meet the standards. Other services, that will not meet the new standards, may become an alternative new community service; this may be a GP access hub.

Principles and standards for Urgent Treatment Centres

Principles

1) Urgent treatment centres (UTCs) are community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as "Type 3 and Type 4 A&E Departments". Urgent treatment centres will usually be led by general practitioners, and are ideally co-located with primary care facilities, including GP extended hours / GP Access Hubs or Integrated Urgent Care Clinical Assessment Services (formerly known as "GP out of hours" services).

Co-location with other services

2) Co-location with, and strong links to, other community urgent care services, such as mental health crisis support, community pharmacy, dental, social care and the voluntary sector will also be beneficial in providing an effective and integrated service. There are advantages if they can be co-located alongside hospital A&E departments to allow the most efficient flow of patients to the service that best serves their need but this will be determined by geographic distribution of urgent care sites and patient flows.

Standards for Urgent Treatment Centres

3) Urgent treatment centres must conform to the following minimum standards. STPs and commissioners may also choose to build upon or add to these, according to their requirements.

(1) Urgent treatment centres should be open for at least 12 hours a day seven days a week, including bank holidays, to maximise their ability to receive streamed patients who would otherwise attend an A&E department. Typically this will be an 8-8 service, but commissioners will wish to tailor to local requirements based on locally determined demand.

(2) Urgent treatment centres should provide both pre-booked same day and “walk-in” appointments, however patients and the public should be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.

(3) Urgent treatment centres, and NHS 111, should support patients to self-care and use community pharmacy whenever it is appropriate to do so. Urgent treatment centres should promote and record the numbers of patients offered self-care management and patient education.

(4) The urgent treatment centre should ensure that there is an effective and consistent approach to primary prioritisation of “walk-in” and pre-booked appointments, and the allocation of pre-booked routine and same day appointment slots.

(5) For patients who require an appointment in the urgent treatment centre this should be booked by a single phone call to NHS 111; locally patients should be encouraged to use NHS 111 as the primary route to access an appointment at an urgent treatment centre.

(6) Patients who “walk-in” to an urgent treatment centre should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary.

(7) Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival.

(8) Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time.

(9) Protocols should be in place to manage critically ill and injured adults and children who arrive at an urgent treatment centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance '*Quality standards for cardiopulmonary resuscitation practice and*

training'[3]*, should be immediately available.* At least one member of staff trained in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of 'design for the usual, and plan for the unusual'.

(10) An appropriately trained multidisciplinary clinical workforce will be deployed whenever the urgent treatment centre is open. The urgent treatment centre will usually be a GP-led service, which is under the clinical leadership of a GP. There will be an option for bookable appointments with a GP or other members of the multi-disciplinary team. Where the centre is co-located with an emergency department there may be justification for joint clinical leadership from an ED consultant.

(11) The scope of practice in urgent treatment centres must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head and eye injuries.

(12) All urgent treatment centres should have access to investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms (ECG) should be available, and in some urgent treatment centres near-patient troponin testing could also be considered.

(13) Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are desirable and considerably increase the assessment capability of an urgent treatment centre, particularly where not co-located with A&E. Where facilities are not available on site, clear access protocols should be in place. Commissioners will need to consider patient throughput in their cost benefit analysis where capital investment will be required.

(14) All urgent treatment centres should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).

(15) All urgent treatment centres should be able to provide emergency contraception, where requested.

(16) All urgent treatment centres must have direct access to local mental health advice and services, such as through the on-site provision of 'core' liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.

(17) All urgent treatment centres should have arrangements in place for staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient's

[3] https://www.resus.org.uk/quality-standards/acute-care-equipment-and-drug-lists/

best interests in an emergency situation where the patient lacks capacity to consent.

(18) There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flags or crisis data should be made available for patients.

(19) A patient's registered GP should always be notified about the clinical outcome of a patient’s encounter with an urgent treatment centre via a Post Event Message (PEM), accompanied by a real-time update of the electronic patient care record locally. For children the episode of care should also be communicated to their health visitor or school nurse, where known, within two working days.

(20) Where available, systems interoperability should make use of nationally-defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMED-CT) and nationally-defined record structures.

(21) Urgent treatment centres should make capacity and waiting time data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.

(22) Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability.

(23) Urgent treatment centres should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.

(24) Where appropriate, patients attending an urgent treatment centre should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).

(25) All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience. From October 2018 all urgent treatment centres must return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.

(26) All healthcare practitioners working in urgent treatment centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.

(27) All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.