Telford & Wrekin COUNCIL

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

Date: 18 March 2014
My Ref:
Your Ref:

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Wednesday, 26 March 2014**
Time: **9.30 am**
Venue: **The Council Chamber, Wellington Civic Centre, Larkin Way, Tan Bank, Wellington, Telford, TF1 1LX**

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

Members of Joint Health Overview and Scrutiny Committee

Gerald Dakin (Co-Chair)	David Beechey (Co-Optee)
Derek White (Co-Chair)	Ian Hulme (Co-Optee)
Tracey Huffer	Mandy Thorn (Co-Optee)
Simon Jones	Dilys Davis (Co-Optee)
Veronica Fletcher	Jean Gulliver (Co-Optee)
John Minor	Richard Shaw (Co-Optee)

Your Scrutiny Officers are:

Fiona Bottrill
Tel: 01952 383113
Email: Fiona.Bottrill@telford.gov.uk

Martin Stevens
Tel: 01743 252722
Email: martin.stevens@shropshire.gov.uk

www.shropshire.gov.uk
General Enquiries: 0845 678 9000
Printed on recycled paper

AGENDA

1   **Apologies for Absence**

2   **Declarations of Interest**

3   **Update on Future Fit** (Pages 1 - 18)

David Evans and Caron Morton, Joint Programme Senior Responsible Officers, and Peter Spilsbury, Future Fit Programme Director, will make a presentation to update the Committee on the progress of the Future Fit Programme. This will include progress since the December JHOSC meeting, timescales for the Programme and the Project Execution Document (including the principles for joint working).

Also attending for this item, and the other agenda items below, are Adrian Osbourne and Debbie Vogler (Shrewsbury & Telford Hospital NHS Trust) and Julie Thornby (Shropshire Community Health NHS Trust)

4   **Future Fit Clinical Model of Care** (Pages 19 - 48)

Bill Gowans, Joint Chair of the Future Fit Clinical Design Group, David Evans, Caron Morton and Peter Spilsbury will present the emerging clinical model of care discussed at the Future Fit Programme Board on 10 March 2014.

5   **Future Fit Benefits Realisation Plan** (Pages 49 - 60)

Peter Spilsbury, David Evans and Caron Morton will present the Benefits Realisation Plan discussed at the Future Fit Programme Board on 10 March 2014.

6   **Evaluation Criteria and Process**

Peter Spilsbury, David Evans and Caron Morton will explain the evaluation criteria and process for the selection of the options and preferred option for the Future Fit Programme.

**7**   **Future Fit Alignment with Other Strategic Plans**

Also attending for this item are Cllr Arnold England (Cabinet Member: Adult Social Care, Telford & Wrekin Council), Cllr Lee Chapman (Portfolio Holder: Adult Services, Shropshire Council), Paul Taylor (Interim Director: Health, Care

& Wellbeing, Telford & Wrekin Council) and Stephen Chandler (Director of Adult Services, Shropshire Council)

8   **Joint HOSC Work Programme**

To agree the issues to be considered by the Committee at future meetings

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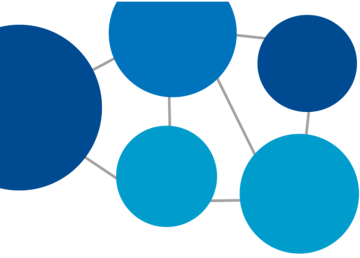
Programme Update Report

Report to:	Joint Health Overview and Scrutiny Committee
Subject:	Programme Update Report
Report by:	Senior Responsible Officers – Caron Morton & David Evans
Date:	26th March 2014

1   OVERALL

1.1   Programme Plan

#### 1.1.1   Phase 1 - Programme Set-up & High-Level Vision

Phase 1 of the Programme has now been completed. Following the approval of the Programme Execution Plan (PEP) at the January 2014 Programme Board, the PEP has since been received by sponsor Boards as follows:

- Shrewsbury & Telford Hospital NHS Trust – approved 30th January 2014;

- Shropshire Community Health NHS Trust – Case for Change approved 23rd January 2014, PEP to be considered 20th March 2014;

- Shropshire CCG – approved 12th February 2014;

- Telford and Wrekin CCG –approved 11th March 2014, and;

- Powys LHB – to be considered on 16th April 2014.

In approving the PEP, the Programme Board initially deferred consideration of the question of Programme decision making processes. A proposal for these processes has since been developed and, at its meeting in March 2014, the Programme Board discussed these and asked the two SROs to consider them further outside the meeting with emphasis on the most appropriate mechanism by which the two CCGs could consider the Programme's final recommendation and deliver a collective agreement (new national guidance having clarified that it is CCGs that are the decision makers for reconfiguration)

Key elements of the PEP are the positive Case for Change (Appendix 1) and the Programme's Principles for Joint Working (Appendix 2). **The Committee is invited formally to endorse these key documents**.

The work of the Programme is overseen by a multi-stakeholder Board (containing the two local Directors of Adult Social Care and observed by a Joint HOSC Chair) and is managed by a Programme Team. In addition, a core group of Programme Sponsors is being formed to improve the speed and pace at which the Programme can operate.
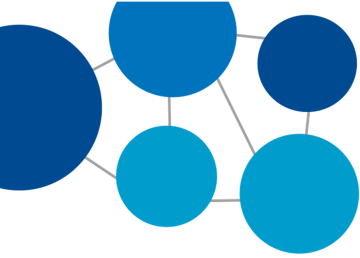
As planned, a full-time and highly experienced Programme Director, Mike Sharon, takes up his post in early April as part of the support team from NHS Central Midlands Commissioning Support Unit. Peter Spilsbury, Director of the Strategy Unit at CMCSU, will continue to contribute senior advisor input as Assignment Director . Paul Elkin , who has supported the Programme on an interim basis since last autumn ends his commitment to us in April and was formally thanked at the Programme Board for his important contribution in the initial stages of Programme set-up.

Under the Programme Team the detailed work of the Programme is conducted by the following five workstreams:

- Clinical Design;
- Activity & Capacity;
- Engagement & Communications;
- Finance, and;
- Assurance (attended by HOSC Officers and a Joint HOSC Chair).

Updates on the activity of these workstreams are provided in Section 2 of this report, including the development of the high level clinical vision.

1.1.2 Phase 2 - Development of Models of Care

The key task in Phase 2 of the Programme is to further develop the high level clinical models and to build activity and capacity projections which reflect those models. This will then enable a range of options to be identified in Phase 3.

The clinical work completed in Phase 1 is far more ambitious and wide ranging than had been anticipated. It is greatly to the credit of local clinicians that they have devoted such time and energy to leading the design process. There have been major concerns that a clinical design that focuses simply on hospitals will not be radical enough to deliver a sustainable solution. Thus the notion of painting the full canvas has emerged, out of which the FutureFit Programme will take forward the elements within its scope and, in relation to elements outside of its scope, will define the critical dependencies to be taken forward in parallel by commissioners.

A report on the emerging clinical models is included as a separate item on the meeting agenda (Appendix B). Further work to test these models is planned for the coming months before the Programme Board is asked to approve an overall model of care. This work will include:

- Iterative testing of the model against specific patient/clinical scenarios and cross-cutting themes (e.g. Mental Health, Social Care, IT);
- Further defining the evidence base for the proposed model;
- Demonstrating alignment with JSNAs and Health and Wellbeing Board strategies;
- Increased patient and public engagement, and;
- External Clinical Assurance.
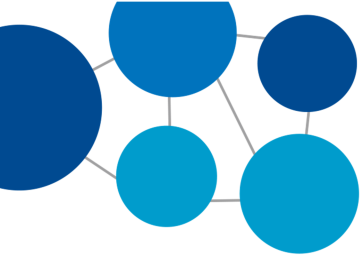
To do justice to the emerging models, and to maintain and extend the engagement we have had to date, will require several more months of work. Without this there is the risk of moving too quickly towards a decision that will not stand up to subsequent scrutiny and, indeed, will not finally deliver the radical change that local patients and clinicians believe to be necessary. It is extremely important that we get the process right. This is truly a once-in-a-generation opportunity.

As a result, the Programme Board has agreed a change to the initial Programme timetable, as set out below:

- The clinical design and activity & capacity projections phase is extended to the end of August (instead of April);

- There is an 8-week period for extended public engagement on the model of care during October and November, with the outcomes of this being signed-off by the Board in December, and;

- Preliminary work to develop a provisional short-list of options commences in October and is brought to the Board for formal approval in December alongside the outcome of the engagement process.

During the proposed extended period, further work would also be undertaken before the May 2014 Board meeting on:

- The overall financial framework;

- The Engagement & Communications Plan, and;

- The options evaluation process.

The Future Fit process is one of genuine discovery. Nothing has been predetermined so, in order to produce for our patients a clinical model that is fully owned and understood (and that we are confident can be delivered), it will be essential to work through the emerging models in detail and to test them through several iterations, facilitated by extensive engagement with the public and with clinicians. The new timeline still however allows a major extended public engagement in October /November in line with expectations and also in line with recommended best practice (the Consultation Institute) which emphasises the criticality of allowing sufficient time to engage thoroughly on the model of care.

1.1.3   Phase 3 - Option Development & Appraisal

The purpose of Phase 3 is to develop and appraise a range of options for how the clinical model could be delivered, leading to the identification of a preferred option. It is also proposed that the timetable for this phase is extended. The Programme Board at its meeting in March received a suggested revised timeline that would see formal consultation on the preferred option commencing in June 2015 (after the General Election). The Board in considering this asked the Core Sponsors Group to have further discussions to see if this could be brought forward. This was because of the perceived urgency of establishing a clear position on the future of the emergency services element in particular in order to create the conditions whereby key staff can be retained and recruited in the certain knowledge of future plans and any interim moves required to maintain safety can be aligned with that plan.
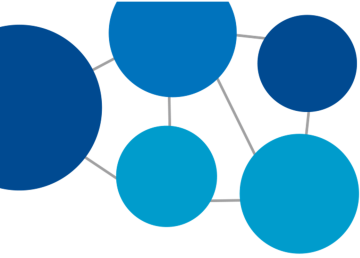
The Core Sponsors met on 14th March and have agreed to map out the implications of a timeline which allows the development of models of care to carry through to end August with extended engagement thereafter (as above) , but which aims to go to formal consultation straight after Christmas on the preferred option for emergency and high acuity care as a key component of that overall clinical model . This would allow the consultation to close prior to electoral 'purdah'. To be able to do this would require some significant work on possible site options etc to be undertaken in parallel, and therefore at risk. It will be vital to ensure that this is presented to the public and wider clinical body with great care and with maximum transparency if trust in the authenticity of a Programme 'without predetermination' (the key ask from Call to Action) is not to be undermined.

We would welcome a discussion with the Joint HOSC on this proposed approach and timeline for public engagement and consultation.

1.2   Risk Register

A Programme Risk Register has been developed and currently contains two red rated risks:

- Programme resources – this mostly relates to the significant resources now required for communication and engagement work and a plan is in place to secure this resource, and;

- Inability of stakeholder organisations to release key staff for the Programme – this has highlighted the need for those organisations to agree with key staff the time and capacity required.

The Programme Team is currently further developing the risk register and associated risk management procedures for the Programme in line with best practice.

1.3   Benefits Realisation Plan

A Benefits Realisation Plan for the Programme continues to be developed including with some extremely helpful input from the Clinical Reference Group. The emerging draft is included as a separate item on the meeting agenda (Appendix C), and will be further developed under the leadership of the Programme Team over the coming weeks, including input from patients.

1.4   Gateway 0 Review

The national Government Gateway Review process seeks to provide an assessment of confidence in the ability of the Programme to deliver its stated objectives. It seeks also to provide recommendations, where appropriate, to improve the likelihood of successful delivery. Gateway 0 reviews are intended to support projects with constructive feedback in the earliest stages.

A wide range of some 26 stakeholders were interviewed by the Review Team from 3rd to 5th March, including Joint HOSC Chairs.

The Gateway Team rated the Programme as Amber, which is in line with expectations at such an early stage. They made positive comment on the commitment and energy they witnessed and on the extent of agreement about the importance of the Programme and the case for change that it was seeking to address. They noted the high calibre of the personnel they interviewed and made a number of recommendations including the need to:
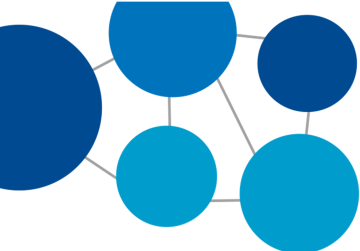
- Review the size of the programme Board to make it more manageable (see Section 1.1.1 above);

- Improve risk management processes (see Section 1.2 above), and;

- Increase the resources available for communications and engagement activities (see Section 2.3 below).

The final report is made in confidence to Programme SROs but will be made public for transparency and openness. Where recommendations are made, the Programme Team will develop and implement an appropriate action plan.

1.5 External Clinical Assurance

The Programme Board has approved a proposal for External Clinical Assurance through the National Clinical Advisory Team (NCAT). Since that time it has emerged that NCAT is to cease to exist and its functions to be taken over by regional Clinical Senates. The Programme is currently in discussion with the West Midlands Clinical Senate with a view to agreeing arrangements for both informal and formal engagement around the clinical model of care.

2 WORKSTREAM UPDATES

2.1 Clinical Design

The workstream continues to meet fortnightly to oversee the clinical design work. It has prepared and facilitated a second successful meeting of the Clinical Reference Group (CRG) which was attended by 40 clinicians and others. Draft clinical model frameworks were reviewed and further developed, and very helpful input into the Benefits Realisation Plan was received. The next CRG meeting is on March 26th.

The outputs of CRG meeting have been used by sub group leads to inform the development key clinical constraints and opportunities – 'system drivers' – which have subsequently been used as a basis for setting out high level models of care. This work has been undertaken by three sub groups: Acute & Episodic, Long Term Conditions & Frailty and Planned Care. Each group met twice during February. In addition, a series of patient focus groups have been held. A summary of this work is on the Programme Board agenda.

The sub groups now need to refine their models and to identify patient types at various points in their designs in order to enable activity and capacity modelling to be undertaken.

2.2 Activity & Capacity

Seven acute hospital workshops have been held to agree the clinical parameters on which activity and capacity modelling of the so-called 'do minimum' option should be based. The projected impact of these parameters has been reported back and discussed by the workstream.

Two community hospital workshops have also been held. The group agreed that the results reflected a radical shift in the utilization of community hospital beds in terms of (a) reducing length of stay (b) increasing the proportion of admissions/occupied bed days for 'step up' rather than 'step down'.
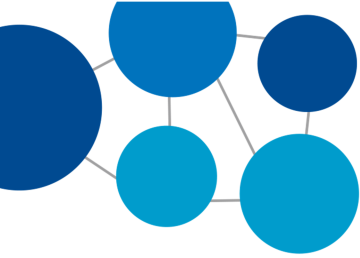
The outputs of the community workshops is published along with a summary report, and the acute output is due to be available shortly.

A key conclusion of these workshops is that marginal change within the current service models would not, of itself, be sufficient to meet the economic challenges faced in the medium term.

2.3   Engagement & Communications

An Engagement and Communications plan has been worked on but is now going to be developed through a co-production event with key stakeholders in order to respond to some of the concerns raised about this aspect of the Programmes activities. Activities to date include:

- Issuing of final branding templates;

- Work to develop a programme website;

- Publication of the first Programme Bulletin, and;

- Planning and delivery of 3 patient focus group events.

Urgent consideration is being given by the Sponsors to the resources required to support the proposed extended engagement activities (at the outset a budget was not established pending further development of the engagement plan)

2.4   Finance

The workstream has established a schedule of meetings and agreed an approach to, and structure of, a single financial model for the Programme. Additional external resource has been procured to support the development of the model. This is an important development as experience elsewhere shows that failure to jointly develop a single financial model can seriously hamper Programme success.

Work has also commenced to assess the likely future capital investment capacity of provider Trusts and the future recurring affordability envelope for Commissioners.

Finance leads have raised a concern about their ability to devote sufficient time to the Programme (see item 1.2 above).

2.5   Assurance

There have been three meetings of the Assurance Workstream:

- The first focused on a detailed review of the workstream responsibilities as set out in the Programme Execution Plan to ensure that each member had a common understanding of the nature, scope and extent of these responsibilities. There was an in-depth discussion on the development of the Assurance Plan which was circulated to all Workstream Members and all Workstream Leads for observation and comment.

- The second meeting focused on a line by line review of the Assurance Plan and areas for refinement and review. The Workstream also reviewed the arrangements for the OGC Gateway Review taking place over 3rd – 5th March 2014 and considered the first iterations of the Benefits Realisation Plan and Risk Register.
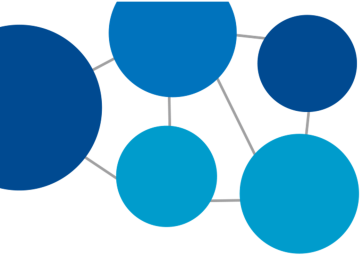
- At its third meeting the workstream agreed the final draft assurance plan for consideration by the Programme Board. A paper was also received setting out how the Programme might work productively with the Joint Health Overview and Scrutiny Committee.

As part of developing the overall assurance plan, the workstream has prepared a matrix of key decisions required and will be clarifying the actions required by each sponsor Board:

| |
| --- |
| Programme Execution Plan/ Case for Change |
| Clinical Model of Care |
| Benefits Realisation Plan |
| Evaluation Criteria & Process |
| Selection of short list of Options |
| Selection of Preferred Option |
| Consultation Document |
| Outline Business Case |

The Programme invites the Joint Health Overview and Scrutiny Committee to advise which of these key decisions it would expect to consider formally.
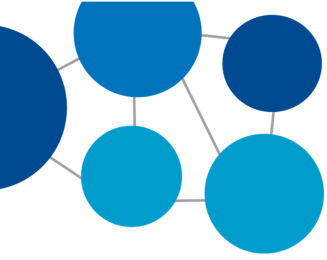
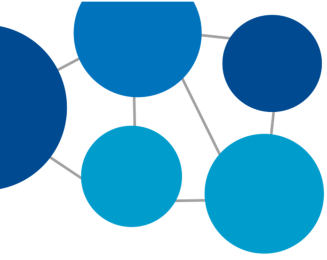**Caron Morton & David Evans**

Programme Senior Responsible Officers
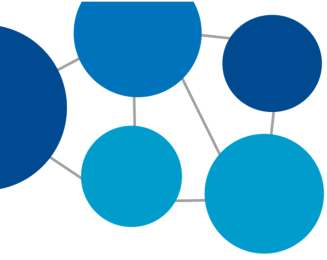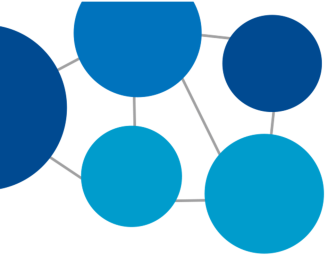
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The Case for Change

Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

This then is the positive case for change.....

......the opportunity to improve the quality of care we provide to our changing population.

The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

Changes in our population profile - The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

Changing patterns of illness - Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

Higher expectations - Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

Clinical standards and developments in medical technology - Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

Economic challenges - The NHS budget has grown year on year for the first 60 years of its life ……in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy and the UK economy within that is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

Opportunity costs in quality of service - In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities - In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

Call to Action

In November 2013 we ran a major consultation exercise with public and clinicians under the national Call to Action for the NHS. The response was very clear in saying that the public wanted full engagement in thinking through options for the future and that nothing should be predetermined. Nevertheless, in the light of the factors described above, there was real consensus between public and clinicians about the following:

- An acceptance of there being a case for making significant change;
- A belief that this should be clinically-led and with extensive public involvement;
- A belief that there were real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;
- An agreement that hospitals are currently misused. This is not deliberate but as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives;
- A belief that it is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of the rural and urban populations of this geography - but if we are to succeed we must avoid being constrained by history, habit and politics.

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Our 'Moral Compass' - Principles for Joint Working

Given the 'Case for Change' and the goals and objectives of the Programme, it is recognised by all parties that complex and difficult decisions lie ahead if this Programme is to succeed in delivering the improvements to care and to health that we seek for the populations we serve. There are several potential trade-offs which cannot be avoided. In every one of these there will be a balance to be found, but one which can never satisfy every individual interest:

§ The 'common good' (for all who look to services in this geography for their health care) versus the individual or locally specific good (the preferences of sub groups);

§ The present versus the future;

§ Organisational interest versus public interest;

§ One priority versus another when resources are limited.

It is the role of leaders to reach decisions on these, and to do so transparently and objectively.

The Programme is a collective endeavour because all who are party to it - sponsors and participants - recognise that this is the only way that the scale of the challenge and opportunity for this whole geography can be met. But working collectively, whilst still acting as separate statutory organisations, requires agreement on what we have called a 'Moral Compass' - ways of working designed to help navigate through when it gets difficult and when the 'trade-offs' have to be decided jointly.

We have agreed the following principles for our Programme - we will hold ourselves to account against them, and would ask others to do the same:

§ We are concerned with the interests of all of the populations in England and Wales who use hospital services provided within the territories of Shropshire and Telford and Wrekin. We desire to maximise benefit for that whole population. Whilst our decisions seek to deliver the greatest benefit to the whole population we serve, we will always consider the consequences of any options for either specific local populations or for the needs of minority and deprived groups and will be explicit about how we weight these and our rationale for so doing.

§ Participant organisations will individually sign up to the single version of the Case for Change and, at the appropriate point, to a single shared strategic vision and high level clinical model that arises out of the Programme and its response to the Call to Action and other engagement processes. This will be in addition to the collective sign-up represented by the Programme Board agreeing the Programme Execution Plan.

§ The Programme will agree, in advance of its key decision–making on the selection of options, an objective set of criteria that will be employed, and these will also be signed-up to by individual constituent organisations at that stage. These will explicitly address the basis for considering the trade-offs referenced earlier.

§ We will make shared decisions on which innovations to roll out at scale, recognising that any one might not always favour all parties and that some sacrifice for the common good will be necessary.

- § We will openly consider all options that can enhance our ability to reach collective decisions on key issues, including governance arrangements which are designed to bind our respective boards together.

- § We will work collectively with our stakeholders, including politicians, to invite agreement from them to the case for change, the clinically –led model and the principles for decision making.

- § We recognise that we will need to find ways that can meet our programme objectives within current levels of overall expenditure. We cannot add costs, instead we need to redistribute resources to achieve a better overall outcome for the populations we serve.

- § We will ensure that we develop a shared financial model so that any plans or changes can be assessed on whether they deliver authentic economic benefit i.e. we will not plan to deliver savings in one part of our system if the inevitable consequence is (unplanned) cost increases in another.

- § We will develop ways to share the financial risk when implementing major change…we recognise that national payment formulae may not support what we are agreeing to do and we will adjust for that where appropriate.

- § We will share all information necessary to allow the Programme to deliver our objectives and will do so in line with the laws and guidance on Information Governance.

- § We will share organisational plans and be transparent re budgets.

- § We will deliver our individual contributions to the work of the Programme to the highest quality possible and on-time.

- § We will all use a single version of documents pertaining to the Programme and these will be prepared for us by the Programme Office. We will coordinate consideration of key documents so that we avoid the issues (of fact and perception) that can arise when key considerations or decisions are taken sequentially rather than simultaneously.

- § We will work together to ensure that public and patient engagement in our Programme is extensive, timely and meaningful and that we engage in the formulation of options as well as in response to recommendations on them - we want this Programme to be characterised by co-production with patients and public.

- § The response to Call to Action told us that the public, whilst wanting full engagement at all stages and no predetermination of outcomes, want and respect clinically-led development of strategies and options. We will ensure that this happens.

- § Whilst partnership and collective working on the Programme is essential, so too at times will be the need for organisations to pursue their own objectives (e.g. in relation to competition amongst service providers). Where this is felt by any constituent to be the case, then we agree to making that explicit to our partners, to explain our position, and to work with the Programme to enable continued collective decision making to continue.

- § The response to the Call to Action asked us to avoid being constrained by history, habit and politics and to look to do 'the right thing'. We will explain any decisions we make clearly and in that light.

- § Being part of the CSR Programme represents a clear commitment, and we will take collective responsibility for making progress towards a shared vision for improved services and health.

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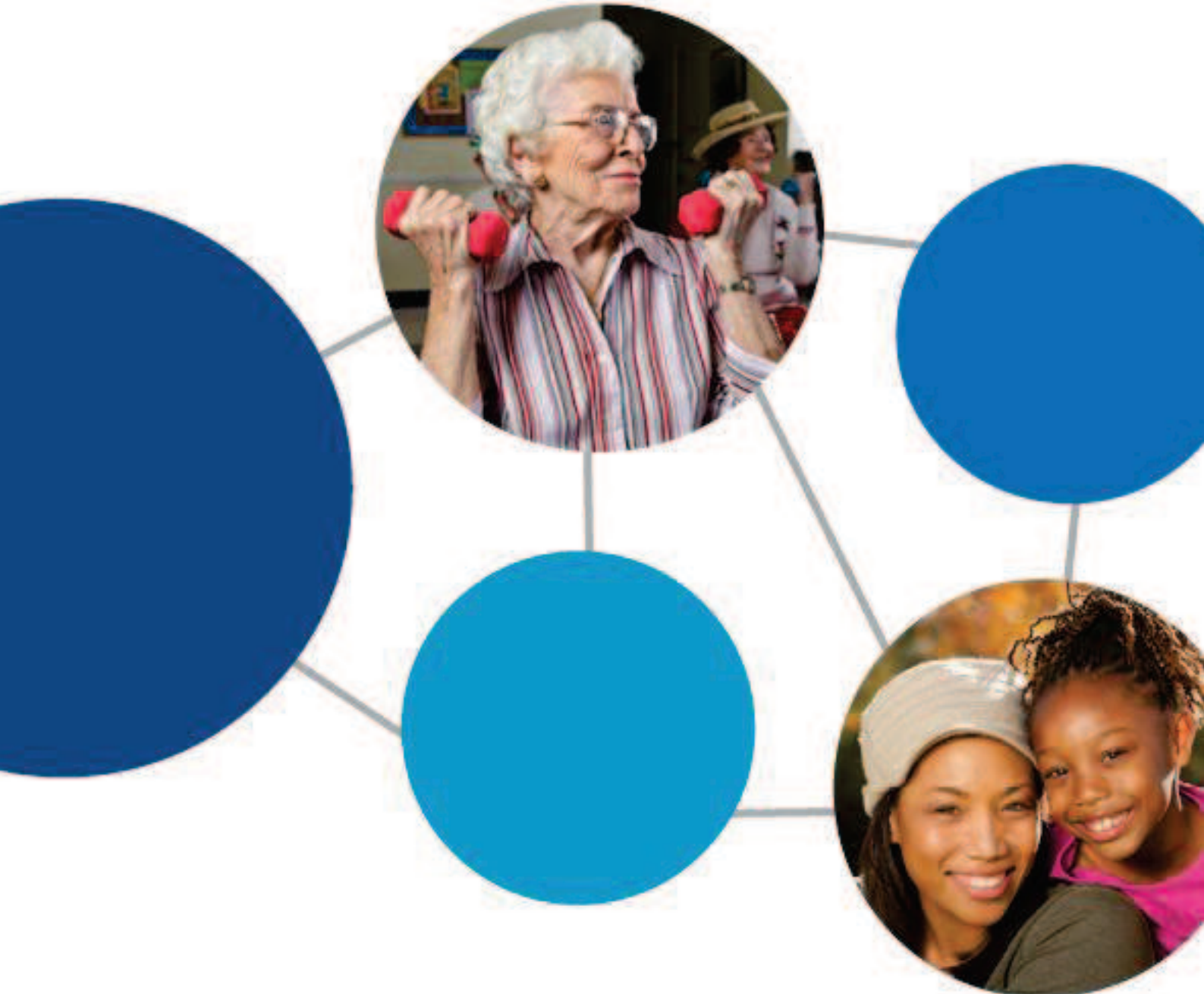
Clinical Design Workstream

A Report of Output
November 2013 -March 2014

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1. Introduction

The Clinical Design workstream was established in November 2013 and used the results from the patients' and clinicians' Call to Action survey and meetings as a starting point for its work. From this, it has established an approach to ensure that the future of hospital and community services is considered within the context of the whole system. It has embedded a process which maximises patient and clinician engagement and co-creation, and agreed that there is a compelling case for change. It has also considered the clinical and design principles applicable to the whole system and key components within it, examined the national and international evidence base and formulated high level models of care across the whole system which have undergone some initial testing.

The output up to this point, together with a summary of next steps, is described fully in the following report.

2. Scope of the Clinical Design workstream

The design of high quality, safe, efficient and sustainable hospital services must be done within the context of a coherent and deliverable whole system plan. So, although the scope of the FutureFit programme is confined to the future of acute and community hospital services, the clinical design work stream is required to consider the health and social economy as a whole and establish models of care which fully integrate all services within it. The success of FutureFit is likely to depend on achieving whole system transformational change. This has significant implications for commissioners as well as the organisations, services and workforce that currently lie beyond the scope of this programme.

3. Process

Following the Call to Action surveys and events, a Clinical Reference Group comprising 50 senior clinicians from health and social care, along with patient representatives, met on November 20th 2013 to receive the results, from which a case for change was established and whole system design principles were debated and agreed.

The Clinical Reference Group met again on January 29th 2014, during which it confirmed the output from the first meeting, suggested what success would look like and how to measure it and discussed the clinical and design principles applicable to the three main areas of health care delivery:

- Acute and Episodic Care;
- Long Term Conditions / Frailty, and;
- Planned Care.

Three subgroups were formed to consider these areas further; each subgroup comprising approximately 30 clinicians from health and social care along with patient representatives. They each met for six hours during February 2014 to add more detail to the design and clinical principles, to establish high level models of care in each area and to begin a process of sense checking, testing and refinement of the models.

The core Clinical Design workstream, reporting to the Programme Team, has planned and overseen this process and will remain responsible for the next steps described at the conclusion of this report.

4. The Case for Change

4.1 Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)

- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

This then is the positive case for change - the opportunity to improve the quality of care we provide to our changing population.

4.2 The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

4.2.1 Changes in our population profile
The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

4.2.2 Changing patterns of illness
Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

4.2.3 Higher expectations
Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

4.2.4 Clinical standards and developments in medical technology
Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult

to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

4.2.5 Economic challenges

The NHS budget has grown year on year for the first 60 years of its life ......in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy, and the UK economy within that, is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

4.2.6 Opportunity costs in quality of service

In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

4.2.7 Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities

In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

5. Acute and Episodic Care

5.1 Key Principles

5.1.1 Care close to home

An enhanced and integrated education and prevention programme, 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. This is discussed further in the LTC section.

Easy access to understandable and trustworthy information about self care options and local services, combined with clear signposting to points of access appropriate for the level of urgent or emergency care required.

A single point of access for professionals to navigate patients to a wider range of integrated and community based services.

Urgent (not emergency) care delivered by expert community generalists as a default, with prompt access to specialist advice and opinion when required.

5.1 2 A needs led service

Patient access to urgent and emergency care should be dependant on the level of care they require. Quality, safety and achieving the best outcomes will come before choice. Services will be rationalised so they are more consistent in their quality and the services they offer. This will make it easier to effectively triage, signpost and brand to ensure more appropriate attendances at the right point of care, which should be the least intensive level required to fully meet every patient's needs in order to maximise efficiency and reduce iatrogenic harm.

5.1.3 Integrated care

Integrated care records are a necessary component of an integrated health and social care system and their development should be of the highest priority. Patients regard them as a reasonable proxy for continuity of care.

Agreed pathways of care should run seamlessly across the whole system and span whole patient journeys. They should be consistent across all localities, 7 days a week. Local variation due to rurality should not obstruct integration.

There should be smooth transitions between levels of care. Providers should define their transitions as carefully as their core business.

Holistic assessments should be the default in all care settings.

5.1.4 Care by experts

An early expert opinion should be available from senior clinicians in all settings. A principle of right care first time: 'triage – diagnose – treat / palliate' should be the default.

An education, training and workforce review will be required and new roles developed in order to provide expert opinions in all settings 7 days a week.

5.1.5 Consistent and consolidated services

A single high acuity emergency centre, providing expert specialist and generalist led services, will provide multiple clinical benefits. It will consolidate resources, improve teamwork and integration, improve quality and safety, allow more effective generalist support in lower acuity settings and provide an economy of scale and high volumes of care to maximise expertise and improve outcomes.

'Some' community based urgent care centres, staffed by expert generalists with easy access to specialist support, will provide services closer to home but at a sufficient scale to ensure consistent, effective and sustainable 'modular' services.

5.1.6 Sustainable systems

The 'critical mass' of urgent and emergency care delivered by one emergency centre and 'some' urgent care centres will enhance recruitment and retention of staff.

Continuous monitoring and learning should be embedded to allow service evolution and improvements and to develop predictive forward planning.

Commitment to this model of care should be long term.

5.2 Model of Care for Acute and Episodic Care

5.2.1 Patient Flows

An internet 'patient portal', available on all platforms, will provide easy, trustworthy and localised information regarding self help, advice and signposting. This will include and integrate health, social and voluntary sector information.

A 'Smart' Single point of telephone access (111) will intelligently triage all requests for urgent care (defined as requests for same day assessment) and signpost patients to the right point of care, including the capacity to make appointments at their GP practice if less urgent, or at one of the urgent care centres. This service will be linked to a live demand and capacity management system to improve patient flow.

As a default, LTC urgent care should be 'planned' as active case management will detect exacerbation at an early stage.

There will be increased signposting to local pharmacies for low level urgent care advice and treatment. Pharmacies will 'cluster' with GP practices and develop closer working relationships.

5.2.2 One Emergency Centre

A single, fully equipped and staffed high acuity emergency centre with consolidated technical and professional resources delivering high quality emergency medical care 24hrs 7 days a week. A combination of expert generalists (Acute physicians, COE consultants and new roles etc) and specialists (ED consultants and specialists) will provide early expert opinions at all times. It will serve as a trauma centre with a co-

located critical care unit. Other adjacencies include facilities for ambulatory care and assessment units with multi-disciplinary teams (including mental health) specifically dealing with patients suitable for 0 day length of stay (LOS) pathways (ambulatory care) and <3 day length of stay (LTC and frailty syndromes). There will be also be full and immediately accessible diagnostic facilities, blood bank and pharmacy.

Access will be via 999 ambulance or co-located urgent care centre.

A single emergency centre will improve safety and quality of care and focus resources to improve teamwork. Integration and consolidation of the workforce will promote better working practices both within the unit and in providing support to generalists in lower acuity settings. Improved trust and relationships across different care settings will be embedded through partnership care and rotating / posts, some in new roles designed to promote integrated care and whole system pathways.

5.2.3 'Some' Urgent Care Centres
Multiple units provided at 'cluster' GP practice level of 'modular' and consistent design to provide low and medium levels of urgent medical and care input. Some diagnostic facilities and a pharmacy will be available on site. Co-located with a range of mental health, community and voluntary sector services, GP Out of Hours, and in some centres medium acuity beds. Timely expert generalist opinion available 7 days. One Urgent Care Centre (UCC) will be co-located with the Emergency Centre and receive all the 'walk in' patients who will not be able to access the Emergency Centre unless transferred by a clinician from the UCC. Urgent Care Centres will be staffed by a combination of advanced practitioners and GPs from the 'cluster' of practices surrounding it. From a GP practice perspective, urgent care will be provided at cluster level, whilst LTC management and other non urgent work will remain at practice level. Continuity of care at urgent care centres will be achieved through integrated care records, whilst continuity of care for patients with LTCs will be through a named clinician or keyworker (in addition to integrated care records).

5.2.4 Partnership Care

Specialist support will be easily and quickly available to support generalists in lower acuity care settings, including urgent care centres. This will be in the context of the development of partnership care across all care settings with a re-definition of generalist and specialist roles to include a greater teaching and learning component to increase generic skills and improve the consistency of care. Communication between professionals will be frequent and direct (not via a third party) which will improve working relationships, feedback and learning. This model is described in more detail in the LTC section.

5.2.5 Professional Navigation
There will be a single point of access (SPA) for professionals to arrange further care and support for patients following their urgent or emergency care contact. This SPA will act as a portal to a wide range of community based integrated care options. For complex care issues, the SPA will initiate contact but care planning will then be finalised through direct conversation between professionals. For simple care issues,

a 'handover' will be managed through the SPA service with integrated care records serving as a valid proxy for continuity of care.

5.2.6 Integrated Community Care

Urgent and emergency care will be delivered in the context of whole system integration. Services will be provided by teams around the patient, not by a series of independent professionals working within their own organisations and professional boundaries. Community capacity will be built to keep people at home and out of hospital, deliver reablement in the community, enhance the role and involvement of primary care and consistently deliver the right care in the right place by the right staff. Access to these services will be available from all points of patient contact via the SPA. This is further discussed in the LTC section.

5.3 Diagrams of the Acute and Episodic model of care

'Some UCCs'

Primary Care & Community Services

Voluntary Sector?
Beds??
Mental Health?
Social Care?
Therapies
Diagnostics
Urgent Care Centre
GP OOH

'One EC'

Urgent Care Centre
Primary Care
GP OOH?
Specialties
Assessment Units
Diagnostics
Emergency Centre
Critical Care
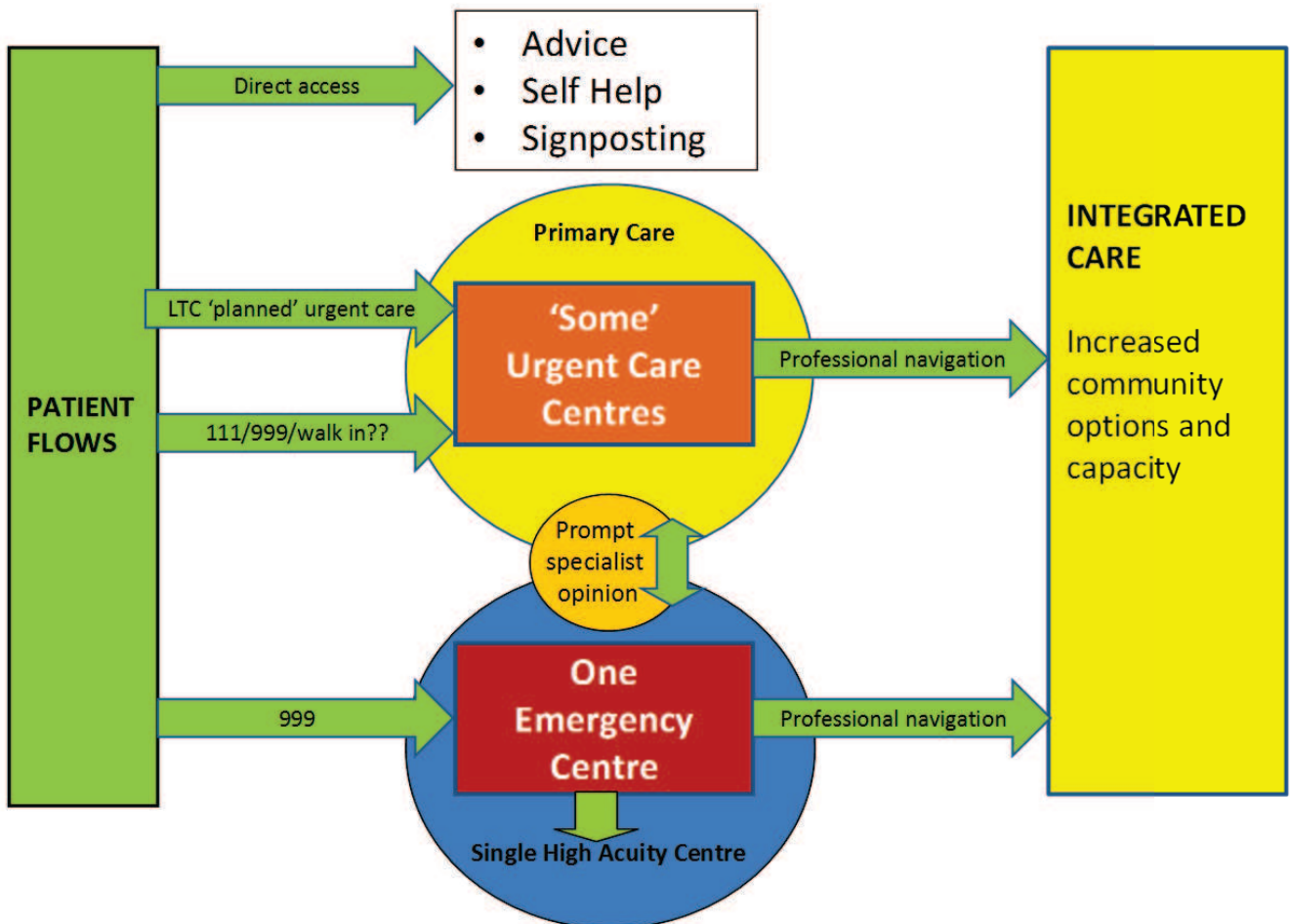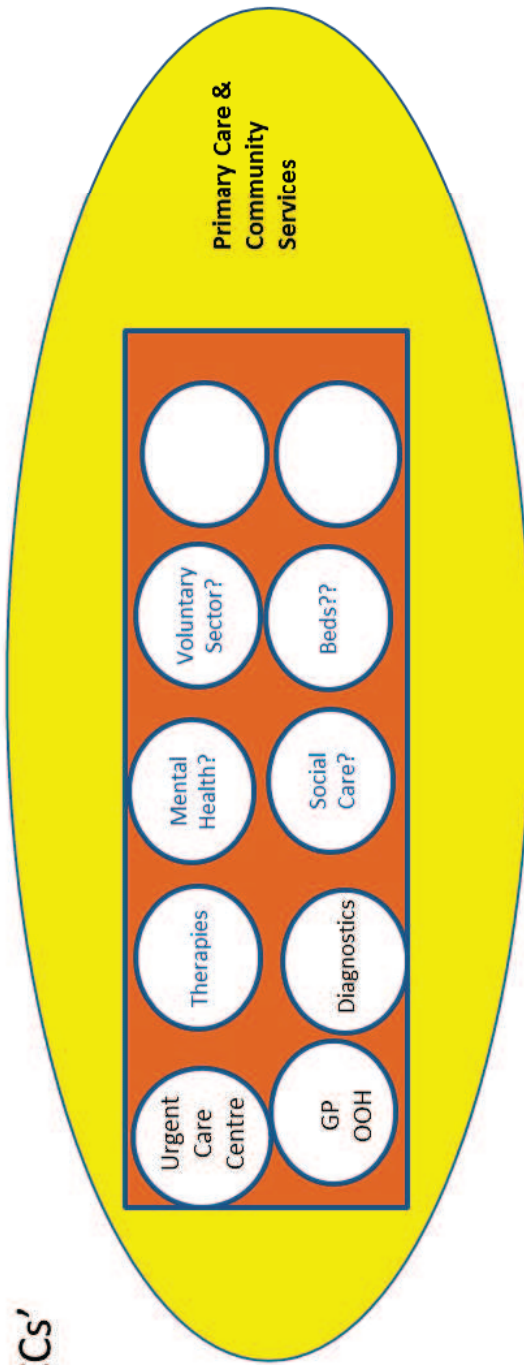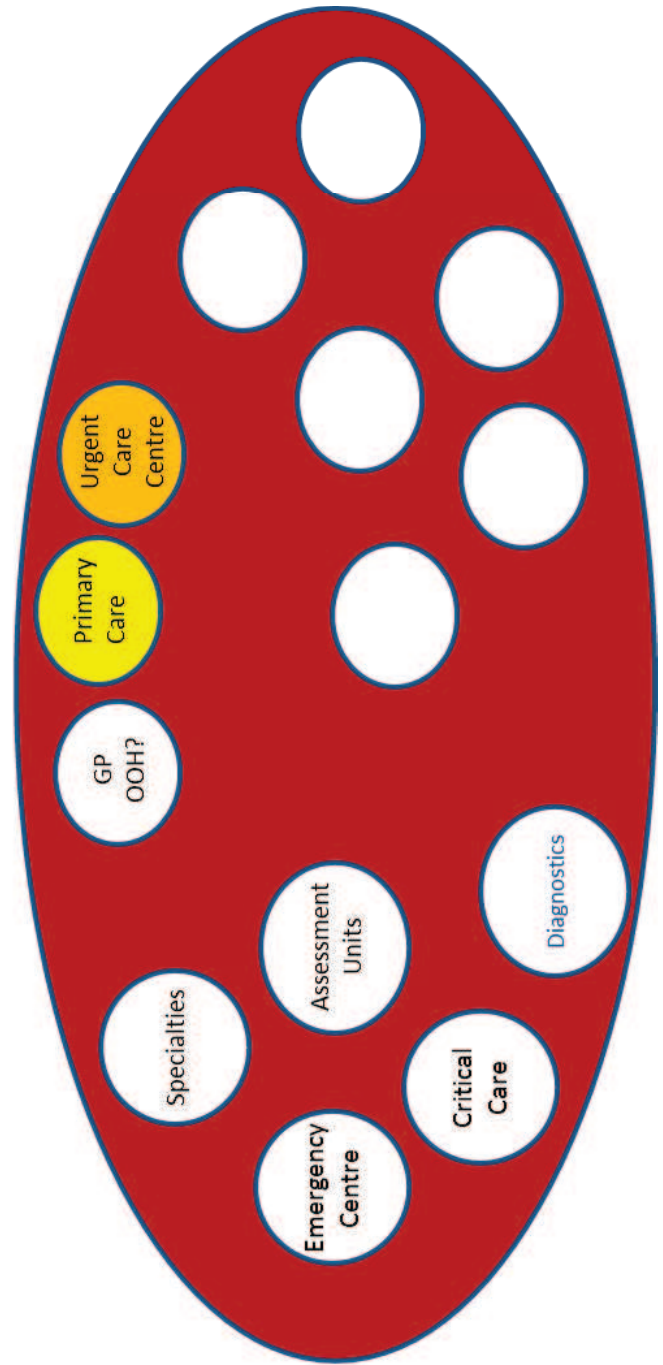
6. Long Term Conditions and Frailty

6.1 Key Principles

6.1.1 Enable patient responsibility for prevention, self care, maintenance and accessing appropriate care

Enabling patient responsibility should be embedded in all models of care. Although there is mixed evidence of short term impact on admissions and cost, there is an overwhelming case for empowering citizens and communities to be co-responsible for managing their lives and social environment, whatever their health status.

Many long term conditions are preventable and systematic secondary prevention shows improved outcomes. The medium and long term potential for reduction in health and social care demand is great.

Targeted prevention activities in social care have demonstrated impact although there is currently no statutory obligation for Local Authorities to invest in prevention.

Public Health and all other stakeholders must be involved and particular focus is required for hard to reach groups. The prevention agenda should form part of the school curriculum.

Behaviour change, education and support will often be more effective and sustainable if delivered by peers rather than professionals.

Self management of Long Term Conditions is at an early stage of development with little hard evidence as yet to support significant investment. It is the view of the clinicians locally however that it is aligned with the principles of citizen empowerment and community mobilisation as well as the emergence of assistive technology, self care should be a central component of LTC management.

People with co-morbidities and who are frail have less capacity for self management and require a different approach, especially when they are ill. Frailty syndromes are now recognised as an independent risk of worse outcomes and do not fit well into pathway driven care which the patient can be co-responsible for. They require a named key worker or responsible clinician with whom they can share decisions and who can act as their advocate. This is also the case for other vulnerable groups such as people with learning difficulties.

6.1.2 Generalist care as a default, with partnership care between generalists and specialists and clearly defined indications for specialist care

Generalists perform holistic assessments as a default and should be available in all care settings. Workforce planning and redesign will increase the number of generalists, many of whom will also develop specialist skills. This includes GPs, community health professionals and acute care clinicians. They will be responsible for initial assessment as well as the co-ordination and continuity of care for the majority of patients.

Specialists will offer timely response to support generalist care. They will assume greater responsibility for education and learning to improve the generic skills of generalists in all care settings. They will continue to be responsible for the care of the most complex patients.

Partnership care between generalists and specialists will become the norm with a more dynamic and greater range of options to share the care of patients through meaningful and direct conversation, interaction and information flow. This will allow the care of a greater proportion of patients to be managed by generalists in a community setting with targeted specialist input when required. Resources must shift to support this.

Partnership care will be developed across the whole health and social economy. The integrated health and social care of a patient will be provided 'in parallel' (not 'in series' as is currently the case) with shared risk management.

Better relationships will allow 'honest feedback' and more effective mutual and case based learning.

Age transitions, especially in mental health and paediatric care are currently a problem which will be resolved when continuity of care is managed by a community generalist working across all age groups.

Integrated care records are a key requirement for partnership care.

6.1.3 Provide a better match between needs and levels of care through a systematic shift towards greater care in the community

People prefer to be cared for in their own home whenever possible, even when they are ill.

Too much care is currently provided at levels of care which are higher than patients require to meet their needs. This is not only resource inefficient, but also increases the risk of iatrogenic harm. Up to 30% (?) of people admitted to acute hospitals could be managed safely and effectively in a different care setting and at a lower level of care.

Patients cared for at home remain connected to their family and carers. Community support remains continuous and the patient is less likely to 'decompensate' by being cared for in a bed based acute environment which is also much more stressful. Individualised care can be delivered more easily by integrated teams. The potentially difficult and harmful transitions from home to hospital and back again are removed. Performing an accurate and holistic assessment of needs is much more difficult when a patient is not in their usual living environment.

Home will not be the right place to care for everyone who is ill. Some of course require high levels of care in an acute hospital bed, but other alternatives must be provided that offer a 'medium' level of care.

Community capacity must be built to accommodate this shift. The required shift in resources to achieve this poses a challenge. It is not necessarily cheaper to provide care at home when intensive input is required.

6.1.4 Move from reactive to proactive care, including risk stratification, care planning, early detection and intervention and 'planned' urgent care

The evidence base supports the provision of proactive care for a number of specific conditions but does not yet show improved outcomes for people with multiple co-morbidities and frailty. Nevertheless, the new GP contract and local clinician consensus both support a move to providing more proactive care. Clinical experience strongly suggests that it reduces the number and severity of crises and gives reassurance to patients, families and carers that they know what to do and who to contact in the early stages of exacerbation.

There is uncertainty about what percentage of the 'at risk' population would benefit from active case management. It is important not to shift resources into ineffective interventions and targeted proactive care will remain preferable until the evidence base is clearer.

6.1.5 Provide timely response to exacerbation and ensure enhanced recovery and rapid reablement with a minimum time spent in acute care settings

Integrated multi-disciplinary teams are needed to address all the issues, both in community and acute settings and care must remain joined up at all times.

An exacerbation related to an existing LTC should not require admission, but may require diagnostics.

Once in hospital, the LTC tends to be ignored in preference to the exacerbation and the patient has an 'asymmetric' experience of their assessment and care because of this. Holistic assessment as a default will address this.

Discharge planning must start at the time of admission, and patients think this should be done by the ward staff caring for them, not a separate team. Provide Estimated Dates of Discharge for all patients soon after admission.

Standardise simple discharge processes and provide bespoke planning for complex discharges.

Employ strategic operational planning to maximise 0 day length of stay (ambulatory care and <3 day length of stay (frailty teams) in acute settings.

'Discharge to assess' as default once medical condition stabilised. Reablement at home where possible and in community setting if not. Aim to return patient to original level of care.

Resolve governance issues around free NHS and assessed social care which currently inhibit integrated care.

6.1.6 Diagnose and plan the last year of life and stop sending people to hospital to die.

Once fully embedded, End of Life (EOL) care will become part of 'the day job' but this will require care co-ordination and equity of care for all terminal conditions. EOL care is currently unstructured and patchily commissioned. To improve this, a consolidated EOL package will provide better care and reduce costs. A roving palliative care team would be effective and cost efficient.

6.2 Model of Care for LTC

6.2.1 Prevention

An economy wide prevention strategy driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim.

Targeted primary prevention across all health and social care settings employing 'make very contact count' and upskilling the workforce in behavioural and motivational change techniques.

Systematic secondary prevention.

6.2.2 Partnership Care

Primary care generalists (mainly GPs) retain continuing responsibility for care and co-ordination with rapid access to specialist support as required.

A menu of options to facilitate timely and personal communication between generalist and specialist to share decisions and improve care planning for patients at all levels of acuity: routine, urgent, emergency and end of life.

Clinical conversations, mutual learning and honest feedback will improve working relationships and the quality of care.

Direct access for generalists to pathway driven diagnostics to reduce unnecessary secondary care referrals.

Specialists will continue to manage and be responsible for the continuing care of a smaller number of the most complex patients, but with a greater responsibility for education and upskilling the generalist workforce.

6.2.3 Self Management and Care Planning

Upscale self management programmes and combine with care planning as a routine for anyone with an LTC.

Active case management for those at high risk, targeted initially to those conditions where benefit is evidenced.

Upscale peer and community support programmes

6.2.4 Integrated teams

Integrated multi-disciplinary teams providing case management, timely response to exacerbation and facilitating discharge.

Strong links with primary care, 'teams around the practice' aligned with 'teams around the patient'.

Specialist skills linked to and augmented by integration with acute care specialists.

Sustainability achieved through generic upskilling across professional boundaries, using individual specialist skills as the teaching resource.

Embed continuous learning and review within the teams to ensure maximum effect from integration

6.2.5 Increased Levels of Care

Timely and appropriate response to exacerbation through a 'tiered' increase in level of care:

- Low medical input provided by a 'hospital at home service' for minor exacerbations where short term additional care and rehabilitation at home allows the patient to continue living independently. With effective case management and early detection of exacerbation, this level of care will be appropriate for an increasing proportion of people with LTC exacerbations.

- Medium medical input provided in a community setting, but not in the patient's home. 'Step up' higher intensity care and rehabilitation can be combined with more frequent and expert medical input to hasten recovery with the aim of returning to the original level of care. Integration of care in these settings with care provided in acute settings will improve quality and flow.

- High medical input provided in a single high acuity unit with a consolidated and integrated workforce as described in the key principles.

6.2.6 Reablement and rehabilitation

Discharge to assess as the default from acute care settings.

Reablement at home as the preferred option with the aim of a rapid return to the original level of care and the withdrawal of additional care and support.

Reablement in a community setting but not at home for those patients with slow to resolve exacerbations, people who will not return to their original level of care, including those awaiting care home placements. Aligned with 'step up' processes, an EDD and discharge planning will be standard for 'step down', using the same or similar criteria to those employed in acute care settings.

Identify and fill gaps e.g. neuro rehabilitation.

6.3 Diagram of the Long Term Conditions model of care

Generalist Care
- Primary and community workforce
- Holistic assessment
- Continuing patient responsibility
- Continuity of care
- Community care co-ordination

Partnership Care
- Generalist as co-ordinator
- Specialist support when required
- Direct communication
- Shared decisions
- Mutual learning
- Health and Social Care
- All services and levels of care

Specialist Care
- Concentrated workforce on one site
- Integrated specialist teams
- Supporting care in lower acuity setting
- Emphasis on education and upskilling

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Patient with LTC
- Targeted prevention
- Early detection
- Self management
- Key worker / named responsible clinician
- Integrated care record

Integrated Teams
- Case management
- Timely response to exacerbation
- Facilitated discharge
- Holistic care
- Generic skills
- Continuity through personal care

Increased Levels of Care

Low Medical Input
- 'Hospital at home'
- Low acuity exacerbation
- Low medical input but high care input
- Team around patient
- Sustainable community support

Medium Medical Input
['Health Hub' Community beds]
- Medium acuity exacerbation
- 'Step up'
- Integrated Acute and Community services
- Designated and resourced private sector beds
- Potential urgent care centre adjacencies

High Medical Input
- One high acuity centre
- 7 day maximum LOS
- Early supported discharge
- 0 day LOS
- Ambulatory care
- Subacute frailty assessment
- 3 day LOS
- Frailty
- Assessment units

Mental Health Beds
- Medico-legal place of safety

Reablement

Reablement at home
- Integrated teams
- Generic workers
- Voluntary sector involvement
- Ambulatory reablement in community facility as an option?
- Return to original level of care
- Updated care plan

Reablement in community
- Intensive rehabilitation
- 'Step down'
- Co-ordinated EDD and discharge planning
- Resolving exacerbation requiring additional care?
- Social issues to be resolved?
- Permanent higher level of care required?

Discharge to Assess

Long Term Conditions Model of Care

7. Planned Care

For the purposes of this report, planned care is defined as care that is non urgent and accessed either directly by the patient or through referral from a generalist to a specialist. LTC management includes much planned care and some urgent care is 'planned' if it is referred to a next day clinic.

7.1 Key Principles

7.1.1   Patient empowerment and navigation
The current planned care system is complex, fragmented and difficult to navigate. It disempowers and frustrates patients who then seek professional help to signpost and navigate when this should not be necessary. The initial referral has benefitted from the Referral Assessment Service (RAS) and the Telford Referral and Quality Service (TRAQS) but their roles do not extend beyond making the first appointment.

Patients want easy access to understandable and trustworthy information about self care options and local services to which they can gain direct access, as well as to information that guides them to seek professional help when necessary.

Patients find it understandably hard to distinguish 'want' from 'need' and, although clear information will resolve some of this, they often require professional expertise to distinguish between the two.

Once referred, patients want clear information about what is going to happen next and the timescale they should expect.

Navigation through the planned care system should be patient focused and facilitate self navigation wherever possible

Professional or peer advocacy to assist in navigation should be the exception rather than the rule.

Some patient groups (e.g. people with learning disabilities) should be offered pro-active advocacy.

7.1.2   Pathways
Planned care should be largely pathway driven, with as few stages as possible to minimise error and delay.

Pathways will vary in type and complexity depending on the degree of diagnostic uncertainty and treatment options. Patients should be able to gain access to the simplest 'out of hospital' and diagnostic pathways without the need for a professional referral, whilst the most complex will require expert specialist decision making at an early stage because of diagnostic uncertainty.

7.1.3 Partnership care

Aligned with the principles described in acute and LTC care, a richer and more dynamic conversation between referring generalist and specialist will result in higher quality referrals, better outcomes and mutual learning.

7.1.4 Levels of care

In planned care, this is about 'who does what where?' There is a compelling evidence base for a tiered arrangement of treatment centres, with the most complex and risky surgery being performed in a site co-located with a critical care unit, but the majority not requiring this. Separate treatment centres for routine surgery can also benefit from being designed and delivered through a different business model.

There is a 'critical mass' issue to consider when planning the number of treatment centres. For minor surgery, this is less of an issue, although the skill of the operator still influences the outcome, whereas for intermediate treatment centres outcomes are influenced by volumes – the larger the number, generally the better the result.

7.2 Model of care

7.2.1 Patient portal

Facilitated self management through a web based patient portal which provides trustworthy localised information about common conditions, when to seek professional help, options for self management and direct access to simple therapies and diagnostics

7.2.2 Pathways

Systematic design, approval and implementation of whole system pathways driving the majority of planned care. A tiered model:

- patient self referral and self management

- diagnosis or symptom complex known with direct GP / generalist access to the pathway

- diagnosis or symptom complex unknown requiring expert specialist decision making early in the pathway.

Reduce stages in all pathways to improve quality and safety and reduce errors. 'Optimise' patients prior to referral as a routine. Referral made by most appropriate professional (e.g. could be physio for arthroplasty). Patient choice expressed at time of referral assisted by navigator and / or Patient Recorded Outcome Measures (PROMS) data. Eliminate duplicated diagnostics. Provide expert opinion at first out patient appointment, preferably from the surgeon who will be performing the procedure. Date of surgery agreed immediately after first out patient appointment. Single multi-disciplinary pre-op assessment to include anaesthetist, physio and social worker. Admit on day of surgery. Enhanced recovery with the shortest possible LOS. Out patient follow up in the community as appropriate.

7.2.3 Navigation

A simpler planned care system requires less navigation. Patients should have access to updated information about their stage of the planned care journey and be able to self navigate as a default. Some advocacy will be required which the RAS and TRACS teams may be able to provide. In more complex and serious situations, or when a patient has special needs, then a navigator / advocate will be required. This could be a peer group volunteer, specialist nurse, therapist, GP or other professional.

7.2.4 Levels of Care

Three tiers of treatment:

- Low professional input. Multiple centres for day case / minors, basic diagnostics and access to therapies

- Medium professional input. One or two centres for intermediates / day case. Beds available for low / medium risk orthopaedics. May or may not be co-located with high input centre. Advanced diagnostics (USS/CT/MRI/Nuclear etc)

- High professional input. One centre for majors, co-located but operating separately from single emergency centre. Co-located HDU. Advanced diagnostics. Potential for repatriation of elements, at least, of out of area specialist surgery (e.g. cardiac, neuro). Whilst it is appropriate that some work goes to specialist tertiary centres, there is opportunity to develop shared care models in which a concentrated local centre might provide pre- and post-operative care.

7.3 Diagram of Planned Care model of care.
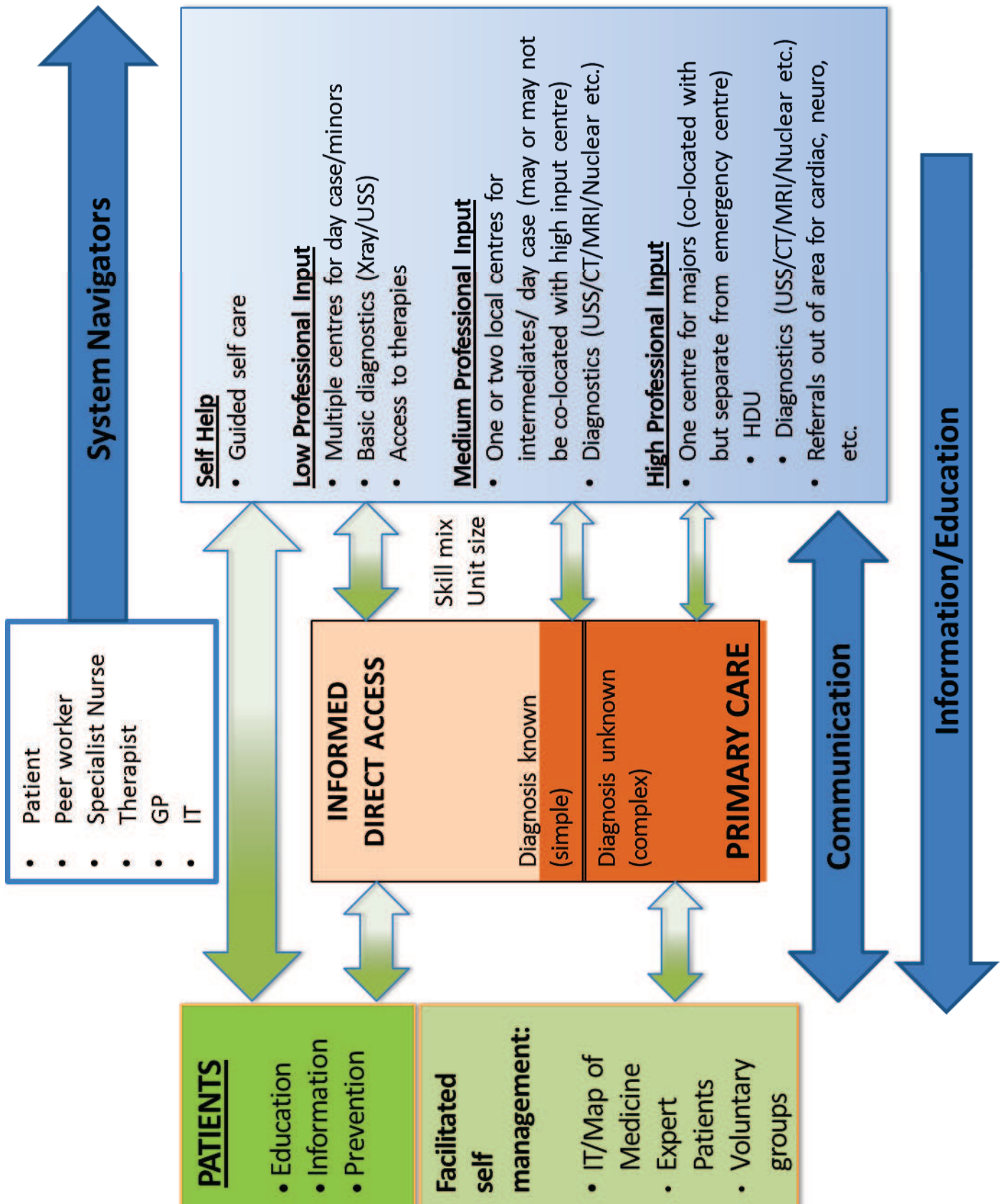
8. Cross Cutting Themes

A number of important cross cutting themes have emerged in all the clinical meetings thus far. The following is a summary of discussion from different clinical meetings.

8.1 Embedding compassion and healthy relationships

Although compassionate care requires the right attitude, this must be translated into action and supported in system design and team working practices. Every member of a team must have clearly understood roles and responsibilities, especially when working within complex systems and environments. However, over-definition of roles, especially when restricted to one care setting, can prevent professionals 'going the extra mile' to ensure compassionate care and seamless patient journeys.

 Named key workers or responsible clinicians will improve co-ordination of care for vulnerable people.

Values based recruitment will become the norm and compassionate attitudes, behaviours and relationships will be more visible throughout the whole organisation.

8.2 Rural and Urban solutions

The problems of providing equality of access and quality of care to rural populations will be partially mitigated by achieving greater care in the community. Care provided by teams around the patient with home as the default can be provided equitably in both urban and rural settings. Access to services that require travel clearly require better transport solutions, but there is also a balance to be achieved between the advantages of providing truly local services for all levels of care and the better outcomes and reduced cost of providing care at larger scale in fewer units.

8.3 Workforce issues

Many parts of the health and social care workforce are in crisis. A full workforce review and plan is required as part of, or alongside the FutureFit programme in order to resolve this. 7 day working is a requirement across the whole system and brings additional workforce challenges.

Local clinicians expressed some strong views about potential components of the solution:

- Consolidate services to make posts more attractive by improving the quality of work, gaining more experience working in larger units, offering better rotations through fully staffed co-located departments and services, all in an improved working environment.

- Fill medical rotas to fit the available workforce and fill the gaps with new roles (Advanced practitioner, Emergency Nurse Practitioner, Physicians assistant etc.).

- Prototype and implement rotating (and split) posts through different care settings to improve mutual learning, understanding and trust, provide better risk management, encourage better use of shared protocols, pathways, training opportunities and shared documentation and improve consistency and quality of care through generic upskilling.

- Improve recruitment and retention of staff through more effective succession planning and better role development and CPD

- Gain academic status by establishing an economy wide link to university and other education and training programmes to attract people to come to Shropshire to train and work.

8.4 Co-ordination, integrated and consistency across the whole system

There is universal agreement that improving the co-ordination, integration and consistency of care delivered across the whole economy is a necessary precondition for achieving sustainable improvements in quality and safety. The will to do this is evident; it is the barriers to it that require systematic identification and removal. These include a fragmented organisational structure, multiple incompatible IT systems, 'old fashioned' commissioning mechanisms and an overwhelming administrative burden. Where any pathway components are supplied under the 'Any Qualified Provider' system or through private sector tendering, these will need to be commissioned in a way which supports improved integration.

'Siloed' care does not incentivise clinicians to 'go the extra mile', and professionals are increasingly reluctant to fill gaps in care if it is not within their defined role. Clinicians should have more control over appointment systems.

8.5 Delivering effective high quality care with no extra money

Financial austerity is one of the key drivers for radical change. There is a need to move beyond organisational interests so that funding follows the patient. Pragmatism is required to find the 'key enablers' of change to concentrate our limited resources.

Currently, the status quo is incentivised with the need for organisations to show a surplus contributing to this.

'Disruptive' change is required to overcome the NIMBY (not in my backyard) problem.

From the clinical perspective, there was a clear case for unifying health and social care funding and to integrate acute and community care.

8.6 Social Care

Health and social care are clearly interdependent and should be designed to reflect this. There is currently an anomaly which makes closer integration difficult in that social care is means tested whilst health care is always free. To achieve integrated working, health and social care should run parallel and share risk, not run in series as is mostly the case at the moment. No-one enters the social care system without a health problem and currently both systems focus on those most in need and pay much less attention to prevention and self care. Although there is no statutory obligation for Local Authorities to invest in prevention, there was a clear consensus that health and social care must tackle prevention, education and patient empowerment to increase self reliance together. The Better Care Fund is a potential vehicle for this, but concern was expressed that, because its not new money, the opportunity would be missed.

The financial challenge in social care provision attracted specific comment and some suggestions to mitigate its effect were made:

- Increase community and carer input

- ensure more patients return to the same rather than a higher level of care

- manage patient and public expectations

- provide more education and information about options

- incorporate the voluntary sector as a core component of care provision

- implement the models of care described in this report which deliver timely response and intervention, enhanced recovery, early supported discharge and reablement

8.7 Mental Health

There was unanimous agreement that mental health should be integrated with primary, community and acute health care. The models of care described in the three main areas of Acute, LTC and Planned Care were all contributed to by mental health professionals and further detailing will demonstrate more clearly the potential for closer integration.

Partnership care in particular was felt to be a model which was equally applicable to mental health services. Psychological management of all LTCs should be 'part of the day job' and, within the context of partnership care, mental health specialists should have a greater role in education and upskilling of generalists. Young people have particularly stressed the need for support for problems with stress and self harm.

The RAID model of liaison in the acute sector was felt to be a good one, but it needed further development, especially in regard to education and training (the RAID effect)

8.8 Children

This area needs further exploration, but initial comments are: there is a lack of psychological and family support. There are big gaps, such as Autism (now 1:80) and age transitions. Obesity is not being systematically tackled. GPs and others are become more and more risk averse around children, Paediatric training for GPs should be mandatory. Partnership care is an excellent model for Paediatrics.

8.9 Therapeutics

Clinicians recognised that a whole system and strategic approach to therapeutics was required and that the importance of this was mostly under-estimated. Community pharmacies are not clustered with GP practices and do not have a defined working relationship with them. Community pharmacies can take a bigger role in minor urgent care and also in routine / repeat prescribing. They would need access to integrated care records to do this. Their impact in minor urgent care would be increased if some OTC medicines were free to stop unnecessary diversion to GPs. All pharmacies should have consistent and longer opening hours. In the acute sector, everyone should have a medication review <24hrs after admission. Evidence that if they are on 4 or more meds then 2 need changing due to acute presentation. These reviews should also apply to lower risk groups – often only the highest risk patients get them. More work with patients at home (e.g. the HARMS scheme) would add value (hoarding, poor compliance etc). There are too many admissions for technical therapeutics which could be done at home or in a community setting. There is little co-ordination of medication across care settings, dressings are a particular example.

9. Whole system synergies

There are a number of key principles and components of models of care which were repeated in slightly different but synergistic forms across all three care areas:

Acute and Episodic Care

'Some' Urgent Care Centres

One Emergency Centre

Levels of Care Planned care

Low Professional Input
- Multiple centres for day case/minors
- Basic diagnostics (Xray/USS)
- Access to therapies

Medium Professional Input
- One or two local centres for intermediates/ day case (may or may not be co-located with high input centre)
- Diagnostics (USS/CT/MRI/Nuclear etc.)

High Professional Input
- One centre for majors (co-located with but separate from emergency centre)
  - HDU
  - Diagnostics (USS/CT/MRI/Nuclear etc.)
- Referrals out of area for cardiac, neuro, etc.

Increased Levels of Care for LTC

Low Medical Input
- 'Hospital at home'
- Low acuity exacerbation
- Low medical input but high care input
- Team around patient
- Sustainable community support

Medium Medical Input ['Health Hub' Community beds]
- Medium acuity exacerbation
- 'Step up'
- Integrated Acute and Community services
- Designated and resourced private sector beds
- Potential urgent care centre adjacencies

High Medical Input
- One high acuity centre
- 7 day maximum LOS
- Early supported discharge

0 day LOS
- Ambulatory care
- Subacute frailty assessment

3 day LOS
- Frailty
- Assessment units

Mental Health Beds
- Medico-legal place of safety

Reablement

Reablement at home
- Integrated teams
- Generic workers
- Voluntary sector involvement
- Ambulatory reablement in community facility as an option?
- Return to original level of care
- Updated care plan

Reablement in community
- Intensive rehabilitation
- 'Step down'
- Co-ordinated EDD and discharge planning
- Resolving exacerbation requiring additional care?
- Social issues to be resolved?
- Permanent higher level of care required?

	Acute Care	LTC / Frailty	Planned Care
Prevention	Make every contact count	Targeted prevention	Information / Self care
	Whole economy long term strategic prevention programme		
Patient Empowerment	Access to reliable info about signposting and self care.	Self management. Care and EOL plans with shared decisions.	Access to reliable info re self care, local services and direct access
Advocacy and Continuity	Integrated care record	Key worker	Pathway navigation
Partnership Care	Timely specialist support to generalist in Urgent Care Centre	GP led care with specialist support and education	Tiered pathway driven care with GP and specialist at defined points. Feedback and education as the norm
Levels of Care (see diagram)	One Emergency Centre 'Some' Urgent Care Centres	Low, medium and high medical input care settings	Low, medium and high professional input care settings for procedures
Integrated Teams	SPA to access integrated community services	Integrated multi-disciplinary teams	Teams integrated around service

10. Next Steps

This report details the output of the Clinical Design workstream over the first 3 months of its activity. The models of care are emerging but are still at a high level.

A process of refinement will continue through a number of cycles where they will be repeatedly tested using patient scenarios, patient characteristics and flow volumes and financial impact.

A further detailed review of the evidence base around each component of the model will be undertaken.

External clinical assurance will be sought from an expert clinical team overseen by the West Midlands Clinical Senate.

Clinical engagement will be deepened, both by continuing involvement of the clinicians in the clinical reference group and subgroups, and through events, such as

webinars and meetings, designed to reach 2/3 of the clinical workforce of Shropshire and Telford & Wrekin.

Patient representatives and patient groups will continue to be involved and co-creating at every stage of the process.

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NHS

futurefit
Shaping healthcare together

Benefits Realisation Plan

Agenda Item 5
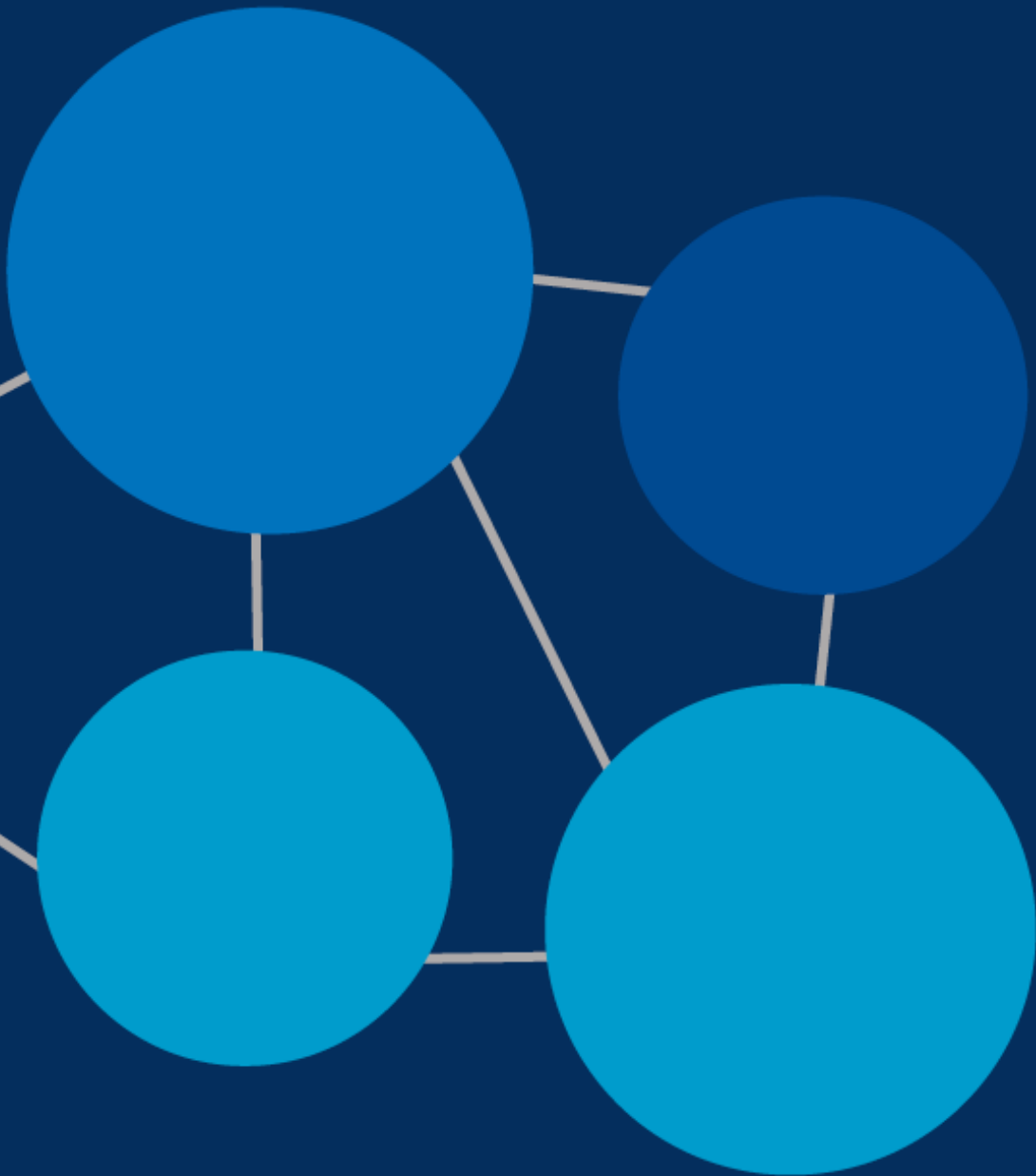
Benefits Realisation Plan

1. IMPROVED CLINICAL EFFECTIVENESS (OUTCOMES)

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
1.1	Securing additional years of life for those with treatable conditions	All age, all cause mortality					
		Increased life expectancy					
		Reduction in years of life lost <age 75					
1.2	Increase in disability free life expectancy						
1.3	Reduction in emergency admissions						
1.4	Reduction in emergency occupied bed days						
1.5	Reduction in medical outliers						
1.6	Improved quality of life for patients with long term conditions, including mental health conditions						
1.7	Improved QALY for specific high morbidity conditions (e.g. COPD)						

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Benefits Realisation Plan

2.	IMPROVED EXPERIENCE OF CARE (INCLUDING ENVIRONMENT)

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
2.1	Improvement in National Inpatient survey	[need to identify relevant questions]					
2.2	Improvement in Friends and Family score						
2.3	Improvements in National Cancer Patient Survey	[need to identify relevant questions]					
2.4	Improvements in GP satisfaction survey						
2.5	Increased number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community						
2.6	Increased number of people with mental and physical health conditions having a positive experience of hospital care						
2.7	Improved patient experience of genuinely integrated care						
2.8	Reduction in complaints						

Benefits Realisation Plan

3. REDUCED HARM

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
3.1	Improved infection control	MRSA					
		C.Difficile					
3.2	Reduction in Serious Incidents						
3.3	No never events						
3.4	Reduction in medicines related admissions						
3.5	Eliminating avoidable deaths in our hospitals caused by problems in care						
3.6							

4. BETTER SUPPORT FOR PEOPLE WITH LONG-TERM CONDITIONS

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
4.1	Reduction in admissions for ambulatory care sensitive conditions						
4.2	Increase in take up for self-care management						
4.3	Increase in patients reporting satisfaction with being supported to manage own condition						
4.4	Reduced time spent avoidably in hospital through better and more integrated care						
4.5	Improved quality of life for people with long-term condition, including mental health conditions						
4.6	Reduction in emergency attendances/admissions for patients with long term conditions/nursing home residents	A&E attendances for LTC/from nursing homes Emergency admissions for LTC/from nursing homes					

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Benefits Realisation Plan

5. BETTER SUPPORT FOR PEOPLE TO LIVE INDEPENDENTLY

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
5.1	Increase in early supported discharge for stroke patients						
5.2	Increase in number of patients with intensive care packages supported to live at home						
5.3	Increased take up of respite care						
5.6	Increase in number of patients in reablement/ rehabilitation/intermediate care						
5.7	Increased the proportion of older people living independently at home following discharge from hospital						
5.8	Reduction in delayed transfers of care						
5.9	Increase in percentage of deaths occurring at home/ outside of hospital settings						
5.10	Increase in the number of patients receiving reablement packages / % of patients requiring no service after reablement						
5.11	Reduction in influenza admissions						

Benefits Realisation Plan

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
5.12	Reduction in non-qualified acute bed days for over 65s						
5.13	Increase in support available in the community						
5.14	Increase in care provided in less acute settings						

Benefits Realisation Plan

6. MOST EFFECTIVE USE OF RESOURCES

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
6.1	Reduction in admissions for patients with mental health and/or drug/alcohol related problems						
6.2	Reduction in spend on procedures of limited clinical value						
6.3	Reduction on acute spend on ambulatory care sensitive conditions						
6.4	Increased commissioner spend on care closer to home	% spend on: • Acute hospital episodes • Community hospital episodes • Integrated community teams • Mental Health					
6.5	Significant reduction in excess bed days	Zero and 27+ days LOS					
6.6	Reduction in emergency attendances/ admissions that could be avoided by improved community mental health or psychiatric liaison services						

Benefits Realisation Plan

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
6.7	More responsible patient behaviour (e.g. healthy living) reduces demand						
6.8	Better coordination/greater streamlining of health and social care produces economies						
6.9	Acute hospital capacity is reduced and clinically/financially sustainable						

7. EQUITABLE ACCESS TO SERVICES

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
7.1	Increased satisfaction with access to a GP	From GP satisfaction survey					
7.2	Reduction in waiting times for A&E	<4 hours					
7.3	Travel time to an Accident and Emergency hospital	(minutes)					
7.4	Compliance with all national waiting time targets	2WW RTT					
7.5	Reduction in rate of ambulance activity leading to an A&E attendance	See and treat rates Hear and treat rates					
7.6	Reduction in median waiting time for elective admissions						
7.7	Increase in non face-to-face outpatient attendances as a proportion of all attendances						

Benefits Realisation Plan

8. IMPROVED STAFF RECRUITMENT, RETENTION, SATISFACTION

REF	DESCRIPTION	INDICATOR	PERFORMANCE		MONITORING METHOD	REVIEW DATE	LEAD RESPONSIBILITY
			Baseline	Target			
8.1	Reduction in staff sickness absence						
8.2	Reduction in staff turnover	Target rate					
8.3	Reduction in vacancy rates	• Medical staff • Nursing staff • AHP staff • GPs					
8.4	Improved staff satisfaction (including wellbeing)	National staff survey (specific questions)					
8.5	Reduction in agency, bank and locum utilisation						
8.6	Number of clinical vacancies filled						

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