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

Date: 11 June 2014
My Ref: MPS
Your Ref:

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Thursday, 19 June 2014**
Time: **9.00 am**
Venue: **Council Chamber, Shirehall, Shrewsbury, SY2 6ND**

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

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

Members of Joint Health Overview and Scrutiny Committee

Gerald Dakin (Co-Chair)	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:

Martin Stevens
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Fiona Bottril
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AGENDA

1 Apologies for Absence

2 Disclosable Pecuniary Interests

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

3 Minutes (Pages 1 - 20)

The minutes of the Joint HOSC meetings that took place on the 24 March and 26 March 2014 are attached for confirmation.

4 Future Fit (Pages 21 - 50)

To receive a programme update report on a number of key areas in the Future Fit programme.

5 Clinical Services Strategy

A report on the Clinical Services Strategy is marked to follow.

Shropshire Council

Joint Health Overview and Scrutiny Committee 24 March 2014 4.00 pm	Item **3A** Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 24 MARCH 2014
4:00PM

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

Present
Councillors Gerald Dakin (Co-Chair), Derek White (Co-Chair), Tracey Huffer, Simon Jones, Veronica Fletcher, John Minor, David Beechey (Co-Optee), Ian Hulme (Co-Optee) and Dilys Davis (Co-Optee)

Fran Beck (Executive Lead Commission T & W CCG)
Fiona Bottrill (Scrutiny Officer – T & W Council)
Stephen Chandler (Director of Adult Services)
Paul Cooper (Commissioning and Service Redesign Lead - Mental Health and Learning Disabilities – Shropshire CCG)
Lesley Crawford (Director of Mental health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust).
Julie Davies (Director of Strategy and Service Redesign – Shropshire CCG)
Peter Herring (Chief Executive Shrewsbury and Telford Hospital NHS Trust)
Chris Needham (Director of Estates and Facilities - Shrewsbury and Telford Hospital NHS Trust)
Adrian Osborne (Director of Communications Shrewsbury and Telford Hospital NHS Trust)
Kate Shaw (Programme Manager – Future Configuration of Hospital Services - Shrewsbury and Telford Hospital NHS Trust)
Martin Stevens (Scrutiny Officer –Shropshire Council)
Helen Swindlehurst (Head of Commissioning – Mental Health and Children T & W CCG)
Professor Rod Thomson (Director of Public Health)

1 Apologies for Absence

Apologies for absence were received from Mandy Thorn, Jean Gulliver and Richard Shaw.

2 Disclosable Pecuniary Interests

There were no new disclosable pecuniary interests declared.

3 Minutes

RESOLVED: That the minutes of the Joint Health Overview and Scrutiny Committee held on Friday, 13 December 2013 at 1pm be accepted.

4 Mental Health Services

The Executive Lead for the Telford CCG introduced her colleagues, Paul Cooper (Commissioning and Service Redesign Lead - Mental Health and Learning Disabilities), Helen Swindlehurst (Head of Commissioning – Mental Health & Children NHS Telford & Wrekin CCG) and Lesley Crawford (Director of Mental Health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust).

She stated that for many years there had been an ambition to build a new patient facility to replace the old asylum, known as Shelton Hospital. The Redwoods Centre opened 18 months ago and Shelton had finally closed. The opening of the Redwoods Centre was part of a wider strategic approach to modernising mental health services. A steering group had been formed to develop a wider modernisation programme which would challenge expectations and transform services. The report before the Committee was an interim report, a final report was expected in June, which she would be happy to report to the Joint HOSC. The preliminary findings suggested that modernisation had gone well but there was much more work required in the future.

The Director of Mental Health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust stated that a review was taking place to assess the assumed services benefits of the modernisation programme. There was still further work required in reducing the average length of stay for inpatients in acute beds. They also wanted to look at Dementia Services where hospital admission was not necessarily the right place to offer care.

Cllr Derek White stated that the report did not go into great detail about the future of mental health services. Whilst he accepted that the Redwoods Centre was excellent it was important to know how to deal with mental health within the community as this was the plan that had been brought to the Committee two years ago. He was also keen to establish how they consulted on services within the community and how local organisations were enabled to support service users. He recognised that the Foundation Trust was required to make significant savings by the CCGs, but the level of savings could not be made without major service changes. He also asked about the implications of the closure of the service at New House and the plans to close the Spruce Suite at the Redwood Centre.

With reference to Castle Lodge it was clarified that it remained open, there had only been a temporary closure of 12 beds. The crisis team continued to work from Castle Lodge. The Chairman asked if the Police were having to keep mentally ill people in cells overnight. In response it was confirmed that the situation was much improved and there had been no issues over the last couple of weeks. The Trust was looking at admissions to the 136 Suite at the Redwood Centre.

The Director of Mental Health Services acknowledged that she had not attended the Joint HOSC previously and recognised the importance of ensuring that the Committee understood the plans of the Foundation Trust.

A Member thanked the officers for their report but stated that it seemed to be a lot of smoke and mirrors. The evidence in the report was weak. She asked that in future the report provide greater clarity and be more straight forward. She asked how community mental health services would work more closely with GP practices and how the Trust would ensure that service users with specific needs in the community are assessed by the appropriate specialists. The Telford and Wrekin CCG Executive Lead apologised that the report did not provide enough information and said that they would come back in June. The Director of Mental Health Services said that the Specialist Community Support Teams were aligned but not attached to GP practices.

A Member asked why Telford and Wrekin was not using the inpatient capacity that was commissioned by the CCG but still using out of area beds. She also asked what support was available for parents and carers when someone with mental health issues needed a change of environment. The Director of Mental Health Services stated that Castle Lodge had been a nurse led unit. If a patient was assessed and needed inpatient care they would be admitted to the Redwood Centre. A judgement would be made by professionals to determine if a patient could be treated in the community or if they needed to be admitted. She added that not all services were provided within the County for example the Psychiatric Intensive Care Unit (PICU) provision was in Staffordshire.

A Member asked what arrangements were made when a patient at the Redwood Centre was discharged but did not have accommodation. The Director of Mental Health Services said that some people ready for discharge from Redwood were of no fixed abode and that some landlords were reluctant to take them back. She recognised that the Trust needed to work more closely with partner organisations.

A Member stated that the report prompted many questions but did not give many answers. He commented on Appendix A which set out the questions that would be used during the engagement sessions. He said that this would not help him form a view on the performance of the service. The Telford and Wrekin CCG Executive Lead for Commissioning explained that the questions had been a starting point for the discussion with patients and service users. She said that they would reflect on the questions and engage with social work colleagues and GPs to ensure that the questions focused on the right areas.

A Member asked about the fluctuations in bed occupancy. The Director of Mental Health Services explained that there would always be peaks and troughs but in the main the Trust would be able to manage within the beds commissioned. The Director of Strategy and Service Redesign – Shropshire CCG said that one of the key pieces of data would be to look at the inpatient psychiatric inpatient weekly bed usage over a 2 or 3 year period. This information had been requested from the Foundation Trust and would form a fundamental part of the review of the service. As CCGs they had to ensure that they commissioned the correct volume of care and look at the rolling average need.

The Telford and Wrekin CCG Executive Lead for Commissioning stated that the move to seven day working in the NHS would make a difference. There was currently a difference in the admission rates during the week and at weekends. Preventing unnecessary admissions at the weekend was better off for the patient and would reduce pressure in the system.

Cllr Shineton stated that she represented a large area in South Shropshire, and felt that the crisis team weren't reaching Cleobury Mortimer. She stated that she would happily provide two patients and two carers to talk about what was going wrong in the area. The Commissioning and Service Redesign Lead - Mental Health and Learning Disabilities stated that he would find it immensely beneficial if their details could be given to him. The process for patient and public engagement had already commenced.

The Cabinet Member for Adult Social Care – Telford & Wrekin Council stated that it was important for local representatives to be involved, service users and local people when making decisions about the future of mental health services. There needed to be a general agreement moving forward of openness and honesty. What was needed was good quality services that met people's needs.

Cllr Derek White stated that it was important to involve the Shrewsbury and Telford Hospital NHS Trust believing that they would be able to help each other. He cited the travel and transport plan as an example and the 12 free beds at the Dawley site. The Executive Lead for the Telford CCG confirmed that they were working with the Shrewsbury and Telford Hospital NHS Trust.

5 **Provision of Stroke Services**

The Communications Director stated that the hyper-acute stroke services was consolidated onto the Princess Royal Hospital last Summer initially as a temporary measure due to staff shortages. This continued on an interim basis when the review suggested that the single site service was providing significant benefits. The trust had undertaken a review of options for the medium term configuration of stroke services. The review had recommended that the hyper-acute stroke services should be maintained at the Princess Royal Hospital whilst the longer term shape of stroke services was agreed through the NHS Future Fit Review.

The Communications Director stated that a target which the Trust were hoping to improve on was the percentage of people receiving a CT scan within one hour of arrival. Receiving a CT scan within one hour of arrival was an important process milestone for patients eligible for thrombolysis.

Cllr Derek White stated that he had three areas of concern in relation to stroke services. These were how the change effected patients in Wales, access to scanning and direct access to the stroke unit so patients did not go to A & E. In response the Director of Communications stated that all of the patients including those in the Montgomeryshire area had seen improvements in the service, with no missed opportunities. The clinical specialists working at Telford had confirmed that the service was working well. Both hospitals retained the ability to perform thrombolysis. The access to scanning would be continued to be reviewed.

The Chair asked if Mr Barry Mckinnon, an Officer from the West Midlands Ambulance Service who was in attendance at the meeting for his views on the stroke service. He responded that when a patient had a suspected stroke it could not be treated in the community and required care in hospital. Having a specialist service improved the outcomes for the patient. The role of the WMAS was to get the patient to hospital as safely and as quickly as possible.

The Communications Director explained that not everyone who has had a stroke was eligible for thrombolysis as it was dependent if the clots that caused the stroke had been caused by a clot or bleed. This was why the pathway was critically important. The patient survey which had been carried out since the service had been centralised at the Princess Royal Hospital found that 1 in 9 patients said that it was too far for family and friends to visit. 75% of patients felt that they were involved enough and none said they were not adequately involved. These figures were above the national average benchmarking data.

A Member welcomed that thrombolysis was available at RSH and stated that further assurances were needed on CT Scanning. She also made reference to some of the dated wards at the Princess Royal Hospital and in particular Ward 16. Ward 16 also seemed to be suffering from being overcrowded. In response the Communications Director stated that there were a lot of areas at the hospital which were out of date and this was one of the drivers for the Future Fit review.

A Member of the public complimented the Shrewsbury and Telford Hospital NHS Trust for turning around a difficult situation when it came to stroke services.

RESOLVED:

a) That hyper-acute stroke services should remain at the Princess Royal Hospital whilst the longer term shape of stroke services be agreed through the NHS Future Fit Review.

b) That the Committee believes there is no need for a public consultation on this recommendation.

6 Future Configuration of Hospital Services

The Programme Manager for the Future Configuration of Hospital Services gave a presentation on the new Women and Children's service suite at the Princess Royal Hospital. She stated that the building was on target with completion expected in four months time. The new building would be fully operational by Monday, 29 September, with dual running for two weeks. There was a real sense of pride and anticipation. There were regular meetings being held to make sure appropriate progress was being made and weekly clinical team meetings.

One area of concern that had been identified was the car parking and travel. It was however fair to say that the move was impacting on every service area. For staff that were unable to transfer, there was a new job swap initiative, where it was hoped alternative employment could be found.

It had been important to ensure that with the children's inpatient facility that there was not an obvious difference between the new accommodation and the old. All the single bed room and four bed bays were en-suite. There was a young people's lounge for secondary age school children and an outside space that had been planted. It was reported that the Trust was on target with work force development. Weekly clinical team meetings were held which were open for all on a rolling programme and a dedicated space had been

identified to provide assurance that after the service had moved to PRH that RSH could respond if a child arrived who needed urgent care.

It was acknowledged that the full Business Case for the reconfiguration of Women's and Children's Service's relied on space that was not available. It had been agreed that no new build would be started until the Future Fit Programme had determined the location of hospital services. The money had been ring fenced and would be available when the Trust was clear what the long term plans would be. To manage the challenges around space, dignity and privacy in the existing building the outpatient services would move to the single rooms that were currently used for in patients. The children's assessment unit would be located next to A & E. The Wrekin maternity unit would be renamed the Midwife Maternity Lead Unit (MLU).

The Chief Executive of the Shrewsbury and Telford Hospital NHS Trust said that assumptions had been made about the bed reductions but on the basis of patient safety the Trust could not reduce the beds and these would be retained during the Future Fit process. It would be wrong to spend significant resources that would not fit with the longer term. He stressed that it was important that as part of the Future Fit Programme that the same assumptions about bed reductions were not made.

A Member asked if there would re-training for staff that could not move or swap jobs. The Programme Manger for the Future Configuration of Hospital Services explained that the job swaps were mainly focussed on the clerical roles and medical secretaries. Many of the clinical roles had already moved sites when acute surgery moved to RSH. A Member asked if the Trust was looking at care at home for children as they recovered better at home. The Director of Strategy and Service Redesign said that this would be considered by the next phase of Future Fit.

Cllr Derek White stated that at the appropriate time it would be useful to have a tour of the new building and hold a Joint HOSC meeting at the Princess Royal Hospital. He said that it was important to ensure the message was communicated to the public and that there were opportunities to work with school and youth clubs. The Communications Director said that there had been some very successful workshops and there would be a major communications initiative over the Summer. The Youth Health Champions were keen to develop networks across the county.

A Member asked for clarification on page 19 paragraph 3.6 of the report, which read that "patients who cannot be stabilised and transferred will be operated at RSH." It was clarified that it should read "will be operated at PRH."

A Member asked about the recruitment of 2 additional paediatricians at the Paediatric assessment unit as outlined in the report. The Programme Manager for the Future Configuration of Hospital Services responded that the recruitment was well underway. The new Unit would attract young ambitious people.

A Member asked if the Trust was hitting its targets in relation to Women's Cancer. The Chief Executive of the Trust stated that the Trust was not meeting all its Targets for cancer treatment in general but not specific to women. The CCG Director of Strategy and Service Redesign stated that there was one target, referral to treatment, which the CCG were particularly focusing on as the Trust was failing in this area.

A Member asked about the option of using the Air ambulance to transfer children at night. The Programme Manager confirmed that there were ongoing discussions with the Air Ambulance. The Director of Estates and Facilities confirmed that the correct lighting was being put in place to permit the helicopter to land. The Programme Manager for the Future Configuration of Hospital Services said that there was ongoing work with the Welsh Ambulance Service and the West Midlands Ambulance Service. Their aim was to get to the PRH but with the ambulance crew retaining the right to stop at a nearer hospital.

The Director of Estates and Facilities stated that the Trust was working hard with stakeholders on the travel and transport plan. There was a need to control the demand for car parking at both the Princess Royal Hospital and the Royal Shrewsbury Hospital. 100 spaces for the Women and Children's centre would be made available at the end of May. There was a desire to move away from staff car parking and increase the amount for use by the general public. It was notable that 40% of the staff working for the Trust lived within a bike ride to their place of work. Whilst it was accepted that it was not realistic to expect all of those to bike to work, even a small percentage take up would be beneficial. 90% of staff drove to work alone and so car sharing was another option which the Trust were trying to encourage. Other areas being explored included flexible working, active travel, price increases for staff, grey fleet reform and new technology on site. The concept of the shuttle bus services between sites had been put on hold as the estimated cost was £600,000 per annum. Cllr Derek White stated that the NHS Staff had not had considerable pay rises for sometime and therefore it was hard to consider raising the car parking fees. There was clearly no easy answer but car sharing seemed like a logical path to start.

A Member commented that the initial discussions about transport between sites also took into account transfer of patient notes. She asked how this would be managed. The Director of Estates and Facilities responded that it was a major piece of work and the Trust had been through a procurement process but that this would not be included with patient transport. The Chief Executive for the Shrewsbury and Telford Hospital NHS Trust said that work had started on electronic patient records but this would not be in place for a few years.

There was a discussion about the services provided at each site and their flexibility. A Member asked about the sharing of patient data and how you could opt out from this. In response the Communications Director stated that the Chief Information Officer of the Trust, Dr Edwin Borman could be contacted and there was also a section on the website around the privacy of data. There was also the GP records which was separate to the records held by the Trust.

<TRAILER_SECTION>

Signed …… (Chairman)

Date:

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TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Wednesday, 26 March at 9.30am at Wellington Civic Centre, Wellington, Telford

PRESENT – Councillor D White (TWC Health Scrutiny Chair) (Chairman), Councillor G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC Health Scrutiny Co-optee), Ms D Davis (TWC Health Scrutiny Co-optee), Cllr S Jones (SC), Cllr J Minor (TWC) and Mr R Shaw (TWC Health Scrutiny Co-optee)

Also Present –

Cllr A R H England (Cabinet Member: Adult Social Care, TWC)
Cllr L Chapman (Portfolio Holder: Adult Services, SC)

Mr D Evans – Joint Programme Senior Responsible Officer
Ms C Morton – Joint Programme Senior Responsible Officer
Mr P Spilsbury – Future Fit Programme Director
Mr B Gowans – Joint Chair of Future Fit Clinical Design Group

Mr A Osborne – Director of Communications, Shrewsbury and Telford Hospital NHS Trust
Ms D Vogler – Director of Business and Enterprise, Shrewsbury and Telford Hospital NHS Trust
Ms J Thornby – Director of Governance & Strategy, Shropshire Community Health NHS Trust

Mrs F Bottrill (Scrutiny Group Specialist, TWC)
Stephen Chandler (Director of Adult Services, SC)
Clive Jones (Assistant Director: Family and Cohesion Services, TWC)
Miss D Moseley (Democratic Services Support Officer, TWC)
Mr M Stevens (Committee Officer, SC)
Paul Taylor (Interim Director: Health, Care & Wellbeing, TWC)

JHOSC-28 APOLOGIES FOR ABSENCE

Mrs J Gulliver (TWC Health Scrutiny Co-optee), Cllr T Huffer (SC) and Mrs M Thorn (SC Health Scrutiny Co-optee)

JHOSC-29 DECLARATIONS OF INTEREST

None

JHOSC-30 UPDATE ON FUTURE FIT

David Evans (Telford & Wrekin CCG) presented a report which updated the Committee on the progress of the Future Fit Programme. He reminded Members of the Programme scope and structure. This focussed on the future provision of Acute and Community hospital services for Shropshire, Telford and Wrekin and Wales. It was recognised that there are key dependencies with primary care, community health services and the demands for A&E. The Committee were informed that Mike Sharon had been appointed as Programme Director, he had experience of major NHS reconfiguration in West Birmingham and Sandwell.

He updated the Committee on the completion of Phase 1 which included the approval of the Programme Execution Plan including Case for Change and Principles for Joint Working; development of acute and community hospital activity projections; extensive work on emerging clinical model; initial engagement activities; assessment of recurring affordability envelope & capital investment capacity; development of the Assurance Plan; drafting of the Risk Register & Benefits Realisation Plan and completion of the Gateway Zero Review and production of the associated Action Plan. The Gateway Zero Review gave the programme an amber rating and did not identify any significant risks. This review was at the early stage of the programme and the Joint Programme Senior Responsible Officers were satisfied with this.

Phase 2 was now underway which focussed on the development of models of care through a comprehensive and inclusive engagement plan, for which additional resources had been agreed. Although timescales were subject to further discussion, it was anticipated that formal consultation at Phase 3 of the Plan would begin prior to the local and general elections in 2015 due to the urgency of establishing the future of emergency services and creating conditions for the recruitment and retention of key staff.

Mr Evans concluded by outlining the future phases of the programme and invited the Committee to formally endorse the Case for Change and Principles for Joint Working.

Questions on all aspects of the presentation were dealt with following all presentations as detailed under minute number JHOSC-34.

RESOLVED that the Case for Change and Principles for Joint Working be endorsed

JHOSC-31 FUTURE FIT CLINICAL MODEL OF CARE

Caron Morton (Joint Programme Senior Responsible Officer) presented the emerging clinical model of care setting out the guiding principles and emphasising that large scale change must be fit for purpose for at least twenty years. More than 90 clinicians had been involved in the work to develop a

clinical vision for the acute sector. She went on to explain the model for urgent care which included a single emergency care centre and some urgent care centres. She acknowledged that securing the right outcomes for patients was time dependent and focussing emergency care in one centre would remove delays by ensuring that experts were available to provide opinions at all times. Currently, the majority of A&E visits were for minor injuries and these would be referred to urgent care centres so that the emergency care centre could be focussed on the highest level critical incidents.

Turning to the model of care for long term conditions, Ms Morton highlighted the need to maintain patients' quality of life following deterioration in condition, integration between specialist, GP and community team, greater self-care and ease of access.

Planned Care, ie non-urgent care, focussed upon patient empowerment, reduction in stages of care with cases dealt with to minimise the length of hospital stays and more dealt with on a day case basis.

Ms Morton continued by noting that a number of key principles and components of models of care were repeated in slightly different but synergistic forms across all three care areas: reablement, increased levels of care when needed and ensuring care was properly planned.

The next steps in the process were to refine the emerging models of care through a process of testing which would include sub-groups with increased patient involvement, exploration of cross- cutting themes, alignment with the evidence base, JSNAs and Health & Wellbeing Board Strategies and activity modelling.

Questions on this aspect of the presentation were dealt with under minute number JHOSC-34.

JHOSC-32 FUTURE FIT BENEFITS REALISATION PLAN

Peter Spilsbury (Programme Director) presented the Benefits Realisation Plan which was discussed at the Future Fit Programme Board on 10 March 2014. He explained he worked for the Commissioning Support Unit that was supporting the Future Fit Programme. He had experience of NHS reconfiguration at the new University Birmingham Hospital, the Right Care Right Here Programme in Sandwell and the Fit for the Future Programme in North Staffordshire.
A comprehensive initial draft had been developed and further drafts would be informed by patient & public views and focus on the measurable benefits expected directly as a result of the model, this work will be reported to the Committee. Members were invited to consider how programme success against the following benefits might be measured:-

- Highest quality of clinical services with acknowledged excellence;
- A service pattern that will attract the best staff and be sustainable clinically and economically for the foreseeable future;

- A coherent service pattern that delivers the right care in the right place at the right time, first time, coordinated across all care provision;
- A service which supports care closer to home and minimises the need to go to hospital;
- A service that meets the distinct needs of both our rural and urban populations across Shropshire, Telford & Wrekin and in Wales , and which anticipates changing needs over time;
- A service pattern which ensures a positive experience of care; and
- A service pattern which is developed in full dialogue with patients, public and staff and which feels owned locally.

Questions on this aspect of the presentation were dealt with under minute number JHOSC-34.

JHOSC-33 EVALUATION CRITERIA AND PROCESS

Peter Spilsbury (Programme Director) advised the Committee that the Programme Board would agree the evaluation criteria and process prior to identification of options, that there was a commitment to transparent & objective decision making and a desire to maximise benefits for the whole population. The consequences of options to be considered were for specific local populations and minority and deprived groups. The rationale & weighting criteria would be explicit. It was anticipated that the first draft of the criteria and process would be considered by the Programme Board in May 2014 and it would also be provided to the Committee for endorsement.

Questions on this aspect of the presentation were dealt with under minute number JHOSC-34.

JHOSC-34 FUTURE FIT ALIGNMENT WITH OTHER STRATEGIC PLANS

Caron Morton (Joint Programme Senior Responsible Officer) advised Members that Future Fit aligned with:-

- CCG 5 year strategic plans
- Better Care Fund
- Re-design of primary care service
- Re-design of community health services
- Plans for sustaining A&E services in the short to medium term

Ms Morton highlighted the Programme Board's close working relationship with NHS England and Members and noted that sustainability was a key issue and, as implementation was not likely to occur before 2018, short to medium term solutions were also required. She said there was real excitement generated among clinicians by this once-in-a-generation opportunity.

At the conclusion of the presentation, the Committee asked a number of questions and put forward comments as follows:

Members noted recent press reports regarding a new build emergency care centre and local opinions that this was the only option. However, Members were concerned as to whether this was a financially viable option and did not want to see the community's expectations raised and time and resources used to develop this if it was not financially viable. Members also queried what Plan B was if a new build was not financially viable.
Response – David Evans noted that the programme was still in the early stages and whilst it was recognised that there was a preference for one emergency care centre, no consideration as to where it should be located had been undertaken. Further work needed to be carried out to evaluate the clinical model and engage with stakeholders. It was too early in the process to even suggest a ball-park figure as the clinical model needed further work regarding beds, range of services, community hospital services and delivery. Regular updates would be made at each stage of the programme.

Caron Morton reminded the Committee that the preferred option needed to be viable for at least twenty years and serve the needs of the population. She advised Members that every £10m borrowed resulted in £1m revenue.

Bill Gowans commented that from a clinical design perspective, the preference for one emergency care centre should not be predicated on site or cost but on deliverability and consolidating the work force to provide maximum efficiency and quality.

Noting current £40m outstanding maintenance costs, Members asked what budget savings would be made.
Response - David Evans indicated that during the process to develop the Outline Business Care evaluation of non-financial benefits, eg access etc, and financial benefits would be appraised. There was a backlog of maintenance issues but the overall revenue consequences for the plans was not yet apparent. if the plans were not sustainable, some review would be required but it was too early to judge at this stage and the process needed to be followed through further. Caron Morton added that some modelling was required on costs but clinicians had been asked to focus on designing the model of care initially and affordability would come later; the project was fundamentally clinically-led in order to maintain integrity.

It was noted that the SaTH currently experienced problems attracting staff to A&E where 10 consultants were required but currently only 7 were employed. How would this project address recruitment?
Response - Caron Morton advised that prospective candidates would see a vibrant, innovative centre with the right support from equipment and colleagues and scope for research. Currently there was a very high workload making for difficult rotas. Consultants felt that the proposals would help recruitment as candidates would see that although they would initially begin work at a split site, the dynamic of the department would be changing.

Members asked how the Case for Change would be rolled out to the public at large and it was suggested that two public exhibitions (one Telford-based, one Shrewsbury-based) would be useful to reach and engage with people who

were not service-users. There was nothing in the report that addressed why the general public had not yet been engaged and it was felt that an opportunity had been missed as the proposals could generate a lot of excitement. It was stressed that it is essential that the public understand the case for change before solutions are presented.
Response - Adrian Osborne advised that the Programme Board were keen to engage the Community. At the start of the project, there had not been significant funds available for communication and initial engagement was focussed where people were already meeting, ie Parish Councils and Patient Groups. This had already generated some rich intelligence. However, a significant uplift in resources for engagement had now been agreed.

Members were excited by the proposals but recognised that a behavioural change was required if individuals were to be responsible for their own health. Some thought as to how difficult groups within the wider community could be reached was required, and examples were given of possible engagement by midwives, antenatal classes and job centres.
Response - David Evans agreed that responsibility to influence and alter behaviour lay within the room as part of the Programme. More joined up working was required and the example of teenage pregnancy, increasing breast feeding rates and reducing smoking during pregnancy was cited.

Caron Morton advised that this was part of a 5-year strategy to change lifestyles and required an integrated approach. It was acknowledged that patient empowerment was a national challenge.

Additionally, Bill Gowans said that this could also be addressed through patient focus groups. Clinician's questions were predicated on behaviours and focussed on the prevention agenda and wants -v- needs led service.

Members felt that patient representatives and groups would readily engage in the process but what methods would be used to engage others?
Response – Caron Morton stated SaTH's Youth Drive had been very successful and the Programme had looked at youth engagement. Engagement had taken place at Parish Council meetings as there was a sense that people did not engage with big exhibitions as they did not feel they could go.

Concern was expressed that Shropshire Patients Group had not yet heard about the Programme and rumours were beginning to circulate. It was important to involve patients to get their buy-in; patients were aware of resource issues but would want to help shape services and could be involved in 'spreading the word'.
Response – Caron Morton advised that greater investment was now available to progress consultation; the scale of the project required a significant input and the next phases would include more patient engagement. She stated she would be disappointed if any 'spin doctors' were involved in the project which was informed by credible clinicians. David Evans added that the Future Fit

Project was funded by the two CCGs which had only engaged Peter Spilsbury and his team at to work on the project.

Joined up working was seen as essential to the success of the Project, especially in the area of Adult Care and it was noted there was no representatives from the field of social work to feed into the process. How would joined up working be achieved to create an holistic service.
Response - David Evans emphasised that the project was not about cost shunting, it was about creating the right model of care for patients. It was important to try to stop people getting sick in the first place but, once they were sick, how could the best possible clinical care be delivered? The Better Care Fund had made significant progress in bringing together health and social care in a very short space of time.

Bill Gowans confirmed that Local Authorities were well represented as part of the clinical design work being undertaken. Caron Morton stated that social workers, for example, were viewed as clinicians.

Members recognised that the Future Fit Programme had taken years to complete and asked if any changes were planned that would relieve the immediate pressure on A&E, for example could the urgent care centres be rolled out first?
Response – Caron Morton advised that looking at the care pathways, the current thinking was that if a better outcome was available for patients and it was not reliant on buildings, then that should be available now. However, some care needed to be exercised in the consideration of urgent care centres as SaTH had inherited an inequitable system. Services needed to meet needs and moving too soon also had associated risks.

Bill Gowans attempted to illustrate the complexities and pitfalls by advising that urgent care centres, as minor injury units, were often passed over in favour of A&E. Patient perspective was key to addressing this, urgent care centres needed to be viewed as part of the hospital and there needed to be confidence in the treatment provided. This required layers of planning, collaboration and integration.

Clarification was sought about how emergencies would be determined.
Response – Caron Morton advised that clinicians would now turn to this aspect of the care model and 28 meetings had been scheduled. Where cases were treated would be dependent on clinical adjacencies as it was acknowledged that emergencies were time critical and consultants needed to be in close proximity. Communication with patient groups, ShropDoc and ambulances would be key.

David Evans stated that in very simplistic terms, life threatening cases would go to the emergency care centre and non-life threatening cases would go to the urgent care centre.

Bill Gowans added that fragmented and inconsistent care centres could cause problems and it was important that all urgent care centres did the same thing so that their services were recognisable from the degree of diagnostics, through to staffing and opening times.

Where does Future Fit fit with the national model?
Response – Caron Morton stated that there were high level trauma centres across the country and the urgent and emergency care centre model was supported by Professor Keith Willett (National Director for Acute Episodes of Care) in light of NHS England's Review of Urgent and Emergency Care.

David Evans pointed to the example of the Stroke Unit and the knowledge that patients experienced better outcomes from one unit sites. SaTH had consolidated its stroke services in the previous summer and latest results demonstrated a clear level of improved service and access times.

Adrian Osborne noted that A&E was often the door to other services and, therefore, it was acknowledged that some services would need to be provided on the same site to see improvement to patient outcomes. Planning between the NHS, its partners and politicians would need to take place on the basis of a population of 400k-500k.

Peter Spilsbury commented that local leaders would be supported in their delivery by a strong evidence base which was published on the website. This would help to keep people informed. He observed that a remarkable level of clinical leadership would be required to make the Programme work. In other areas of the country external consultants were brought in to develop models but in this instance a bespoke model would be created. Meetings were led by clinical leaders which resulted in a radically different dynamic that took time but could not be over-valued. He felt that this was a distinguishing feature of this process that the people who were designing the model of care are the people who will have to make it work.

Were there any models from elsewhere in the country that could be drawn upon to inform the project?
Response – Caron Morton stated this aspect was part of Peter Spilsbury's remit and whilst it was important to look at evidence and intelligence from elsewhere, there was a unique challenge in Shropshire, Telford & Wrekin with a complexity that did not exist in other counties.

Bill Gowans considered that even if the best international evidence was brought together, the solution would be disappointing. It was important to look at local evidence and get a consensus on the right thing to do, then look at bridging any gaps and secure buy-in. He felt there would be inevitable polarisation with regard to split sites or a single site and the rest was an 'iceberg under the water' but it was essential that the model of care worked or urgent care would not either. He felt there was a danger that past mistakes could be perpetuated.

When would the financial models be available?

Response - Peter Spilsbury suggested that costings could be available by the following spring. The models of care needed further testing so that clinicians descriptions could be converted into numbers, then that would be converted into facilities, sizes and cost options. There was a highly robust and technical set of processes to meet the national requirements so this stage could not be rushed.

It was important that services were fit for purpose. Would future reports include configurations of services outside urgent/emergency care?
Response – Bill Gowans stated that although the scope of Future Fit was around hospital and community-based hospital services it was important to 'paint the whole canvass' to make sense and offer certainty. Peter Spilsbury advised that financial modelling would look at the whole system.

Would financial modelling only look at public sector services? What about, for instance, social service requirements for beds in private nursing homes?
Response – Caron Morton noted that elements of the private sector worked in conjunction with the NHS, for example Nuffield, but whilst all services had to be paid for, the crux was what proportion was required for the hospital. David Evans agreed that these services would be factored into the discussions.

The Chairman noted that potential sites for the emergency care centre had not been considered but that if services in Telford & Wrekin and Shropshire were to be unified, siting would be crucial. He noted the consultation period was set for January to March 2015 which would be a politically sensitive period due to the May 2015 local and general elections. He personally hoped that work would continue with the best interests of the whole community at heart and that there would not be a political divide. He asked what was the impact of waiting to consult on the proposals until after May 2015 to prevent electioneering? The Committee felt that it was important that all the facts were publicly available before the election to prevent false claims.
Response – Debbie Vogler stated that SaTH was managing the workforce challenge alongside local and national challenges and working with CCGs regarding the critical care and medical workforce as a whole but may need to implement mitigatory interim measures.

Caron Morton advised that consideration had been given to pre-election protocols and the difficulties of consulting prior to the election. However, it was considered that essentially delaying the provision of services for three months was not in the best interests of the local community and that the Senior Responsible Officers were prepared to shoulder the inevitable pressure that would result. Consultation would not take place until the project was at an appropriate stage, but it did not feel right to delay for an election.

The Chairman impressed upon the Senior Responsible Officers that quick and clear responses to any claims made during the pre-election period would be essential.

Debbie Vogler stated that the sooner consultation could take place, the better. Pre-engagement was scheduled for October/November and it would be natural to move to formal consultation after that.

What level of consultation was taking place in October/November 2014?
Response - Caron Morton stated that this period would involve an extended period of public engagement which would then be followed by a 12 week formal consultation in December – March.

David Evans considered that engagement during October/November would build upon the current discussions, setting out the case for change and further refinement, enable time to take account of clinicians' work so that options for consultation could be offered.

Paul Taylor (Interim Director: Health, Care & Wellbeing, TWC), Clive Jones (Assistant Director: Family and Cohesion Services, TWC) and Stephen Chandler (Director of Adult Services, SC) commented on the Local Authority perspective on the Better Care Fund. Paul Taylor felt that it would be useful for a discussion to take place around the Better Care Fund and its holistic approach so that there was no detraction from Future Fit. Clive Jones considered that the presentation given by Caron Morton had shown that the Future Fit Programme was engaging with the Better Care Fund and would enhance service provision and model solutions. Stephen Chandler felt that this was a very exciting time in an environment that would get the right solution. He noted discussion about communication and agreed this was a key aspect in increasing public confidence in Future Fit. He considered that part of the journey in redesigning services and stopping old practices was about fitting the model into the broader strategic environment and resources; however, the fact that financial constraints would have a significant impact could not be ignored.

Members considered that the positive case for change had been made and could be endorsed together with the principles of joint working. The initial programme timetable was also supported.

JHOSC-35 JOINT HOSC WORK PROGRAMME

Caron Morton invited the Committee to consider receiving further reports throughout the scope of the programme.

RESOLVED – to receive further reports on the following matters:-

Evaluation Criteria & Process
Clinical Model of Care
Benefits Realisation Plan
Selection of short list of Options
Selection of Preferred Option
Consultation Document
Outline Business Case (Confirming Preferred Option)

The Chairman thanked everyone for attending and concluded the meeting at 11.43am

Chairman……..……

Date……..……

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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:	**11th June 2014**

The purpose of this report is to provide the Joint HOSC with an update on recent Programme progress and on future plans.

Key supporting documents are appended to this report and are also publicly available on the Programme website: http://www.nhsfuturefit.co.uk/

1 OVERVIEW

The Programme has now entered its second phase.

In Phase 1 the programme's constitution was completed through the approval of its Programme Execution Plan (PEP) which sponsor organisations have since been ratifying, along with the Case for Change and the Principles for Joint Working. These documents were endorsed by HOSC at its meeting in March 2014. The programme also subjected itself to an external review by the Health Gateway Team in order to identify further improvements in its ways of working, and an action plan has been implemented in response.

The focus of Phase 2 to date has been the development of a full clinical model based on the high level vision set out in Phase 1. This resulted in an intense period of clinical activity involving over 200 local clinicians – supported by patient representatives and focus groups – working together to shape the model of future care for the people of Shropshire, Telford & Wrekin and northern Powys.

HOSC involvement has continued through observation of Programme Board meetings, through membership of the Assurance Workstream and through informal meetings and other contacts with Programme staff.

2 NHS ENGLAND ASSURANCE

NHS England (NHSE) has a key role in the assurance process for major service reconfigurations. The most significant of these comes prior to formal Public Consultation but an initial Sense Check was conducted in early May.

The Local Area Team reviewed a comprehensive evidence pack submitted prior to the Sense Check, and subsequently congratulated the Programme for the tremendous progress made to date, in particular the impressive clinical engagement throughout the process. NHSE recognised there is still a significant amount of work to do and acknowledged that a realistic timescales for getting to Public Consultation was now proposed.

A set of recommendations has been received and the Programme Team has developed an action plan in response.

3 PROGRAMME EXECUTION PLAN (PEP)

The PEP is scheduled to be refreshed by the Board for each new phase of the programme. Changes recently agreed include:

a) A process for reviewing sponsor and stakeholder plans which are outside the scope of the programme. This is so that the Board can ensure that other health economy plans are aligned with FutureFit plans and avoid prejudging Programme outcomes.

b) Clarifying the Board's ability to take all necessary decisions in the management of the Programme, alongside identifying which decisions need to be approved or received by other bodies including HOSC.

c) The formation of a Core Group made up of each of the five Programme Sponsors in order to make recommendations to the Board. Only in exceptional circumstances will the Core Group take urgent decisions on behalf of the Board, and will promptly report any such decisions to Board members.

d) The creation of two additional workstreams to

   i. Undertake a feasibility study of the single emergency care centre proposal; and

   ii. Ensure that appropriate Impact Assessments of programme proposals are planned and completed.

   As with all existing workstreams, patient representatives have been invited to join these new workstreams.

e) Revision of the programme budget amounting to c.£1.4m for 2014-15, largely to reflect the substantial increase in resource allocated to engagement and communication activities as well as the technical expertise required to develop and test detailed proposals during the next Phase.

f) The addition of a strategic context document, following feedback from the NHSE Sense Check meeting, to provide supporting evidence to the Case for Change embodied in the PEP.

In addition to these changes, the Board agreed a revised Programme timeline (**Attachment A**) which works towards formal Public Consultation on a Preferred Option as soon as possible after the 2015 General Election. This aligns with advice from NHS England which was concerned that a timetable for Public Consultation before the pre-election period would not be feasible. The timetable remains very tight, however, and assumes that some tasks are undertaken in parallel rather than sequentially. **HOSC is invited to note the revised timetable.**

4 ENGAGEMENT & COMMUNICATIONS PLANS

The Board approved a strategic plan for communication and engagement which has been co-produced with patients and reflects a "you said, we did" structure. There has been strong

feedback about using existing networks, ensuring the accessibility of materials through the use of patient readers, going where people are and monitoring who has been engaged in order to target any groups being missed.

A more detailed implementation plan based around key activities scheduled for coming months will be brought to Board at the end of June.

5 CLINICAL REPORT

In November 2013 the clinical community was set a clear task by the local people of Shropshire, Telford and Wrekin: not only to design a clinical model for locally sustainable acute and community hospital services for the next 20 years but also to lead the process of redesigning these services. This task was to take into account the health needs of all of the populations who receive acute services within Shropshire and Telford and Wrekin, including patients from Powys.

Our four clinical leads - Dr Bill Gowans, Dr Mike Innes, Dr Edwin Borman and Dr Alastair Neale – have, alongside the Clinical Reference Group of 90 local clinicians and in conjunction with the wider clinical community, developed first a vision for hospital based healthcare (published March 2014) and then outlined in their final report the detailed structure for the delivery of this care for our patients.

Throughout this work we have witnessed an unprecedented commitment by local clinicians to create a system that allows them to deliver the best possible outcomes for their patients. The ethos of the work has been reliant on the principles that patients should be cared for as close to home as is feasible; that clinicians be empowered through having access to the best equipment and support from colleagues co-located on single sites; that solutions be innovative and integrated; and that we free ourselves from the constant threat of loss of services by creating a sustainable system for Shropshire, Telford and Wrekin and parts of Powys.

The clinical models are based on three areas of care - acute and episodic illness, the management of long term conditions and frailty and the delivery of planned care - all underpinned and united by principles and working practices applied across the whole system.

The structural changes proposed describe the consolidation of specialist services to achieve ‘critical mass’ on the one hand, whilst, on the other hand, also addressing the need to improve quality and patient experience by delivering more care closer to home.

The principles and changes in working practices proposed in the report reflect the requirement for a sustainable health and social care system, but balance that requirement with the need to empower patients, clinicians and communities.

- The clinical model for acute and episodic care describes an urgent care network, within which one central emergency centre works closely with peripheral urgent care centres.

- For planned care, one central diagnostics and treatment centre will provide circa 80% of planned surgery whilst the majority of assessment, diagnosis and follow up will be performed closer to peoples' homes.

- The care of people with long term conditions will be seamless, responsive and lifelong.

The clinicians also strongly emphasise three additional challenges, beyond the reconfiguration of hospital services, which should be addressed:

- The need to integrate health and social care and to resolve the funding anomalies between them;

- The absolute requirement to create community capacity to manage the shift in care closer to home; and

- The need for local communities and society as a whole to tackle the prevention and wellbeing agenda.

The full report is published on the Programme website along with extensive appendices which set out the clinical evidence base and which record all the clinical conversations which contributed to the model. A summary presentation is appended to this report (**Attachment B**). **HOSC is invited to endorse the models proposed.**

6 DRAFT EVALUATION PROCESS & CRITERIA

The Board has approved proposals for how the Clinical Model will be converted into a long list of options, and for how criteria will be developed which will enable the long list options to be reduced to a short list (**Attachment C**).

A stakeholder panel has been formed with a single representative from each of the Board's 29 member organisations, including 5 patient representatives from Shropshire, Telford & Wrekin and Powys. The panel will hold 4 workshops (the first two in mid June and the other two in late September) to:

a) Generate ideas for options and identify parameters for reducing these ideas to a long list;

b) Propose a set of criteria against which options will later be assessed;

c) Agree weightings for the finalised criteria; and

d) Score the agreed long-list against the criteria to produce a short list.

This process embodies three key periods of wider public engagement:

- **From June to August** – extensive community and clinical engagement on a proposed long list of options and draft benefit criteria (coming out of the first two panel workshops). This, along with the results of the emergency centre feasibility study

(see below) and activity & capacity modelling of the new clinical model, will inform the Board's identification of the final long list and how this is reduced to a short-list;

- **From October to January** – further community and clinical engagement on the short listed options. This will contribute to the final appraisal of these; and

- **From June to January** - ongoing engagement on the implications of the clinical model.

HOSC is invited to endorse the proposed approach to the development of a short list.

Subsequent proposals will be developed in time for the September Board on the process for developing and appraising short-listed options.

7 EMERGENCY CENTRE FEASIBILITY STUDY

The Board has commissioned an additional piece of work to test the feasibility of the clinical proposal for a single Emergency Centre. This study will look at three options for the potential location of an Emergency Centre in order to determine whether any of these options are not feasible or are likely to be significantly more costly than others, prior to confirmation of the long list in September.

The three options to be examined are:

- The Emergency Centre being located on the Royal Shrewsbury Hospital (RSH) site;

- The Emergency Centre being located on the Princess Royal Hospital, Telford, site; and

- The Emergency Centre being located on an as yet to be defined New Site on the A5 corridor between Shrewsbury and Telford.

No assumptions will be made about the location of non-emergency services except for those which, for clinical reasons, are essentially co-located with Emergency Care facilities. The tasks of the study will be to:

- Setting out the high level physical requirements on each site for each Option;

- Developing plans for the Physical Solutions on each site for each Option (1:1,000 Site Plans and 1:500 Block Plans);

- Producing Capital Cost forecasts for each Option (plus direct revenue impact);

- Assessing the sensitivity of the results of the appraisal to changes in the assumptions used;

- Producing a Report for sign-off by the Programme Board in September to inform the final shortlisting of options proposed for October.

8 PROGRAMME RISKS

A draft list of risks identified by the Programme Team and the Assurance Workstream has been received by Board. This was as part of a process to enhance Programme risk management as recommended by the Health Gateway Review Team.

The list will be further revised, scored and mitigated, and it was agreed that the Board would in future receive regular reports on risks rated 'red' (before and/or after mitigating actions are taken).

David Evans & Caron Morton

Senior Responsible Officers

Attachment A
Programme Timeline

Overview of Phases 2-4

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		Date	Governance	Engagement	Feasibility	Technical	Clinical	Modelling	Evaluation	Impact
2014	May	05/05/2014		Develop Engagement Plan & Materials	Feasibility Brief	Develop Technical Team Brief	Clinical Model Revision		Evaluation Process	
		12/05/2014			Commission Study		Clinical Model Approval		Develop Long List & Benefit Criteria	
		19/05/2014	BOARD							
		26/05/2014								
	June	02/06/2014			Undertake Feasibility Study		External Clinical Assurance	Activity and Finance Modelling		Integrated Impact Assessment
		09/06/2014	BOARD							
		16/06/2014								
		23/06/2014	BOARD							
		30/06/2014		Public Engagement on Clinical Model, Long List & Benefit Criteria		Procure Technical Team				
	July	07/07/2014								
		14/07/2014								
		21/07/2014								
		28/07/2014								
	August	04/08/2014								
		11/08/2014								
		18/08/2014								
		25/08/2014								
	September	01/09/2014	GATEWAY	*Public Engagement on Clinical Model continues till January*					Confirm Long List/Criteria	
		08/09/2014							Shortlisting Workshops	
		15/09/2014	BOARD							
		22/09/2014							Confirm Short List	
		29/09/2014								
	October	06/10/2014				Develop Physical Solutions & Workforce Projections		Activity Modelling of Options		
		13/10/2014	BOARD							
		20/10/2014		Public Engagement on Short List						
		27/10/2014								
	November	03/11/2014								Integrated Impact Assessment
		10/11/2014								
		17/11/2014								
		24/11/2014								
	December	01/12/2014								
		08/12/2014								
		15/12/2014	BOARD							
		22/12/2014								
		29/12/2014								
2015	January	05/01/2015					External Clinical Assurance			
		12/01/2015								
		19/01/2015								
		26/01/2015								
	February	02/02/2015	BOARD			Financial & Economic Appraisal				Integrated Impact Assessment
		09/02/2015								
		16/02/2015								
		23/02/2015								
	March	02/03/2015							Non-financial Appraisal	
		09/03/2015								
		16/03/2015								
		23/03/2015								
		30/03/2015								
	April	06/04/2015								
		13/04/2015	BOARD							
		20/04/2015								
		27/04/2015								
	May	04/05/2015								
		11/05/2015								
		18/05/2015								
		25/05/2015	GATEWAY		Identify Preferred Option					
	June	01/06/2015		Preparation for Consultation	CCGs Decision & NHSE Assurance Process (tbc)					
		08/06/2015								
		15/06/2015								
		22/06/2015	BOARD							
		29/06/2015								
	July	06/07/2015								
		13/07/2015								
		20/07/2015								
		27/07/2015								

Attachment B
Clinical Models of Care

NHS

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Programme Board

10 June 2014

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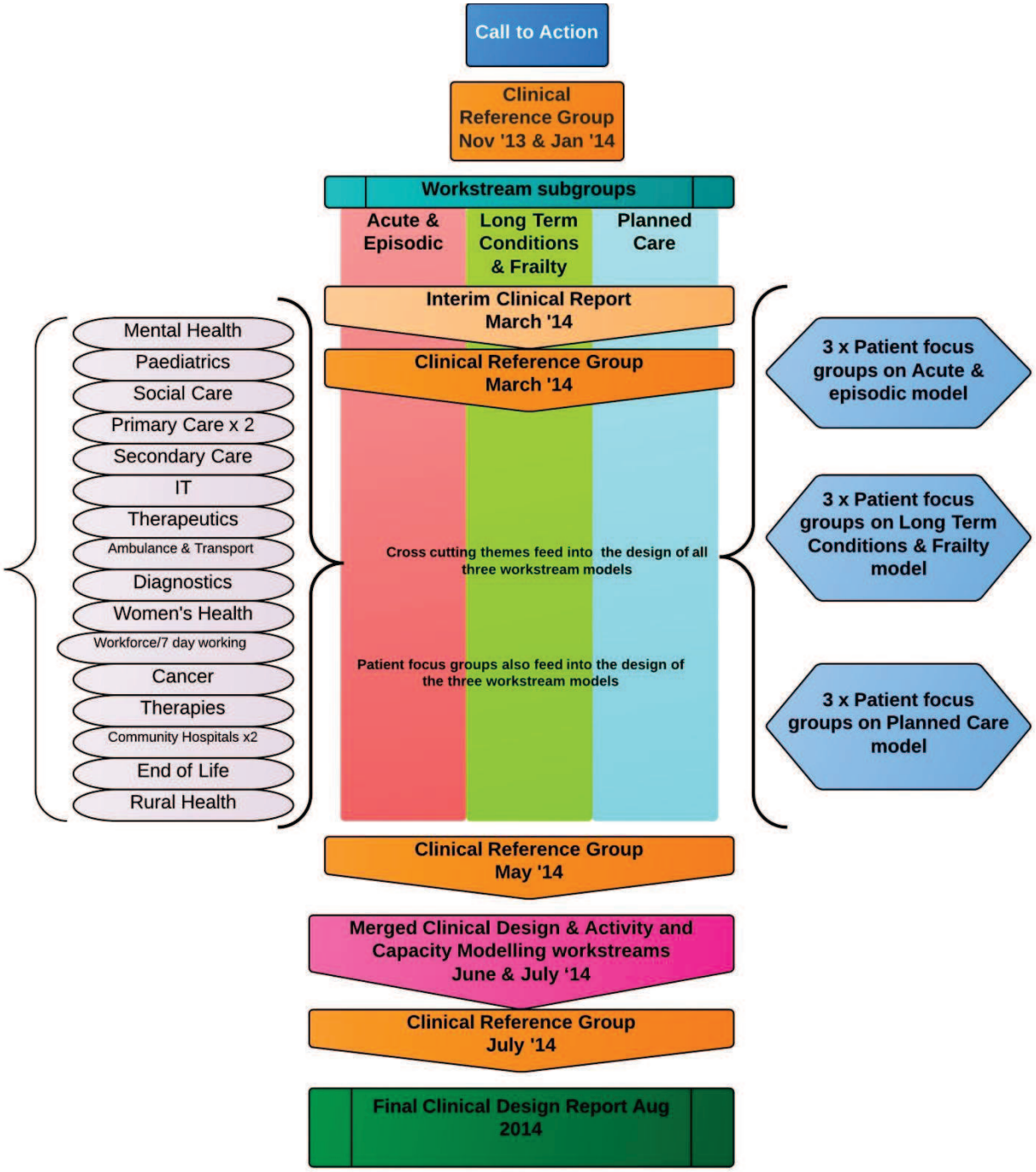
NHS

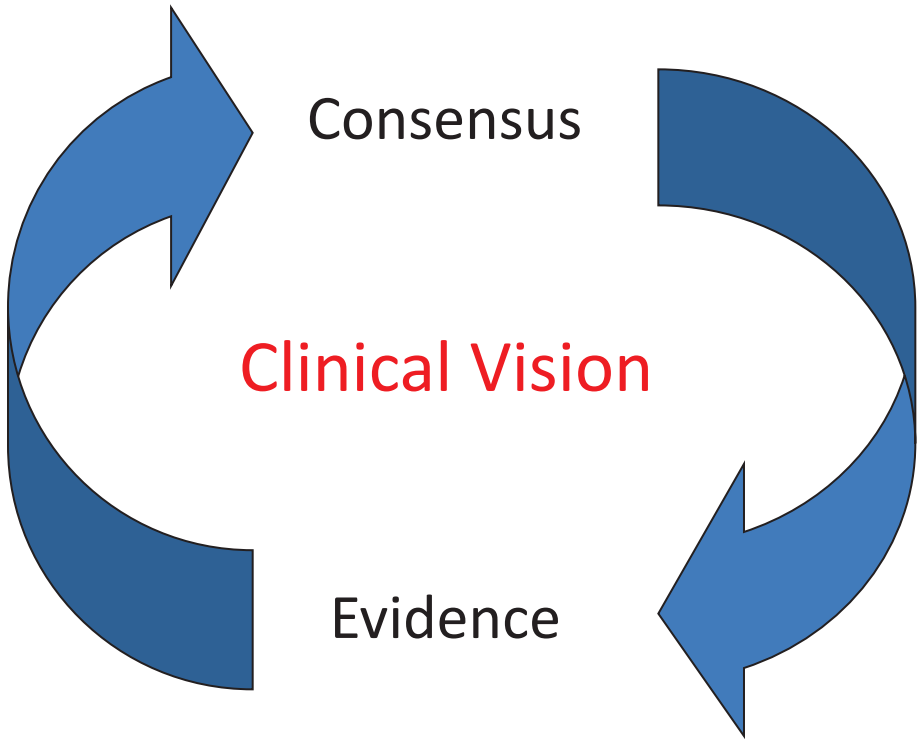
System Principles

- Home is normal
- Empowered Patients
- Empowered Clinicians
- Empowered Communities
- Financial Sustainability
- Workforce Sustainability
- Service Sustainability
- Integrated Care
- Partnership Care
- Integrated IT to support integrated and partnership care



Cross Cutting Themes

NHS



Reconciling
Sense checking
Modelling
Planning
Future proofing
Sustainability

Needs led
Experience based
Principles
Models of Care
'Common good'
Collective responsibility

Modelling
Options
Consultations
Reviews

Service description

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NHS

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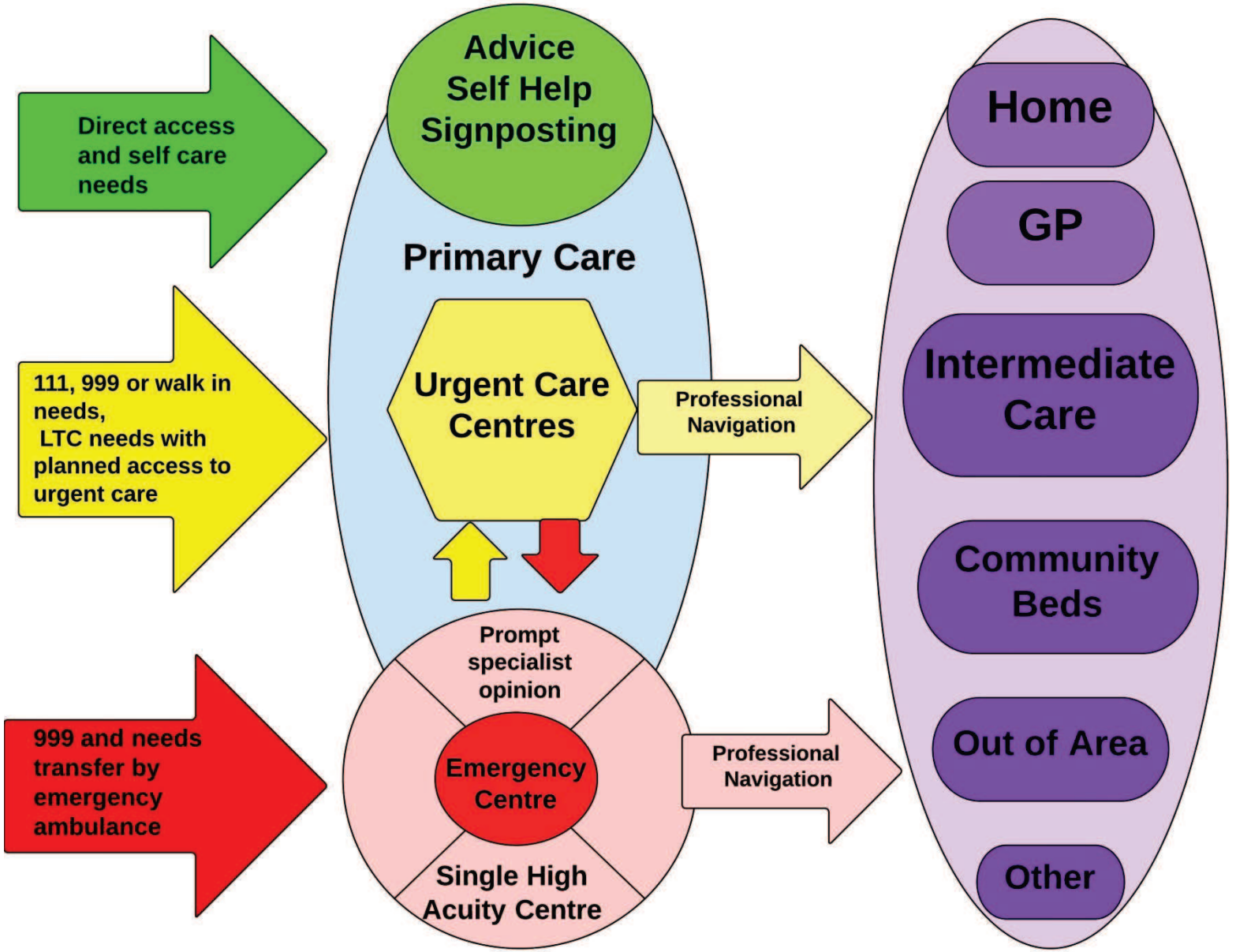
Emergency and Urgent Care

NHS



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Emergency and Urgent Care

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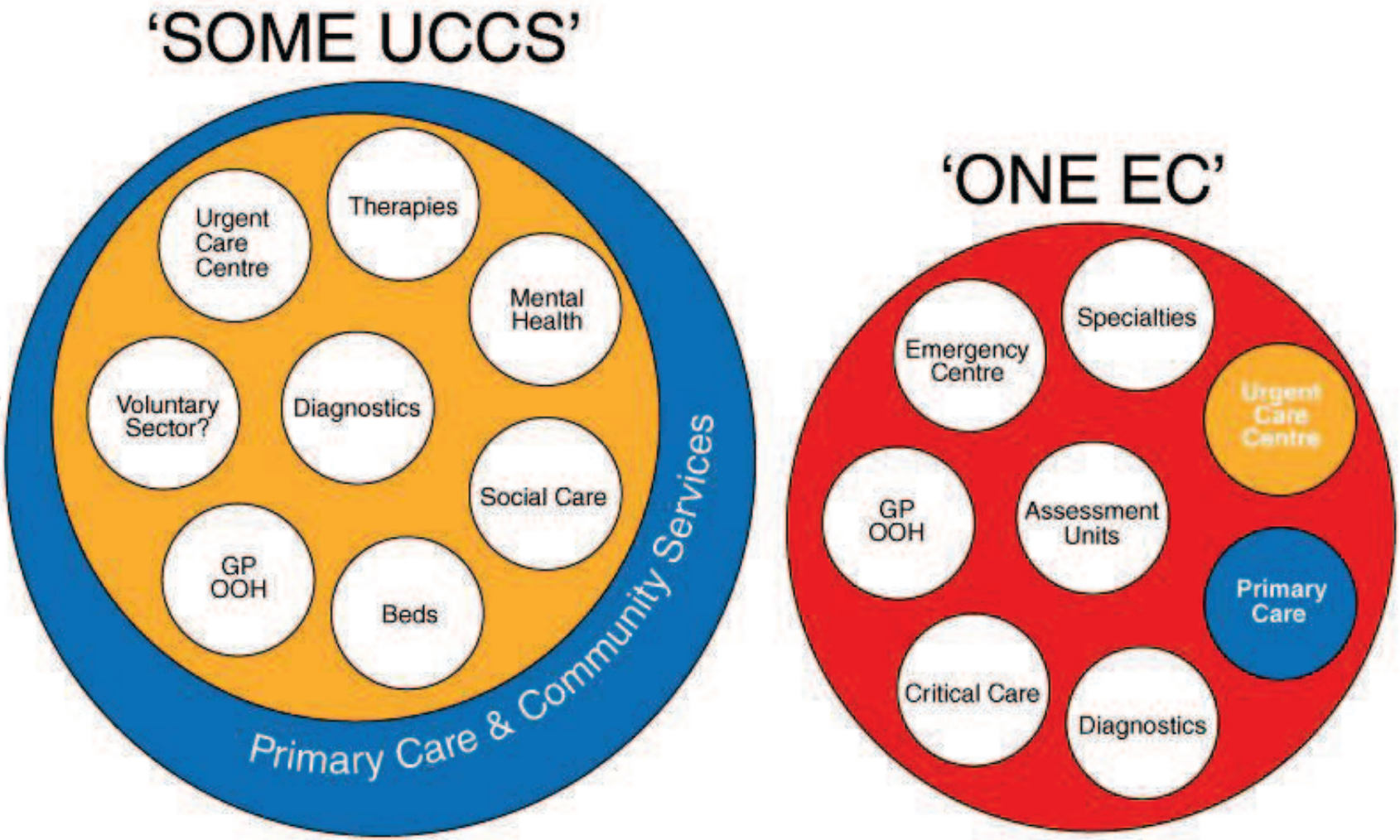

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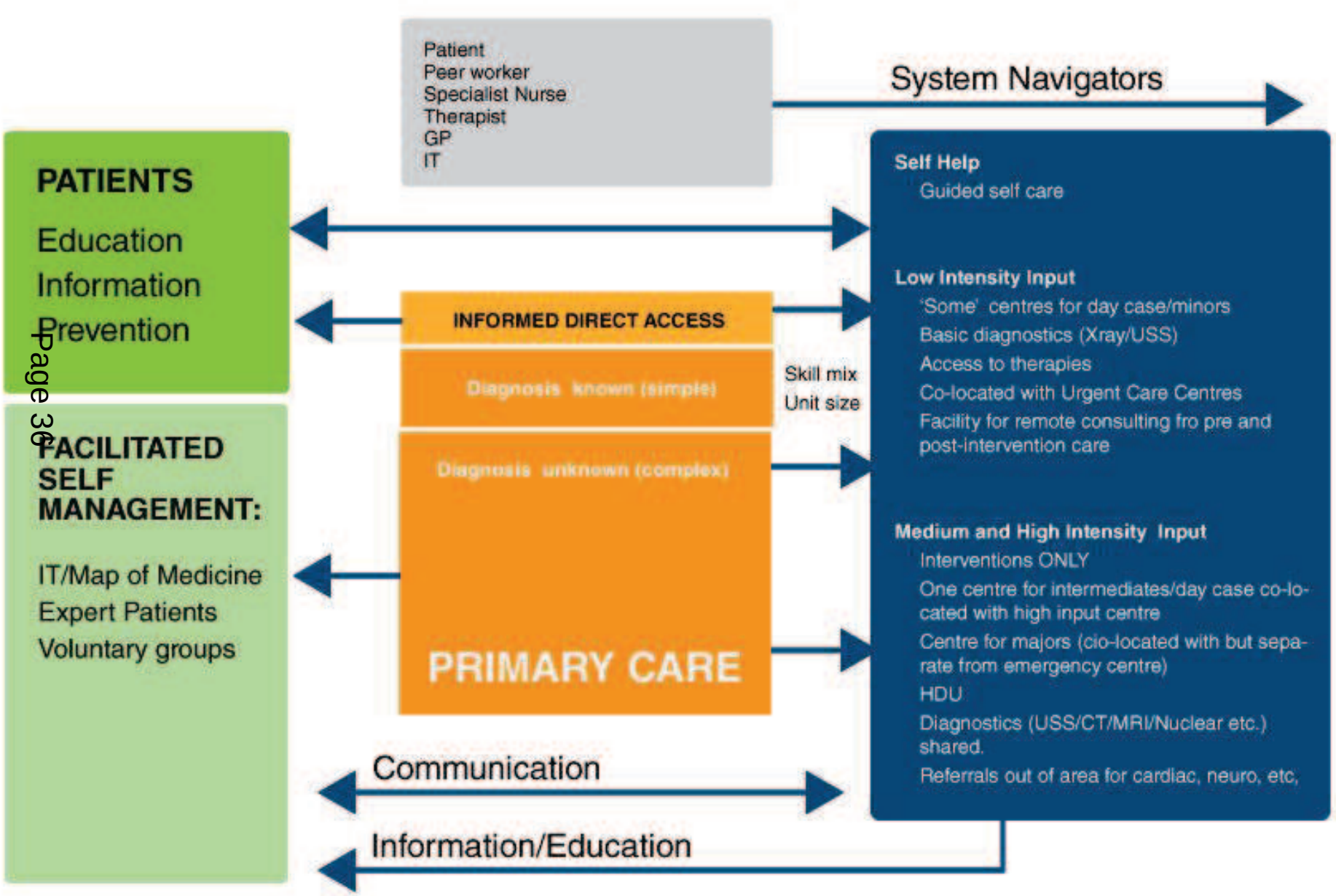
Planned Care

NHS



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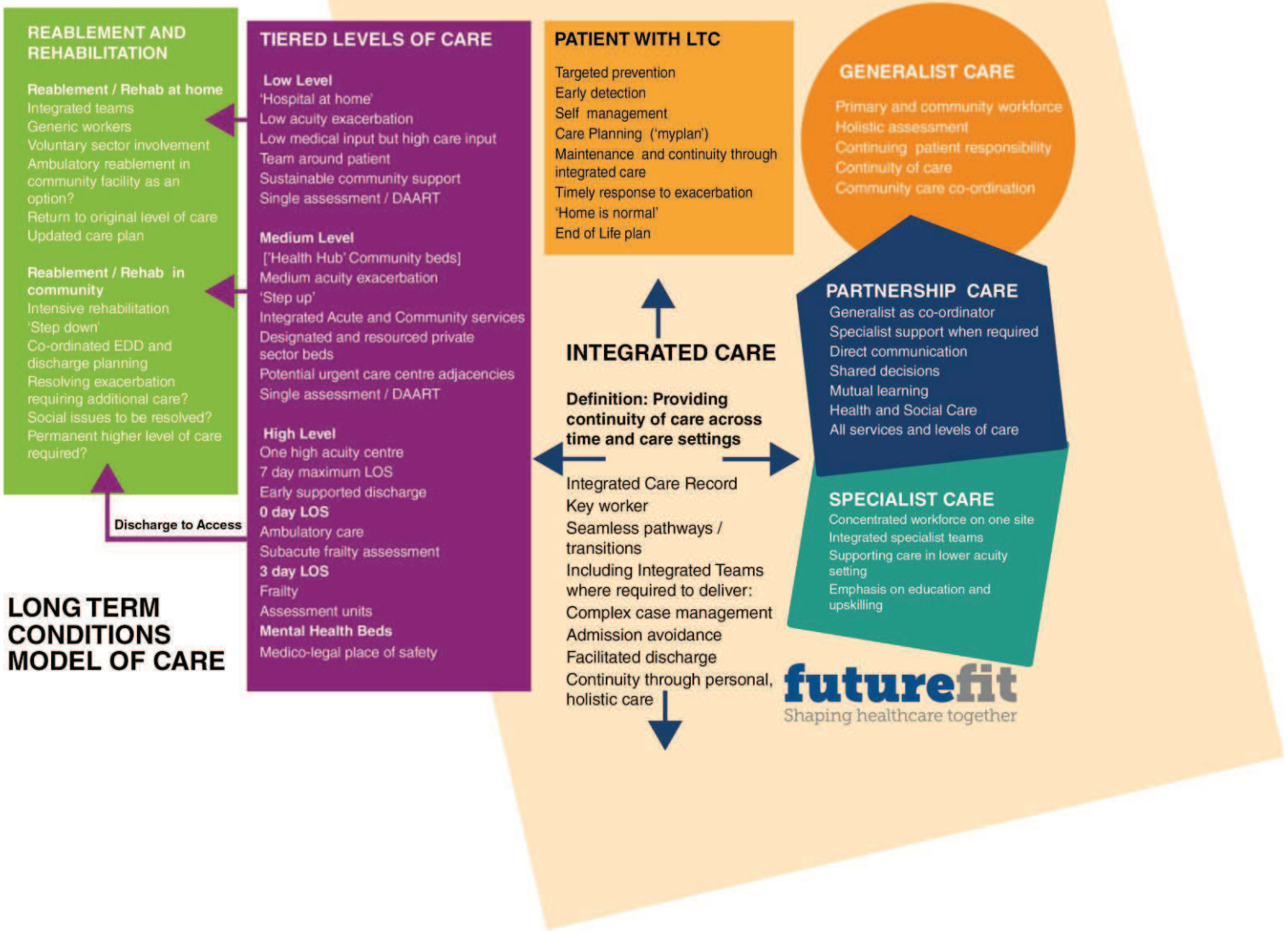
Long Term Conditions

NHS



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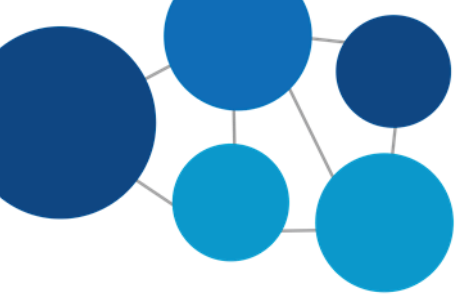
NHS

Next steps

- Forms the bedrock for all FutureFit work
- Sets out a vision for future development of health and care system
- Platform for future activity and capacity planning
- Platform for developing facilities options
- Platform for wider system redesign e.g. IT and workforce
- Formation of clinical steering group (Senate)



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Attachment C
Evaluation Process & Criteria

Identification and Short-listing of Options

Report to:	**Programme Board**
Subject:	**Identification and Short-listing of Options**
Report by:	**Mike Sharon, Programme Director**
Date:	**21st May 2014**

1 Introduction

The work of the Clinical Design workstream to define the future model of care is due for completion by the end of May, with the detailed activity and capacity projections to reflect this model then due for completion by the end of August.

Concurrent with this work, there is a need to identify the short-list of options for detailed development and appraisal, alongside the criteria to be used in that appraisal, so that option-specific activity and capacity projections can then be developed, which will form the basis for the physical solution and resource impact for each option.

The Programme's Principles of Joint Working set out that it *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.*

The relevant key milestones within the proposed programme plan are as follows:

Table 1 Key Milestones

	Key Milestone	Completion by	Programme Board sign-off
1	Clinical Model	28th May	10th June
2	Public Engagement	28th August	17th September
3	Activity Modelling	28th August	17th September
4	Emergency Care Feasibility Study	28th August	17th September
5	Determine short list of options	30th September	15th October

The purpose of this report is to set out the proposed process and timetable for identifying the range of options available and selecting the short-list of options for further development, subject to the Board's approval of the revised timeline. A subsequent paper will set out the proposed process for the evaluation of short-listed options once developed. Key components of the initial process are set out below.

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Getting to a Shortlist

Brainstorm Workshops	Programme Board sign off	Engage	Programme Board Revised long list & criteria	Shortlisting Workshop	Programme Board sign off	Engage
Panel convened Wide thinking on long list Developing evaluation criteria Mid June	Programme Board agrees draft long list and draft benefit criteria for public engagement June 25	Public asked for views on clinical model, long list and benefit criteria July, August	Programme Board reviews outcome of engagement and revises accordingly Mid September	Panel reconvenes Uses criteria to develop shortlist Late September	Programme Board agrees shortlist which is then worked up October	Public asked for views on shortlist prior to final non-financial appraisal October onwards

2 Guidance and Best Practice

The processes adopted by the Programme need to align with a range of national guidance. This guidance is summarised below.

2.1 HM Treasury

Treasury guidance is contained in *The Green Book: Appraisal and Evaluation in Central Government* (2013). In relation to developing a shortlist of options (Section 5.3 – 5.7), HMT advises that:

For a major programme, a wide range should be considered before short-listing for detailed appraisal….. At the early stages, it is usually important to consult widely, either formally or informally, as this is often the best way of creating an appropriate set of options.

It also notes the need to include a 'do minimum' option in order to judge the reasons for more interventionist action.

2.2 NHS England

In its *Business Case Approvals Process* guide (2013) NHS England refers to the Department of Health's *Capital Investment Manual* (1994). This contains guidance on the generation of options. In particular it notes that:

The drawing up of a long list of possibilities will usually require consultation of a range of people… The generation of options provides an opportunity to be creative and innovative, to challenge constraints, and to revisit the objectives of the investment. (Section 2.12.1, p.28)

It also suggests that brain-storming sessions with an experienced panel are held to support this before each identified option is described (two or three paragraphs) and options are then reduced to a short list of between three and six options by excluding those options which are not feasible, are unaffordable or do not meet the programme's objectives.

2.3 NHS Trust Development Authority

NHS TDA has issued a Business Case Checklist as part of its guidance for NHS Trusts - *Capital Regime and Investment Business Case Approvals* (2013), Appendix 2. In relation to this early stage of the appraisal process it poses these questions:

- *Has a wide-ranging long-list of options (including a do-nothing or do-minimum) for achieving the investment objectives been drawn up? Does it reflect the views of all stakeholders?*
- *Are the criteria for the short listing of options clear? Do they derive clearly from the investment goals set out in the Strategic case, and have the reasons for their relative weightings been set out?*

3 Long List of Options

3.1 Development of a Long List of Options

The development of the Long List comprises three key tasks:

- Generating ideas;
- Engaging the Community and Clinicians, and;
- Describing the Long List.

a) Generating Ideas

This will involve setting out the multiple configuration options (i.e. various combinations of the number and location of clinical facilities and services) through which it may be possible to implement the elements of the approved Clinical Model which are within the Programme's scope.

In line with national guidance (see Section 2 above), ideas will be generated by an experienced panel formed of all Programme Board sponsor and stakeholder organisations, as follows:

Organisation
Shropshire Clinical Commissioning Group
Telford & Wrekin Clinical Commissioning Group
Powys Local Health Board
Shrewsbury and Telford Hospital NHS Trust
Shropshire Community Health NHS Trust
Shropshire Patient Group
Telford & Wrekin Health Round Table
Healthwatch Shropshire
Healthwatch Telford & Wrekin
Montgomeryshire Community Health Council
Shropshire Council
Telford and Wrekin Council
West Midlands Ambulance Service NHS FT
Welsh Ambulance Services NHS Trust
Robert Jones & Agnes Hunt Hospital NHS FT
South Staffs & Shropshire Healthcare NHS FT
G.P. providers
Shropshire Doctors' Cooperative Ltd
NHS England Shropshire & Staffordshire Area Team

These organisations will each be asked to nominate a single representative and will also be encouraged to brain-storm potential options within their organisations prior to the panel meeting (for which background information would be supplied). A single half-day workshop will be held for the panel at which it will be asked to recommend a long list of around 10-12 configuration options for approval by the Programme Board.

- **Workshop 1**

The workshop will include:

- Provision of information on-
  - Programme Objectives
  - The Clinical Model
  - Basic demographic data
  - Existing acute and community hospital sites (although new site options are also to be considered);
- Brain-storming of potential options which cover the following requirements –

Acute & Episodic Care	One Emergency Centre
	Some Urgent Care Centres
Planned Care	One Diagnosis & Treatment Centre
	Assessment, diagnostics and follow up closer to home
Long Term Conditions & Frailty	Health Hub/Community Beds

- Reduction of ideas to a provisional long list (through removal, by consensus, of ideas which are duplicated and/or judged by the panel not to be feasible).

b) Engaging the Community and Clinicians

In addition to the initial process whereby sponsor and stakeholder organisations can involve their staff/members in brainstorming ideas prior to the first workshop, the provisional long list which emerges from the workshop will then be subject to community and clinical engagement to test that no feasible options have been omitted.

c) Describing the Long List

Following public engagement the Programme Board will confirm the long list. It will then be necessary to prepare a brief description of each option to inform the subsequent short-listing process. A suggested template for these descriptions is attached as **Attachment A**. This work will be led by the Programme Team supported by its constituent workstreams, and will be reviewed for accuracy and completeness by the Programme Board's Core Group before entering the short-listing process.

4 Short-listing

4.1 Evaluation Criteria

It is proposed that the criteria to be used in evaluating the short-listed options should be determined in advance by the Programme Board. These criteria will need to reflect the programme's goals and objectives, as set out in the Programme Execution Plan:

a) Objective

To agree the best model of care for excellent and sustainable acute and community hospital services that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin, and Mid Wales.

b) Goals

The key benefits to be secured from the programme are:

- Highest quality of clinical services with acknowledged excellence in our patch;
- A service pattern that will attract the best staff and be sustainable clinically and economically for the foreseeable future;
- A coherent service pattern that delivers the right care in the right place at the right time, first time, coordinated across all care provision;
- A service which supports care closer to home and minimises the need to go to hospital;
- A service that meets the distinct needs of both our rural and urban populations across Shropshire, Telford & Wrekin and in Wales, and which anticipates changing needs over time;
- A service pattern which ensures a positive experience of care; and
- A service pattern which is developed in full dialogue with patients, public and staff and which feels owned locally.

In addition, the criteria should be informed by factors recommended by the DH which are commonly used in non-financial appraisals:

• Access to services	• Meeting Policy Imperatives
• Clinical Quality	• Training, Teaching, Research
• Environmental Quality	• Effective Use of Resources
• Development of new/existing services	• Ease of Delivery.
• Strategic Fit	

♦ **Workshop 2**

Prior to final determination of the short-listing criteria by the Board, a stakeholder workshop is proposed (to take place between May and late June Board meetings) so that a recommendation can be developed. This could be combined with the long-listing workshop described above, in order to utilise the same representative membership.

4.2 Process

The process for selecting the short-list of options for further development and appraisal needs to be robust, transparent and justifiable in the event of a challenge.

It is therefore proposed that a formal and structured non-financial appraisal of the long-listed options be undertaken, involving as wide a range of stakeholders as possible within the time available (see 4.3 below). The process will also need to include an explicit assessment of whether any options are clearly unaffordable (DH, 1994, Section 2.14.3) and the methodology for this will need to be set out by the Finance Workstream.

The non-financial appraisal will comprise two further half-day workshops, possibly taking place on the same day. Guidance suggests that *Objectivity is enhanced by separating the exercises of scoring the options from that of weighting the benefit criteria* (DH, 1994) although a single expert and representative panel is envisaged.

- **Workshop 3 - Criteria weighting**

  The panel determines the weighting of the criteria through a process of step-by-step pair-wise comparison, as set out in national guidance (DH, 1994, Section 2.21.1).

- **Workshop 4 – Presentation of the options and scoring**

  The description of each option developed by the Programme Team will be presented to the panel after which panel members will discuss each option before individually scoring them against each of the criteria. The resulting scores will be recorded and the agreed weightings applied in order to produce initial non-financial scores. These will then be reported back to the panel (individual scores will be held in confidence) to inform further discussion and individual re-scoring, if desired. Following the scoring workshop, a report will be produced which summarises the scores and analyses them by stakeholder type. The report will be presented to the Programme Board which will then need to reach a consensus, informed by the report, on which options should proceed to full appraisal.

4.3 Short-listing Panel

It is proposed that the panel to undertake the shortlisting should be constituted in the same way as the long-listing panel, with single representatives from each sponsor and stakeholder organisation (see 3.1). These representatives should ideally be the same individuals as for long-listing.

An alternative approach considered was to utilise the Programme Board membership, with the addition of any other key stakeholders whom the Programme Board considered should be involved. There are governance benefits, however, to Programme Board members not being actively involved in the process until they receive its output.

5 Timescale

As noted in Table 1 above, a provisional short-list of options needs to be identified in late September for sign-off by the Programme Board in October in order that work on developing the options can commence. The short-list will also then be subject to further community and clinical engagement which will inform the final non-financial appraisal of options.

The following timetable is therefore proposed:

Table 2 Short-listing Timetable

	Key Milestone	Work to be completed by	Programme Board sign-off	T&W CCG Board	Shropshire CCG Board	Powys LHB	SCHT Board	SaTH Board	JHOSC
1	**Approval of short-listing process**	15th May	**21st May**	10th June	11th June	19th June	22nd May	29th May	19th June
2	**Clinical Model finalised**	28th May	**10th June**	10th June	11th June	19th June	17th July	26th June	19th June
3	**Workshop 1: Generation of provisional long-list**	18th June	**25th June**	8th July	9th July	4th September	17th July	26th June	July (tbc)
4	**Workshop 2: Identification of provisional short-listing criteria**	18th June	**25th June**	8th July	9th July	4th September	17th July	26th June	July (tbc)
5	**Engagement on Clinical Model and Provisional Long List and Benefit Criteria**	End August	-	-	-	-	-	-	-
6	**Preparation of description of long-listed options**	Mid September	-	-	-	-	-	-	-
7	**Workshop 3: Criteria weighting**	End September	-	-	-	-	-	-	-
8	**Workshop 4: Option scoring**	End September	-	-	-	-	-	-	-
9	**Analysis of Results and identification of short-listed options**	8th October	**15th October**	11th November	12th November	16th October	20th November	30th October	October (tbc)
10	**Engagement on the short-listed options**	End January	-	-	-	-	-	-	-

The sponsor/stakeholder meeting dates in the table above are those already scheduled. In order for this timeline to be feasible, it may be necessary for extraordinary meetings to be held if those organisations are formally to consider Programme outputs before further work is undertaken. There would otherwise be considerable delay. Key community and clinical engagement opportunities are highlighted in green.

6 Actions Required

The Programme Board is asked to consider the following aspects:

- The proposed approach to establishing a long-list of options
- The proposed process and timetable for selecting a short-list of options
- The composition of the long-listing, short-listing and criteria setting panel.

Mike Sharon

Programme Director

futurefit
Shaping healthcare together

ATTACHMENT A

OPTION DESCRIPTION

OPTION 1

ACUTE HOSPITALS	COMMUNITY HOSPITALS	IMPACT ON OTHER SERVICES*
SERVICE CHANGES	**SERVICE CHANGES**	**SERVICE CHANGES**
Acute Episodic Care Planned Care Long-term Conditions & Frailty	Acute Episodic Care Planned Care Long-term Conditions & Frailty	Acute Episodic Care Planned Care Long-term Conditions & Frailty
FACILITIES CHANGES	**FACILITIES CHANGES**	**FACILITIES CHANGES**
WORKFORCE IMPACT	**WORKFORCE IMPACT**	**WORKFORCE IMPACT**
IT IMPACT	**IT IMPACT**	**IT IMPACT**

* Including Primary Care, Community Health Services, Social Care, Ambulance Services, Care Homes, Community Pharmacies

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