**Questions from Joint HOSC for Committee Meeting on 18th October**

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

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

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

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

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

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

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

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