Response to Joint HOSC Questions

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

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

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