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

Date: 7 December 2015

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Tuesday, 15 December 2015**
Time: **10.00 am**
Venue: **Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, 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)	Andy Burford (Co-Chair)
John Cadwallader	Veronica Fletcher
Tracey Huffer	Rob Sloan
David Beechey (co-optee)	Barry Parnaby (co-optee)
Ian Hulme (co-optee)	Rajash Mehta (co-optee)
Mandy Thorn (co-optee)	Dag Saunders (co-optee)

Your Officers are:

Amanda Holyoak Scrutiny Committee Officer
Tel: 01743 252718
Email: amanda.holyoak@shropshire.gov.uk

Fiona Bottrill Scrutiny Group Specialist
Tel: 01952 383113
Email: fiona.bottrill@telford.gov.uk

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 - 8)

The minutes of the meeting held on 28 September 2015 are attached for confirmation

4 Public Question Time

To receive any statements, questions or petitions of which members of the public have given notice. Deadline for notification is 5.00 pm on Thursday 10 December 2015.

5 Member Question Time

To receive any statements, questions or petitions of which Members have given notice. Deadline for notification is 5.00 pm on Thursday 10 December 2015.

6 Children and Adolescent Mental Health Service (Pages 9 - 12)

To receive a briefing, attached marked: 6, from Shropshire and Telford and Wrekin CCGs, Shropshire Council and Telford and Wrekin Council, regarding future plans for the Children and Adolescent Mental Health Service.

7 Future Fit and Community Fit (Pages 13 - 58)

To receive an update on progress of the Future Fit Programme, attached marked: 7A (page 13) and on the first phase of the Community Fit project, attached marked: 7B (page 43)

8 Winter Plan

To receive a report, attached marked: 8, on action taken to address hospital discharge and winter pressures since the last meeting of the Committee on 28 September 2015

9 Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services (Pages 59 - 88)

To receive a briefing from Shrewsbury and Telford Hospital Trust on 'Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services' and consider the Committee's role in providing a review. Information attached marked: 9

10 111/Out of Hours Service

To receive a briefing, **TO FOLLOW** marked: 10, from Shropshire and Telford and Wrekin CCGs regarding Procurement and Consultation plans for the 111 and Out of Hours Services.

This page is intentionally left blank

SHROPSHIRE COUNCIL/TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on 28 September 2015 at Castle Farm Community Centre, Hadley, Telford at 12.30pm

PRESENT – Cllr A Burford (TWC Health Scrutiny Chair) (Chairman), Cllr G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC co-optee), Cllr J Cadwallader (SC), Cllr V Fletcher (TWC), Mr I Hulme (SC Co-optee), Ms D Price (substitute for Mrs M Thorn – SC Co-optee), Mr D. Saunders (TWC Co-optee), Cllr R Sloan (TWC), Ms G Stewart (substitute for Mr B Parnaby -TWC Co-optee)

Also Present –

K Allward (Integrated Community Services Lead, SC/Community Health Trust)
F Bottrill (Scrutiny Group Specialist, TWC)
S Chandler (Director Adult Social Care, SC)
Cllr L Chapman (Portfolio Holder, Adult Social Care, SC)
J Ditheridge (Chief Executive, Community Health Trust)
I Donnelly (Assistant Chief Operating Officer, SaTH)
D Evans (Accountable Officer, Telford & Wrekin CCG)
W Greenwood (SaTH)
A Hammond (Deputy Executive, Telford & Wrekin CCG)
A Holyoak (Committee Officer, Shropshire Council)
N Nisbet (Finance Director, SaTH)
A Osborne (Communications Director, SaTH)
J Smith (Access and Assessment Manager, TWC)
P Taylor (Director of Health, Wellbeing and Care, TWC)
P Tulley (Chief Operating Officer, Shropshire CCG)
S Wright (Chief Executive, SaTH)

JHOSC-1 APOLOGIES FOR ABSENCE

Apologies were received from Cllr T Huffer (SC), Mr B Parnaby (TWC Co-optee) and Mrs M Thorn (SC Co-optee)

JHOSC-2 DECLARATION OF INTERESTS

None

JHOSC-3 MINUTES

RESOLVED – that the minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 12 February 2015 be confirmed as a correct record and signed by the Chairman.

JHOSC-4 HOSPITAL TRANSFER

The Chairman stated that the Joint Committee had asked for an update on the current position on delayed discharge and transfer of care of patients from hospital. The Joint Committee was mindful of the huge spike in patient admissions last winter, which led to a lot of cancelled operations, and wanted reassurances that the various health and social care bodies were working together to address capacity issues before the onset of the winter period.

Anna Hammond (Deputy Executive: Integrated Care, Telford & Wrekin CCG) gave a presentation, which provided information on:

- Definitions of terms – it was added that a change in the Department of Health's guidance/terminology was expected soon;
- Targets for each defined area of delayed transfer of care (DTOC) and medically fit for discharge (MFFD);
- Performance against key targets – for acute care, there had been a growth over the summer period of the proportion of beds being occupied by patients waiting to be transferred from hospital – up to 5.4% against a target of 3.5%. Delayed days in Shropshire community hospital beds had fallen since April but were still above target. There was an improving trend for reducing the number of FTT patients but the total remained above target. For Better Care Fund patients, the Telford & Wrekin health economy had achieved their target in months 1-3, but the Shropshire health economy was above target.
- Key challenges - these included different interpretations locally of definitions and targets for DTOC and MFFD, and access to domiciliary care particularly in the most rural parts of the county.
- Commissioning Strategies – there were three key plans in development based around admission avoidance, improving patient flow and early supported discharge schemes. Winter planning was built into this.

Julie Smith (Access and Assessment Manager, TWC) explained the Telford & Wrekin approach, which meant that from 12 October 2015 there would no longer be a hospital social work team. It was realised that assessing people in a hospital setting was not the right thing, and that the way forward was to provide information and assistance to help people to stay at home. This would involve working with partners and key professionals, with a joint hub of intermediate care services based at the PRH site to receive referrals/contacts. It was planned that people would be seen initially within an hour. In terms of the discharge of more complex cases who had been admitted to an acute hospital, a fact finding assessment would be carried out by SaTH staff on the ward. If a patient was identified for discharge, a senior social worker would co-ordinate the discharge and the support package that was required for the patient, with the aim of the patient leaving an acute bed within 24 hours.

Kerrie Allward (Integrated Community Services Lead, SC/Community Health Trust) explained Shropshire's approach to commissioning, which was similar to Telford & Wrekin's. A model of Integrated Community Services (ICS) had been developed, bringing together a number of different Council and health

services with voluntary/independent sector providers. ICS would be the default service for Shropshire in terms of patient discharge from hospital, and there were similar patient pathways as the Telford & Wrekin model. ICS had been trialled in the Shrewsbury area from November 2013, and rolled out in phases to the rest of the county. The final phase (for the north and south of the county) was due to be launched shortly.

Ian Donnelly (Assistant Chief Operating Officer, SaTH) gave a presentation which provided information on:

- SaTH definitions of and targets for MFFD and DTOC;
- Performance against key targets – for DTOC there had been a continued rise in delays over the period April 2014 to August 2015. On average the DTOC figure was currently running at 8% (equivalent to 53 beds) against a national target of 3.5%, with an agreed stretch target of 2.5%.
- Weekly discharge pattern and quarterly discharges;
- Cancelled operations – last winter's spike had returned to normal levels. It was stressed that urgent operations were not cancelled;
- Comparison and percentage of delays by site (RSH and PRH) across the last two years;
- Increase in over 70s admissions – there had been a marked increase in over 70s admitted to both hospitals, with a significant rise over the last winter period.

The Committee then went on to ask questions of NHS and Local Authority representatives regarding delayed transfer of care and discharge, and highlighted particular issues:

With the new strategy of having a joint/integrated team to assess patients for discharge etc, to what extent were family and/or primary carers involved in the assessment process?

And how would self-funders be looked after to ensure they were safe after discharge from hospital?

The Access & Assessment Manager, TWC explained that the first assessment of a patient for hospital discharge would take place on the ward and be relatively quick. Depending on the likely pathway, there would then be further discussions with other professionals and the family/carer. Any domiciliary care/rehabilitation required would be funded free for up to six weeks. Self-funders would not be treated any differently, and would be covered by re-enablement funding for the first 6 weeks. Voluntary sector partners (eg Red Cross) were being used to ensure people were safe when they went home. The Assistant Chief Operating Officer, SaTH added that the 'fact-finding' document from the initial assessment provided enough information about the patient to determine discharge.

There were still concerns that patients were being discharged from hospital late at night. Was this practice still continuing?

The Assistant Chief Operating Officer, SaTH advised that this may still happen following discussions with the patient's family and/or with a care home that was admitting the patient. However, if necessary, discharge would be delayed until the next morning.

Was there a reduction in the amount of elective surgery as a result of the sort of increase in cancelled operations seen last winter?

The Deputy Executive: Integrated Care, Telford & Wrekin CCG reported that there was a planned reduction in elective surgery during the third quarter to take account of the likely increase in admissions. The Assistant Chief Operating Officer, SaTH added that occasionally temporary additional resources had been put in to address demand and keep cancellations to a minimum.

Within the independent care sector, it was felt that more practical assistance from the health services was needed to allow patients to be admitted to a care home and for their needs to be met. To what extent were communications between SaTH and the independent care home sector taking place?

The Assistant Chief Operating Officer, SaTH stated that the capacity teams at each hospital site did discuss daily discharges with the independent sector.

Clarification was sought as to the main cause for delayed transfer of care within the ICS model in Shropshire.

There was some disagreement as to whether this primarily related to the Hospital Trust or to other health services. The Accountable Officer, Telford & Wrekin CCG advised that a significant proportion of the health element would be related to intermediate care and its availability. Some would relate to social care. However, all sectors were committed to reducing the number of DTOCs.

Mr I Hulme provided an example of a case where he believed the transfer of care had not been handled properly, and that the elderly patient had been sent home without proper care in place. It was felt that the system was understaffed and overstretched, that family and friends needed to be part of the discharge planning process, and that the quality of care needed to be higher.

The Chief Executive, Community Health Trust expressed regret for any such failures. Patient safety always came first, and elderly patients were not treated any differently.

The Joint Chairs stated that it was clear that the JHOSC still had concerns about the continued rise in DTOCs above the target figure, and the missing of key targets. While acknowledging the measures being put in place, regular monitoring was needed in order to see the direction of travel. The Committee wished to have a regular single report submitted by all partners in the health economy, with a greater explanation of the reasons for delays in the system, and how this was impacting on admissions. The Chief Executive, SaTH

suggested that such a report could be produced within the next month, and agreed that a single version agreed by all partners would be preferable. SaTH would be committed to trying to reduce the numbers of people coming into hospital, and that the report to Members would include the Trust's plans for dealing with any increases in demand over the winter period while maintaining patient safety and standards of care.

The Committee welcomed the offer of a further report within the next month, which would be circulated to Members for information.

JHOSC-5 FUTURE FIT

Simon Wright, Chief Executive, and Adrian Osbourne, Communications Director, Shrewsbury & Telford Hospital NHS Trust presented a paper setting out the framework for developing a Consultation Plan for formal consultation on the Future Fit proposals for safe and sustainable acute and community hospital services..

The Chair welcomed Simon Wright, who had just started his role as Chief Executive of SaTH, to his first meeting of the JHOSC.

In the context of the overall Future Fit programme, the Chief Executive, SaTH explained the challenges facing the Trust in terms of the numbers of consultants and other specialists, and being able to put together staff rotas for both hospital sites. He confirmed that the services are safe however, rotas are difficult and services are frail. Decisions needed to be made in a timely and measured way to produce a resilient solution, rather than have to introduce emergency measures in the event of one consultant leaving.

The Communications Director, SaTH reported that the Framework had been agreed by the Future Fit Programme Board on 13 August 2015. Further work had taken place since then on developing the Consultation Plan, which would be submitted to the Programme Board on 1 October for approval. The Framework document included details on Consultation Principles, the Consultation Plan timetable, key requirements, resources and risks. The formal consultation period on the Future Fit proposals would take place between December 2015 and March 2016. All communities and stakeholders would be able to have their input into the process and make their views known, but it was not a public vote or opinion poll. The pre-election period for Welsh Assembly elections in the Spring gave a window for the review and analysis of the comments received, with a decision being made in late Spring 2016. A detailed consultation plan/programme would be worked on during October 2015, and any comments/views from the JHOSC could be fed into that final Plan.

Members of the JHOSC then expressed views on, and asked a number of questions about, the Future Fit Programme and the Framework for the Consultation Plan.

Concern that the Programme is just focussing on acute hospital services and their reconfiguration, and not addressing issues of an ageing population, preventative care, and new ways of working etc.

The Communications Director, SaTH stated that Future Fit was one part of a wider approach to addressing all the issues in the health economy, and it needed to be linked to those other things. The Accountable Officer, Telford & Wrekin CCG added that ensuring safe clinical services in hospitals had always been a key part of Future Fit, but it was recognised that it was linked to wider health and care issues within Shropshire and Telford & Wrekin. The Chief Executive, SaTH agreed that there needed to be wider solutions in the long term, but at the same time solutions needed to be in place to protect services against current fragilities in the system.

Concern that there might be a misunderstanding as to what this consultation was about, and that it needed to be made clear what was being consulted on and what changes in service were being proposed. Acute services could not be divorced from all other sectors of the health economy, and all the implications needed to be understood.

The Accountable Officer, Telford & Wrekin CCG advised that a lot of the work that had been carried out previously had been clinically-led and looked at a whole range of care pathways/outcomes and models of care. While much of the public focus had been on emergency care, it should be clear that the Programme was also about other issues such as long term conditions, planned care etc.

During the consultation it was important that the public were engaged directly, and that the consultation goes to them rather than the other way round.

The Communications Director, SaTH stated that there would be a lot of consultation activities and events, and these would be outlined in the detailed Consultation Plan.

The consultation should do more to promote Urgent Care Centres so that the public could understand the role they would play if A&E services were confined to one hospital site.

The Accountable Officer, Telford & Wrekin CCG stated that roughly 75% of patients currently seen in A&E could be more appropriately treated in Urgent Care Centres or other settings. Urgent care centres in Telford and Shrewsbury, but not rural urgent care centres, would be part of this consultation.

What were the timescales and what would happen if the timetable slipped?

The Accountable Officer, Telford & Wrekin CCG explained that if the formal consultation did not start in December 2015, it would then be delayed to May 2016, after the Welsh Assembly elections.

The Co-Chair said that the issue of A&E is an emotive subject and often people see A&E as the hospital. However, more should be done to promote the Urgent Care Centres on both sites so they are in a position to do much of what an A&E currently does. Members of the public should be advised of this.

The Chair explained that one of the roles of the Joint HOSC is to make sure that people understand the facts and that the process for Future Fit is clear. He asked who will be carrying out the consultation? Will it be each CCG or a Joint CCG Committee?

The Accountable Officer, Telford & Wrekin CCG responded that the consultation will be the responsibility of the Commissioners. The consultation in July will be run by both CCGs.

It was agreed that comments and feedback summarised above be considered by the Future Fit Engagement and Communications team in the construction of the final Consultation Plan.

JHOSC-6 JOINT HOSC TERMS OF REFERENCE – UPDATE

The report of the Scrutiny Group Specialist, TWC was received. Appended to the report were proposed amendments to the Joint Committee's terms of reference in order to reflect more recent guidance from the Department of Health in relation to health scrutiny. In particular, guidance published in 2014 provided greater detail on the specific powers of delegation of health scrutiny issues. If any consequent changes were required to each Authority's Constitution, these would be dealt considered through the appropriate process operating within each Council.

In response to a question, the Scrutiny Specialist added that there would be no changes to the voting scheme for the JHOSC, but she would circulate the scheme to members for information.

RESOLVED – that the draft terms of reference, as shown at Appendix 1 of the report, be endorsed.

JHOSC-7 JOINT HOSC WORK PROGRAMME 2015/16

The Scrutiny Group Specialist, TWC reported that the two main agenda items at this meeting would continue to be the focus of the current year's work programme. Members had also agreed to look at mental health services for children, and this needed scoping.

Reference was made to any follow up work relating to the scrutiny of wider mental health services. The Scrutiny Group Specialist and the Director of Health, Wellbeing & Care, TWC advised that the issue about the future of the Castle Lodge facility had been picked up by Telford & Wrekin's Health & Adult Care Scrutiny Committee, and that Shropshire might want to look separately at anything of specific concern to them. It was reported that a commissioning review of mental health services would be discussed at a meeting the

following week, and the Chair advised that any developments would be monitored in case any joint issues arose.

JHOSC-8 CHAIRS' UPDATE

Cllr Burford advised that he would circulate the current TWC Health & Adult Care Scrutiny Committee work programme to JHOSC members.

The meeting closed at 2.52 pm.

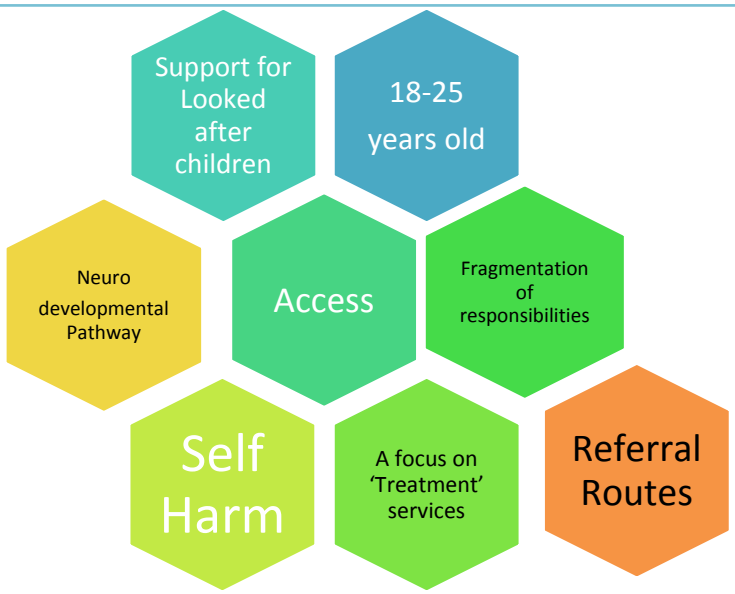
Chairman……

Date……

Meeting of the Joint Health Overview and Scrutiny Committee

15 December 2015

0-25 Emotional Health and Wellbeing Service
Responsible Officer
Anna Hammond, Senior Responsible Officer for the programme (Deputy Executive Commissioning and Planning, Integrated Care from Telford and Wrekin CCG) **Produced on behalf of Shropshire CCG, Shropshire Council, Telford and Wrekin Council and Telford and Wrekin CCG. Presented by Anna Hammond and Fiona Ellis (Commissioning and Redesign Lead, Women and Children from Shropshire CCG)**
Purpose of this document
This brief paper provides a high level summary of the case for change around children and adolescent mental health services. It moves onto highlight the aspirations of a new service development of a 0-25 year emotional health and wellbeing service. **This development began because of feedback received from professionals, children, young people and their families. All organisations involved have committed to continue this meaningful engagement to ensure any service is designed by those groups affected most. We want to discuss this approach with the Scrutiny Committee to confirm they are supportive of such a programme of engagement from the outset.** **Actions for the Committee to Consider:** • ***Are the committee satisfied that the appropriate approach has been taken to support the development of a new service*** • ***Would the committee (or representatives of the committee) be happy to receive the draft communication and engagement plan for consideration in January?*** • ***At what points would the committee like to receive updates/comment on progress made?***
Summary of the proposed change
Over the past few years feedback has been received from young people, families, local professionals about the need to improve children and adolescent mental health services. The following diagram outlines the key problems raised:



In response to these comments the CCGs and Local Authorities across Shropshire, Telford and Wrekin have been working together to commission a seamless service to improve emotional health and wellbeing of those aged 0-25 years. This will include the following:

- **Increased support for looked after children and children on 'the edge' of care**
- **A service that extends to young people aged 25, if that is necessary and appropriate for an individual**
- **The development of a dedicated neurodevelopmental service separate to the core CAMHS services**
- **Improved and easier access (including a 'no wait' ethos)**
- **A joined up service across health and social care organisations to make a coherent offer**
- **A strong focus on increasing resilience, rather than purely on treatment services**
- **Much more innovative solutions: peer support, safe on line information,**
- **An improved urgent response**

In order to support this change the four commissioning organisations have agreed to scope Emotional and Health Well Being Services (CAMHS) with a view to market testing (subject to the CCGs and Local Authorities ratification).

Engagement: What have we heard to date and what have we got planned?

The proposed solution is a direct response to the messages we have heard through a range of different sources. The commissioning organisations have held events (general and specific to this area), received complaints, listened to patient stories and engaged at an individual level with families. The main points are summarised in the diagram above and a large number of issues raised centre around waiting times, lack of choice and the way in which services are delivered. In addition, the organisations have been working with the young health champions who have defined a set of outcomes on which the specification for future services will be based. There has been much debate and consultation nationally which has informed some major publications and policy changes such as 'Future in Mind'[1]. These also contain some useful guidance and best

practice which will be included.

Commissioners are keen to ensure this development is treated as an iterative process to promote innovation and for the people who would be affected by such services to shape the way they look in the future. A comprehensive communication and engagement plan is in development which will be drafted by the end of December 2015. This is planned to be a modern and proactive approach and will involve a set of activities over the next 18 months including:

- **Utilisation of a methodology called 'experience led commissioning', which is about commissioners using people's experiences of care to drive the commissioning process**
- **Further work on the development of the service model and outcomes required with the young health champions. This will involve a programme to train young people to employ the best techniques to talk to their peers who may be experiencing mental health issues**
- **A specific piece of engagement with the more vulnerable groups affected such as looked after children and children at risk of entering the care system. This will be commissioned from local third sector organisations or community groups**
- **Inclusion of children and young people in the assessment of potential providers as part of the procurement.**
- **Requirement of new provider/s to include children and young people in the final design of their service**

Rather than duplicate the work of local organisations the team will connect with existing experts/organisations/interested people. This includes the work of Healthwatch who are embarking on a piece of work with schools, existing networks in the local authorities and groups such as the local parent/carer groups including PODs and PACC.

ENDS

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

This page is intentionally left blank

futurefit
Shaping healthcare together

Programme Board Report

19th November 2015

The purpose of this report is to provide stakeholders with a summary of the last Programme Board meeting. All final papers considered by the Board are published on the Programme website - **nhsfuturefit.org**.

1 PROGRAMME TIMELINE

At the October Board meeting it had been agreed that the Core Group should set out a new programme timetable which reflected the implications of the decision to defer any conclusion on reaching a preferred option until there is an approvable case for investment.

Since that meeting the Core Group has held a number of discussions, including with representatives of NHS England and NHS Trust Development Authority. Advice has also been received from NHS England's Project Appraisal Unit which supports the national Oversight Group for Service Change and Reconfiguration. These conversations highlight the difficulty in setting a comprehensive timetable to consultation in advance of the Department of Health and HM Treasury confirming the acceptability of the deficit reduction plan. They also note the limited availability of capital funds for which a number of schemes may find themselves competing.

In the light of the advice received, the proposed revised critical path sets out the key pieces of work for the next phase and notes the risks around external approvals which are not within the Programme's control. Subject to those approvals the timeline indicates that:

- Public Engagement activities would continue, focusing initially on the Clinical Model and, especially, Urgent Care services;
- A preferred option would be identified in June 2016;
- Formal Public Consultation would take place from December 2016, and;
- The two CCGs would reach a final decision in June 2017.

The high-level timetable can be found at Appendix One.

2 MANAGING KEY INTERDEPENDENCIES

Key to the development of a plan for the next phase are two critical interdependencies:

a) Developing a deficit reduction plan for the Local Health Economy, and;

b) Completing a revised Strategic Outline Case for acute services which prioritises the most pressing clinical challenges.

An overview of how the programme proposes to manage these independencies was discussed and agreed, and of the scope and timing of these two pieces of work was noted. It was also agreed that a similar approach should be taken in relation to the development of Information Technology dependencies.

3 RURAL URGENT CARE

Following receipt in October of the sub-group's report on rural urgent care, plans have been developed to:

a) Get further clarity on how urban Urgent Care Centres could work and on what support they will require from the wider Health Economy, and;

b) Further explore how best to provide enhanced urgent care services in rural localities.

A separate report provides more detail about these two pieces of work.

In addition, the Workforce workstream is considering the requirements for an urgent care workforce, and the Communication and Engagement workstream has developed a plan for enabling a greater public understanding of urgent care provision.

4 COMMUNITY FIT

The NHS Community Fit programme (formally outside the scope of the Future Fit Programme) is progressing well and remains on track to complete its first phase by end March 2016. This will provide a uniquely valuable and integrated view of out of hospital activity (Third Sector, Mental Health, Primary Care, Social Care and Community Healthcare).

The terms of reference of the NHS Community Fit steering group and a paper setting out the potential broader scope of the overarching programme of work have been submitted to CCG boards for approval and to agree any future phases. It was agreed that CCG Governing Bodies should consider their requirements from future phases of Community Fit.

A separate report set out current progress in more detail.

5 CLINICAL DESIGN

The workstream of key Clinical Leaders is collaborating with the Communications Team to shape plans for communicating with the public about the case for change, the clinical model and the urgent care offer. This includes a document summarising where patients would attend with a variety of conditions – both currently and as a result of Programme proposals. Plans for the ongoing engagement of clinical staff will also be considered.

In addition, the workstream will begin preparations for presenting Programme proposals to the West Midlands Clinical Senate for assurance around the clinical evidence base prior to Public Consultation.

6 IMPACT ASSESSMENT

The next phase of Integrated Impact Assessment (IIA) work will run in parallel with public consultation. Nearer that time, the workstream's plans for the required activity will be finalised (in the light of the exact scope of the proposals to be consulted on). Until that time is reached the activity of this workstream has been paused.

7 WORKFORCE

The October Board meeting reviewed the draft Workforce Case for Change and asked for the scope of the document to be extended beyond hospital staff.

The Workstream has since expanded its membership to reflect the wider health and social care economy, and this larger group has started to take an overview of local challenges faced by all providers. A summary of those challenges is set out in a separate report.

The workstream's other main focus has been the workforce requirements for urgent care centres. Information has been sought both from the pilot UCCs at PRH and RSH and from a range of other UCCs in the region and beyond.

8 ASSURANCE

The Assurance workstream had met in the days before the Board meeting to seek assurance about:

- The proposed new timeline;
- The process for managing interdependencies, and;
- The communications plan for the next phase.

The workstream also review the updated reconfiguration guidance from NHS England - *Planning, Assuring and Delivering Service Change for Patients.* This does not replace the 2013 guidance but seeks to add clarity around assurance processes and decision making levels. It also sets out the requirements for Pre Consultation and Decision Making Business Cases for the first time. Key points include in the guidance include:

a) The planning and development of reconfiguration proposals are rarely linear. The most successful proposals ensure continuous discussion and involvement of the local population and key stakeholders throughout the process.

b) There must be clear and early confidence that a proposal satisfies the four tests and is affordable in capital and revenue terms.

c) Proposals affecting services valued under £350m may be determined by the NHSE Regional Director rather than the Chief Financial Officer or Investment Committee.

d) CCGs should assure themselves that those proposals have the support of their member practices.

e) Schemes have struggled to build public support where they have not adequately addressed public concerns that:

- The proposals are perceived to be purely financially driven.
- Patients and their carers will need to make journeys that may reduce access.
- Emergency services will be too far away, putting people at risk.

f) Until approval for the SOC is in place organisations should not incur material costs progressing to the next formal stages of the scheme (OBCs and FBCs).

g) Commissioner decision making involving two or more CCGs can be based on two models – committee in common or joint committees.

9 ENGAGEMENT AND COMMUNICATIONS

Following the Board meeting at the beginning of October, an announcement and a more detailed statement was shared with the public and stakeholders about the necessity of delay whilst a plan is developed to reduce the deficit.

Regular statements and media briefings have continued, a newsletter is being used to provide updates to key stakeholders and a range of engagement events has taken place with Local Joint Committees, Parish Councils, Community Groups, Patient Groups and GP surgeries. A comprehensive engagement programme is also speaking to specific groups, including the homeless, older people and Eastern European workers.

Politicians continue to be updated on a regular basis through MP briefings by the SROs and there are plans to hold further pop-up shops out in the community.

The website has been updated to improve document access. Presentations to workforce groups have been taking place and more are planned in the months ahead.

A summary document containing the Programme's key outputs to date has been published on the website.

The workstream will shortly be finalising plans for the critical next phases of activity before and after the identification of a preferred option. This will involve a significant amount of work both by the Communications team and by key people in sponsor organisations.

10 FINANCE

The Finance workstream met on 5th November. Although the work to develop a deficit reduction plan is outside of the scope of the Programme, the meeting provided an opportunity for discussion of the scope and approach of the work to be undertaken. The need for external support was highlighted.

The Programme is facilitating a meeting of Finance Directors and Chief Officers which will take place in early December to take this work forward. It will involve all local NHS organisations as well as NHS England as the commissioner of specialised services.

It was recognised that the priority is to move towards a sustainable health economy for the long term. Although individual organisations may continue to carry deficits over the intervening period, the focus should be on making progress against the plan as whole health economy.

Any potential impact on social care services, and vice versa, would also be considered.

11 PROGRAMME RISKS

The Risk Register continues to be comprehensively reviewed by the Programme Team each month, and by the Core Group, after which it is published on the Programme website. All workstreams may raise new risks or recommend revision of existing risks at any point.

The Board has previously agreed that all red-rated risks (both pre- and post-mitigation) should be reported to it. These are appended to this summary (see Appendix Two).

There are currently a significant number of risks for which the post-mitigation rating remains above the indicated risk appetite of the Programme. The view of Programme Team is that, whilst the appetite to reduce certain risks further is appropriate, it is also to be expected that a Programme of this scale and complexity will carry a significant degree of risk.

Board agreed that there was a particular risk currently around change in leadership in sponsor organisations, and the register will be reviewed to ensure that this risk is adequately captured and mitigated.

12 PROGRAMME EXECUTION PLAN

An update of the PEP will be produced following agreement by the Board on the scope and timing of the next phase of Programme work.

The schedule of Board meetings will be reviewed as part of this.

13 PROGRAMME MANAGEMENT

At the inception of the Programme, Commissioners sought the support of The Strategy Unit from NHS Midlands and Lancashire Commissioning Support Unit to provide the Programme Management Office. It was expected that this support would run until 2016 after which the later phases of the Programme could be managed locally (though still with access to support from The Strategy Unit).

To avoid undue disruption, a managed transition is proposed which would take place during 2016. First, the responsibilities of Programme Director would be brought in-house by local Commissioners but with other Programme Office functions remaining in place. Then, at a later date, these other functions can also be adjusted to reflect the changing needs of the Programme.

futurefit
Shaping healthcare together

APPENDIX ONE – PROGRAMME TIMELINE

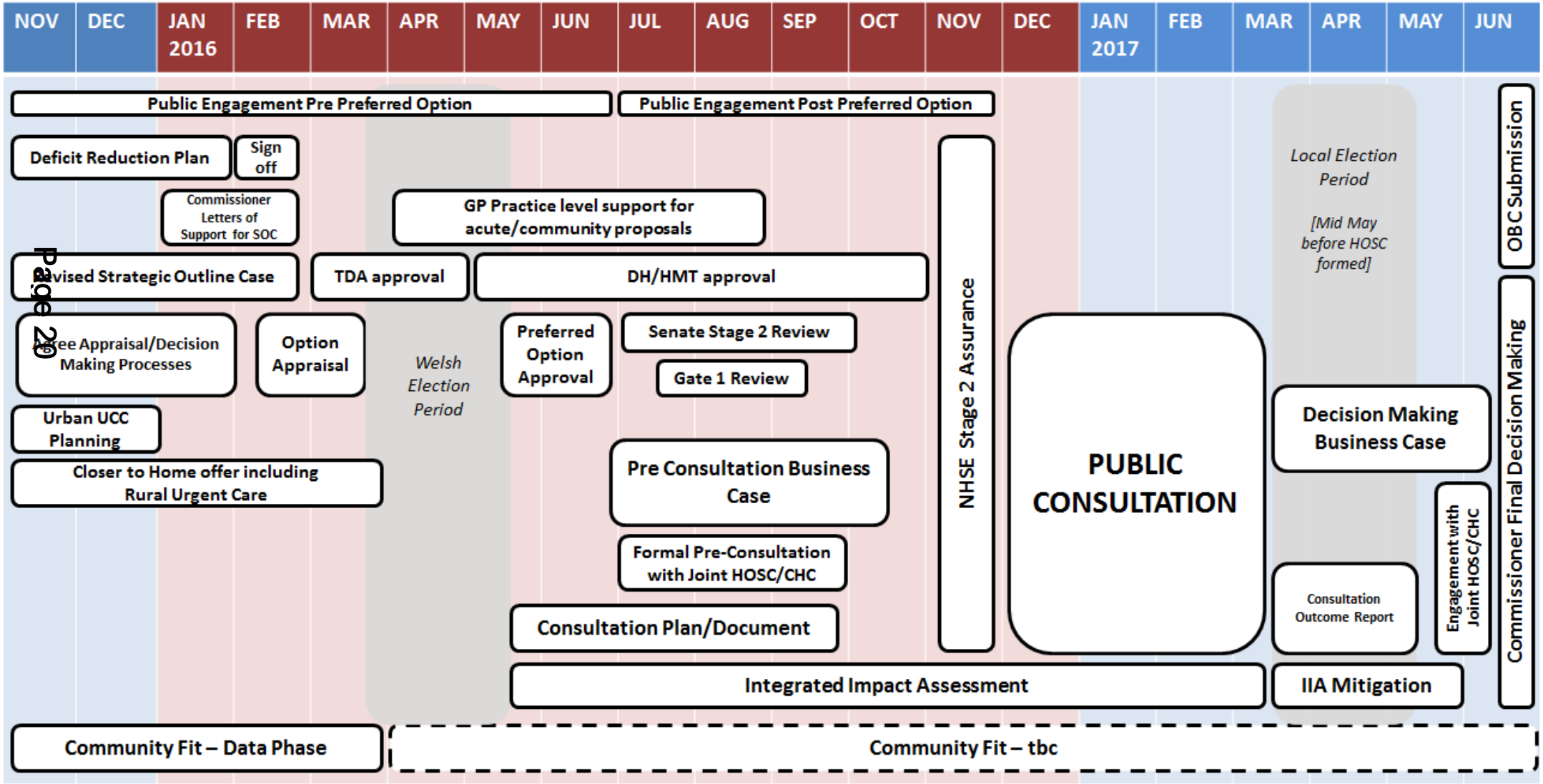
HIGH LEVEL CRITICAL PATH

futurefit
Shaping healthcare together

The following diagram sets out the expected timeline for the next phase of the Programme. This is critically dependent on external approval processes which are beyond the Programme's control and could materially affect the timeline. The critical path also reflects the key assumptions below:

1. Work to produce an adequate deficit reduction plan will be completed by end January 2016 and signed off by all parties by end Feb 2016;
2. A revised Strategic Outline Case for acute facilities will be approved by SaTH by end February 2016;
3. The value of the SOC will remain over £50m. TDA guidance indicates 2 month approval process but no guidance is given for DH/HMT approvals;
4. SOC and PCBC approval are required before consultation;
5. Plans for Urban UCCs will be completed alongside SOC work and space requirements, at least, will be included in SOC;
6. Work on the wider community offer continues in parallel (including rural urgent care solutions and the potential to extend Local Planned Care/develop Health Hubs) and the PCBC will include (at least) any rural urgent care offer;
7. The appraisal of options has to be repeated in the light of new information and the changed scope of proposals;
8. Options B, C1 & C2 each remain under consideration;
9. Phase 2 modelling assumptions/financial implications continue to form the basis of the revised SOC work;
10. Commissioners and SaTH are willing, in principle, to support all of the remaining options , and Commissioners set out, before the option appraisal is revisited, how they will confirm a preferred option and reach a final decision (and what factors will influence those decisions);
11. Work to reach agreement with the Joint HOSC and CHC around any recommendations they may make post-consultation is completed by mid-June2017.

futurefit
Shaping healthcare together



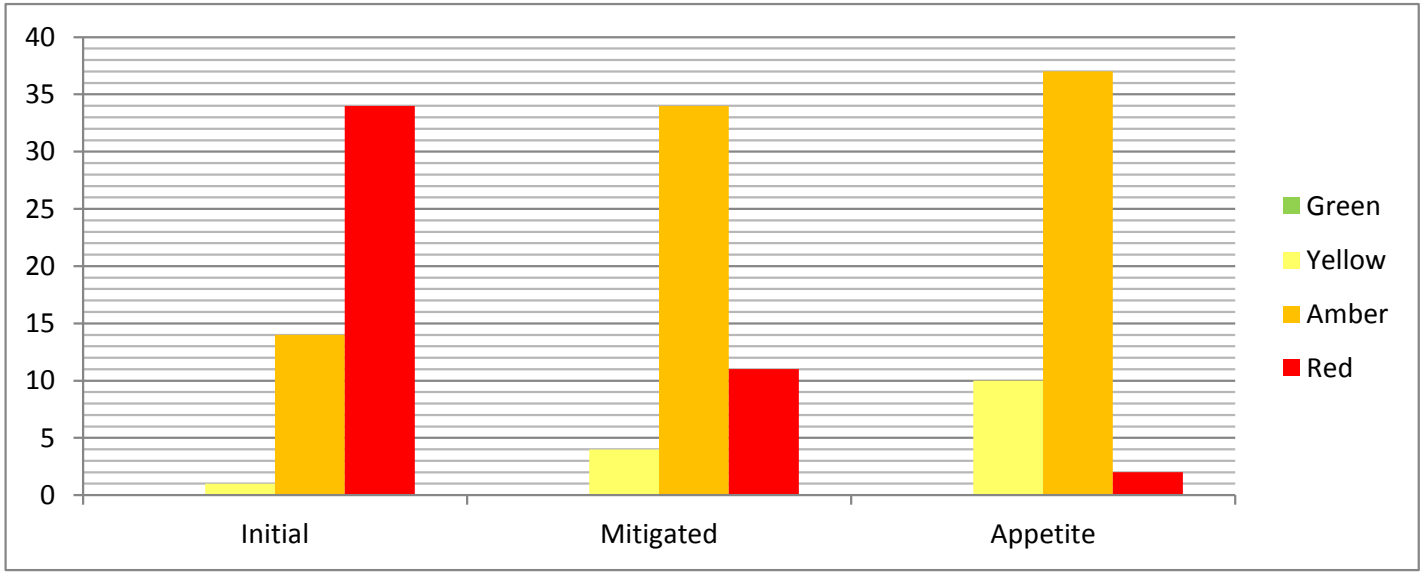
APPENDIX TWO – RED RATED RISKS

futurefit
Shaping healthcare together

PROGRAMME RISK REGISTER

The NHS Future Fit programme has developed this register which, in line with best practice, sets out the areas which could adversely impact the development and/or implementation of programme proposals. This uses qualitative and quantitative measures to calculate the overall level of risk according to likelihood of occurrence and potential impact.

Each risk is given an initial Red/Amber/Green rating, and a summary of how the risk is being mitigated by the programme is also provided. Where further action is needed, this is also set out. The Risk Register is formally reviewed and updated on a monthly basis by the Programme Team. Risks rated 'red' (either before or after mitigation) will be reported to the Programme Board.



	Initial	Mitigated	Appetite
Green	0	0	0
Yellow	1	4	10
Amber	14	34	37
Red	34	11	2
Totals	**49**	**49**	**49**

NOTES

- Risks are generally causes rather than consequences of an adverse event.
- Mitigation actions must be accurate, timely and owned. They may be significant enough to warrant a task within a programme plan.
- All risks and actions should be updated regularly and the owners of mitigation actions called to account for progress or lack thereof.
- All programme members have a duty to identify and report risks to the programme office.
- The programme appetite for risk (i.e. what risk overall can the programme tolerate) must be clearly articulated by the programme team.
- In general, only those risks that require defined Programme Board action should be formally raised to, and discussed with, the Programme Board
- Risks should be managed as low down the programme structure as possible.
- Issues are essentially Risks with a probability of 100% (i.e. they have materialised and are thus in need of urgent action).
- If a defined risk or issue does not threaten the success of the programme, it need not be entered in the risk

SCORING

Likelihood	Narrative	Probability
1	Rare	<20%
2	Unlikely	20-40%
3	Possible	40-60%
4	Likely	60-80%
5	Very likely to occur	>80%
Consequence	**Narrative**	**Possible Quantification**
1	Insignificant	Revenue impact <£20,000; Capital impact <£0.5m; Delay <1 month
2	Minor	Revenue impact >£20k <£100k; Capital impact >£0.5m <£1.0m; Delay >1 month <3 months
3	Moderate	Revenue impact >£100k <£500k; Capital impact >£1.0m <£3.0m; Delay >3 months <9 months
4	Severe/Major	Revenue impact >£500k <£2.0m; Capital impact >£3.0m <£6.0m; Delay >9 months <24 months
5	Catastrophic	Revenue impact >£2.0m; Capital impact >£6.0m; Delay >24 months

Likelihood	**Consequence**				
	1 – Insignificant	**2 - Minor**	**3 - Moderate**	**4 - Severe/Major**	**5 - Catastrophic**
5 - Almost Certain	**5**	**10**	**15**	**20**	**25**
4 - Likely	**4**	**8**	**12**	**16**	**20**
3 - Possible	**3**	**6**	**9**	**12**	**15**
2 - Unlikely	**2**	**4**	**6**	**8**	**10**
1 - Rare	**1**	**2**	**3**	**4**	**5**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
1	27/03/2014	20/03/2015	Y	FI CD	**Key Staff Time**	Inability of stakeholder organisations to release key staff for the Programme leading to adverse impact on programme deliverability	SROs	4	4	**16**	Use of multi-site meetings increased. Evening meetings scheduled to support clinical involvement in design phase. Portable video-conferencing capability implemented. Critical path communicated to highlight consequences of any delay. Finance meetings moved to support attendance.	4	3	**12**	Programme Director to keep under review and to escalate to sponsors as required.	4	2	**8**
2	27/03/2014	24/08/2015	Y	CD	**Clinical Engagement**	Inadequate clinical engagement leads to lack of support for clinical model	BG	5	3	**15**	Extensive clinical engagement in developing model. Model approved by CRG and Board. GPs engaged on development of rural urgent care and 'Community Fit' plans. Staff engagement through sponsor organisations (including Trade Unions)	5	2	**10**	Further meetings of Clinical Reference Group to be held. Ongoing staff engagement.	5	1	**5**
4	27/03/2014	04/08/2015	Y	AS EC	**Engagement Assurance**	Inadequate patient and public engagement may lead to failure to meet assurance tests re: due process, contributing to Independent Reconfiguration Panel referral or Judicial Review	AO	5	3	**15**	Comprehensive engagement & comunications strategy and plans developed and being implemented. Ongoing support from Consultation Institute. Activity log to be shared every quarter with workstream and Programme Office updates shared bi-monthly.	5	2	**10**	No further action required.	5	2	**10**
5	27/03/2014	05/11/2015	Y	EC	**Public Support for Plans**	Public resistance and objections to plans leading to lack of support for preferred clinical model	AO	4	4	**16**	Communication and engagement plans to be implemented including extensive pre-consultation public engagement around the case for change/clinical model (supported by NHSE funding).	4	3	**12**	No further action required.	4	3	**12**
6	24/11/2014	04/08/2015	Y	EC	**Negative Presence in Media**	Risk includes distraction to the process including utilisation of resources; it may undermine confidence in the programme which may lead to a financial impact	AO	4	4	**16**	To implement the Engagement and Communication Strategy and subsequent plans. To undertake more proactive communications including media training with Core Group. Increased SRO engagement with press.	4	2	**8**	No further action required.	4	2	**8**
10	24/11/2014	04/08/2015	Y	EC IIA	**Powys engagement**	Confusion due to a number of programmes impacting Powys healthcare leads to reduced Powys engagement in Future Fit activities and potential challenge	AO	4	4	**16**	E&C workstream and PtHB E&C leads have met and agreed plan of action including tactics to clarify FF Powys engagement plans. E&C workstream will monitor progress on plan over next few months and report to Programme Team . Regular meetings to continue.	4	3	**12**	No further action proposed.	4	3	**12**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
12	24/11/2014	04/08/2015	Y	EC	**Clinical leadership**	Failure to gain and sustain support from clinicians to be visibly leading the programme. Consequences may include dwindling public support and undue burden on small number of leaders.	AO	5	4	**20**	To implement the Engagement and Communication Strategy and subsequent plans. Particular emphasis on 1. Repositioning leadership in public 2. Changing the message from 'no news' to 'we have achieved...'. Messaging workshops to be held to engage and develop clinical leaders.	5	3	**15**	Escalate to Core Group to ensure clinical leaders are able to be support programme activities.	5	2	**10**
14	24/11/2014	04/08/2015	Y	EC	**Divergence off proactive plan**	Failure to implement a process to agree a plan and all programme to comply appropriately. Risk includes inability to implement a timely plan to meet best practice standards with no subsequent ownership	AO	5	4	**20**	To implement the Engagement and Communication Strategy and subsequent plans. Additional focus includes creation and maintenance of risk register.	5	3	**15**	Review and update the plan and risk register	5	2	**10**
17	04/08/2015	04/08/2015	Y	EC	**Failure to comply with Gunning Principles**	Inadequate time allowed for consultation fails to comply with Gunning Principles leading to legal challenge	AO	5	4	**20**	Programme Board to approve plan which complies with Gunning Principles.	5	2	**10**	No further action proposed.	5	2	**10**
19	24/11/2014	04/08/2015	Y	EC	**Inadequate workforce engagement**	Failure to effectively engage with health and care staff thus raising risk for negative PR, workforce disengagement and 'on ground' lack of support / champions. This applies across commissioners, providers, and Welsh Healthboard	Key partners	4	4	**16**	Executives to take lead, fully supported by the E&C team. HJ to draw up initial opportunities starting with both CCGs and SaTh then draw out to all others including colleagues in Powys. Each organisation to provide quarterly update on workforce engagement to workstream.	4	3	**12**	No further action proposed.	4	3	**12**
21	30/10/2014	09/06/2015	Y		**Approval Requirements**	Lack of clarity about the nature and alignment of external approval processes prevents agreement of a robust timetable.	MS	4	5	**20**	NHSE/TDA proactively engaged re: approval process requirements and interrelationships.	4	4	**16**	TDA & NHSE to confirm common view on pre-consultation approval requirements.	4	2	**8**
23	27/03/2014	30/10/2014	Y	AS	**Stakeholder Strategies**	Development of stakeholder strategies and plans constrains or conflicts with the Programme	SROs	4	4	**16**	Programme model underpins 5 year plans. Stakeholders to check routinely whether plans fit Programme objectives.	4	2	**8**	No further action proposed.	4	2	**8**
24	29/05/2014	24/08/2015	Y	FI	**Sponsor Financial Risk**	The need to address short term financial risks in individual sponsor organisations compromises programme progress and/or outcome.	SROs	4	4	**16**	Programme financial model developed in alignment with sponsor 2 and 5 year plans.	4	3	**12**	Alignment to be kept under review in case of any change to long term plans.	4	2	**8**
25	27/03/2014	24/08/2015	Y		**Political Support for Plans**	Lack of political support for large-scale service changes resulting in challenge to preferred option	SROs	4	4	**16**	Regular engagement with HOSC & MPs, presentations to Local Joint Committees and workshops with Councillors. Further evidence gathered to support case for change, especially re: workforce challenges.	4	3	**12**	Local Assurance Panel to be considered.	4	2	**8**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
26	04/08/2014	04/08/2015	Y	WF	**Interim A&E Plans (SaTH Risk Register)**	Inability to safely staff the Emergency Department with medical workforce. Potential adverse impact on quality and safety of care for patients. Poorer patient flow into and within hospital. Inability to meet national guidance in relation to levels of senior cover. An increase in costs if there is a reliance on internal locum shifts. possible mismanagement of patient care. Difficulty meeting Trauma Network standards for Consultant cover.	SaTH Board	5	5	25	Attempts to recruit Locum/ Substantive Consultants ongoing. Recruitment and training of Advanced Practitioners. Additional SHO shift allocated to PRH on late shift to support flow and safety to avoid the night shift being left with a backlog leaving the department vulnerable. Negotiation ongoing to cover Trauma Rota and Job Planning to make best use of Consultant resource. We have recruited a fixed-term Locum to cover our ED Consultant who is away on a sabbatical; and a Locum Consultant to work with us until February 2016. Ad hoc consultant on site cover over the weekends to support the department when in extreme difficulties.	5	4	20	Business continuity planning underway and key stakeholders engaged. Options provided to execs however no requirement for change agreed at this point. Need to implement interim plan for sustaining A&E services. Complete job planning process. Development of ED staffing strategy. Gap analysis, development of business case to support recruitment of additional consultants.	5	3	15
27	04/08/2015	04/08/2015	Y	WF	**Non compliance with Critical Care Standards for Intensivist Cover within ITU (SaTH Risk Register)**	Critical care standards set out that ITU should have Intensivist cover 24/7 and that Intensivists should undertake twice daily ward rounds. Guidelines from the Faculty of Intensive Care Medicine (FICM) state that there is clear evidence that units with dedicated intensivists are the safest and most clinically effective way to deliver Intensive Care with reduced ICU and hospital mortalities and reduced ICU and hospital lengths-of-stay. In general, the consultant/patient ratio must not exceed a range between 1:8 to 1:15 and the ICU resident/patient ratio should not exceed 1:8. At both sites, these ratios are significantly exceeded. The risk has been exacerbated at PRH due to a high level of medical staff sickness and an imminent retirement.	SaTH Board	5	5	25	In order to safely staff ITU, the Trust may need to stop elective work and shift sessions to Critical Care. This will affect our ability to staff all elective lists, which will have an impact on waiting lists and patient care unless a timely solution is found as the service and the team are highly vulnerable to further vacancies or unexpected absences. Splitting the Rota at RSH means we can ensure 24/7 cover of both intensive care, by intensivists and also take care of emergency activity. Critical Care is being provided with a mix of general anaesthetists and the small number of intensivists available but consultant presence is still well below recommended levels.	5	4	20	The case has now been presented to Trust Board. The case for further recruitment has been supported. Efforts to recruit will be expedited and prioritised. A business case needs to be drafted and submitted for funding for medical capacity increase. Anaesthetic job planning needs to be completed in conjunction with management team and lead anaesthetists. Business case will be presented on 22 April. A decision will be awaited and then progressed.	5	3	15

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
28	27/03/2014	26/02/2015	Y		**Interim A&E Plans**	The need to implement interim plan for sustaining A&E services over the interim period adversely affects Programme	DV	4	4	16	Key partners agree to engage with Programme Board on decisions which may impact on remit of Programme. Communications and engagement plan to be provided to all key stakeholders on necessary actions should interim plans be initiated. 5 year and 2 year plans submitted. ED business continuity plan supplied to with commissioners and TDA and actions to mitigate being implemented re: recruitment of consultant and middle grade staff.	4	3	12	Seek identification of preferred option at the earliest opportunity, taking account of work required to reach robust decision.	4	2	8
29	01/07/2014	05/11/2015	Y	AS	**Inter-dependencies**	Failure to effectively manage programme interdependencies adversely impacts the implementation of the preferred option	SROs	4	4	16	Sponsors to initiate further pieces of work to develop and implement plans to address interdependencies. Monitoring process agreed for the review of sponsor plans by the Programme's Assurance workstream. Document drafted for Board identifying all major interdependencies and setting out governance linkages and the alignment of key outputs.	4	3	12	Board to receive progress reports on Community Fit and IT Project activities, and to monitor development of the Powys SDM programme. Approach to managing additional interdependencies of deficit planning and acute business cases to be considered at November Board.	4	2	8
30	26/02/2015	05/11/2015	Y	EC	**Urgent Care Centre Offer**	Inability to adequately define UCC offer leads to lack of support for single Emergency Centre.	MS	4	4	16	Workshops held and initial report completed in September. Additional workshops to be held re: urban UCCs	4	4	16	Focused communication and engagement activities to take place around current and future urgent care offer by locality. Workshop to take place to clarify urban UCC model	4	2	8
31	24/08/2015	05/11/2015	Y	EC	**Urgent Care Proposals**	Failure to articulate rural urgent care offer before consultation adversely affects consultation	MS	4	5	20	Urban UCCs proposed for RSH and PRH at shortlisting. First phase of work to develop additional rural urgent care solutions nearing completion; next phase to actively involve local practices and patient groups to build proposals around local asset base. Scope of proposals in public consultation to be confined to EC, DTC and urban UCCs with no reduction in existing rural urgent care services. Further engagement planned around urban UCCs.	4	4	16	Further engagement to take place around potential rural urgent care offer aligned to the development of a primary care strategy	4	2	8
32	23/02/2015	20/03/2015	Y		**Out of Hospital Services**	Lack of clarity on plans for out of hospital services impacts public support for acute and community hospital proposals	SROs	4	4	16	Scope and initial activities of 'Community Fit' programme agreed.	4	3	12	Initial Community Fit work to be undertaken and reported to Future Fit Board.	4	2	8

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
33	23/03/2015	09/06/2015	Y	WF	**Workforce Deliverability**	Difficulties in recruiting in line with workforce plan (including new roles) adversely impacts implementation of programme proposals	tbc	4	4	**16**	Workforce workstream to identify new roles and to liaise with HEE and education providers to ensure supply of required roles. Develop a more comprehensive "work in Shropshire" offer.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
34	23/03/2015	09/06/2015	Y	WF	**Resistance to Workforce Change**	Lack of appetite for change/new roles locally and from Royal Colleges and others adversely impacts definition of a deliverable workforce plan	tbc	4	4	**16**	Workforce workstream to liaise with Royal Colleges and others to engender support.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
35	27/03/2014	24/08/2015	Y		**Option Appraisal**	The number and/or complexity of shortlisted options identified for appraisal delays the Programme	MS	4	4	**16**	Shortlist of 6 agreed in line with national guidance. Number of options reduced on affordability grounds.	4	2	**8**	No further action required.	4	2	**8**
36	26/02/2015	05/11/2015	Y	FI	**SaTH Affordability**	Financial analysis demonstrates that one or more shortlisted options are not affordable, potentially leading to reconsidering shortlisting decision and significant delay.	NN	4	5	**20**	Phase 2 assumptions agreed by SaTH. Financial costs and benefits of options to be set out by Technical Team. A number of options excluded on affordability grounds. Remaining options potentially affordable to SaTH.	4	4	**16**	Option costs to be reassessed as revised SOC developed, and scope of SOC to be confirmed.	4	2	**8**
38	27/03/2014	27/07/2015	Y	FI	**Capital Availability**	Lack of availability of capital to fund preferred option delays implementation	AN	4	5	**20**	Discussion with TDA/DH re: availability of funding. PF2 to be explored if necessary.	4	4	**16**	Phased approach to implementation could be considered, and potential sources of funding clarified.	4	2	**8**
39	29/05/2014	05/11/2015	Y	FI	**Commissioner Affordability**	Lack of revenue affordability to Local Health Economy of capital requirement and of whole system change adversely impacts identification of the preferred option	AN	5	5 ↑	**25**	Affordability assessments to form part of appraisal processes. Extensive work undertaken to reconcile 5 year plans with Phase 2 assumptions and to allow for community investment.	5	5 ↑	**25**	5 year plans to be kept under review. CCGs to develop community investment plans. Impact of deficit reduction plans to be assessed.	5	2	**10**
40	05/11/2015	05/11/2015	Y	FI	**Local Health Economy Deficit**	LHE deficit undermines viability of business cases	SROs	4	5	**20**	Commissioners and providers to set out nature and scale of deficit and to develop a deficit reduction plan acceptable to regulators.	4	4	**16**	FDs scoping scale of challenge. FDs/CEOs to participate in planning workshop in early December.	4	3	**12**

								Initial Rating				Post Mitigation Rating				Risk Appetite		
No.	Date Added	Date Last Revised	Main Register	Work-stream	Risk Name	Description	Risk Owner	C	L	Score	Mitigating Actions	C	L	Score	Further Actions (if required) to reduce risk to acceptable level	C	L	Score
42	23/03/2015	09/06/2015	Y	WF FI	**Dual Workforce Costs**	Sufficient resources are not available to support double-running costs associated with introducing new roles, leading to delayed implementation	VM	4	4	**16**	Workforce workstream to set out requirements and to liaise with Finance workstream on resourcing.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
45	27/03/2014	29/01/2015	Y	FI	**Programme Resources**	Programme resources / staffing inadequate leading to difficulties in running Programme to agreed timelines	SROs	4	4	**16**	CoreProgramme Budget agreed. Additional requirements for each phase to be identified. Budget for 2015-16 agreed.	4	2	**8**	No further action required.	4	2	**8**
49	27/03/2014	09/06/2015	Y	AS	**NHS Approvals**	Failure to secure necessary NHS approvals at key milestones delays the programme	MS	4	4	**16**	Engagement with NHSTDA, NHSE Project Appraisal Unit and NHSE Regional Team to clarify requirements and duration of approval processes. Sense Check Action Plan monitored monthly by Programme Team and evidence against the Four Tests being assembled. Stage 2 assurance being planned.	4	3	**12**	NHSE/TDA to provide common view on pre-consultation approval requirements.	4	2	**8**
50	09/03/2015	05/11/2015	Y	AS	**Government Approvals**	Uncertainty about timescales for DH/HMT approvals leads to flawed assumptions being made in the Programme Plan and to delay (including to the start of consultation).	MS	4	5	**20**	Programme Plan contains estimated approval periods for DH/HMT. Advice sought from NHSE Project Appraisal Unit.	4	4	**16**	Revised plan to take account of advice from Project Appraisal Unit, NHSE & TDA.	4	2	**8**
51	09/03/2015	05/11/2015	Y	AS	**Decision making**	Lack of an agreed process for reaching a final commissioner decision (including clarifying the role of Powys tHB) prevents a final decision being agreed	SROs	5	4	**20**	Commissioners to agree approach to final decision making in advance of Stage 2 Assurance. Proposal draft for CCG boards. Legal advice received.	5	3	**15**	All relevant commisioners to agree process. SROs to arrange Board-to-Board.	5	2	**10**

This page is intentionally left blank

Future Fit Workforce Workstream Update

Background

Workforce challenges are a key driver in the Future Fit case for change. This challenge has initially focused on the acute provider: The Shrewsbury and Telford Hospital NHS Trust (SaTH). The Workforce workstream agreed the need to ensure these challenges were understood and addressed, however the scope of workstream felt too narrow. Discussions with a small membership from across the health economy highlighted similar challenges, for example recruiting adult registered nurses. This led to a collective view that membership needed to be widened and the focus broadened.

Membership has been extended across the health and social care economy over the last four months to support a system view of workforce. Whilst a breadth in membership has happened it is yet to reach across the system, it is hoped this will be achieved over forthcoming months.

At this month's meeting achievement of the system view was discussed, members of the workstream agreed this was vital however concerns were raised regarding the scale of this work.

Workforce Challenges

At this month's workforce workstream a view of challenges across the system was presented and agreed to be a fair representation:

Acute Sector

Across the acute workforce a number of staff groups are facing severe challenges leading to workforce and service fragility. Services are being delivered through a heavy reliance on temporary staffing and continued efforts of staff. Looking specifically at the Medical Workforce a number of specialities are unable to recruit the substantive number of consultant and middle grade doctors needed, most notably: Emergency Medicine, Acute Medicine, Critical Care, Gastroenterology and Dermatology. Some specialities have half the substantive workforce required, this leads to onerous on call commitments, a need to work down and reliance on temporary staff. The situation does not support an attractive employment offer; for example on call frequency within SaTH can be as much as five times higher than neighbouring trusts.

It is nationally acknowledged that an under supply in Adult Registered Nurses exists, SaTH has faced continued difficulties to fully recruit to identified staffing levels. Recent efforts to

recruit from overseas have been delayed due to Certificate of Sponsorships. The recent announcement to temporarily add nursing to the shortage occupation list will support better recruitment. However sustainability remains a concern.

In addition to medics and nurses, the Trust has faces difficulties to recruit Bio Medical Scientists (BMS) leaving the service vulnerable particularly when delivering two out of hours rotas.

Specifically at the Royal Shrewsbury site domestic staff are difficult to recruit, this challenge is not seen to same degree at The Princess Royal site, better public transport is highlighted as a key reason.

The Trust has a number of strategies in place to support these challenges including recruitment, workforce transformation and home growing talent.

A full workforce profile will be presented to the Board early in the New Year.

Primary Care

Discussions relating to Primary Care workforce have concluded real challenges in recruiting General Practitioners (GP's. At a national level there is a commitment to train more GP's however this is a longer term solution. Current concerns focus on difficulties to recruit and an ageing workforce. Similarly Practice Nurses carry a substantive vacancy across primary care.

Community Trust

Like the Acute Trust, Community Services face challenges to recruit adult registered nurses, in particular to community hospitals which are further challenged by rural locations. A heavy reliance of agency staff exists, which are often expensive agencies. Psychiatry roles in children's mental health services are identified as difficult to recruit to, with a constant vacancy.

Specialist Hospital

Challenges to recruit and retain Operating Department Practitioners (ODP's) present a persistent vacancy factor. In addition the Trust identifies recruiting operational managers as a real challenge impacting on service delivery.

Mental Health

The Mental Health Trust has identified psychiatry as difficult to recruit to roles and mental health nurses also feature. The Trust covers a wide geographical foot print across the country and for the county.

Local Authority

Across both authorities have difficulties in securing social workers and domiciliary care workers both of whom are critical to support discharge and support people to stay at home.

Conclusion

The Workforce workstream has made progress in terms of a better understanding of the system. However there is still a significant piece of work to further develop a system workforce plan. Membership is yet to cover the whole health and social care system which essential if a system view and plan are to be achieved.

It is important that the workforce challenges facing the acute trust are addressed as Future Fit progresses however when pursuing workforce transformation and ensuring sustainability a system wide strategy and plan are essential.

Funding from the West Midlands Local Education and Training Board has been secured to support this work.

This page is intentionally left blank

Managing Key Programme Dependencies

Introduction

The purpose of this paper is to highlight two new key Programme Dependencies that have arisen and to propose how we manage them.

Background

At the last Programme Board it was agreed that:

- SaTH would take forward the work on developing the SOC and OBC for new acute hospital facilities. The Programme will no longer be resourcing or managing this work and the technical team have been stood down.
- The SROs would ask the Finance Directors to scope and define a whole system deficit reduction plan, starting with an assessment of the current underlying deficit position for the health economy.

It was decided that this work sits outside of the Future Fit Programme.

Issues

Before the Programme can set out a revised timeline, the scope, milestones and end point of these two pieces of work needs to be agreed.

It is also likely that the SOC cannot be completed without reference to the external context created by the deficit reduction plan.

Therefore, not only is the Programme dependent on these two pieces of work, but the SOC work is likely to be dependent on the outcome of the deficit reduction work. Some parallel running of these two pieces of work is inevitable, but presents a further risk.

The programme can develop a draft timeline but without a clear understanding of the scope and length of time needed for these two pieces of work, the Programme should not publicly commit to a timetable.

Conclusion

The following actions are proposed:

- The Programme Board establishes both pieces of work as key Progamme dependencies
- The next Programme Board receives a report at its next meeting setting out the scope, milestones and deadline for each of the above pieces of work to reach a conclusion.
- The Programme Board receives a formal update report for each piece of work at each of its meetings

In handing over the SOC development to SaTH, the Programme makes the following assumptions:

That further development of the current shortlisted options that prioritise the most urgent clinical workforce challengers including A&E and ITU and will allow for the physical creation of the key components of the Clinical Model on the SaTH sites, namely:

- A single Emergency Centre
- A single Diagnostic and treatment Centre
- An Urban Urgent Care centre on the RSH and PRH sites
- Local Planned Care on the RSH and PRH sites
- That the income envelope that is used for the SOC remains the Phase 2 modelling

No assumptions have so far been made about the scope and process for the deficit reduction work as this is an entirely new piece of work that has not been within the scope of the Programme.

Mike Sharon

Report on Programme Interdependency

Acute Hospital Business Cases (Sustainable Services Programme)

What is the objective of the project?

- To develop a Strategic Outline Case (and subsequent Outline/Full Business Cases) that address the Trust's workforce challenges in the short to medium term; focussing on the immediate challenges of emergency/urgent care whilst also understanding the impact and opportunities for planned care.

What is the scope of the project – what is included, and what is excluded?

- Completion of all business case requirements (in line with national guidance) for workforce and facilities on the PRH and RSH sites (see Key Assumptions).
- This includes workforce and facilities options to deliver the whole of the Clinical model including one Emergency Department and associated Urgent Care Centre provision, one Critical Care Unit plus associated interdependent services and beds. A Diagnostic and Treatment Centre and Local Planned Care on both sites
- The Future Fit Programme will have responsibility for:
    - Overall Programme management
    - Rural Urgent Care offer
    - Community Fit Managed as a dependency and overseen by its own steering group)
    - Whole system workforce solutions
    - Production of Pre Consultation Business Case

What are the project deliverables and timescales?

- SOC – February 2016
- The OBC can be completed by Autumn 2016 and a Full Business Case by early 2017 but this is dependent on external approvals which is likely to extend the required by date for these deliverables.

Key assumptions that the project is making

- The deficit reduction plan is completed by the end of January 2016
- That a whole system IT solution is being developed through the health economy IT steering group
- The activity and income assumptions will not be materially different from the Phase 2 modelling outputs without agreement from commissioners, although these will be refreshed to reflect the current position against the 2018/19 trajectory
- Introduction of new information may result in the need for a reappraisal of the Future Fit options
- The SOC and subsequent business cases will be developed in line with TDA guidance
- Patient and public engagement and involvement in relation to the Sustainable Services Programme

Key risks to the project.

- The wider health economy deficit reduction plan materially affects the activity and capacity assumptions within business cases
- Clarity of responsibilities and work plans for Future Fit and the identification of interdependencies

Report on Programme Interdependency

Deficit Reduction Plan

What is the objective of the project?

To develop a plan which will return the local NHS health economy to a sustainable financial position.

What is the scope of the project – what is included, and what is excluded?

1. All NHS organisations within Shropshire.
2. Specialised services which are currently commissioned by NHS England.
3. Organisational five year financial plans commencing 1st April 2016.

What are the project deliverables and timescales?

1. The size and composition of the current financial deficit, broken down by organisation and recurrent and non-recurrent.
2. To establish the phased, five year extrapolated position based on organisational financial strategies and previous submissions to the Future Fit Finance Workstream.
3. To extrapolate forward, on a phased five year basis, the impact of historic commissioner QIPP (Quality, Innovation, Productivity and Prevention) performance on health system stakeholder organisations and to compare the analysis to current plans.
4. To extrapolate forward, on a phased five year basis, the impact of historic provider CIP (Cost Improvement Programme) performance on health system stakeholder organisations and to compare the analysis to current plans.
5. To review the analysis of the cost base of health system organisations in deficit. The analysis will be split in to fixed, semi fixed, standard variable and premium variable.
6. Based on the cost analysis, derive the level of activity that requires "deflection" or to be "lost" to address the deficit. The activity reduction will also need to offset the cost additional investments to fund the "deflected activity".

Main project milestones for delivery with dates.

1. Chief Executives and Finance Directors to meet to ratify the scope of the programme and discuss options and opportunities on 7th December 2015.
2. Organisational revised financial plans to be submitted by 11th December 2015.
3. Final report produced by the end of January.

Key assumptions within the project.

1. Future Fit Phase 2 activity projections will be used where applicable.
2. Organisational restructuring within the local NHS has not been considered.

Key risks to the project.

1. Outcome of the Comprehensive Spending Review (CSR).
2. Internal resource availability.
3. Deterioration of the financial position of the local health economy.

futurefit
Shaping healthcare together

Urgent Care Centres

An update for the Future Fit Programme Board

19 November 2015

1. Introduction

There are two potential types of urgent care centre considered in the Future Fit clinical model: urban and rural. This paper sets out the approach and timelines to finalising and agreeing with all stakeholders the detail of these centres.

2. Urban urgent care centres

It is essential that there is clarity regarding the operation of the two urban centres as the relationship between these Centres and the Emergency Centre needs to be clear before the Acute Trust SOC can be completed. Prototype urgent care Centres are already in operation on both sites and there is a need to understand the learning from these prototypes. A workshop has been scheduled for Monday 3rd December and a small working group has been tasked to plan this workshop to ensure that the following issues can be addressed and signed off in early 2016:

- Lessons to be learned from current models in Shrewsbury and Telford and more widely in the West Midlands and Cheshire
- The activity assumptions and condition types
- The staffing model
- The services on which the UCCs are dependent that will be provided b y SaTH or other secondary care providers(eg X ray or specialist opinion)
- The relationship and mutual requirements between the UCCs and the GP out of hours service
- The relationship and mutual requirements between the UCCs and the 111 service
- The relationship and mutual requirements between the UCCs and the West Midlands and Welsh Ambulance services

The Future Fit team are preparing a report describing the operating models and workforce arrangements for a number of urgent care sites currently in place across the West Midlands, and Cheshire and this will be will be available to inform the workshop discussions alongside the previously shared rapid literature review.

2.1 Governance of urban urgent care centre work

The rural urgent care work is governed by a steering group which report into CCG governing bodies and the Future Fit programme board. The Future Fit programme is responsible for ensuring a specification for the two urban urgent care centres is developed for Future Fit board sign off in early 2016. .

3. Rural urgent care centres

The rural urgent care work is governed by a steering group which reports into the Future Fit Programme Board.
Considerable GP, patient and public engagement has taken place over the past 18 months on the issue of Rural Urgent Care centres. It has become apparent that a solution needs to be found for each of the localities in rural Shropshire. It is also apparent that an urgent care service in a rural setting cannot be considered in isolation from current and future primary care services and other local health and care services.

This work now needs to be brought to a conclusion by March 2016 in order to inform an engagement process with local communities prior to any formal proposals being developed for formal public consultation.
The Programme team will work with the CCGs to develop a detailed plan to ensure a proposal is delivered by March 2016.

Recommendations

The Board is asked to agree the steps and timelines outlined in this paper.

futurefit
Shaping healthcare together

NHS Community Fit

Future Fit Board Paper

November 2015

Introduction

The purpose of this paper is to provide a progress report on the first phase of the Community Fit project and to highlight the need for further work to be undertaken on the broader programme.

Phase one delivers an understanding of the underlying community activity trends and the additional impact that Future Fit may create.

The Community Fit steering group has been assembled to oversee phase one of Community Fit and the group reports into the two CCG Boards, as commissioners of the work. Programme management and analysis for Community Fit is being provided by the Strategy Unit at Midlands and Lancashire CSU. At their November meetings, the boards of both CCGs approved the Community Fit steering group terms of Reference for Phase One.

Progress to date on Community Fit

Phase one requires the gathering and merging of pseudonymised patient activity data from local hospital, community, mental health, GP and social care providers in order to provide a holistic view of out of hospital activity.

It has taken longer than planned for this data to be supplied. However, data of a sufficiently high quality has now been received from all health care providers. A technical issue has prevented some social care data from being delivered but this issue is due to be resolved on 13 November.

Initial workshops with each of the 5 constituent workstreams (Third sector, mental health, primary care, social care and community health care) are planned prior to Christmas. The first workshops will confirm the descriptive analysis of the data and provide assurance for the second round of workshops which will preview the linked data and agree high level descriptors (taxonomies) to assist with the classification of care packages by level of patient / service user need.

The voluntary sector workstream (the first of which is to be held in Shrewsbury on Friday 13th) have had strong sign up from across the sector. Delays in receiving some of the data has meant that two planned workstreams (community health and mental health) have had to be postponed but these are being rescheduled prior to Christmas.

Conditional on receipt of all data sets in line with current agreements, Community Fit is still on track to deliver the final outputs of Phase One by March 2016. Innovative work around GP data, with the potential to link these across health and social care to give a fuller understanding of a whole patient / service-user journey, is making encouraging progress.

The wider Community Fit ambition

The attached paper sets out the broader objectives and approach to Community Fit. The scope of NHS Future Fit is limited to hospital services. The clinical model, however, creates fundamental dependencies – the new hospital model will only work if community and primary care services are able to implement synchronised delivery of their part of the model.

There are challenges faced in primary and community services independently of the consequences of the NHS Future Fit clinical model; changing and rising demand; workforce sustainability issues; the need for greater service integration and structural challenges in maintaining high quality and comprehensive service offers in remote locations

Phase 1 is simply an enabler to better inform the case for investment in alternative services to hospital care.
Future phases of Community Fit will need to be agreed once the outputs from phase 1 are understood. The Steering Group will be asked to produce proposals for the CCGs to consider after March 2016

Recommendations

The Future Fit Board is asked to

- Approve the progress made by the Community Fit steering group to date
- Receive the paper regarding the broader description of the potential full scope of the Community Fit programme and agree a process for specifying and managing the Community Fit plan after March 2016.

Overarching Community Fit Briefing paper
APPROVED by CCG boards, November 2015

Further to an earlier draft of this paper being shared at the Future Fit Programme Board in August 2015, some revisions have been made to the sections regarding primary care development. The principle recommendation is that further collaborative discussions should now take place to understand the extent to which a common approach to primary care development across Shropshire, Telford and Wrekin in helpful or desirable in relation to the Community Fit programme of work, potentially involving the GP Federation.

1. Introduction

The purpose of this document is to set out the approach of Shropshire and Telford and Wrekin Clinical Commissioning Groups to developing services outside hospital. The name given to this programme of work is Community Fit.

2. Aim:

The aim of Community Fit is to deliver a sustainable, community based, health and social care system focussed on prevention and continuity of care, delivered by integrated teams of clinicians, through bespoke local solutions utilising their unique local asset base.

3. Background:

Community Fit was borne out of the need to describe in detail how the NHS Future Fit model (reconfiguration of acute and community bed-based services) would function and enable the intended transfer of inpatient activity to be delivered within the primary care setting. However, a significant amount of work had already taken place over the preceding months where both sponsoring CCGs (Shropshire and Telford & Wrekin) had started prototyping models of care that would become central to the delivery of Community Fit. These projects ranged from supported discharge through the Rapid Response and ICS teams integrating health and social care; admission avoidance through CHAS; increasing the scope of the co-ordination centre and referral services to utilise local resources differently; piloting and embedding care pathways aimed at LTC management at home through schemes such as COPD, heart failure and Osteoarthritis. Work was also already underway with the Third Sector to strengthen community support and resilience, focussed on the most vulnerable in our society and projects such as “Team around the Practice” were starting to be explored.
Collectively these projects had started to cover the spectrum of support and care needed to enable patients to be discharged earlier, managed in the community and treated by local teams. Ranging from community support with volunteers through to formal clinical interventions and active case management we had created the basis for the Community Fit model.
However, to enable safe transition from the current care model, which is heavily inpatient based, all aspects of care will need to be covered to ensure that the reliance on inpatient beds is adequately met by community alternatives before the Future Fit model is fully implemented.

4. Principles:

Future Fit had focussed on a suite of principles co-created by local clinicians and patients. Community Fit will need to draw on the key themes.

1. **Adequate access** to services within the local community utilising the community asset base in that area through bespoke solutions
2. **Providing joined up care** through full integration of services and teams – avoiding any patient feeling "abandoned" by the system as they transition the care pathway
3. Eradicating silo working and ensuring that **no clinical decision be made in isolation**
4. Adopting a permissive approach to **local bespoke solutions** whilst upholding the expectation of equitable outcomes across the whole county and both CCGs.

Delivery of Community Fit programme will need to align with the Future Fit model focussing on identified care pathways of:

1. Urgent Care
2. Planned Care
3. Long term condition management
4. Prevention

And adding the additional area of

5. Community resilience

5. Themes

5.1 Urgent Care: Based on the model of networked delivery of urgent care through a single Emergency Care Centre (focusing on time critical cases) networked with Urgent Care Centres (focusing on urgent cases that aren't time critical) a model for local urgent care services will need to be developed.
Ensuring that UCCs meet the needs of the local population, work in an integrated way with the Emergency Centre and support admission avoidance will be the main aim of these models. To enable delivery of urgent care within both urban and rural care environments a bespoke solution option may need to be adopted on the understanding that local areas utilise their asset base to staff, and deliver care in the UCC, with the explicit understanding of equitable patient outcomes and agreed core minimum service standards.

5.2 Planned Care: Developing care pathways, skilled teams and integration with secondary care to enable earlier discharge back into the community and a shift from reliance on inpatient stays post intervention to day case procedures.

5.3 Long Term Care (LTC) pathways: Working through integrated teams a suite of LTC pathways will need to be co-designed and embedded across primary and secondary care to enable patients to be cared for in, and around, their home environment for as long as possible

5.4 Prevention: Focus on early prevention strategies through to preventing further deterioration in health and admissions.

5.5 Community resilience: Enabling local primary care clinicians, alongside patients and volunteers, to co-design solutions, and support networks, that enhance wellbeing, independence and self-care

5.6 Enablers: key enablers to deliver the Community Fit programme:

1. Shared care records and integrated information system
2. Co-ordination of care ranging from formal co-ordination centre through to care co-ordinators for individual patient cases
3. New models of care – MSCP,PACs, Integrated care team delivery, Team around the practice
4. Meeting the seven day service requirement
5. Skills based training and education programmes focussed on new working practices
6. Communication, information and education packages for patients and the public.

6. Phase 1 enabling project

Work has begun on Phase 1 of a key enabling project which is intended to model and describe the demand for primary care and community services to absorb the activity coming out of the acute trust and the other changes which will impact on the use of primary and community health and social care services such as demography, ageing population and increased demands on the primary care and community.

This work will take place between October and February 2015. Assuming the timely transfer of data, phase one will deliver the following:

- An agreed way of modelling activity in of social care, primary care, community healthcare, and mental health
- An agreed taxonomy (classification) of care packages delivered by each of these sectors
- An agreed estimate the impact of demographic change on activity levels within these sectors
- A linked health and social care dataset, identifying patients receiving care from two or more sectors and describing the care they receive
- A description of the activity that the NHS Future Fit Programme models anticipate will move out of the acute setting and therefore may have an impact on primary care, community services, mental health and social care services.

In response to feedback at the Provider Forum launch of Community Fit, an additional workstream has been added, focussing on the contribution from voluntary and 3rd sector partners. Therefore an additional deliverable has been added to the Phase One work programme:

- An assessment of the potential voluntary and third sector services contribution to the broader programme and suggestions of mechanisms and approaches that might be employed to maximise this contribution.

Alongside this focused piece of work, both Shropshire CCG and Telford & Wrekin Clinical CCG are implementing the overarching aims of Community Fit through their own existing strategies. A summary of these is set out below.

7. Engagement of Citizens

Both CCGs have put the engagement of citizens in their care, in the design of services and in commissioner decision-making at the heart of their everyday business. CCG committees are established which review the work programmes and activities of the CCGs to ensure that patients and the public are being effectively engaged in all aspects of the commissioning process. Support is provided to patient and public representatives to enable them to engage effectively in this work.

The CCGs led a major local engagement process as part of the national Call to Action programme. Almost 3,000 responses were received and the Call to Action process was brought together at a conference in November 2013 at which the Chief Executive of NHS England was the keynote speaker. Key messages from the Call to Action – from the public and from local clinicians – are particularly shaping the Future Fit programme but are also being used within other key development strands for the CCGs. There is strong representation from patient groups on the Programme Board and a substantial programme of public and patient engagement will ensure that there is meaningful and authentic citizen participation in the design of the plans and decision-making process.

There is a strong network of practice patient participation groups (PPGs) which provide a strong foundation for public engagement. CCGs have also been working closely with Healthwatch organisations and building wide networks of engagement to include PPGs, voluntary sector organisations, disease specific groups, groups based in particular localities, disease specific groups and young people.

Engagement with young people includes the development of Youth Champions. The aim is for these young people to become active and valued partners, working with service providers and commissioners, to jointly deliver better health and wellbeing outcomes. In addition to the benefits for local organisations and wider communities, the young people taking part will individually benefit through improved confidence and a sense of pride in their achievements.

Further information on the specific approaches of each CCG are set out in the CCGs' Operational Plan submissions.

8. Carers

Both Shropshire and Telford & Wrekin CCG's have dedicated work streams focusing on the role of and support for carers. Examples of current schemes are:

- Funding carer breaks – provision of non-residential respite and support services for family carers
- Shared lives for people with dementia - respite provided in people's own homes on a regular basis rather than institutionalised respite care
- Hospital carers link worker - supporting carers of people coming out of hospital in order to ensure they have information about the support and services available to them
- Dementia CQUIN including supporting carers – now included in acute contracts

The Royal College of General Practitioner's recommendations in general practice for improving support to carers will be used the basis to develop the local NHS strategy. The CCG's will also work in partnership with their local councils and voluntary sector organisations to develop a new health economy wide strategy, following the publication of the Care Bill.

Local Councils and CCGs already work together to support carers. This work will form a strand of work under the better Care and will build on existing local arrangements as well as absorbing funding for carer breaks (in line with the NHS Operating Framework 2012-13 stipulations.)

The work within the areas outlined above is linked to the delivery of the system vision via the implementation of the CCG's Operational Plans . A summary of these plans can be found in the Improvement Interventions section of this document.

9. Management of Long Term conditions

The key overarching aims in relation to LTC are to shift resources to strengthen self-care and prevention, to ensure that the patient remains at the centre of their care, to work with a multidisciplinary focus with the GP at the centre, ensuring effective case management of patients. In addition work will also be undertaken to reduce time spent in hospital by people with LTC. Further schemes will focus on Pulmonary Rehabilitation, respiratory services, development of diabetes services and the role of telehealth.

Each of the CCGs has established strategies and plans for long term conditions which support the delivery of the aims set out in the paragraph above. These are consistent with the high level models produced by the Future Fit programme and the development and implementation of existing priorities will continue alongside the Future Fit programme. Both CCG strategies focus on developing care closer to home and the establishment of integrated care teams based on clusters of GP practices. It is anticipated that this approach will result in a reduction of admissions to acute hospital beds.

CCG Operating Plans include more detail on the actions which are being taken to improve services for people with long term conditions and ensure that people with multiple long term conditions are offered a fully integrated experience of support and care.

CCG BCF submissions also include the detail of the plans to integrate care across health and social care.

10. Primary Care

In addition, each CCG has developed plans to strengthen primary care. Further collaborative discussions should now take place to understand the extent to which a common approach to primary care development across Shropshire, Telford and Wrekin in helpful or desirable in relation to the Community Fit programme of work, potentially involving the GP Federation. There are clearly synergies in the approaches which Community Fit can capitalise on. It is recommended that these conversations take place over the next few months to agree and set out the extent and manner in which primary care development features in the Community Fit programme. It is likely that there are significant areas e.g. urgent care network where it would be helpful to develop a collaborative approach and others which would be characterised as a Community Fit programme dependency which individual CCG's take the responsibility to deliver.

Working with the GP Federation

General practices in Shropshire have established a GP Federation as a vehicle for enhanced collaboration between practices and providers. This has the potential to support primary care to operate at a greater scale to improve access and continuity of care, both in relation to core GMS

services and beyond. CCGs are in discussion with the Federation regarding the development a collective vision for Primary Care in collaboration with all practices in the County. It is therefore essential that The Federation are involved in discussions regarding the role of Primary Care in the Community Fit programme.

Appendix 1 Telford & Wrekin : The Journey towards excellence in General Practice

The CCG's strategy is about facilitating, shaping and exploring possibilities, in partnership with their stakeholders. They have a vision of a Primary Care Service, led by GPs who are sufficiently resourced to offer appropriate and prompt access to excellent quality care for their population that is robust against challenge.

Their GPs will innovatively lead multi-disciplinary teams, which will include many disciplines of health and social care workers as well as those historically involved such as community nursing teams. This model will be clustered around Health hubs as proposed by the Clinical Reference Group of the Future Fit Programme and Community Fit. Primary Care Services will be designed around the needs of our population, as mandated by Patient Focus Groups. his will require careful and thoughtful management of patient expectations, and a care navigator role for many of the clinicians and other health and social care professionals.

Telford and Wrekin will continue to be an attractive place for Primary Care Clinicians of all disciplines to work as evidenced by the number of applicants for every job advertised and the excellent reputation of their Primary Care regionally and even nationally.

10.1.1 Telford and Wrekin CCG - Eight Areas of Commitment

To provide a framework for the new arrangements of delegated responsibility for Primary Care, the CCG is considering eight areas of commitment. These build on the wider objectives of the CCG and will specifically impact on the Primary Care outcomes, putting the patient and the local GP at the heart of a person-centred model of care. The CCG has re-designed their staffing structure to enable coordination of these outcomes and close working with the wider CCG team, local General Practices, Patients and stakeholders will jointly debate these areas of commitment with the aim to receive approved commitments during the first quarter of the 2015/16.

Engagement, Empowerment and Involvement – No decision about me without me	Sustainable Multi-disciplinary and seamless care pathways - Social prescribing	Patient Centred high quality and safe care
Improved Access for urgent and routine care	Reduced bureaucracy - Time to improve outcomes	Reduction in variation care and inequalities

The outcomes of these commitments are shown below, with some of the key interventions that are being considered to bring them to fruition. The CCG is currently awaiting formal approval from stakeholders, once approved; measures will be set against the outcomes that will be monitored by the Primary Care Committee.

For more information about Telford & Wrekin CCG primary care commissioning please visit http://www.telfordccg.nhs.uk/download.cfm?doc=docm93jijm4n6983.pdf&ver=10919

futurefit
Shaping healthcare together

CCG Eight Areas of Commitment: key interventions and outcomes

Engagement and Empowerment	Patient Participation Groups in all Practices Access to information via multi-media Multi-morbidity personal care plans	All Patients will have the opportunity to contribute. All Patients with a long term condition will have agreed personal care plans and feel empowered to self-manage care
Sustainable Multi-disciplinary working	Team around the Practice Social Prescribing Seamless pathways of care Professional Development and support	Patients will receive care from appropriately qualified and caring team of clinicians. Patients will be signposted to voluntary and community organisation for support
Patient Centred high quality and safe care	New model for the management of Long Term Conditions New improved Quality Assurance Framework Review of Enhanced Services and Quality/outcomes Framework	Patient will understand the quality of care they should receive and contribute to their management plans, putting their needs at the heart of their care
Care closer to home – admission avoidance	Better Care Fund Streamlined working with health and social care Risk Stratification	Patients will receive high quality coordinated care in a safe environment close to their home whenever possible. Health and Social care will jointly support this commitment
Improved Access for urgent / routine care	Improved communication with Ambulance and Out of Hours Enable flexible appointment schedules Clear understanding of demand and capacity needs	Patients will identify a new flexible approach to accessing Primary Care, which is improve productivity and be reactive to patient needs
Reduced bureaucracy	Review of current reporting arrangement for GP practices Allowing more time to see patients Improved Contract requirements	Increased use of technology and automated data collection combined with the information requests that lead to improvements in patient care
Reduction in variation care and inequalities	TRaQs will continue to drive quality and improve referral processes Improved referral pathway for 2 week waits for Cancer Practices supported to meet their specific patient needs	Variation will be understood by practices and patients Best practice will be shared and implemented across Practices Process will be better managed and improved Quality of Referrals will be increased
Indicative Budgets	Practices will be encouraged to consider ownership of their whole budgets and recommend changes to improve the outcomes for their specific population	Practices will understand their patient expenditure and work with patient groups to identify areas for improvement. Improved use of financial incentives

Appendix 2 Shropshire CCG Primary care Development

The Potential of Primary Care to Deliver the CCG Ambition

On the 1st April 2013, Shropshire CCG became the official statutory body responsible for commissioning health care services for the resident population of Shropshire. At the same time, the CCG also assumed formal responsibility for assuring the quality of primary care services, delegated to us by the NHS Commissioning Board. The commissioning of Primary Medical Services however, remained the responsibility of NHS England.

A Shropshire CCG primary care strategy was developed and approved by the Governing Body Board in 2013 to meet the CCG's responsibility for maintaining and improving primary care quality.

Up to this time this primary care strategy has defined the priorities and work plans for the CCG in regard to primary care. The strategy concentrated on three areas;

- Maintaining and improving high quality general practice
- Providing targeted education and better communication
- Promoting service development and transformation

Delegation of responsibility for the commissioning of Primary Medical Services
In May 2014, NHS England invited clinical commissioning groups (CCGs) to come forward with expressions of interest to take on an increased role in the commissioning of GP services. The intention was to give CCGs more influence over the wider NHS budget and enable local health commissioning arrangements that can deliver improved, integrated care for local people, in and out of hospital.

The Chief Executive of NHS England anticipated that the potential benefits of co-commissioning for the public and patients would include:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home
- High quality out-of-hospitals care
- Improved health outcomes, equity of access, reduced inequalities
- A better patient experience through more joined up services.

Shropshire CCG now has full delegated responsibility for the commissioning of Primary Medical Services. The commissioning of pharmacy, dental and optical services have not been delegated and remain the responsibility of NHS England. For legal reasons, NHS England remains liable for Primary Medical Services and so retains an assurance role, overseeing the discharge of the CCG's delegated responsibilities.

The development of the Primary Care Work Plan
In recognition of the need to rapidly establish a focus and clarity of role for the Primary Care Commissioning Committee, to develop a functioning primary care directorate within the CCG and to ensure efficient and effective working relationships with the NHS England area team, a decision was made to concentrate on the development of a practical and prioritised work plan which, over time, can be developed into a full primary care strategy, rather than to attempt to develop a full blown strategy from the outset.

The draft work plan is derived from the Delegated Functions defined in the delegation agreement of March 2015 **and** from the primary care strategy based on primary care quality dating back to 2013.

The broad areas covered in the draft plan are Quality, Sustainability, Innovation & Transformation and Working with NHSE.

Because the terms of reference of the Primary Care Commissioning Committee relate only to the delegated functions, the draft work plan therefore contains areas of work which lie beyond the statutory remit of the Committee. The CCG however, retains the wider responsibility for primary care quality and service innovation and transformation, as well as the newly delegated functions.

The work plan will therefore provide the basis for the CCG's activity in regard to primary care, only a part of which will be the direct responsibility of the Committee. Judgements will need to be made around which areas of work require assurance and decision making by the Committee, and which areas should report to other sub-committees of the Governing Body Board.
The provisional priority areas across the full range of CCG responsibilities in regard to primary care are marked in red.

Key Priorities for the Primary Care Commissioning Committee
In light of the 'mismatch' between the wider CCG responsibilities in regard to primary care and the statutory role of the Primary Care Commissioning Committee, this paper identifies some key priorities contained within the draft work plan which do lie within the statutory responsibilities of the Committee and which require work and development over the coming months in order to enable the Committee to effectively discharge its delegated functions and to properly exercise its delegated powers.

These key priorities are:

1. **To agree the Quality and Performance reporting and Governance processes between the CCG and the NHSE team**
   This is described in the delegation agreement as requiring collaboration between the CCG and NHS England resulting in 'a co-ordinated and common approach to the commissioning of primary care services' and 'an agreed staffing model'. There are also a range of transactional activities required to achieve this objective, also listed in the delegation agreement and reflected in the work plan under the heading 'Working with NHSE'.
2. **To embed the necessary assurance processes within the Primary Care Commissioning Committee, including a full and proper assessment of risks**
   This will include, but not be confined to the development of a primary care risk register which will include risks pertaining to practices in regard to Premises, Staffing, CQC identified risks, Performance risks, Quality and Safety risks and risks relating to Access to services.
3. **To develop robust mechanisms to plan, manage and develop primary care premises**
   This work requires co-ordination between the NHS England and CCG primary care staff and encompasses the management of practices who are at risk of loss of premises as well as responding to the opportunities provided for a more strategic approach to practice premises development through the Primary Care Infrastructure Fund.
4. **To progress the NHS England area team review of PMS contracts**
   The NHS England area team have indicated that they are committed to progressing PMS contract reviews. The Committee awaits further information and guidance from them on this issue.

Whilst these key priorities are the responsibility of the Primary Care Commissioning Committee, the Primary Care Working Group will provide a forum to progress much of the work. It's membership has been refreshed and now has a representative from the NHS England Area Team. Once the CCG primary care directorate is fully formed and posts recruited to, this will also provide additional capacity to progress to rapidly progress the work.

Quality	
Performance	Planning and review of primary medical services
	Management of quality concerns and poorly performing practices
	Liaison with CQC
	Liaison with NHSE regarding complaints management
	Delivery of Constitutional Pledges
	Practice Support Functions
Education	Redefining the CCG education offer (including nurse education facilitation)
	Recruiting a new GP education lead
Communication	Fully implement Shropshare
	Enhance SI reporting and feedback through Datix (or national system - STEISS)
Medicines Management	Full implementation of Scriptswitch
	Adherence to formulary
	GP engagement with pharmaceutical industry – review of custom and practice
	Poly-pharmacy and de-prescribing (including secondary care?)
	Liaison with NHSE re pharmacy issues
IT and Data	Improve quality and relevance of practice and locality level activity data
	Support federation in enhancing inter-operability between practices
Sustainability	
Premises	Premises risks to continuity of service
	Primary Care Infrastructure Funds
	Closures, New practices and Mergers
	Premises Costs Directions Functions
Workforce	Individual practice support
	Working with HEE and other training bodies
	Enable peer group support networks – e.g. sessional doctors, Shropshire women doctors
Business continuity	Out of area patients
	Practice manager training
Service definition	Inappropriate primary care work
QIPP	Primary Care QIPP
	Other QIPPS e.g. Meds Management
Innovation & Transformation	
Community Fit	7 day services
	Team around the practice
	Multi-Specialty provider model
	Prime Ministers Challenge Fund
	'Primary Care at Scale'
	Pharmacy e.g. common ailment scheme (an enhanced service)
Contracts	
Primary Medical Services contract	National PMS review

management	
Enhanced Services	2% DES
	Local Enhanced Services Review
	Other local incentive schemes – e.g. QOF alternatives
Discretionary Payments	
Management of delegated funds	
Working with NHSE	
Collaboration	Developing a co-ordinated and common approach to commissioning of Primary Medical Services
	Staffing model
IT and Data	Personal Data Agreement
	IT inter-operability between CCG and NHSE
Monitoring and Reporting	General
	Public information and access targets
	Financial provisions and liability
	Claims and Litigation
	Contract Management
	Information sharing with NHSE
Management	Delegated Funds
	National Performers List (NHSE responsibility)
	Revalidation and Appraisal (NHSE responsibility)

Summary of Shropshire CCG Primary care development Committee workplan

To view the mandate document and the five year strategy please visit: http://www.shropshireccg.nhs.uk/strategies

This page is intentionally left blank

EXTRACT FROM 'PUTTING PATIENTS FIRST DECEMBER 2015'

JOINT HOSC 15/12/15 9

Agenda Item 9

Library photos from NHS Picture Library

Maintaining safe, effective and dignified Urgent and Emergency Care Services

Patients and staff at Shropshire's two acute hospitals—and across Shropshire, Telford & Wrekin and mid Wales—are being asked for their views on how the Trust which runs them can maintain services in a safe, effective and dignified way while awaiting the outcome of the NHS Future Fit Programme.

NHS Future Fit, which will define the shape of healthcare for generations to come, was launched because the current model of care is not sustainable in the long-term.

But as we await the outcome of that programme, The Shrewsbury and Telford Hospital NHS Trust (SaTH), which runs the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital, is taking all possible steps to ensure we can keep services running safely and effectively for the 500,000 people we serve across Shropshire, Telford & Wrekin and mid Wales.

However, listening to our Doctors, Nurses and other health professionals in A&E and also in acute medicine, critical care and other specialties, we know how fragile some of our services are.

Our first duty of care is to our patients, and therefore it is vital that we have contingencies in place should the continued safe, effective and dignified running of these services become unsustainable because there are not enough staff to provide a safe service 24-hours a day in two A&E departments. In common with many other acute trusts across the country, one immediate measure could be the temporary overnight closure of one of our A&E departments. We need to consider this and other options carefully.

This is not a decision that would be taken lightly and, indeed, the main focus of our work is to prevent the need for any significant changes before NHS Future Fit reaches its conclusions.

Instead, our goal is that any changes should be made in a planned way based on agreements through the NHS Future Fit programme following widespread public consultation next year.

But NHS Future Fit is due to conclude in Spring 2017 and, given the fragility of some of our clinical services, it would be irresponsible of us not to fully explore the contingency measures that might be needed if our service reaches a tipping point where it was no longer possible to maintain two safe A&E Departments.

We need to make sure that our services remain safe over the next 18 months NHS Future Fit concludes.

This means that over the coming months, SaTH Board members will be talking to staff, partners and with communities about the best way forward.

In particular, there are a number of questions that we are looking at:

- What situations might constitute a "tipping point" within an Emergency Department which would mean the service could not be maintained in its current format?
- What further steps can we take to prevent tipping points being reached?
- If a tipping point was reached, what scenarios could be considered?
- What impact would those scenarios have on patients and communities and on other services inside and outside our hospitals?

We want to take into account as many thoughts and opinions as possible. If you have any views on these issues we would love to hear from you. You can share your thoughts by emailing consultation@sath.nhs.uk or writing to the Chief Operating Officer at the Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, SY3 8XQ or at the Princess Royal Hospital, Apley Castle, Telford, TF1 6TF.

More information is available from our website at **www.sath.nhs.uk/bcp**

This page is intentionally left blank

Reporting to:	**Trust Board, 3 December 2015**
Title	Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services **-** Developing our service continuity plan
Sponsoring Director	Debbie Kadum, Chief Operating Officer
Author(s)	Adrian Osborne, Communications Director
Previously considered by	
Executive Summary	The medium and long term vision for health services in the county is being developed through the NHS Future Fit programme. This programme envisages a new model of sustainable safe care including a network of urgent care centres supporting a single Emergency Centre. Work is continuing, with ongoing public engagement over the coming months followed by public consultation in 2016/17 on the proposed site for local services including the single Emergency Centre. In the meantime, the challenges that prompted the initiation of this work are growing, and the scenarios available to us to respond if an emergency arose are reducing. The most significant of these challenges is the continued availability of sufficient workforce to continue to provide two 24-hour emergency departments and associated clinical services. This risk features as one of the principal risks in our Board Assurance Framework (ref 859) and is therefore subject to ongoing Board scrutiny and review. It is also forms part of the progamme of review and scrutiny by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin. The Trust aims to maintain 24-hour emergency departments whilst the plans for the medium and long term are developed through NHS Future Fit. However, we are mindful that there continues to be a risk that a situation could be reached where maintaining two 24-hour emergency departments is unsafe and emergency measures must be taken. As a responsible public authority the Trust must ensure effective business and service continuity plans for our emergency departments and wider clinical services so that these measures, if required, could be implemented safely. Any emergency measures categorically do not pre-judge the essential work through the NHS Future Fit programme to develop an agreed vision for the future of health services for patients and communities across Shropshire, Telford & Wrekin and mid Wales. Instead, they would be taken to mitigate clear and present risks to the safety of the services we provide. In addition, the presentation of this paper does not signal any plan or intent to implement emergency measures; instead it signals the commitment of this Trust to continue to put patients at the heart of everything we do by being prepared for actions to protect their safety. It also reinforces that our primary focus as a Trust remains (a) to prevent the need for emergency measures and (b) to agree the medium and long term vision for local health services through NHS Future Fit and associated programmes. The attached discussion document "Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services: Developing our service continuity plan" therefore provides an overview of the risks and challenges, outlines the process to define "tipping points" that would prompt

	emergency measures to be initiated, and sets out the work to develop and test those emergency contingency measures. It invites comment from staff, communities, partners and wider stakeholders. The main focus for this work over the coming months includes: - developing clear contingency measures where we have confidence that the measures would satisfactorily reduce the overall risk to the Trust and our patients, and that potential adverse consequences have been considered and mitigated. - ensuring that there are clear timelines for implementation so that "tipping points" can be defined sufficiently to allow sufficient lead-in time for safe implementation of contingency measures. The next steps include: December 2015: Stakeholder workshop to consider potential scenarios and undertake desktop exercise to develop outline implementation options; work to identify "Tipping Points" to enable timely decisions; continue to develop workforce profile and risk assessment to prevent tipping points being reached. January/February 2016: Further stakeholder workshop to confirm tipping points and desktop test of contingency measures; develop quality impact assessment for review through Quality & Safety Committee; develop communications plan. February to April 2016: Agreement of Tipping Points; continue monitoring process led by executive team; consider "live test" to further test contingency measures. April/May 2016: Quarterly stakeholder workshop to review Tipping Points and contingency measures, and recommend updates based on changing environment and context. Ongoing: Monthly stakeholder bulletin to keep staff, communities and partners informed and engaged. This work will be overseen on behalf of the Trust Board by the Hospital Executive Committee, with quality review and assurance through the Quality and Safety Committee.
Strategic Priorities 1. Quality and Safety 2. People	☒ Reduce harm, deliver best clinical outcomes and improve patient experience. ☐ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☐ To undertake a review of all current services at specialty level to inform future service and business decisions ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme ☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation 4 Community and Partnership 5 Financial Strength: Sustainable Future	☐ Support service transformation and increased productivity through technology and continuous improvement strategies ☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies ☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☐ If the local health and social care economy does not reduce the **Fit To**

	Transfer (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm ☒ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we are unable to resolve our structural inbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well led
☒ **Receive** ☐ **Review** ☒ **Note** ☐ **Approve**	**Recommendation** The Trust Board is asked to RECEIVE and NOTE the update on the development of the service continuity plan for the Trust's urgent and emergency care services.

The Shrewsbury and Telford Hospital NHS
NHS Trust

Paper 7

Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services

Developing our service continuity plan

Version 1, 25 November 2015

Summary

- The sustainability of safe urgent and emergency care services in Shropshire and Telford & Wrekin has been subject to continuing debate over many years without resolution.

- These services face a range of challenges, including:
  - Ensuring sustainable rotas of skilled and experienced clinical professionals to provide 24-7 care
  - Bringing the latest life-saving technologies to the county.
  - Meeting the changing needs and expectations of patients and communities, particularly as more of us live longer with long term conditions.

- There are a number of constraints to addressing these challenges, including:
  - Workforce issues including availability, and changes in clinical training and accreditation.
  - The continued environment of financial austerity across the entire public sector.
  - Estate issues, including size and quality of current healthcare estate and scope for investment.

- One impact of the prolonged debate without resolution is that the need to address these challenges becomes more critical, and the options for addressing them reduce. For example, some options involving the development of new skills and roles have a long lead-in time, and those requiring capital developments need to be planned and delivered.

- As a Trust we are focused on three explicit phases of work:
  - Long Term: Creating a shared vision for the future of health and care services with our clinicians and communities. This should set out a future state for safe and sustainable urgent and emergency care services as part of a wider vision for health and healthcare.
  - Short to Medium Term: Taking steps in the medium term that help us maintain safety and continuity until the long term vision is achieved.
  - Immediate Service Continuity: Addressing immediate risks to the safety and continuity of services, and preventing the need for emergency measures to be taken.

- The sooner we are able to reach a shared agreement on a long term vision, the less likely that emergency measures would be needed and the more likely that medium term action can be delivered in the form of interim steps towards a long term vision.

- The Long Term vision is being developed through the NHS Future Fit Programme and options for the Short to Medium Term options are being developed in parallel with this work. Further information is included in the NHS Future Fit update to Trust Board on 3 December 2015. Our work to ensure immediate business continuity is described in this report, particularly in Section 7.

1. The main features of urgent and emergency care services for people in Shropshire, Telford & Wrekin and mid Wales

The majority of urgent care takes place outside hospitals in people's homes, in GP surgeries, through pharmacies and other local services. Treatment and care for the most serious and life-threatening injuries and illnesses is provided outside the area in major tertiary centres such as Birmingham and Stoke. Both Princess Royal Hospital and Royal Shrewsbury Hospital provide 24-hour Accident and Emergency Departments, but the challenges of maintaining these services are increasing.

1.1 Providing urgent care as close to home as possible

The significant majority of urgent care takes place outside hospitals:

- in people's homes (including residential and nursing homes) through self-care
- via web and telephone support (e.g. NHS Choices, NHS 111 and NHS Direct in Wales)
- in community pharmacies
- in GP practices or walk-in centres, and out-of-hours primary care services
- in the community through first responders and paramedics
- in Minor Injury Units and Urgent Care Centres.

Our goal is to maintain and increase the way in which urgent care needs can be met as close to home as possible, whilst ensuring that we are giving the best life chances for people with the most serious illnesses and injuries that need the specialist range of services that can only be provided in hospitals.

1.2 Providing specialist care for the most serious illness and injuries

Treatment and care for people from Shropshire, Telford & Wrekin and mid Wales with the most serious and life-threatening illnesses and injuries takes place outside the area in major tertiary centres that bring together the full range of expertise and technology that is not available in the county's district general hospitals. This expertise includes:

- Major trauma centre services
- Heart and chest surgery
- Neurosurgery
- Specialist burns
- Children's trauma and critical care services

Emergency care pathways take patients to a range of specialist hospitals outside the area. These include Queen Elizabeth Hospital in Birmingham, Royal Stoke University Hospital, Birmingham Children's Hospital and New Cross Hospital (e.g. following heart attack) as well as specialist hospitals in Merseyside or south Wales.

The majority of these specialist services are likely to continue to be provided in regional specialist hospitals that bring together this full range of expertise and technology. However, we need to protect and build the services provided within the county:

- We should seek to maintain our full range of services in the county rather than see them move to specialist centres elsewhere (e.g. hyper-acute and acute stroke services, cancer unit)

- We should take opportunities to repatriate services where it is safe and feasible to do so (for example, where technology, skills and pathway development enable more care to be provided within local hospitals).

1.3 Urgent and emergency care at Princess Royal Hospital and Royal Shrewsbury Hospital

Both the Princess Royal Hospital and Royal Shrewsbury Hospital provide 24-hour Accident and Emergency departments supported by a range of clinical services including acute medicine, radiology, critical care, pathology.

Royal Shrewsbury Hospital provides a 24-hour Accident and Emergency Department with the back-up of acute surgery and is a Trauma Unit as part of the region-wide Major Trauma Network. The hospital also provides inpatient and ambulatory cancer services and has the support of a daytime Children's Assessment Service. There is a daytime primary-care led Urgent Care Centre co-located with the A&E Department. There is an Acute Medical Unit for the assessment of urgent medical referrals and an Acute Surgical Unit (Surgical Assessment Unit) for the assessment of urgent surgical referrals, and ambulatory models of care are increasingly being developed in these departments.

Princess Royal Hospital provides a 24-hour Accident and Emergency also provides the county's main hyper-acute and acute stroke service on a temporary basis pending the outcome of the NHS Future Fit review. It is the county's main centre for inpatient women and children's services including a 24-hour children's assessment unit. There is a daytime primary-care led Urgent Care Centre within the hospital grounds. There is an Acute Medical Unit for the assessment of urgent medical referrals and ambulatory models of care are increasingly being developed in the department.

The sustainability of safe emergency care services at the Princess Royal Hospital and Royal Shrewsbury Hospital has been the subject of ongoing debate without resolution for many years. A solution is needed as, whilst the challenges are increasing, the options for addressing them are reducing.

Page 67

2. The national vision for transforming urgent and emergency care services

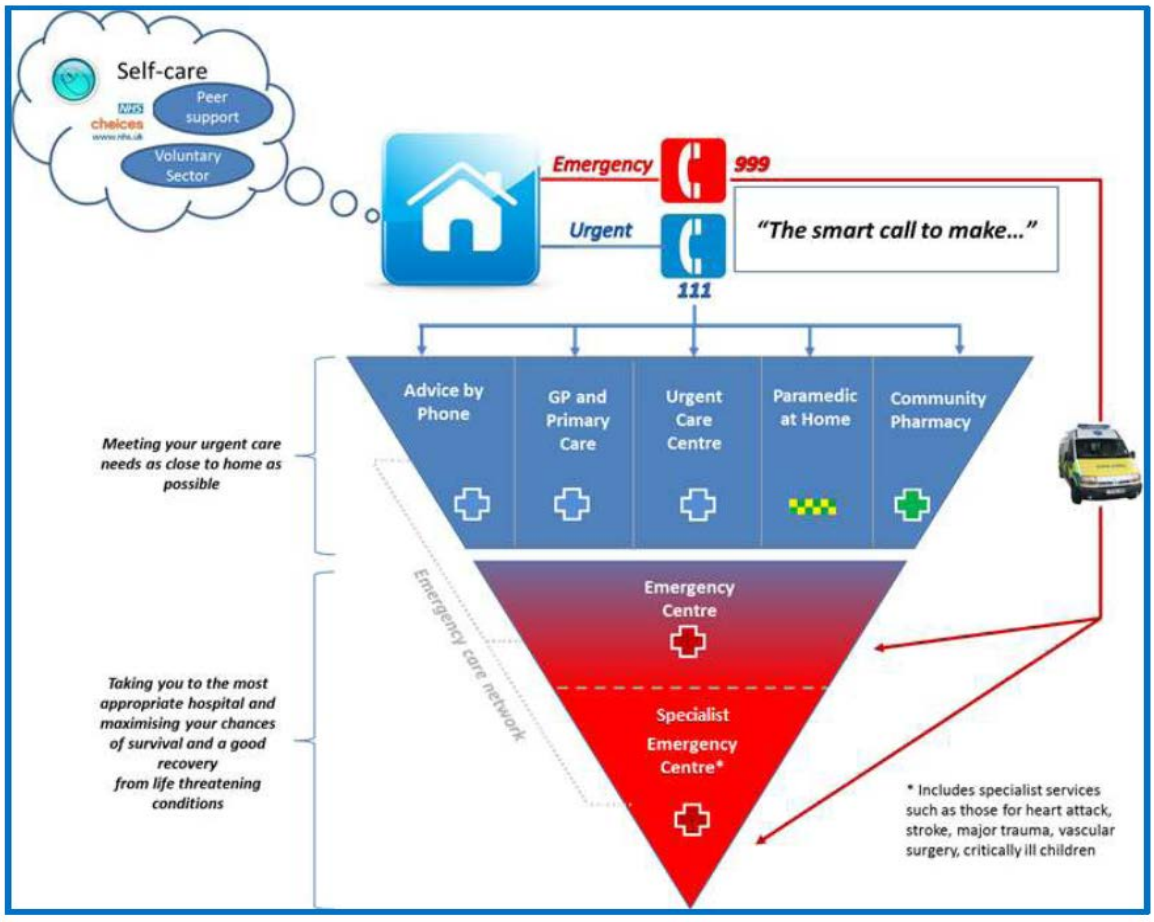
A national vision for Urgent and Emergency Care is being set out through NHS England's national Urgent and Emergency Care Review led by Sir Bruce Keogh. The review has set out a vision for urgent and emergency care services and establishing Urgent and Emergency Care Networks (including the North West Midlands Urgent and Emergency Care Network encompassing Shropshire, Telford & Wrekin, Stoke and Staffordshire) to oversee the delivery of the national vision at a local level.

2.1 National Vision

NHS England is setting out a national vision for urgent and emergency care services in England through the Urgent and Emergency Care Review led by Sir Bruce Keogh[1,2]. This envisages:

- Firstly, for those people with urgent but non-life threatening needs we must provide highly responsive, effective and personalised care services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families.
- Secondly, for those people with more serious or life-threatening emergency needs we should ensure they are treated in centres with the very best expertise and facilities, in order to maximise their chances of survival and a good recovery.

This vision is summarised in the diagram below:



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

[2] NHS England (August 2014) "Transforming urgent and emergency care services in England: Update on the Urgent and Emergency Care Review"

2.2 National Delivery

The national review proposes that five key changes need to take place to help create the conditions for establishing the new vision[3]:

- Providing better support for people and their families to self-care or care for their dependants.
- Helping people who need urgent care to get the right advice in the right place, first time.
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week, so people no longer choose to queue in hospital emergency departments.
- Ensuring that adults and children with more serious or life-threatening emergency needs receive treatment in centres with the right facilities, processes and expertise in order to maximise their chances of survival and good recovery.
- Connecting all urgent and emergency care services together so the overall physical and mental health and social care system becomes more than just the sum of its parts.

2.3 Urgent and Emergency Care Networks

Health and care organisations are asked to work together through regional Urgent and Emergency Care Networks to develop and oversee the regional strategy for achieving this vision[4]. These networks will be based on "the geographies required to give strategic oversight of urgent and emergency care on a regional footprint … of 1 to 5 million (depending on population density, rurality and local factors)".

Their purpose is to improve the consistency and quality of Urgent and Emergency Care by bringing together System Resilience Groups (SRGs)[5] and other stakeholders to address challenges in the urgent and emergency care system that are difficult for single SRGs to address in isolation. This will include coordinating, integrating and overseeing care and setting shared objectives for the Network where there is clear advantage in achieving commonality for delivery of efficient patient care (e.g. ambulance protocols, NHS 111 services, clinical decision support and access protocols to specialist services such as those for heart attack, stroke, major trauma, vascular surgery and critically ill children).

Objectives for Networks include:

- Creating and agreeing an overarching, medium to long term plan to deliver the objectives of the Urgent and Emergency Care Review;
- Designating urgent care facilities within the network, setting and monitoring standards, and defining consistent pathways of care and equitable access to diagnostics and services for both physical and mental health;
- Making arrangements to ensure effective patient flow through the whole urgent care system (including access to specialist facilities and repatriation to local hospitals);
- Maintaining oversight and enabling benchmarking of outcomes across the whole urgent care system, including primary, community, social, mental health and hospital services, the interfaces between these services and at network boundaries;
- Achieving resilience and efficiency in the urgent care system through coordination, consistency and economies of scale (e.g. agreeing common pathways and services across SRG boundaries);

[3] NHS England (August 2015) "Safer, Faster, Better: good practice in delivering urgent and emergency care: A guide for local health and social care communities"

[4] NHS England (June 2015) "Role and establishment of Urgent and Emergency Care Networks"

[5] System Resilience Groups (SRGs) are forums that bring together local health and care stakeholders to plan the delivery of local services. More information can be found in "Operational resilience and capacity planning for 2014/15" (Monitor, NHS England, NHS Trust Development Authority, ADASS; June 2014)

Page 69

- Coordinating workforce and training needs: establishing adequate workforce provision and sharing of resources across the network;
- Ensuring the building of trust and collaboration throughout the network;
- Spreading good and best practice and demonstrating positive impact and value, with a focus on relationships rather than structures.

The geographical footprint for our System Resilience Group is Shropshire and Telford & Wrekin. The area covered by our Urgent and Emergency Care Network is North West Midlands Urgent encompassing Shropshire, Telford & Wrekin, Stoke and Staffordshire.

3. The local vision for transforming urgent and emergency care services

A vision for the future of the county's health services is being developed through the NHS Future Fit programme. The safety and sustainability of services needs to be maintained in the short and medium term until that vision is realised.

Considerable work has taken place through the NHS Future Fit programme to:

- Understand local needs and expectations (e.g. through the Call To Action).
- Review local clinical challenges.
- Assess national and international evidence and strategic direction.
- Translate this into a local model of care that is fit for future generations.

A key output from the NHS Future Fit programme has been the development of a Clinical Model for future services. This model outlines a future vision for:

- Planned Care
- Urgent and Emergency Care
- Long Term Conditions

More information about the NHS Future Fit programme and the proposed clinical model is available from the NHS Future Fit website at www.nhsfuturefit.org

In relation to Urgent and Emergency Care, the key features of the NHS Future Fit clinical model mirror the national strategic approach. This includes:

- A network of urgent care centres treating people who don't have life-threatening illnesses or injuries but can't wait to see their GP.
- A single emergency centre treating the most serious illnesses and injuries that are treated in the county.
- Effective assessment, stabilisation and transfer to regional specialist centres for those illnesses and injuries that are not treated in the county's hospitals (e.g. neurosurgery, heart and chest surgery).

Whilst work continues through the NHS Future Fit programme to establish and agree the future vision, and develop detailed plans for putting it into practice, as a Trust we also need to ensure we maintain safe services in the short to medium term.

4. Opportunities and Challenges

National policy sets out opportunities for the NHS to transform healthcare, which in turn will save lives and reduce long-term ill health. However, our health system faces a number of challenges. Our two-site model contributes to the fragility of several clinical services including A&E, critical care and acute medicine. We struggle to recruit and retain the workforce needed to maintain services across two small hospital sites. We also face difficulties investing in duplicated equipment and infrastructure, whilst at the same time meeting the changing needs of our patients and communities. Whilst much of the debate has focused on "A&E", this department relies on a wide range of other clinical services, all of which need to be safe and viable for the A&E service to be maintained.

4.1 Opportunities

There is clear evidence that early access to senior clinical decision-makers can save lives and reduce long-term ill-health for the most seriously ill and injured patients. Studies have shown both a direct patient benefit through rapid access to definitive diagnosis and treatment, as well as indirect benefit (e.g. reducing unnecessary admissions, improving hospital flow).

The local NHS has a significant opportunity to transform urgent and emergency care to deliver the vision emerging from NHS England's national Urgent and Emergency Care Review. The national vision is built on patient and clinical evidence from the UK and abroad[6]. As outlined in the End of Phase 1 report for the Urgent and Emergency Care Review[7]:

> *The reasons for the growing pressures our A&E departments are experiencing have been well rehearsed. Two things in particular are often cited. Firstly, an ageing population with increasingly complex needs is leading to ever rising numbers of people needing urgent or emergency care. Secondly, we know that many people are struggling to navigate and access a confusing and inconsistent array of urgent care services provided outside of hospital, so they default to A&E. While both these things are true, they arguably underplay the fact that A&E departments have become victims of their own success. The A&E brand is trusted by the public and, despite increasing pressure, continues to provide a very responsive service with an average wait for treatment of only 50 minutes and the overwhelming majority of patients being treated within 4 hours. So, we should not be surprised that people choose to go to A&E.*
>
> *But, the reality is that millions of patients every year seek or receive help for their urgent care needs in hospital who could have been helped much closer to home. The opportunities for bringing about a shift from hospital to home are enormous. For example, we know that 40% of patients attending A&E are discharged requiring no treatment at all; there were over 1 million avoidable emergency hospital admissions last year; and up to 50 per cent of 999 calls requiring an ambulance to be dispatched could be managed at the scene. To seize the opportunities these numbers present, we will need to greatly enhance urgent care services provided outside of hospital. This forms a key part of our proposals.*
>
> *The second part of our vision relates to those people with the most serious or life threatening emergency care needs who do require treatment in hospital. In the 1970s most A&Es and their hospitals could offer people the best treatment of the day for most conditions. Clinical practice has taken great strides forward in the last four decades, and this is no longer the case.*

[6] NHS England (November 2013) Transforming urgent and emergency care services in England: Urgent and Emergency Care Review End of Phase 1 Report. Appendix 1 – Revised Evidence Base from the Urgent and Emergency Care Review

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

Take heart attacks for example. In the 1970s, heart attacks were treated with bed rest. The hospital mortality rate was about 25 per cent. Today, as a result of advances in medical science, we now mechanically unblock the culprit coronary artery which was causing the heart attack. This treatment has seen mortality rates fall to just 5 per cent. But this improvement has required very expensive diagnostic equipment and cardiologists with special skills. This highly effective, advanced treatment of serious heart attacks cannot be provided by every hospital; it is currently delivered by half the hospitals in England, with about a third providing a comprehensive 24/7 service. We have very good results by international standards because the diagnosis can be made in the ambulance and the right patients are taken to the right hospitals for the most advanced treatment. This means that for paramedics to get patients to the best and most appropriate services, they will sometimes drive past the nearest A&E to get the patient to the right place. This is a good thing. The recent national reorganisation of major trauma services which resulted in the designation of 25 major trauma centres has produced, in its first year, a 20% increase in survival despite increased travel time for patients who now bypass A&Es that previously treated only a handful of these very serious and complicated cases.

Similarly, the treatment of strokes which occur when the blood supply to part of the brain is blocked, has evolved. Effective treatment requires rapid transfer to a highly specialised unit with expensive diagnostic scanners and clinical expertise so that drugs can be given to minimise the brain damage that occurs. Stroke services in London have been reorganised to offer this high level treatment, but this required redirecting patients with suspected strokes from 32 admitting hospitals to only 8. The end result is that London has the best stroke services of any capital city in the world, saving more lives and returning more patients to independent living.

We have made good progress on treating heart attacks and strokes, although there is still more to do in these and other areas in order to reduce risks and improve outcomes. Advancing science has directed the way we deliver services to achieve the best results, but it also exposes the illusion that all A&Es are equally able to deal with anything that comes through their doors. We now find ourselves in a place where, unwittingly, patients have gained false assurance that all A&Es are equally effective. This is simply not the case.

We also know that the likelihood of recovering from a particular illness or injury varies considerably between hospitals. Despite the best efforts of the staff who work there, many hospitals and their A&E departments do not have consistent consultant presence overnight or at weekends. The support services available also vary considerably, with 1 in 7 lacking at least one "essential" on-site service, such as critical care, acute medicine, acute surgery or trauma and orthopaedics.

So, A&E departments up and down the country offer very different types and levels of service, yet they all carry the same name. We need to ensure that there is absolute clarity and transparency about what services different facilities offer and direct or convey patients to the service that can best treat their problem. Most importantly, we need to ensure that anywhere that displays a red and white sign is a place that will provide access to the very best care for the most seriously ill and injured patients, 24 hours a day and 7 days a week. A place that can resuscitate, make a diagnosis, start treatment and ensure rapid transfer to the right place if it can't offer the very best care.

Professor Sir Bruce Keogh in the introduction to the End of Phase 1 Report for the Urgent and Emergency Care Review

Locally there are opportunities, therefore, to:

- Provide more care closer to home, particularly for illnesses and conditions that do not need the specialist expertise provided in an A&E department.
- Use new treatments and technologies to ensure earlier, definitive diagnosis and treatment to reduce mortality, morbidity and long-term disability.

- Strengthen care pathways to ensure that more patients reach the point of definitive treatment more quickly.

4.2 Challenges

Patients and communities across Shropshire, Telford & Wrekin and mid Wales expect and deserve the highest standards of urgent and emergency care that increases survival rates, improve quality by reducing disability and shortening recovery times, and improves patient experience.

The Shrewsbury and Telford Hospital NHS Trust strives for the highest standards of urgent and emergency care, and working with patients and partner organisations through the NHS Future Fit programme we have already begun to develop a vision for the future of health and healthcare in the county.

However, the services we provide for our patients face some challenges which continue to increase:

- Providing a sustainably safe clinical model that brings the patient and clinician together as quickly as possible – reducing the need for patients to travel between our hospitals or elsewhere for specialist care, and ensuring that when such travel is needed it is safe and timely (see 4.2.1).
- Ensuring sustainable rotas of skilled and experienced clinical professionals to provide 24-7 care, and continuing to fulfil training requirements so that we continue to attract doctors in training (see 4.2.2).
- The duplicated costs of bringing the latest life-saving technologies to both hospitals (see 4.2.3).
- Meeting the changing needs and expectations of patients and communities, particularly as more of us live longer with long term conditions (see 4.2.4).

At the heart of the challenge is a vicious circle:

- We have a historic model of care spread across two small hospital sites. This is associated with a significant degree of civic and community pride.
- Clinical roles in smaller hospitals face a number of challenges in terms of recruitment and retention: small departments are less likely to see a wide and changing case-mix, which would make the role more attractive and support the maintenance of clinical skills; on-call rotas may be more onerous; fewer on-site clinical adjacencies create greater complexity in the care pathway.
- Our Trust receives the same income is if services were provided from a single site. Double-running of services across hospital sites also does not attract additional income but does incur additional costs. This means that departments have dated equipment and IT infrastructure, and are less able to adopt the latest technologies and techniques.
- Overall, we need more staff, equipment and infrastructure than if the same services were provided from a single site. This alongside our rural location creates challenges in recruiting and retaining our permanent workforce. This in turn leads to additional costs through agency and locum expenditure to sustain safe staffing.
- There are also limited opportunities to flex capacity to meet changing demand, requiring implementation of inefficient measures during times of escalation that reduce the staffing and resources available for other hospital services.
- The duplication of costs of staffing, equipment and infrastructure contributes to a deficit financial position. This reduces the availability of working capital to invest in new ways of working that will drive efficiency. This means that our service model is not responding fast enough to our changing environment, and our challenges continue to grow faster than our scope to address them.

4.2.1 Clinical Model

A&E services have very strong public recognition, but understanding of the services that need to sit alongside an effective 24-7 A&E department is much less widespread. Whilst A&E teams have specialist expertise in immediate assessment and stabilisation, the degree to which hospital emergency departments can save lives and ensure a good recovery is critically dependent on the links between A&E and other clinical specialties:

- Acute surgery (e.g. colorectal, upper gastro-intestinal, vascular) and Trauma & Orthopaedic Surgeons to provide life-saving operations.
- Critical Care & Anaesthetic teams to stabilise and support the most critically ill and injured patients, and provide 24-7 support in the operating theatre.
- Acute Medical teams to assess and treat medical conditions.
- Diagnostic specialists providing imaging and blood tests so that the best clinical decisions can be made, and life-saving treatment can start without delay.
- Effective pathways to regional specialist services (e.g. heart, chest, neurosurgery, burns, major trauma, critically ill children).
- Obstetric, gynaecology and paediatric services to assess and treat women and children.
- Oncology services to provide intervention and support for acutely ill cancer patients.
- Therapy support, for example to ensure immediate initiation of programmes that will accelerate recovery.
- A wide range of clinical support services that enable the delivery of front line care.

Each element of the service is subject to its own clinical and governance standards that aim to maintain and improve clinical outcomes, safety, patient experience and working lives. Where standards are not met within any one of these services this can have a number of effects including:

- Poor outcomes, safety and experience for patients.
- Service closure, or compliance or regulatory action requiring service improvement.
- Removal of education and training status (e.g. whereby hospitals no longer attract doctors in training – this has a direct impact on the available workforce, as well as on wider recruitment and retention).
- Staff dissatisfaction and low morale.

If one vital clinical adjacency is lost then this can result in the “closure” of an A&E department in its current form.

There is no single model for A&E care in England. Indeed the service model will be different at every hospital, typically emerging organically from the needs, the opportunities and the politics of the local area. The current national review aims to enable local solutions within a framework of national clarity and transparency.

If too few of these services are clinical adjacent to the A&E department then more patients will face delays or need to be transferred elsewhere, more ambulances will need to bypass the hospital to access these specialist skills elsewhere. This requires effective assessment and triage with clear emergency pathways in place.

Conversely, the greater consolidation of these services on a single site means that patients are able to have quicker access to specialist opinion, but it does mean that fewer sites provide the service that we have traditionally understood as “A&E”.

This understandably creates a level of tension in debates within communities:

- The overall goal may be to reduce the overall time from emergency call to definitive consultant-led treatment, through better assessment and triage, improved 24-hour availability of specialist clinicians, and fewer delays from the hospital door to multi-disciplinary assessment and initiation of treatment.
- The perception often focus on the element of the emergency care pathway from home to hospital, rather than the critical steps that take place both before and after this[8]. Whilst generally people recognise the need for the most critical injuries to be transferred out of the county to regional specialist centres, a level of reassurance is gained from having "a local A&E" with understandable anxiety if these services may move further from home.

So, the challenges do not solely relate to the A&E department, but to maintaining safe services across a range of clinical adjacencies.

4.2.2 Workforce

The NHS nationally faces significant workforce challenges, and SATH is no exception. We do not currently meet recommended staffing levels for the emergency department, critical care or acute medicine – each of which are vital clinical adjacencies for our A&E departments at both PRH and RSH.

The "Keeping It In The County" consultation in 2010/11 was driven by similar workforce challenges in both acute surgery and paediatrics; consolidation of inpatient services onto a single site (acute surgery at RSH and paediatrics and PRH) has significantly improved recruitment and retention in these areas, helping to sustain vital services in the county rather than see them move to specialist centres elsewhere. However, the split-site model of care between PRH and RSH still presents challenges for these specialties.

Medical Staffing: Emergency Department, Critical Care and Acute Medicine

The main areas of medical workforce fragility are emergency department, critical care and acute medicine.

Between these three areas we estimate that substantive consultant-level staffing is less than half required levels (this is based on national standards & requirements, clinical caseload and our two-site operating model – the adoption of single-site models would significantly reduce the staffing challenges).

This presents a number of challenges, including:

- Small teams have **onerous on-call responsibilities** – in some cases this is twice the levels in neighbouring hospitals, making roles in SATH much less attractive in a competitive employment market.
- **Workforce resilience** is significantly affected if the workforce is thinly spread. Vacancies or illness have a more significant impact on the workload for the remaining team and can lead to services reaching a tipping point[9].
- Vacancies need to be managed through short-term and unsustainable measures such as **locum & agency staff and "acting down"**.

[8] The overall emergency care pathway typically includes (a) identification of symptoms (b) decision to call for help [e.g. GP, NHS111, 999] (c) pre-hospital care [e.g. GP or paramedic attendance, assessment, stabilisation and/or treatment] (d) transfer [e.g. conveyance to hospital] (e) arrival at hospital (f) multi-disciplinary assessment and diagnostics (g) senior decision-making on intervention and treatment (h) ongoing care, rehabilitation and recovery. For some conditions, the overall period from (a) to (g) has a significant impact on outcomes and recovery, and the travel time is just one element of a pathway where significant and compensatory gains can be made in other steps.

[9] This was experienced in stroke services in 2013 where workforce gaps led to the hyper-acute and acute stroke service being temporarily consolidated onto the PRH site. As a result of the clinical benefits observed during this temporary consolidation, a further review was undertaken leading to this service model being retained on an interim basis pending the outcome of the NHS Future Fit review. Hyper-acute and acute stroke services therefore remain temporarily consolidated at PRH.

- Providing “on call” cover **reduces availability** of senior clinicians during the day at the busiest times for our clinical services.

Despite ongoing recruitment efforts, departments continue to rely on high levels of unsustainable agency staffing. There is significant competition within the NHS – and internationally – for these roles and our onerous on-call rotas, small size and limited facilities of our hospitals, and limited range and case-mix of presentations at each site, impact adversely on our ability to recruit and retain new consultants.

We also face challenges in other medical roles– middle grade and junior doctors. The development of roles such as Advanced Care Practitioners offers excellent potential as an alternative workforce to medical staff. However, currently it is difficult to support the development of advancing and extending practice for non-medical staff as the capacity for medical staff to mentor, support and supervise training is compromised by the workforce pressures outlined above.

Nursing and Support Roles

In addition to these three specialties, we face recruitment difficulties across a number of other skills and specialties including nursing, operating department practitioners, diagnostic radiographers and healthcare scientists. The double-running of services across two small hospital sites means that more staff are needed to provide 24-7 cover than if the services were provided on a single site and/or they require onerous on-call duties from our workforce.

NHS funding models anticipate that hospital services across the country will achieve the efficiency levels of the best and do not provide financial flexibility to fund duplicated rotas.

These challenges will increase with the growing requirements for seven-day services in the NHS.

Way Forward

Based on (a) discussions with our clinical teams, (b) our assessment of the future medical and nursing workforce market, and (c) the potential for extended and advanced non-medical roles, a combination of recruitment/retention and role development will not solve our workforce sustainability issues. Instead, the Trust needs to consider options for consolidation of further services onto a single site, which in turn will provide (a) a more attractive recruitment offer, (b) less onerous on-call responsibilities, (c) greater potential to sub-specialise for the benefit of our patients and (d) greater potential to invest once in life-saving new technologies (rather than requiring duplicated investment).

Our plans must address the immediate risks whilst ensuring a realistic workforce plan for the future.

4.2.3 Technology and models of care

Healthcare is changing. Every day, new technologies provide new opportunities to save lives and reduce long term ill health.

However, providing services across two small hospitals presents two main challenges:

- Either, it requires duplication of equipment (and indeed will often require more equipment overall than if the service was provided at a single site). The majority of equipment purchase, maintenance and replacement within the NHS is funded from organisational capital and revenue budgets. In other words, we need to fund this from the income we receive for patient care services, and from any working capital that we are able to generate.
- Or, the catchment of our small hospitals means either that the equipment is not viable at hospital population-level or that we are not able to compete with larger centres elsewhere as part of national deployment programmes.

The financial settlement for the NHS over the next five years anticipates levels of efficiency that cannot be delivered by maintaining the current levels of duplication of equipment and services.

Investing in the equipment needed for future healthcare requires us to develop new models of care.

4.2.4 Changing needs

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

Long-term conditions are increasing due to changing lifestyles. This means health services need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community with consistent support for self-management and care.

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

Changing needs and expectations require is to think differently about how best we use finite NHS resources.

5. Constraints

The challenges we face are primarily clinical: reaching our full potential to save lives and reduce long term ill health, through a range of steps including earlier access to senior clinical decision makers. However, our constraints in responding to these challenges encompass a wide range of factors including financial, workforce, estate and local expectations. Achieving the national efficiency programme for the NHS requires bold decision-making so that we leave a legacy of safe and sustainable health services for future generations.

There are a number of key constraints that impact on the potential solutions to these challenges, including:

- **Financial resources: Plans to address these challenges must be affordable to the local NHS and offer value for money for taxpayers.**
  The NHS funding model for acute hospitals in England is based on a Payment By Results system, where providers of health care services receive a payment for an episode of care. One of the most significant effects for this Trust is that there is minimal recognition within the funding model for multi-site services. Trusts that provide services dispersed across multiple sites receive the same income as if these services were provided from a single site, and therefore need to ensure high levels of efficiency to accommodate the costs of double-running (e.g. staffing rotas, medical equipment, estates and facilities services and infrastructure).
  The impact of this on SATH has been well documented and we estimate the costs of duplication to be in the region of £12m a year – funding that this therefore not available for direct care.
  The government's plans for the NHS anticipate the most far-reaching efficiency savings ever achieved since the establishment of the NHS. Therefore, all organisations, and the health & care systems within which they operate, must identify and deliver challenging cost improvement plans to ensure that the NHS can meet growing demand whilst also attending to the expectations of our patients and communities.
  Whilst the drivers for change in urgent and emergency care services are clinical and needs-led, finance is a constraint to the options available.
- **Scope for capital developments: Plans to address these challenges must be based on a realistic assessment of the potential both from the current estate and for future development, whilst not tying the NHS unnecessary into costly buildings-based care.**
- **Workforce: Plans to address these challenges must be based on achievable plans for workforce development and recruitment**
  We need to be realistic about the future workforce market locally, nationally and internationally. Our workforce represents our most valuable asset – and the most significant proportion of NHS expenditure. Future service models have to take account of the expected workforce availability as well as our potential to develop new roles (and the time frame needed to achieve this).
- **Technological infrastructure: Plans to address these challenges need to take advantage of potential from technological advancement whilst also recognising the current capacity and capability.**
- **Community and political expectations: Plans to address these challenges must take account of community expectations, and must fulfil statutory requirements for engagement and consultation.**

6. Responding to these challenges and constraints

We and our patients face challenges to immediate service & business continuity, as well as in the medium and long term. We need to ensure that we have plans to sustain safe services right now whilst planning for a healthy future.

Phase	Timeframe	Goal	Activities
Immediate Business Continuity (see Section 7)	Immediate action to address risks and fragility	Maintaining services until a clear plan for the medium-to-long term has been agreed	• Understanding the risks and potential tipping points for emergency care services. • Delivering plans that address these risks and prevent these tipping points being reached, so that emergency measures do not need to be implemented. • Understanding the scenarios in which emergency measures may be unavoidable and having robust service continuity in place
Short to Medium Term (see NHS Future Fit update to Trust Board on 3 December 2015)	Action within the next 18 months to maintain safety and continuity of services.	Agreeing and delivering any interim steps and transition that supports us to move towards the long term vision.	• Develop two OBC options for the emergency site - one at Telford and one at Shrewsbury.
Long Term (see NHS Future Fit update to Trust Board on 3 December 2015)	Action within the next five years to create and deliver the shape of health and care services fit for future generations	Agreeing a long term vision for the future of safe and sustainable health and care	• Continuing the work through the NHS Future Fit Programme to establish a future vision for safe and sustainable health and care

7. Immediate Service Continuity

This section sets out emerging ideas to ensure immediate service continuity for Emergency Care in the county's main hospitals. It outlines possible tipping points, measures to prevent those tipping points being reached, scenarios that could be implemented if those tipping points were reached, and suggested next steps. It sets out a series of questions for discussion and feedback by staff and communities.

The workforce challenges in some clinical departments mean that there is ongoing risk that these departments will reach a "tipping point" beyond which those services cannot be maintained in their current form. This is because, to put it bluntly, there will not be enough staff to provide a safe service 24-hours a day in two A&E departments.

These risks are particularly acute in the emergency department. We have great teams in our emergency departments – and in the wider hospitals – who work tremendously hard 24-7-365 to provide the highest standards of care and treatment. But, we have to recognise that the pressures on those teams may reach levels where urgent change is needed in order to protect us as patients, and protect them as staff.

These risks are real. If they were not, then we would not have embarked on the NHS Future Fit programme to develop a strategic vision for the shape of health services fit for generations to come.

Whilst the NHS Future Fit programme continues, our primary focus as a Trust is on **actions to prevent a tipping point being reached**. We do not want to make emergency changes and we have no plans to do so. Instead, we believe that any changes should be made in a planned way based on agreements through the NHS Future Fit programme following widespread public consultation.

But, as a responsible public body we must also ensure that we have:

- **Considered what emergency contingency measures could be taken, and developed and tested plans for their implementation, including understanding how long these would take to implement.**
- **Considered the tipping points that may lead us to consider implementing these emergency measures, and ensuring that systems are in place to keep these under review so that action can be initiated with sufficient lead in time to deliver changes safely.**
- **Assessed the risks and consequences, assuring ourselves that the emergency measures represent an overall reduction in risk to our patients.**
- **Considered the staff, community and wider stakeholder engagement in developing and testing these measures.**

This can be summarised as follows:

Current position *Ensure a detailed understanding of the current position and risks*	⇨ *Continue to take action to reduce risk that tipping points are reached*	**Tipping Point** *Ensure that tipping points are defined and kept under review*	⇨ *Ensure a detailed and tested plan is in place to enact contingency measures safely and swiftly, with clear timescales*	**Contingency measures in place** *Keep contingency measures under review include benefit/impact and triggers for returning to current position*

⇨ **Ongoing engagement with staff, partners, communities and wider stakeholders to review risks and tipping points and develop contingency measures** ⇨

7.1 What situations might constitute a tipping point within an Emergency Department?

A range of factors may constitute a "tipping point" for our emergency departments:

- Irretrievable gaps in staffing that would lead the service to become unsafe (e.g. sustained non-availability of medical staffing)
- Irretrievable failure of estate or infrastructure (e.g. department no longer fit for use)
- Irretrievable failure of essential clinical adjacency (e.g. critical care, diagnostics)

A fortnightly meeting takes place in the Trust to review service continuity for the emergency department and related services in the hospital. This provides an opportunity to review the workforce profile and other issues and risks within the hospital and wider health system.

The next steps will ensure a more systematic approach by:

- Defining potential tipping points in more detail and particularly ensuring that these are defined in a way that enables sufficient lead-in time to enable us to put in place contingency measures – in other words, how do we spot problems sufficiently early that we can take effective action?

Q	**What "tipping points" can you identify that might prompt the need for emergency changes to A&E services in the county? How likely are they to occur? How should these "tipping points" be kept under review? What is the best way to make decisions on whether "tipping points" have been reached and emergency action is needed?**

7.2 What steps are being taken to prevent tipping points being reached?

The main current risk relates to Emergency Department staffing. As outlined in Section 4, substantive medical staffing levels fall below required levels. The Trust continues to seek to mitigate this risk through a range of steps including:

- Continued focus on recruitment of permanent medical staffing
- Continued focus on recruitment of locum medical staffing
- Exploring opportunities for partnership working with other clinical departments (e.g. new models of consultant appointment) and with neighbouring organisations
- Developing extended and advanced workforce roles, such as Advanced Care Practitioners and Emergency Nurse Practitioners

The next steps include:

- Refreshing our workforce profile and establishing a risk assessment linked to the "tipping points" that includes mitigation plans that aim to sustain staffing levels and prevent "tipping points" being reached.

Our primary focus continues to be the management of these risks in order to maintain the current service model pending the agreements to be made through the NHS Future Fit programme.

Q	**What further steps could be taken to attract more permanent and locum staff in the short term (i.e. within the next six to twelve months)? Are there new workforce roles that we are not taking advantage of – if so, what could we do to bring these about quickly? Do you have insights into the likely workforce market that you can share – are there factors that we might not be aware of that could help us to recruit and retain?**

Page 82

7.3 If a tipping point was reached, what scenarios could be considered?

A range of scenarios could be considered if a tipping point was reached, which are set out below.

These have been considered at a high level and will continue to be reviewed based on our emerging understanding of (a) the "tipping points" and (b) the workforce profile and risks.

The main criteria for initial assessment of these scenarios include:

- Sufficiency and risk – the degree to which the scenario sufficiently address the service risks and to which it creates new risks
- Quality – impact on patient experience, patient safety and clinical outcomes (including the impact of access on these factors)
- Feasibility and deliverability – the ease and speed of implementation, impact on other services and sectors
- Cost – the direct costs of implementing any changes (revenue, capital) and opportunity costs (e.g. impact of things we are no longer able to do)
- Impact – the wider impact on other services and pathways

	Site 1	Site 2	Description	Assessment	Priority
A	Close	Close	All A&E services in the county's hospitals would close. Establish 24-hour pathways from both Sites to neighbouring hospitals.	This would have a significant impact and this option is not required as other scenarios could be achieved safely and effectively.	Discounted
B	24-hour	Close	Establish 24-hour pathways from Site 2 to Site 1 (or to other neighbouring hospitals if required). Walk-In Centre (if Site 2 is PRH) or Urgent Care Centre (if Site 2 is RSH) continues.	Full closure of A&E at one site can be avoided as other scenarios are achievable. Neither of the current sites would have the capacity to accommodate consolidated 24-hour A&E activity from both sites without significant capital development.	Discounted
C	Daytime	Daytime	Establish overnight pathways to neighbouring hospitals.	This option is not required as overnight services can be maintained in the county.	Discounted
D	24-hour	Daytime	Establish overnight pathways from Site 2 to Site 1.	This scenario is feasible and should be assessed further.	Priority 1

E	24-hour	Daytime A&E service with GP / OOH-led service overnight	Establish overnight pathways from Site 2 to Site 1. Develop GP-led service overnight in Site 2.	This scenario would require strengthening of speciality support (e.g. acute medicine which is also a challenged specialty) to the GP-led service. It also relies on 24-7 GP cover (there are significant GP workforce challenges nationally and locally), and may lead to a misperception that A&E remains open overnight.	Priority 2
F	Single Emergency Centre	Urgent Care Centre	Accelerate the proposed NHS Future Fit Clinical Model to establish a Single Emergency Centre on one site.	This prejudges the decisions to be made through the NHS Future Fit programme. It could also not be achieved quickly as a business continuity measure due to the significant changes needed in critical care and bed capacity, and in wider hospital services.	Priority 3
G	24-hour	24-hour	Maintain both departments 24 hours a day.	If the "tipping point" had been reached then, by definition, we have reached a point where it is no longer possible to maintain both A&E departments 24-hours a day	*
	* It remains our goal to sustain the current service model until the future vision is agreed through NHS Future Fit. However, the risks and challenges are real and the service continuity scenarios listed above do require active consideration and planning in the event that they need to be implemented.				

Our current assessment is that Scenario D is the most feasible contingency scenario.

It is important to note that no scenario is simple to implement. Contingency action would only be taken where it was clear that the current risks could not be managed and tipping points had been reached beyond which the current service model could not be retained.

Key considerations in the further development of Scenario D would include:

- The potential for other hospital admissions to remain open even if A&E is closed (e.g. direct medical or surgical admissions)
- Options for creating the additional ward, theatre and wider clinical capacity required at the "overnight site", for example through linked service moves
- Clinical and pathway relationships with other services on each of the hospital sites such as Women and Children's Centre, Trauma Unit, Acute Surgery etc.
- Impact on wider hospital services, both clinical and non-clinical (e.g. pharmacy, phlebotomy, facilities etc.)

- Impact on wider services beyond the hospital, such as ambulance services primary care OOH services, Urgent Care Centre / Walk-In Centre etc.
- Understanding the potential impact on patient behaviour and choice of service.

The next steps include:

- Assessing Scenario D in more detail, including at a stakeholder workshop in December where the pros and cons of overnight closure of (a) PRH and (b) RSH will be reviewed and more detailed contingency measures developed. These contingency measures will need to be tested further to consider the impact on quality (experience, safety and outcomes including access), the feasibility and deliverability, the cost of implementation and the wider impact.
- Continuing to review potential scenarios, drawing on the views of our staff, communities and other stakeholders.

Q	**Are there other scenarios that we could consider? What are they and how feasible are they? What are their "pros and cons" against the criteria listed above? Are there other significant criteria that should be considered as part of this assessment?**

8. Next Steps

The next steps will include:

December 2015	Stakeholder workshop arranged for mid December: • Consider Scenario D in more detail, and specifically to consider the relative pros and cons of overnight closure of (a) PRH and (b) RSH taking account of factors such as: quality (experience, safety and outcomes including access), feasibility and deliverability; cost of implementation; and, wider impact. • Desktop exercise to develop outline implementation options. Continue work to develop agreed "Tipping Points" – need to ensure these are defined in such a way that a decision to implement contingency measures is taken in sufficient time to enable those contingency measures to be put in place. Continue to update workforce profile and risk assessment, maintaining actions that will reduce the likelihood that a "Tipping Point" is reached.
January/ February 2016	Further stakeholder workshop to: • Review and agree "Tipping Points" • Undertake desktop exercise to test contingency measures and identify further actions to support service continuity Develop Quality Impact Assessment for review by Quality and Safety Committee on behalf of the Trust Board. Ensure communication plan is in place that can be implemented if "Tipping Points" are reached to inform patients and communities across Shropshire, Telford & Wrekin and mid Wales of the contingency measures being enacted.
February to April 2016	"Tipping Points" and contingency measures agreed by Hospital Executive Committee. Keep "Tipping Points" and contingency measures under executive review on an ongoing basis (at least fortnightly, and by exception if required). Progress and exception reports to Trust Board via Hospital Executive Committee and executive members. Consider "live" test exercise to ensure that contingency measures and their wider impact is understood more deeply.
April/May 2016	Quarterly stakeholder workshop to review "Tipping Points" and contingency measures, and recommend updates based on changing context and environment.
Ongoing	Publish monthly stakeholder bulletin providing an update on service continuity planning. Continue to seek staff, community and wider stakeholder feedback to inform and refine service continuity plans.

Key outputs will include:

- Defined trigger points
- Service continuity plan
- Quality Impact Assessment
- Communications Plan

Sharing Your Views

Comment is invited on this document on an ongoing basis via the email address or postal address below. We are particularly grateful for your feedback on the questions in Section 7 of this report.

Please also check for the latest updates which will be available from our website at www.sath.nhs.uk/bcp (please note that this page will be published by 10 December 2015).

We welcome your feedback and input to help us ensure that patients and communities across Shropshire, Telford & Wrekin and mid Wales continue to receive the highest standards of urgent and emergency care that increase survival rates, improve quality by reducing disability and shortening recovery times, and improve patient experience.

Contact details for feedback:

- In writing to the Chief Operating Officer at the addresses at the bottom of the page.

- By email to consultation@sath.nhs.uk

The Shrewsbury and Telford Hospital NHS Trust

Princess Royal Hospital
Apley Castle
Telford
TF1 6TF

Royal Shrewsbury Hospital
Mytton Oak Road
Shrewsbury
SY3 8XQ

www.sath.nhs.uk

This page is intentionally left blank