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

Updated Reports Attached

Date: 23 February 2016

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Wednesday, 2 March 2016**
Time: **1.00 pm**
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
Heather Kidd	Rob Sloan
David Beechey (Co-optee)	Rajash Mehta (Co-optee)
Ian Hulme (Co-opted)	Barry Parnaby (Co-optee)
Mandy Thorn (Co-optee)	Dag Saunders (Co-optee)

Your Committee Officer is:

Amanda Holyoak Scrutiny Committee Officer
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AGENDA

1 Apologies for Absence

2 Disclosable Pecuniary Interests

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

3 Minutes (Pages 1 - 10)

The minutes of the meeting held on 5 February 2016 are attached for confirmation.

4 Future Fit and Community Fit (Pages 11 - 26)

To receive an update on progress since the Joint HOSC meeting on 15 December 2015 and any decisions made by the Programme Board, or CCG Boards. Report TO FOLLOW marked: 4

5 Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services (Pages 27 - 56)

To receive an update from Shropshire and Telford Hospital NHS Trust on progress against the timetable and actions which were presented to the 15 December 2015 Joint HOSC meeting. Report attached marked: 5 *and further information will follow.*

6 Winter Pressures and Hospital Discharge (Pages 57 - 98)

To receive a report on performance since the 15 December 2015 Joint HOSC meeting. Report attached marked: 6, *further information will follow.*

7 Deficit Reduction Plan for the Local Health Economy (Pages 99 - 154)

To consider progress made since the 15 December 2015 Joint HOSC meeting on reducing the local NHS budget deficit. Report attached marked: 7 (*and further information to follow)*

8 Chairs' Updates

To receive verbal updates from the Joint Health Scrutiny Chairs on progress since the previous meeting and any issues arising

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 Friday 5 February 2016 at Addenbrooke House, Telford at 1.30pm

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 R Mehta (TWC Co-optee), Mr B Parnaby (TWC Co-optee), Mr D Saunders (TWC Co-optee) and Cllr R Sloan (TWC)

Also Present –

F Beck (Executive Lead – Commissioning, Telford & Wrekin CCG)
F Bottrill (Scrutiny Group Specialist, TWC)
D Evans (Accountable Officer, Telford & Wrekin CCG)
A Hammond (Deputy Executive, Telford & Wrekin CCG)
A Holyoak (Committee Officer, Shropshire Council)
L Noakes (Director of Public Health, Telford & Wrekin Council)
T Parker (Communications & Engagement Lead, Midlands & Lancashire Commissioning Support Unit)
A Smith (Executive Lead Governance & Performance, Telford & Wrekin CCG)
P Smith (Democratic Services Team Leader, TWC)
R Thomson (Director of Public Health, Shropshire Council)
S Wright (Chief Executive, SaTH)

JHOSC-1 APOLOGIES FOR ABSENCE

Apologies were received from Cllr T Huffer (SC), Mr I Hulme (SC 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 15 December 2015 be confirmed as a correct record and signed by the Chairman.

JHOSC-4 CHILDREN and ADOLESCENT MENTAL HEALTH SERVICE

Further to the report to the last meeting, Anna Hammond (as the Senior Responsible Officer for the Project) and Tamsin Parker (Project Communication Lead) provided an update to the Committee on the project to

design a new 0-25 Emotional Health and Wellbeing Service. Midlands and Lancashire Commissioning Support Unit had been engaged to develop and implement the Communication and Engagement Strategy for the service re-design. As agreed at the last meeting, the Joint Chairs had met with AH to look at the draft Strategy. There was a tight timetable for the project, with the aim of completing the initial outreach and consultation work by 17 March 2016 prior to a market testing exercise. The current provider was aware of the intentions, and a contract termination notice would be served at the end of March. The new contract would begin on 1 April 2017. The finalised Communication and Engagement Strategy was attached to the agenda for Committee endorsement and sign-off.

The Communication and Engagement Strategy outlined the main stakeholders, key messages and frequently asked questions. The Strategy would be adopting an "Experience Led Commissioning (ELC)" approach to help develop an outcomes based specification which reflected the outcomes most valued by children, young people and their families. A team of people would be interviewing service users and their families/carers, as well as meetings/visits to local support groups and children's homes. The team was working with the two local authorities to identify and target any 'difficult to reach' groups or individuals. ELC also had access to a database held by Oxford University which collated feedback from similar exercises and research across the country. In addition, there would be general engagement work with stakeholders and use of social media to raise awareness of the consultation. There would be a pre-market provider engagement event on 19 March 2016 to be attended by children and young people, professionals and potential bidders for the new service, at which the outcomes would be finalised.

The Committee then asked a number of questions regarding the Communication and Engagement Strategy:

Would the Youth Offending Service and Youth Justice Panel be consulted?
AH stated that they would look at these areas, but that they might need to look at other pieces of work linked to young offenders. Mental health services for the Youth Offending Service were procured separately by NHS England.

The House of Commons Select Committee report on Children's Mental Health was due soon. During the evidence sessions Ministers had indicated that there would be changes to the service – was there going to be anything coming out of that which might impact on the service re-design?
AH stated that she was not specifically aware of that report, but there were a lot of things happening nationally and some flexibility had been built into the timetable in order to be able to respond to any national developments.

The Chair suggested that possible changes to national requirements could be added to the risk outlined in the report.

Healthwatch had been carrying out a survey with children and young people, which might provide information relevant to the Strategy.

TP reported that they might be working with Healthwatch on an analysis of their survey results.

How would children and young people be able to feed back their views?
TP stated that they were initially focussing on the targeted engagement work, as referred to earlier. However, there would also be opportunities for young people to provide general feedback at drop-in events or through surveys etc

Within the new service, would there be help available in schools for children affected by mental health problems – particularly in smaller primary schools that did not have the capacity to provide specialist support?
AH reported that this would be part of the service specification. However, they had already secured some money to take this forward and were already starting to work with schools. The Severn Alliance group of schools was involved in the consultation and the CCG would also work with Headteachers. The new service would recognise the role of universal workers.

How would parents' expectations for the new service be managed?
AH explained that part of the consultation and engagement exercise was to ask parents what worked best for them. Parents often didn't know where to find out information about these services, and part of the work would be around guiding them to the right access points to the service.

It was suggested that ELC could work with 'Fresh' – an organisation that represented people within the nine protected characteristic groups.

The Committee was pleased with the report and the approach set out in the final Communication and Engagement Strategy to focus on the outcomes that were valued by children, young people and their families. However, there was a need to ensure that expectations were managed. He also added that, as there would be an emphasis on universal workers, it would be important to monitor where there were particularly high or low numbers of referrals from specific organisations – as this might indicate if there were problems.

The Chair stated that the JHOSC would wish to scrutinise the service specification for the new contract, as it was likely to represent a substantial variation in service. TP advised that the development of the specification would probably be around mid-April 2016.

RESOLVED – that the Communication and Engagement Strategy for the development of the new 0-25 Emotional Health & Wellbeing Service be endorsed.

JHOSC-5 111/OUT OF HOURS SERVICE

The Chair expressed frustration that the Committee had only received the Engagement and Equality Analysis Report a short time before the meeting, which made it difficult for proper scrutiny to be carried out. He reminded

Members that this exercise was about the service, not specific providers, and that the Committee needed to examine the options for moving forward so that current satisfaction levels were continued and enhanced.

Alison Smith and Fran Beck from Telford & Wrekin Clinical Commissioning Group presented an update on the procurement of 111/Out of Hours services for Telford & Wrekin and Shropshire.

AS explained that since the last JHOSC meeting when the Engagement Plan was supported, the CCGs had undertaken an extensive engagement programme to seek views and comments on both the current service and on preferences for the future delivery of the service and how it was accessed. Due to consent issues, it had been difficult to engage directly with recent service users from protected characteristic groups. However, they had been encouraged to respond to the online survey. Both Healthwatch groups supported the engagement activities through promoting the survey and listening events. The engagement period ended on 22 January, so there had not been much time to analyse the results and produce a report.

AS then provided a summary of the engagement feedback and response to the four questions that had been at the heart of the engagement exercise:

- Understanding and knowledge of the NHS 111 service and its functions.
While the questionnaire survey indicated a high level awareness of the existence of NHS 111, there was a varied level of awareness amongst protected characteristic groups and a general lack of clarity on the function of the service.
- Understanding and knowledge of the Out of Hours (OOH) Service and its function.
The levels of awareness of OOH were similar in the questionnaire responses to that for NHS 111, but feedback from other sources (eg the older population) indicated that there was a greater degree of knowledge of the OOH GP service.
- Experiences of accessing these services and opinions on possible improvements.
In relation to NHS 111, there were a number of messages for commissioners in terms of low levels of trust and satisfaction reported by those who had used the service. In relation to OOH, 94% of respondents who had used OOH stated that they were satisfied with the service they had received. There were strong opinions in favour of maintaining a separate OOH service, with particular value placed on the skills/local knowledge of the call handler. Both services could be improved if response times were better, and for NHS 111 there were views that the volume and relevancy of questions asked by call handlers should be reviewed. Having access to appropriate patient records was also deemed important for dealing with individuals with complex health needs.
- Preferences on potential change in phone number as a result of integration of services.

There were a number of different views expressed, but with a majority of survey respondents being against the use of NHS 111 as the single telephone number to access urgent care services.

FB then explained the national model for accessing urgent care services. Providing NHS 111 for the whole population was a "must do" for CCGs, and it must be functionally integrated with (at least) Out of Hours Services. In other parts of the country the NHS 111 service was working well where it had become embedded or joined-up with other services. Locally, the current model was relatively complex and involved some duplication. In order to meet national standards, the CCGs would like to move to a model that would merge some of these functions and to make it a simpler process – eg: a call made to the 111 number could not be transferred directly to the OOH service. The preferred model was to have a 111/Regional clinical hub (which would provide specialities such as dentistry), a Local clinical hub, and then the different pathways to accessing urgent care. For this to work there would need to be integrated processes for call handling and initial assessment, telephone clinical advice and face-to-face treatment services. This model would also dovetail with the Future Fit vision, and there might be the opportunity to streamline with other services. However, there would be challenges in bringing about these changes immediately.

Both CCG Boards would be meeting on 10 February to consider the feedback from the engagement exercise and to look at options for how to ensure NHS 111 and OOH services met the commissioning standards for integrated urgent care. The procurement of the NHS 111 service would proceed along the regional timescales, so this would start in October 2016. The four options for the procurement of the OOH service were that:

1) it should run to the same timetable as the 111 service
2) it should start in April 2017;
3) it should start in April 2018;
4) it should start in April 2019.

Under options 2, 3 and 4, the current OOH provider would continue to provide the OOH service until the procurement process was completed. During this period the OOH number would change to 111.

David Evans, Accountable Officer – Telford & Wrekin CCG, advised that the preferred option would be for a new fully integrated service to commence in April 2018, which would give time for further work on the model and for procurement of the new service. In the interim, it was proposed that the current OOH contract with Shropdoc be extended for a further two years to March 2018.

Members of the JHOSC then expressed views on, and asked a number of questions about the future provision of the NHS 111 and OOH services:

Would there still be separate numbers for NHS 111 and Shropdoc OOH service up until April 2018?

FB stated that if the current OOH provider's contract was extended by two years, there would be a process (with appropriate publicity campaign etc) to move towards a single number.

Would the specification for the new regional NHS 111 contract include provision for the OOH service, and how far could local needs be incorporated into a regional structure/solution?
FB confirmed that it would, but that there needed to be a balance between getting functional integration and not being too overly prescriptive on the solution. So there would be some flexibility on how the integrated service would be structured and provided. But ultimately, they did not want a disjointed service, and this would be reflected in the specification.

There were risks in moving to a single number for urgent care, and it was important that any solution/option needed to link to the Future Fit programme and what came out of that.
FB advised that they would be working with the Shrewsbury & Telford Hospital Trust and others in order to get an effective multi-disciplinary approach to joining up urgent care services and a systems-based solution. This exercise was not about saving money, but in finding a simpler and more effective model.

Would a possible two year delay in meeting the commissioning standards for integrated urgent care be acceptable to NHS England?
DE stated that as long as they could demonstrate that Shropdoc could work with the new regional NHS 111 provider, then the proposed contract extension for the current OOH provider should be acceptable to NHS England. There was a strong case for allowing sufficient time for the OOH service to be properly integrated with other urgent care services and the Future Fit outcomes.

It was important that the introduction of a single contact number was properly handled and that people were fully aware of the situation.

DE agreed that there needed to be a smooth transition. There would probably be a move towards the 111 number (with national advertising and other publicity) and so within six months the Shropdoc number would probably be shut off. FB added that if the model worked as envisaged, the number became less important.

How would it work in practice for the 111/OOH service to have access to patient records? Who would be responsible for putting that information on the system?

DE advised that currently Shropdoc could look at doctors' notes and the hospitals could access a patient summary record. So things were further forward than they were, but additional work would need to be done with the NHS 111 provider and others. It was proposed there would be "flags" in the system to identify those patients with complex needs, end of life patients etc

In terms of the location of call handlers, it would help if the 111 and OOH services were in the same place or there was some kind of joint contact/working. It was important that the current high satisfaction levels with the current OOH provider were not lost, and that once the decision had been made by the CCGs it should be communicated to the public.
DE stated that the value that people placed on a locally provided service was recognised. However, it also needed to be recognised that the current system was not perfect and sometimes led to increased pressure on hospital services. The OOH service had not been tendered for in the past 20 years and, irrespective of the 111 service, it needed to be tested against the market in terms of best value for public money.

Would the service provided by 111 be able to respond appropriately to children who were ill and whose condition could deteriorate very quickly?
DE referred to criticism of the 111 service in one area of the country as a result of the death of a child. He had not read the report, but from media coverage of the case it appeared that there were a number of stages at which there were different options during the episode of care, and it was not just the final conversation. He also highlighted the issue that it was important to help all clinicians to better identify sepsis.

Having received the presentation and heard the answers to questions, the Committee were supportive of the preferred option 3 for a delay until April 2018 in the introduction of a fully integrated 111/OOH urgent care service for the reasons outlined, and for the extension of the contract for the current OOH provider in the interim. The support of the Committee was subject to the following points:

- patient safety is the priority and that the high quality of the OOH service should be maintained;
- the procurement of the OOH service should take into account the development of the Community Fit Programme and the Rural Urgent Care Centres;
- the OOH call handlers should continue to be co-located with the OOH clinicians until the procurement process is completed. It is on this basis that the Committee recognise that this is not a substantial variation in service;
- further information being provided on how the integration of the 111 and OOH services would be specified in the contracts at key stages in this process.

RESOLVED – that Option 3 be supported and recommended to the CCG Boards, subject to the points set out above.

JHOSC-6 DEFICIT REDUCTION PLAN FOR THE LOCAL HEALTH ECONOMY

The Chair stated that the update report from the SaTH Finance Director attached to the agenda had intended to be an information only item. But as the SaTH Chief Executive and the Accountable Officer - Telford & Wrekin CCG were present, there was an opportunity for the Committee to ask any questions.

The report explained that Pricewaterhouse Coopers (PWC) had been commissioned to work with local health organisations to provide an independent assessment of the scale of the financial challenge that needed to be addressed. PWC would be consolidating each of the medium term financial plans of the four provider organisations working within the Local Health Economy (LHE) and the two Clinical Commissioning Groups into a single LHE Income and Expenditure account. This would then allow review and challenge of the assumptions underpinning these plans to ensure there was a consistent and coherent financial plan across all parties. This process would include engagement with Shropshire and Telford & Wrekin Councils to consider the challenges also facing social care. The ultimate outcome of this work would be a LHE income and expenditure account to 2020/21 that provided a consolidated assessment of the financial deficit to be addressed.

This approach would also support the local health system in fulfilling the requirements of the new NHS Shared Planning Guidance which expected NHS organisations to work together within localities to create a 5 year Sustainability and Transformation Plan.

In terms of timescales, a first assessment of the scale of the challenge was expected to be available by mid-February 2016, with the work completed in early March. An interim update would be provided at the next JHOSC meeting.

Would this work affect the timescales for the Future Fit programme?
SW advised that there was no slippage in the timelines for Future Fit, and it was still expected to reach a decision on the preferred option in the early summer. The work on the capital expenditure elements was being refined within the agreed project timetable.

Would hospital services still be resilient until Future Fit was resolved?
SW stated that he believed urgent care services were more resilient now than they had been for a couple of years, partly due to an additional A&E consultant and two other intensive care workers. But it was accepted that key staffing levels were still below where they needed to be.

What was the current position on nursing levels?
SW stated that they continued to be compliant on staffing levels, and 54 nurses had recently been recruited from overseas. But this continued to be a national issue.

Was there confidence that PWC would be able to complete their work within the timescales referred to in the update report?
SW stated that he believed the work would be completed on time. But after that, there would be a lot more detailed work to be carried out.

The meeting closed at 3.15 pm.

Chairman……

Date……

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Post Board Update Report

February 2016

The purpose of this report is to provide Sponsors and Stakeholders with a brief update on recent Programme progress and to summarise the activities in the next phase.

1 PROGRAMME DIRECTOR

Following Mike Sharon's appointment as Director of Strategy at the Royal Wolverhampton Hospital NHS Trust, as reported to the last Board meeting, Debbie Vogler has been appointed to fulfil this role going forward.

Debbie will provide continuity for the programme having been involved from the outset in her role as Director of Business and Enterprise at The Shrewsbury and Telford Hospital NHS Trust. Her appointment to the Programme Director role is on a secondment basis for two years and she will report to the joint Senior Responsible Owners for the NHS Future Fit Programme.

To have Debbie with her considerable skills and experience of 38 years in the NHS, and a decade of experience locally, is a huge bonus in this next critical phase of the NHS Future Fit programme.

2 PROGRAMME TIMELINE

In November 2015, we set out a new ambition to have identified a preferred option for acute services during Summer 2016, to move towards formal Public Consultation from end 2016 and to reach a final decision in Summer 2017. Progress continues to be made in line with this ambition.

The indicative critical path in Appendix One sets out a view of deadline dates by which key pieces of work must be completed in order to deliver our ambition. In addition to the work within the control of the programme, it will also be dependent on a range of external approval processes which may affect the timetable.

At the December Board meeting it was noted that 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.

Progress with these interdependencies and with other key programme workstreams is summarised below.

3 DEFICIT REDUCTION PLAN

This work commenced last year with a full day workshop for the Chief Officers and Finance Directors of all local NHS organisations. The day produced an initial view of the scale of the local financial challenge and a set of ideas for how that challenge could be addressed.

To further develop that work, expert external support has been commissioned from PwC under the leadership of Neil Nisbet, Director of Finance at SaTH. An initial high level plan has been drafted and was reviewed by the Finance Workstream in early February and, subsequently, by the Programme Board. This projects the scale of the health economy deficit going forward and sets out how a sustainable position could be reached. Local work on the projected deficit is now being validated by external consultants PwC.

The initial local plan will then be more fully developed by May, within the remit of the Sustainability and Transformation Plan.

4 SUSTAINABILITY AND TRANSFORMATION PLAN

All English health economies are required to produce a Sustainability and Transformation Plan (STP). The STP will be the vehicle through which local partners create a shared and ambitious blueprint for accelerating implementation of the *Forward View*. STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016.

It has been agreed locally that the 'transformation footprint' should be the area covered by Shropshire and Telford & Wrekin CCGs, and a Partnership Board has been formed involving all NHS organisations providing services in the area as well as both Local Authorities.

The Future Fit Board has agreed a variation to governance arrangements to ensure the alignment of plans and to avoid duplication (see Appendix Two). Martin Whittle has been appointed to coordinate this work

5 STRATEGIC OUTLINE CASE - SUSTAINABLE SERVICES PROJECT

SaTH is nearing completion of a revised SOC. This will reflect the brief it was given by the Programme Board in October of setting how it could address its most pressing clinical workforce challenges.

Once that work is completed the Programme will be able to set out a detailed plan leading to public consultation and a final decision.

6 RURAL URGENT CARE

Work remains on track for high-level proposals to be defined by end March.

Work with providers has enabled the collation of a lot of data on current activity. Working from the 'home is normal' principle set out in the Clinical Model, this work will confirm the services that patients can currently access across the county and it also aims to suggest potential enhancements to local services. This could include local diagnostics (e.g. point of care testing and X-ray) as well as greater consistency of minor injury services locally. Locality workshops will be held in early March.

This work has been characterised by very helpful collaboration between providers; an example of this is the work being done to map urgent care practitioner competencies. The workforce workstream is co-ordination an approach that will work towards the consistent adoption of an urgent care practitioner career ladder, underpinned by a common competency framework, to be consistently applied across the county.

7 COMMUNITY FIT

Following the initial collation of data from across health and care providers, the first data specific workshops have been held to discuss mental health, social care and community health data. These have been well attended and characterised by full engagement from across health and social care providers, as well as patient groups. A few gaps have been identified, as well as some data quality issues, and these are currently being resolved jointly with providers.

A second round of meetings in early March will preview the linked data sets. Primary care data will not be included in phase one output and we are agreeing a proxy measure for this. Significant progress has been made with the primary care data and we are working with the Board of the GP Federation - aiming to get an at scale extract of data from GP practices to support a future phase of work.

Work with the Private, Independent and Voluntary sectors is continuing and the existing and potential contribution from these important groups will form part of the output of phase one. The work remains on track to have a final output from phase one at the end of March. Further phases will be outlined before that time.

8 CLINICAL DESIGN

The Clinical Leaders' group has continued to meet to ensure the development of plans in line with the Clinical Model.

It has recently published a blog summarising key evidence in relation to the impact of patient travel times.

It is currently planning a further meeting of the wider Clinical Reference Group in April to review and inform emerging proposals.

9 WORKFORCE

At the last Board meeting, the workstream presented a wider view of the workforce challenges across the health and social care economy.

The workstream has since held a workshop to explore what a whole-system workforce plan might look like and how it could be developed. That work is now underway. As well as supporting Future Fit proposals it will also be a key enabler of the STP.

The workstream is also supporting the review of urgent care competencies.

10 ENGAGEMENT AND COMMUNICATIONS

The Communications and Engagement team are striving to ensure that our stakeholders and public are reassured that the programme is progressing forward and remains on focus.

Campaigns underway include a series of engagement pop up events in local centres and community hospitals, with people invited to give their views and comments on the clinical model, shortlisted options, their health concerns as well as ask questions. The recent Radio Shropshire 'hot seat' programme also supported the aim of keeping NHS Future Fit in the public domain and allowed listeners the opportunity to ask questions on key hot topics, including the wider CCG pressures.

As part of the ongoing equalities outreach work, an initial report has been received of outcomes of work with traditionally 'hard to reach' groups. The team is exploring ways to expand on this useful piece of work, reaching more localities and approaching a wider range of these groups. Engagement work also continues with a series of conversations/ presentations with stakeholders and community groups, with recent updates to the Telford & Wrekin Parish Council Forum and further meetings planned in with Members in Powys and in Shropshire, Local Joint Committees, community groups, Patient groups and GP surgeries.

In the coming weeks the promotion and delivery of a number of 'pop up' stands will continue. In addition, a high-level workshop is being delivered to confirm the key messages

going forward over the next few months and further ahead as the programme continues to develop.

11 FINAL DECISION MAKING

In order to agree the process which leads to a final decision being reached by commissioners next Summer, a workshop for members of both CCG Boards will be held in the next two months in advance of the identification of a preferred option.

12 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.

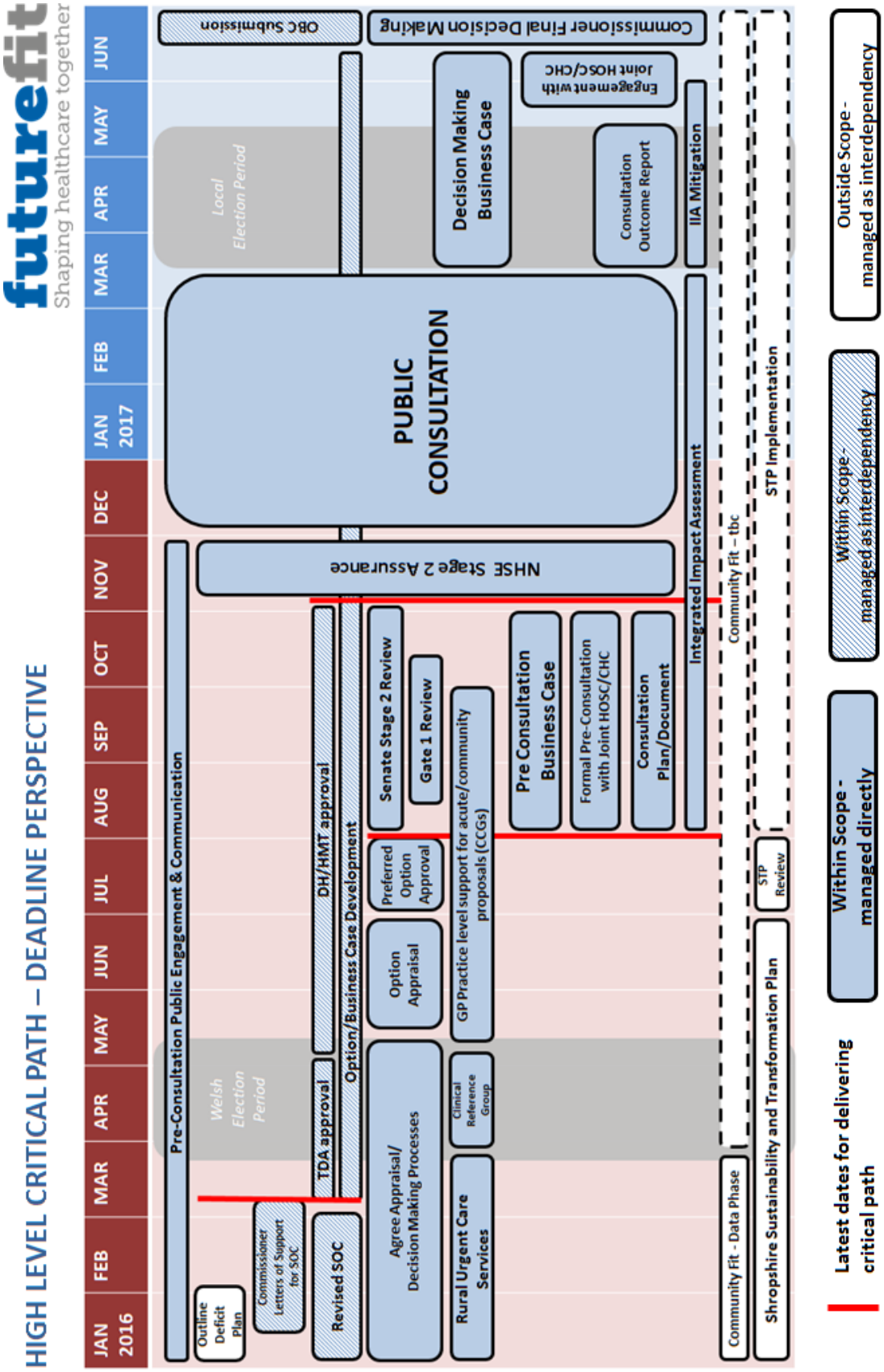
The Board has previously agreed that all red-rated risks (both pre- and post-mitigation) should be reported to it. The current list of red-rated risks is attached to this report (see Appendix Three).

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.

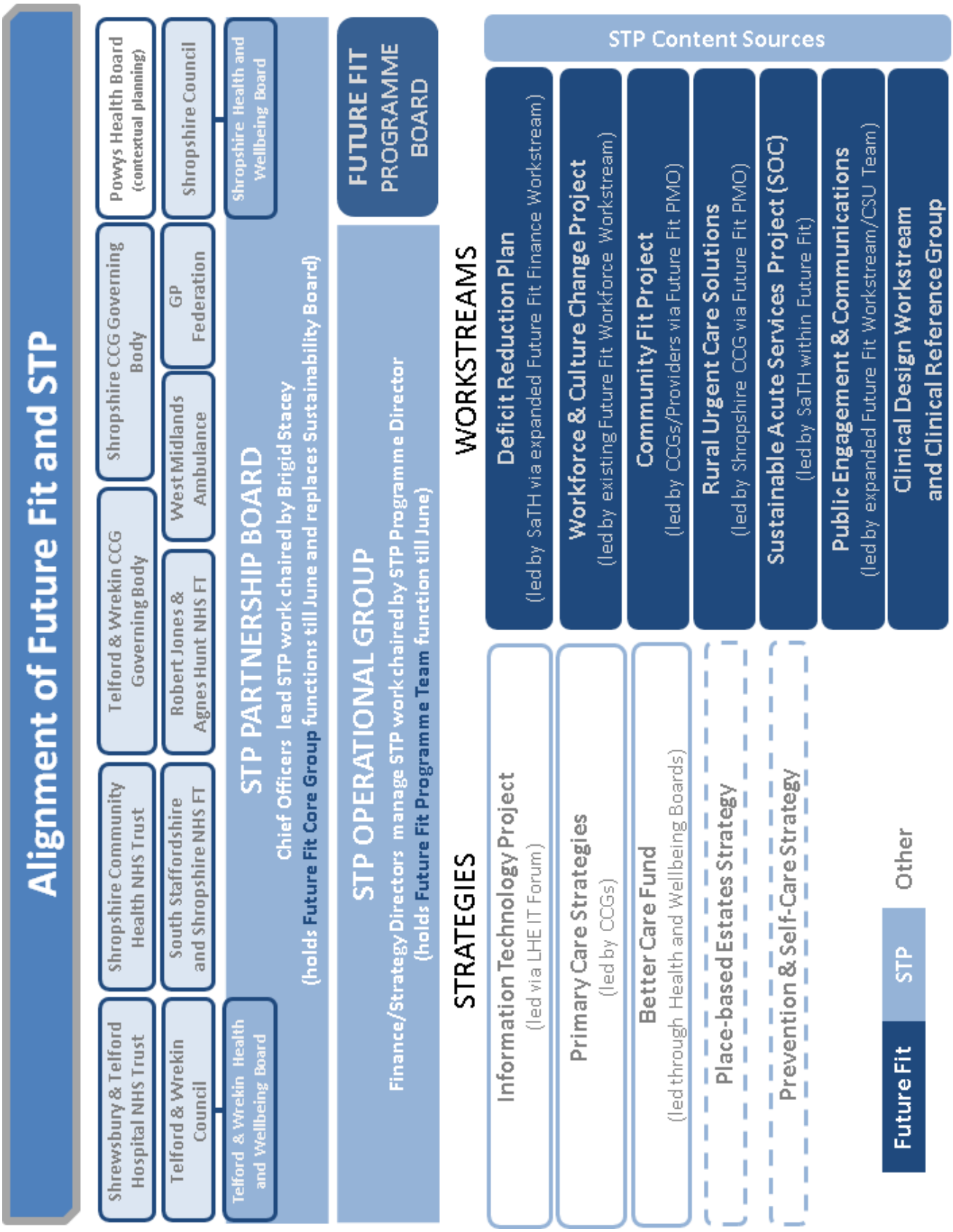
David Evans & Brigid Stacey

Senior Responsible Officers

APPENDIX ONE – 'DEADLINE' CRITICAL PATH



APPENDIX TWO – RATIONALISING GOVERNANCE STRUCTURES



APPENDIX THREE – RED RATED RISKS

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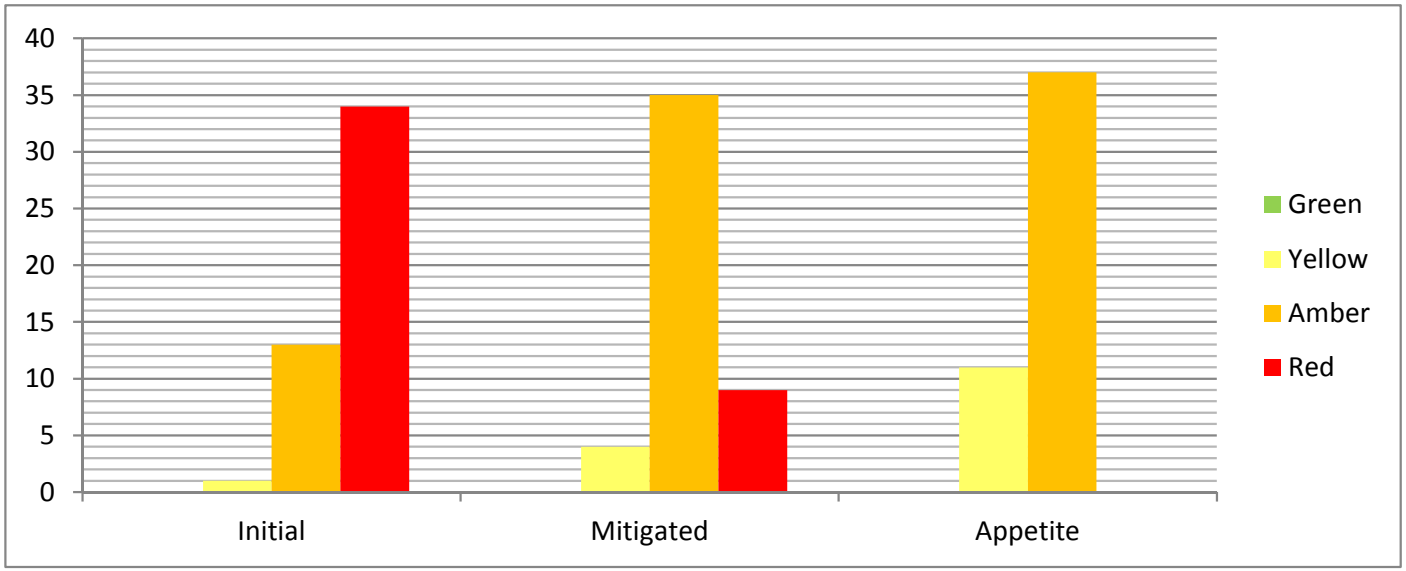
PROGRAMME RISK REGISTER

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	11
Amber	13	35	37
Red	34	9	0
Totals	**48**	**48**	**48**

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	10/02/2016	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**	Frequency and scope of meetings to be reviewed to reflect needs of STP work until June 2016.	4	2	**8**
2	27/03/2014	28/01/2016	Y	CD WF	**Clinical Engagement**	Inadequate clinical engagement leads to lack of support for clinical model	MI	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 in April to consider latest work on acute SOC, rural urgent care and Community Fit.	5	1	**5**
4	27/03/2014	16/01/2028	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 & communications strategy and plans developed and being implemented. Ongoing support from Consultation Institute. Activity log to be shared every quarter with work stream 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 work stream and PtHB E&C leads have met and agreed plan of action including tactics to clarify FF Powys engagement plans. E&C work stream 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 WF	**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	Capacity to be reviewed once requirement of STP work known.	5	2	10
19	24/11/2014	04/08/2015	Y	EC WF	**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 work stream.	4	3	12	No further action proposed.	4	3	12
21	30/10/2014	28/01/2016	Y		**Approval Requirements**	Lack of clarity about the nature and alignment of external approval processes prevents agreement of a robust timetable.	DV	4	5	20	NHSE/TDA proactively engaged re: approval process requirements and interrelationships. NHSE/TDA confirmed reasonableness of revised timeline. New guidance noted.	4	2	8	No further action required.	4	2	8
23	27/03/2014	28/01/2016	Y	AS	**Stakeholder Strategies**	Development of stakeholder strategies and plans constrains or conflicts with the Programme	SROs	4	4	16	Programme to inform development of whole system Sustainability and Transformation Plan, and ensure alignment.	4	2	8	No further action proposed.	4	2	8
24	29/05/2014	28/01/2016	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 plans. Deficit reduction work initiated by programme.	4	3	12	CCG Boards to reconsider SOC activity implications in March (in light of high level deficit reduction plan). Ensure alignment between programme proposals and development of STP.	4	2	8
25	27/03/2014	28/01/2016	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	Regular briefings of key stakeholders to continue. New phase of engagement to focus on clarifying urgent care offer and clinical model.	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	17/12/2015	Y	WF	**Interim A&E Plans (SaTH Risk Register)**	Insufficient consultant capacity in Emergency Department which adversely affects patients safety and patient flow.	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.	5	1	**5**
27	04/08/2015	17/12/2015	Y	WF	**Non compliance with Critical Care Standards for Intensivist Cover within ITU (SaTH Risk Register)**	Non compliance with Critical Care Standards for Intensivist Cover within ITU: 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**	Recruit to the 4WTE at PRH and 2 WTE at RSH substantive vacancies and additional 3 WTE at PRH and 1 additional WTE at RSH new posts.	5	1	**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
28	27/03/2014	28/01/2016	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	10/02/2016	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 work stream. 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. STP will have coordinating oversight of all programmes.	4	2	**8**
30	26/02/2015	28/01/2016	Y	EC	**Urgent Care Offer**	Inability to adequately define urgent care offer leads to lack of support for single Emergency Centre.	DV	4	4	**16**	Workshops held and initial report completed in September. Additional workshop held re: urban UCCs. Process in place for engaging localities in defining rural urgent care offer by end March.	4	3	**12**	Locality proposals to be finalised. Key public messages to support understanding of urgent care system.	4	2	**8**
31	23/02/2015	28/01/2016	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. Updates reports provided at Board.	4	3	**12**	Plans for next stage of Community Fit work to be established via STP process.	4	2	**8**
32	23/03/2015	28/01/2016	Y	WF	**Workforce Deliverability**	Difficulties in recruiting in line with workforce plan (including new roles) adversely impacts implementation of programme proposals	VM	4	4	**16**	Workforce work stream 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**	Whole system workforce plan to be developed.	4	2	**8**
33	23/03/2015	28/01/2016	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	VM	4	4	**16**	Workforce work stream 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**
34	27/03/2014	28/01/2016	Y		**Option Appraisal**	The number and/or complexity of shortlisted options identified for appraisal delays the Programme	DV	4	4	**16**	Shortlist of 6 agreed in line with national guidance. Number of options reduced on affordability grounds. Revised SOC exploring different ways of delivering the options.	4	4	**16**	Options to be reviewed in light of work in revised SOC.	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
35	26/02/2015	28/01/2016	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.	4	2	**8**
37	27/03/2014	28/01/2016	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**	Capital requirement to be discussed with NHSE/TDA in light of revised SOC and deficit reduction plan.	4	2	**8**
38	29/05/2014	28/01/2016	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**	Revised SOC to maintain Phase 2 financial implications. Commissioner affordability to be reviewed in light if high level deficit reduction plan and final STP.	5	2	**10**
39	05/11/2015	10/02/2016	Y	FI	**Local Health Economy Deficit**	LHE deficit undermines viability of business cases or other proposals	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**	High level deficit reduction plan to be completed alongside revised SOC. Full sustainability plan to follow in June.	4	3	**12**
41	27/03/2015	28/01/2016	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 work stream to set out requirements and to liaise with Finance work stream on resourcing.	4	3	**12**	Further actions to be defined once workforce plan developed.	4	2	**8**
44	27/03/2014	28/01/2016	Y	FI	**Programme Resources**	Programme resources / staffing inadequate leading to difficulties in running Programme to agreed timelines	SROs	4	4	**16**	Core Programme Budget agreed. Additional requirements for each phase to be identified. Resourcing for 2016/17 to be agreed.	4	3	**12**	Resourcing for 2016/17 to be agreed including completing in-sourcing of PMO function and clarifying CSU support requirements.	4	2	**8**
47	27/03/2014	28/01/2016	Y		**Loss of Key Personnel**	Loss of Sponsor/Programme personnel leads to disruption and/or delay	DV	4	5	**20**	New Chief Officers provided with programme briefings. Close involvement of wider CSU team throughout Programme to ensure ability to provide backup. New programme director involved from outset.	4	3	**12**	Ongoing CSU support to be confirmed.	4	2	**8**
48	27/03/2014	28/01/2016	Y	AS	**NHS Approvals**	Failure to secure necessary NHS approvals at key milestones delays the programme	DV	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. New guidance received and factored in to plans.	4	3	**12**	Programme to continue developing business cases in line with regulator requirements.	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
49	09/03/2015	28/01/2016	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).	DV	4	5	**20**	Programme Plan contains estimated approval periods for DH/HMT. Advice received from NHSE/TDA. Reasonableness of timetable confirmed. Uncertainty around duration of higher approvals is beyond Programme control.	4	3	**12**	Ensure completion of local approvals in line with the timetable.	4	2	**8**
50	09/03/2015	28/01/2016	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 commissioners to agree process. Strategy Unit to arrange Board-to-Board workshop in March for CCG governing bodies.	5	2	**10**

Report to:	Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin, 2 March 2016

Title	Update on "Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services"
Purpose	To update the Joint Health Overview and Scrutiny Committee on work to maintain the safety and effectiveness of emergency department care at The Shrewsbury and Telford Hospital NHS Trust
Author	Adrian Osborne, The Shrewsbury and Telford Hospital NHS Trust
Date	24 February 2016
Previously considered by	The Shrewsbury and Telford Hospital NHS Trust Board, 3 December 2015 Joint Health Overview and Scrutiny Committee, 15 December 2015 Stakeholder Workshop, 15 December 2015

Executive Summary

The work to develop the medium and long term vision for health services in the county continues through the NHS Future Fit programme, with public consultation due later in 2016/17 ahead of a decision on the future shape of the county's hospital services in Spring 2017.

In the meantime, the challenges that prompted the initiation of this work remain, and the scenarios available to The Shrewsbury and Telford Hospital NHS Trust if a tipping point was reached prior to resolution on NHS Future Fit are reducing.

Attention by the Trust and the wider health system remains firmly on preventing tipping points being reached. However, given the ongoing challenges, the Trust published a discussion document "Maintaining Safe, Effective and Dignified Urgent and Emergency Care Services" in December 2015 to encourage discussion and response by communities and partner organisations.

A presentation on this work was made to the meeting of the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin on 15 December 2015, and a stakeholder workshop also took place on 15 December 2015. The slide pack from that event, along with an update published following the workshop, is attached for information.

The Trust has received over 50 letters and emails in response to the discussion document. The main issues included: concern about the potential impact on patients & communities; the importance of effective publicity if changes were implemented; the impact on other care pathways; the importance of not pre-empting the work under way through NHS Future Fit; and, recommendations for sustaining services and preventing tipping points from being reached.

A further stakeholder workshop is taking place on 22 February 2016 and the summary presentation slides for that event are attached. The conclusions of that workshop are currently being written up and will be shared with JHOSC members at or before the meeting on 2 March 2016. A further update will be presented to the meeting of the Trust Board on 31 March 2016 and shared with JHOSC members.

Enclosures:

- Presentation slides from Emergency Department Business Continuity Planning workshop on 15 December 2015
- Output statement from Emergency Department Business Continuity Planning workshop on 15 December 2015
- Summary Presentation slides from Emergency Department Business Continuity Planning workshop on 22 February 2015
- Output statement from Emergency Department Business Continuity Planning workshop on 22 February 2015 (to follow)

The Shrewsbury and Telford Hospital NHS
NHS Trust

Business Continuity within the Emergency Department

Dec 2015

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

December 2015 Stakeholder Workshop

- Welcome
- Background
- The journey so far
- Work to identify "Tipping Points" to enable timely decisions
- Continue to develop workforce profile and risk assessment to prevent tipping points being reached
- Consider potential scenarios

Background

There has been a debate over several decades without resolution about the sustainability of the county's hospital services.

These clinical sustainability challenges – particularly the fragility of emergency care services – are part of the "case for change" for the NHS Future Fit review.

That programme aims to create a long term vision for the county's health services.

But in the meantime these services remain fragile. Whilst we are doing our best to keep them running we have a duty to ensure business continuity plans so that we can act quickly and safely if a tipping point was reached.

- ✓ This is about keeping our patients safe
- ✓ It is about responding if, and only if, a crisis point was reached
- ✓ It is about fulfilling our obligations to our communities to respond safely and promptly if this happened

- ✘ This isn't part of our winter plan
- ✘ It is not something we *want* to implement – particularly ahead of the decisions to be made through NHS Future Fit
- ✘ But we may *need* to implement if a tipping point was reached.

Where are we now?

- Safe staffing
  - National availability of emergency doctors
  - Local services unattractive due to onerous on-call, service model, facilities
  - Need to maintain a sustainable urgent & emergency care service
- Looking to the future, and responding to the changing needs of patients and community
- We need a viable business continuity plan
- Provide assurance if “tipping point” is reached

Journey so far…..

- Recognised as high risk
- Initial paper to board
- Initial review of tipping points and scenarios (including Pros, Cons , Consequences, Impact)
- Identified the “most” feasible contingency – Scenario D (*Maintaining Safe, Effective Dignified Urgent & Emergency Care Services Nov 2015.)*

Tipping Points: ED Staffing

- No Middle Grade available to work 24/7 in either of the emergency departments;
  - currently 7 substantive posts below the recommended staffing levels (Covered predominately by locums).
- No emergency medicine consultant on call covering the emergency departments.
  - Currently working a 1:4 rota for the last 12-months this is unsustainable.
- No SHO level junior doctors working out of hours (after 1800 hours and at weekends) -

Tipping Points: ongoing mitigation

- Continued National & International recruitment
- Review shift times to match demand
- Extending recruitment of ENP's
- Developing ACP training posts
- Review potential of speciality doctors supporting area
- Considering different recruitment models

Tipping Point: Other issues

- Estates –
  - Catastrophic event
  - Utilities failure
- Recruitment challenges for other specialities
  - Theatres, Diagnostics, Acute Medicine, Intensive Care
- Clinical adjacency

Tipping Points: Questions

- Are there other potential risks and tipping points that we need to consider?
- What further action could take place to prevent tipping points from being reached:
  - By SATH
  - By other local partners
  - By national bodies

Possible Scenarios

A. Fully close both emergency departments	✗
B. Fully close one emergency department	✗
C. Daytime opening only of both emergency depts	✗
D. 24-hour opening of one emergency department, daytime opening of other	✓
E. 24-hour opening of one emergency department, GP/OOH led service overnight at other	?
F. Single Emergency Centre plus UCC at one site, Urgent Care Centre at other (accelerate NHS FF)	✗
G. Maintain 24-hour emergency departments at both sites	Our Business Continuity Plan is for circumstances where this is no longer possible

Possible Scenarios: Questions

- If we reached the position where it was not possible to sustain two 24-hour A&E departments, what other scenarios could be considered?

- Are any of these scenarios feasible?

Discussion

Group discussion on scenarios

Timetable

- Jan/Feb 2016 Further stakeholder workshop

- Confirm tipping points
- Develop quality impact assessment
- 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

- Review Tipping Points and contingency measures
- Recommend updates based on changing environment and context.

Quality is our highest priority

Discussions take place on maintaining safe, effective and dignified Urgent and Emergency Care

16 December 2015

Senior clinicians and hospital leaders have met with health partners and patient representatives to discuss the best way of keeping patients safe in the event of fragile services becoming unsustainable.

The Shrewsbury and Telford Hospital NHS Trust (SaTH), which runs the Royal Shrewsbury Hospital and Telford's Princess Royal Hospital, is seeking views from staff, partners, patients and their families over what short-term measures could be taken ahead of a decision by NHS Future Fit, which will define the future of healthcare for generations to come.

Doctors, Nurses and other health professionals in emergency care and also in acute medicine, critical care and other specialties, tell us how fragile some of our services are, and it is therefore vital that we must 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.

As part of that contingency planning, SaTH leaders – including Doctors, Nurses and support staff – met with healthcare partners and patient representatives this week to look at what scenarios should be considered should a "tipping point", where safe services could no longer be maintained, be reached. These included the possible, temporary overnight closure of one of our two A&E Departments at some point in the future.

Debbie Kadum, Chief Operating Officer at SaTH, said: **"We must emphasise that we are doing everything we can to avoid reaching a tipping point, including continued national and international recruitment and extending the recruitment of Emergency Nurse Practitioners. We are also reviewing shift patterns in order to best meet times of high demand.**

"Continuity planning is part and parcel of normal business and we have continuity plans for a whole range of scenarios in our hospitals, but clearly Emergency Departments have a much higher profile than many of the other things we discuss.

"The discussions we are having are about looking after our patients and looking after our staff. It is about responding if – and only if – a tipping point was reached so that we can continue to fulfil our obligations to our patients and communities.

"This is not something we ever want to implement and is absolutely not part of our Winter Plan or a way of closing one of our A&E Departments 'by the back door'.

"We do not pretend that we have all the answers, and this meeting provided some excellent views for us to look at in greater detail. What the meeting emphasised is that there is no easy answer. That is why we set out on the journey with NHS Future Fit to begin with. If there was a simple solution to the NHS Future Fit debate, we would have implemented it some time ago.

"We have seen reports from some people saying it is 'obvious' that we would close the A&E at Shrewsbury overnight if we reached a tipping point, while others have said it is 'obvious' we would close Telford. There is no 'obvious' choice, and that is why we want to consider as many views as possible.

"With continued demand for hospital care, I would like to give my personal thanks to the teams in our Emergency Departments, in local hospitals and across local health and care services for their

compassion and commitment.

“I would like to thank everyone who has already shared their concerns and hopes.”

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.

For more information visit **www.sath.nhs.uk/bcp**

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The Shrewsbury and Telford Hospital NHS Trust

Business Continuity within the Emergency Department

February 2016 Update

Proud To Care
Make It Happen
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Together We Achieve

February 2016 Stakeholder Workshop

- Welcome
- Background
- The journey so far
- Consider one scenario
- Pathway mitigations
- Outcome
- Next steps

Background

There has been a debate over several decades without resolution about the sustainability of the county's hospital services.

These clinical sustainability challenges – particularly the fragility of emergency care services – are part of the "case for change" for the NHS Future Fit review.

That programme aims to create a long term vision for the county's health services.

But in the meantime these services remain fragile. Whilst we are doing our best to keep them running we have a duty to ensure business continuity plans so that we can act quickly and safely if a tipping point was reached.

- ✓ This is about keeping our patients safe
- ✓ It is about responding if, and only if, a crisis point was reached
- ✓ It is about fulfilling our obligations to our communities to respond safely and promptly if this happened

- ✘ This isn't part of our winter plan
- ✘ It is not something we *want* to implement – particularly ahead of the decisions to be made through NHS Future Fit
- ✘ But we may *need* to implement if a tipping point was reached.

Journey so far…..

- Recognised as high risk
- Initial paper to board
- Initial review of tipping points and scenarios (including Pros, Cons , Consequences, Impact)
- Identified the “most” feasible contingency – Scenario D (*Maintaining Safe, Effective Dignified Urgent & Emergency Care Services Nov 2015.)*

Tipping Points:

- ED Staffing
- Estates –
    - Catastrophic event
    - Utilities failure
- Recruitment challenges for other specialities
    - Theatres, Diagnostics, Acute Medicine, Intensive Care
- Clinical adjacency

Public and Stakeholder Feedback

- Over 50 letters and emails
- Main issues raised included:
  - Concerns about potential impact on patients, communities and staff of the options identified in the paper
  - The importance of effective publicity if changes were implemented, and of contingency arrangements (e.g. if patients arrive at a service that is closed)
  - The need for clarity in relation to care pathways (e.g. trauma, stroke, women & children's, ENT)
  - The importance of not pre-empting the work under way through NHS Future Fit; and,
  - Suggestions for sustaining services and preventing tipping points from being reached.

Progress to date

- Recruitment
- Urgent care / walk-in centres
- AEC
- GP services

Scenario D – Overnight closure.

- A business continuity plan featuring temporary overnight closure of RSH is not feasible due to the complexity of service moves for trauma and acute/emergency surgery (RSH is the county's main centre for trauma and acute/emergency surgery).
- A business continuity plan featuring temporary overnight closure of PRH is potentially feasible and work is underway to consider this in more detail, including the impact on patients and pathways.
- This would be a temporary measure in response to tipping points in the immediate term and would be undertaken without prejudice of the work taking place through the NHS Future Fit programme.

Scenario D1 – Close PRH over night

Impact on RSH (between 2000 hrs and 0800 hrs)

- 490 additional ambulances per month = 18 per day
- 700 "Other" attenders per month = 26 per day;
- 500 additional admissions per month = 19 per day
- 350 admissions per month into the general bed base (30% being discharged from AMU/SAU), 12 admissions into the bed base per night;
- This will require additional **42** inpatient beds and **18** Short Stay beds to be available / created through bed transfers on the RSH site.

Considerations

- Pathways
  - Acute Stroke
  - Paeds / neonates /Obstetrics
  - Women
  - ENT
- Capacity
  - Additional beds
- Workforce

Work is underway to develop business continuity plans for each pathways and options for workforce & physical capacity

Conclusions

- Is this workable/ Possible in the time frame?
- Should we be considering mutual aid initially?
- Where does this sit with NHS Future Fit and sustainable services?

Report to:	Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin, 2 March 2016

Title	Update on Winter Pressures and the Urgent and Emergency Care System
Purpose	To update the Joint Health Overview and Scrutiny Committee on work across the health and care system to improve urgent and emergency care and address winter pressures
Previously considered by	Shropshire and Telford & Wrekin System Resilience Group Joint Health Overview and Scrutiny Committee, 15 December 2015

Executive Summary

Health and care partners across Shropshire and Telford & Wrekin have worked together, with support from the national Emergency Care Improvement Programme (ECIP) to develop an updated Urgent and Emergency Care Recovery Action Plan aiming to improve patient experience and timely access to appropriate care.

A presentation on that work was made to the Joint Health Overview and Scrutiny Committee on 15 December 2015, highlighting four themes of work aiming to sustain improvement in urgent and emergency care:

A. The acute hospital focusing on delivering improvements in bed flow processes, ED efficiency and fully implementing ambulatory emergency care (AEC)

B. The community services and local authorities focusing on enhancing capacity and impact of integrated re-ablement teams to avoid admissions and speed up complex discharge

C. Commissioners focusing on driving greater throughput at treatment centres co-located at each site, and ensuring that demand management schemes are effective in reducing ED attendance

D. Collective effort focusing on managing complex medically fit patients with fewer delays, and implementing improvements to support and divert greater numbers of over 75 year old patients outside of acute hospital.

The demand for services, and the complexity of needs of our patients & communities, has remained high and at 10 February, system performance is 12% below trajectory.

Whilst some areas have shown improvement (Clinical decision maker breaches, DTOC lost bed days, Sunday discharges, ICS complex discharges) others are well behind plan (e.g. Urgent Care Centre / Walk In Centre streaming, admissions avoided remain, non-admitted breaches) and further remedial action is required.

A presentation will be made to the meeting outlining:

- the current position as at 2 March 2016
- progress, opportunities and challenges in each of the four themes of work

Enclosures:

- Annex 1: Summary position on whole system Emergency Care Recovery Action Plan as at 10 February 2016
- Annex 2: Emergency Care Improvement Programme System Concordat, 9 February 2016
- Annex 3: Reducing discharge delays: SATH partnership with Virginia Mason Institute, 28 January 2016
- Annex 4: Detailed position on whole system Emergency Care Recovery Plan as at 13 January 2016
- Annex 5: Emergency Care Improvement Programme Whole System Diagnostic

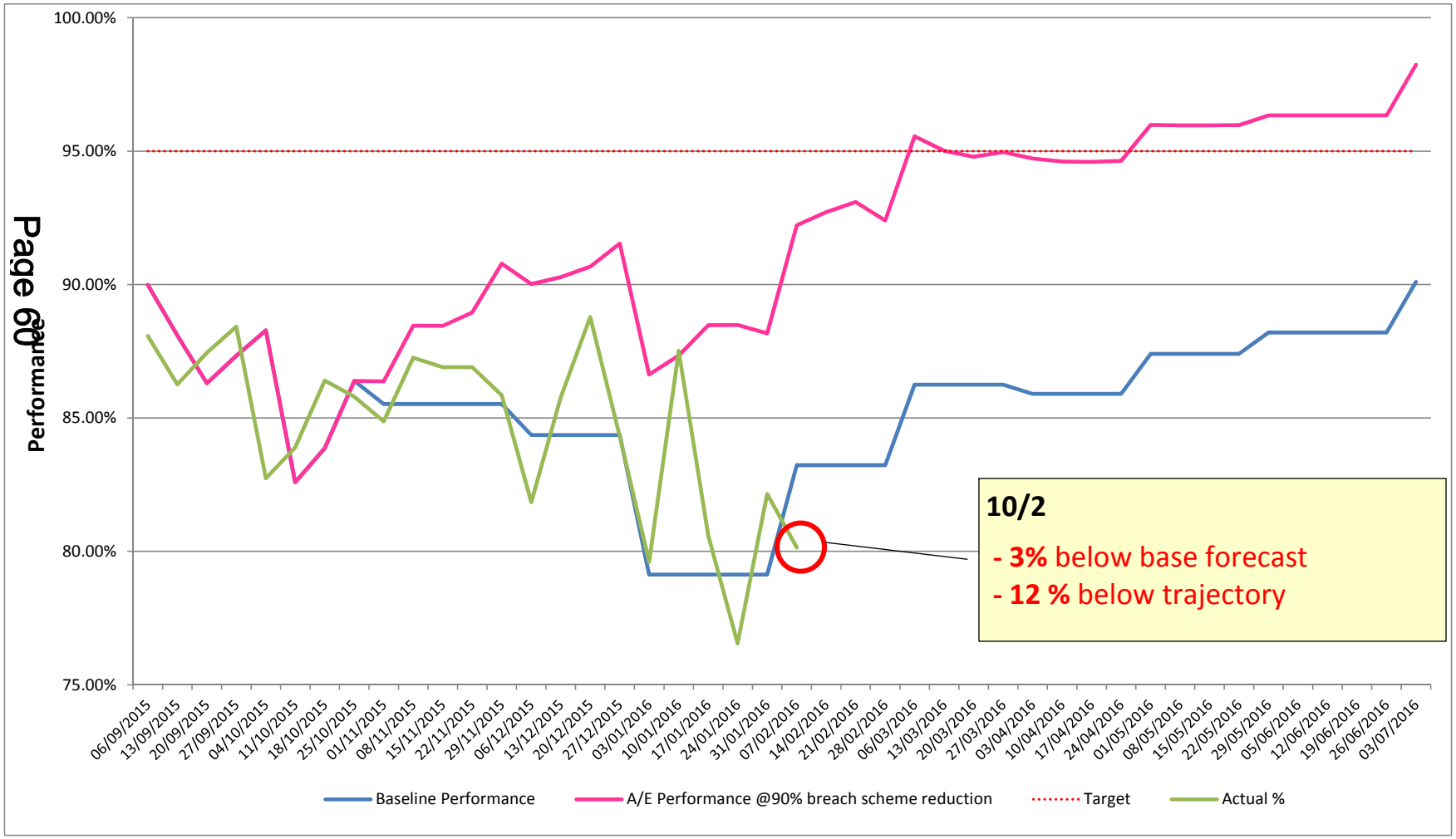
Update on Winter Pressures and the Urgent and Emergency Care System

Annex 1

Summary position on whole system Emergency Care Recovery Action Plan as at 10 February 2016

1. Performance against trajectory

Performance has fluctuated in relation to the forecast. Last week performance fell behind base forecast and was 12% behind the trajectory



Key headlines

Signs of improvement:

- Clinical decision maker breaches now c 0% for last 7 weeks
- DTOC lost bed days had been consistently low for 3 weeks (although showing increase from February)
- Sunday discharges rising on both sites for 3 weeks (although dipping again mid February)
- ICS complex discharges keeping pace with target

Areas for further action include:

- **UCC/ WIC numbers continue to be below potential streaming volume**
- **Admissions avoided remain consistent but below target**
- **Non admitted breaches remain high on both sites**

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 2

Emergency Care Improvement Programme System Concordat, 9 February 2016

Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS

9th February 2016

David Evans
SRG Lead and Accountable Officer, Telford & Wrekin CCG

CC: Simon Wright Chief Executive Shrewsbury and Telford Hospital NHS Trust; Brigid Stacey Accountable Officer Shropshire CCG; Jan Ditheridge Chief Executive Shropshire Community NHS Trust, Paul Taylor, DASS Telford; Stephen Chandler, DASS Shropshire

Marianne Loynes, Monitor Regional Director (Midlands & East)
Paul Watson, NHS England Regional Director (Midlands & East)
Dale Bywater, NHS TDA Regional Director (Midlands & East)

Dear David,

Re: Emergency Care Improvement Programme (ECIP) - Concordat

Further to our recent discussions, we are writing to set out a formal concordat between yourselves and the Emergency Care Improvement Programme (ECIP). This concordat will be signed by leaders from each part of the system and the regional tripartite to demonstrate the overall commitment to the objectives set out.

Having now visited the system over the course of a number of weeks, undertaken diagnostic exercises and met with a number of key clinical, managerial and executive stakeholders, we would like to propose that the SRG prioritise the following five areas for action:

1. Development of a system wide vision for UEC and delivery of an effective communication strategy to cascade to all staff.
2. To enhance the Acute Frailty pathway and along with this develop a system wide vision for Frailty with an overall aim of enabling people to remain in their own home. When a hospital admission is required the acute pathway should allow them to return home in the most timely manner to avoid prolonged hospital stay.
3. To introduce the SAFER patient flow bundle across all bed based services in acute and community Trusts to ensure consistency across ward process. This needs to be outcome focused with agreed metrics that are monitored weekly.
4. Introduce Discharge to Assess across the health and social care system. This is the planning of post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This should be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this. Home with care needs to be urgently reviewed and a solution found to ensure domiciliary care is responsive to avoid hospital deconditioning or inappropriate transfer to a community bed based area.
5. To review opportunities to support resilience of the acute Trust EDs.

It is our view that focusing on these areas will help Shropshire, Telford & Wrekin SRG best improve the performance of their urgent and emergency care pathways, reduce waits and occupancy and so improve outcomes, including reducing mortality, for patients in their system.

As you are aware ECIST have provided support to this system ahead of the system's inclusion in ECIP. This concordat aims to formalise this support and establish the priorities for your system. These priorities along with the ECIP support package will be reviewed with you before 31st March 2016. We also recommend that the SRG use some granular improvement metrics to monitor progress. Some suggestions are included in the table below. In addition, the SRG should set itself an ambition to improve system performance against the 4 hour emergency care standard as this is a key barometer of system success and is linked to good patient experience and outcomes.

ECIP expects that the system should define its own goals for these improvement metrics and the ways it will gather and monitor the information. If you do not already have a PMO to support this, we recommend that you should put one in place.

Programme Aim	Improvement in patient care and making the system safer with: • Improvement in performance against the emergency care 4 hour standard • Reduction in daily and weekly variation in performance against the emergency care 4 hour standard • Reduction in mortality • An increase in the proportion of patients returning directly to their usual place of residence from hospital

Action	**ECIP Support**	**Suggested improvement metric**
1. UEC Vision	• ECIP onsite support for a minimum 1-2 days per week • ECIP intensive support managers allocated to sites across the system • Access to wider ECIP team including clinicians and social care • Access to website, all ECIP resources, webinars and events	Patient engagement and staff engagement, measured by surveys
2. Acute frailty pathway		Reductions in conversion rates of over 75s Reductions in length of stay for over 75s
3. SAFER		Reductions in stranded patients; Increased discharges before 10 am Improved reports from audits of board and ward rounds
4. Discharge to assess		Reduce LOS of frailty patients Reduce length of time it takes to get a care package
5. Support resilience of acute EDs		Reduction in non-admitted reaches

Support to develop and implement the work streams will be undertaken through a structured programme that will include on-site visits from the team specified in the table above. These may reduce in intensity over time as the work streams and projects mature.

We would also suggest that a formal review of progress with ECIP and the SRG be undertaken on a monthly basis to ensure we track progress and ensure delivery. To ensure

accelerated delivery of the support programme, we would also suggest that key members of the SRG meet ECIP weekly in the first instance to regularly establish progress against agreed actions, issues and next steps.

The following accountability will apply:

- The Trusts will remain accountable to the NHS TDA or Monitor for their performance, as applicable
- The CCGs will remain accountable to NHS England for their performance
- The Regional Tripartite will hold the system to account for overall delivery of this plan and the realisation of improvement in Emergency Care
- ECIP will provide a support function as set out above so that the SRG is in the best possible place to secure improvement

In summary, we would like to thank you for engaging with ECIP and inviting us to provide a more detailed review of the internal clinical processes within your system which has been the main focus of this concordat.

Yours sincerely,

Steven Christian
Head of Improvement
ECIP

Vincent Connolly
Medical Director
ECIP

Glen Burley
Senior Responsible Officer
ECIP

[Approved by]

Frances Shattock
Regional Director, Midlands & East
Monitor

Dale Bywater
Regional Director, Midlands & East
Trust Development Authority

Emergency Care Improvement Programme

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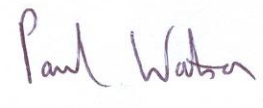


Paul Watson
Regional Director, Midlands & East
NHS England

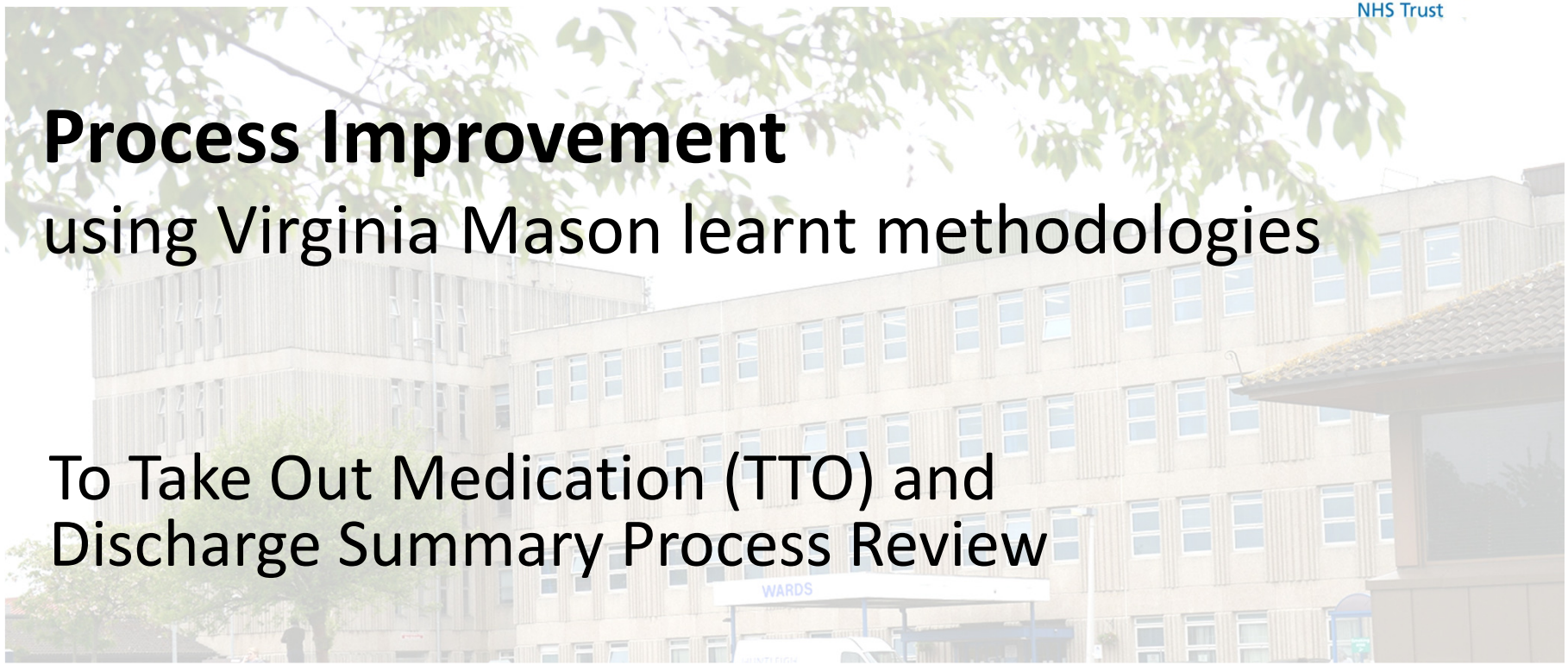
[Agreement from]

David Evans
Chair, Shropshire, Telford & Wrekin SRG

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 3

Reducing discharge delays through the SATH partnership with Virginia Mason Institute, 28 January 2016



Process Improvement

using Virginia Mason learnt methodologies

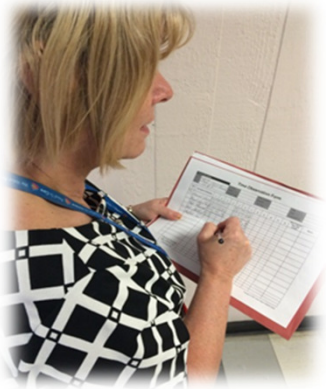
To Take Out Medication (TTO) and Discharge Summary Process Review

What is the problem we are trying to solve?

- ❑ Improvement & Transformation Team formed to focus on a key improvement for the Trust
- ❑ **Breaking the Cycle week** identified To Take Out Medications (TTOs) and Discharge Summary as priority
- ❑ Ward and Pharmacy teams fully engaged as key stakeholders
- ❑ Aim to reduce **turnaround time** of TTO **by half**

"We believe that a high number of discharges are delayed due to the process of producing TTOs and discharge summaries"

Improvement Methodology



- Provide current state information to stakeholders
- Ideas for improvement generated by teams
- Scientific method used to prove or disprove hypothesis
- Using Plan, Do , Study, Act (PDSA) cycles, experiment and measure improvement activity
- Review, adapt and retest ideas
- Encourage continuous improvement through many small local changes
- Support teams to make improvement by providing advice, guidance and facilitative resource
- Start small, think big

Current State Value Stream Map

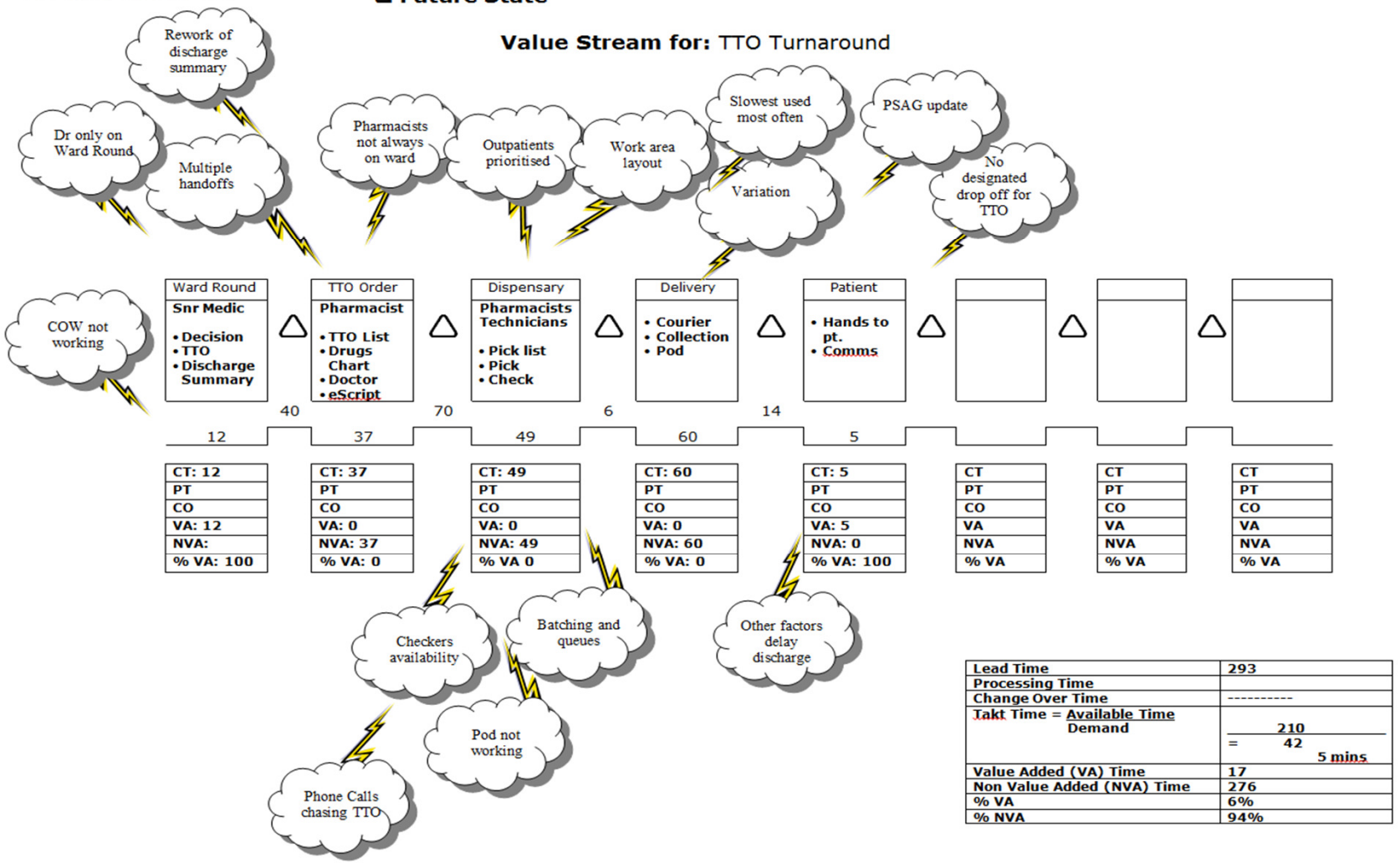
The Shrewsbury and Telford Hospital NHS
NHS Trust

Process Boundaries
From: Patient declared fit to leave
To: Patient receives TTO

☒ **Current State**
❑ **Future State**

Author: Nick Holding
Date prepared: 14/10/15

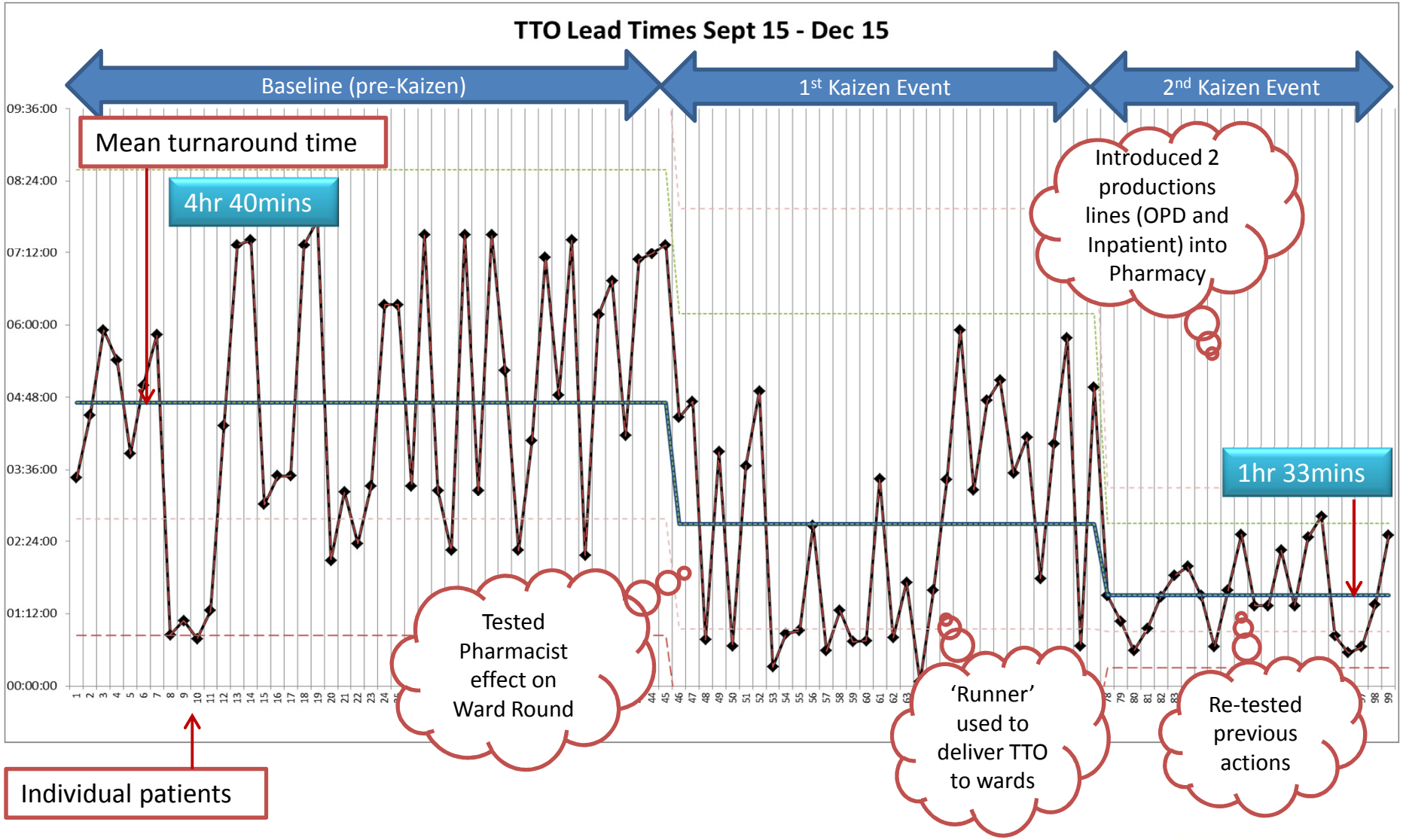
Value Stream for: TTO Turnaround



Lead Time	**293**
Processing Time	
Change Over Time	----------
Takt Time = Available Time / Demand	210 / 42 = 5 mins
Value Added (VA) Time	**17**
Non Value Added (NVA) Time	**276**
% VA	**6%**
% NVA	**94%**

TTO Turnaround Times

The Shrewsbury and Telford Hospital NHS
NHS Trust



Source. Sema, eScript, Pharmacy dept docs & direct observation

Improvement and Transformation

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Summary

- **Overall TTO lead time reduced by 67% (3hours)**
- **Patient TTO delays reduced by on average 10 hours per day (1 ward)**
- **Potential release of approx. 300 hours per day of bed usage time, across inpatient areas (USC & SC)**
- **Earlier discharge time**

- Used Virginia Mason methodologies
- Care Groups identified TTO and Discharge Summary process as area of focus, following Breaking the Cycle week
- Collected real time current state data
- Working with operational teams, ran a number of improvement events to test ideas using PDSA cycles over 3 months

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 4

Detailed position on whole system Emergency Care Recovery Plan as at 13 January 2016

Emergency Care

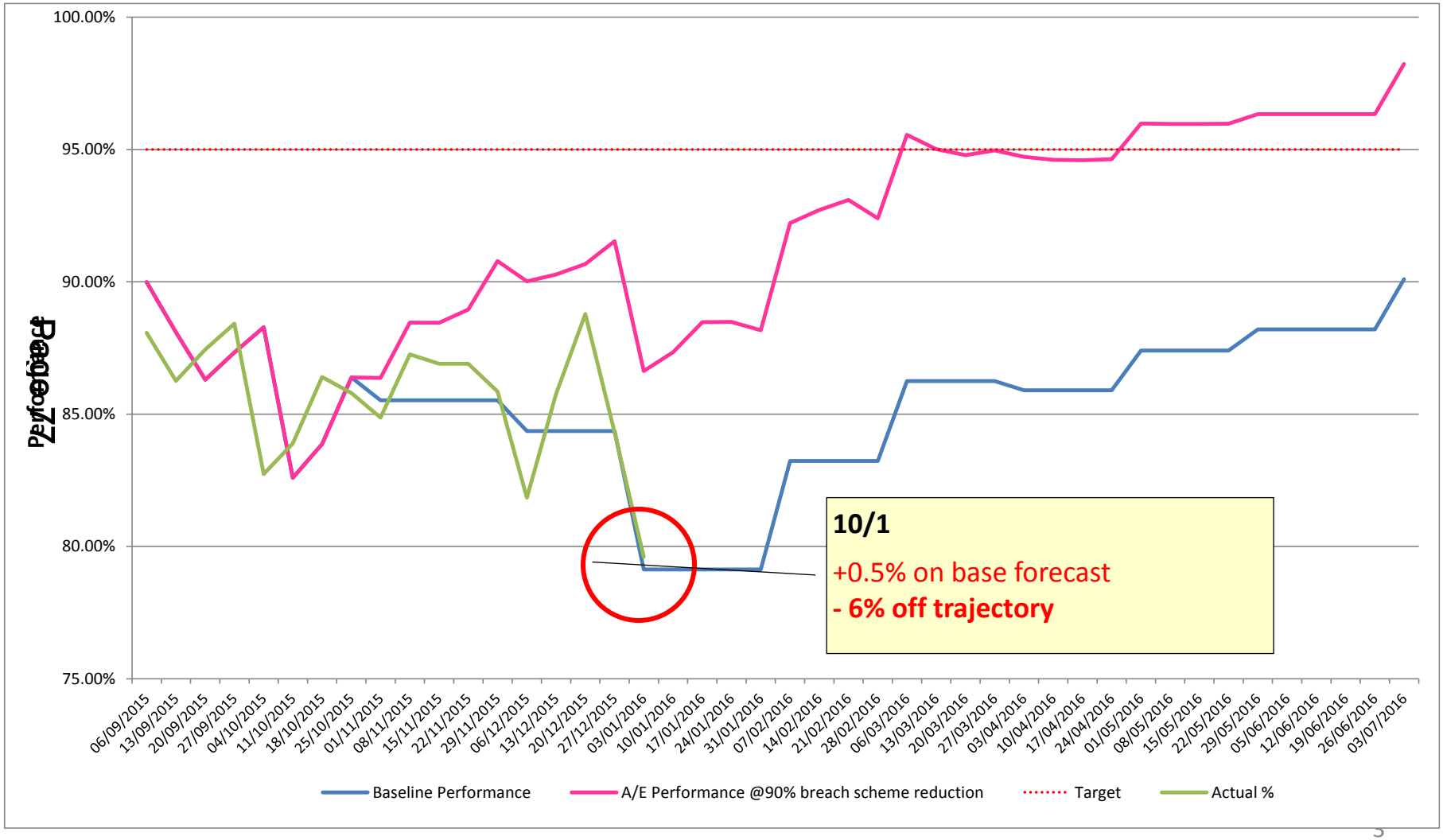
Recovery Action Update

January 13th 2015

CONTENTS

1. Performance against trajectory

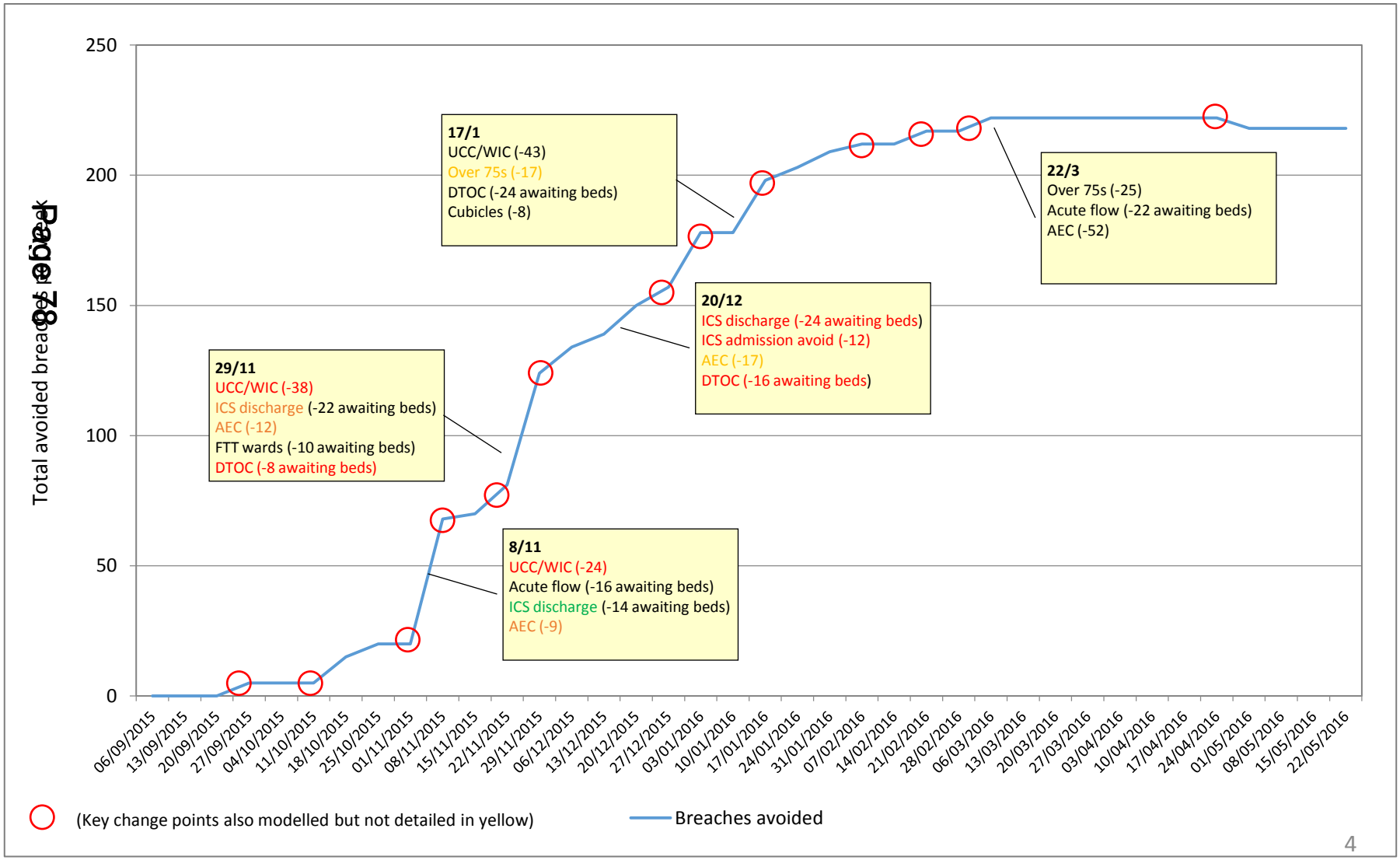
Performance has tracked close to forecast base performance. It dipped to 82% on the 13th Dec but rose sharply to 88.8% w/e 27th Dec. Performance at the start of the New Year is better than previous years (plus 6%) but fell back to -4% vs 2015 in w/e 10th Jan.



1. Breach trajectory tracker

Key actions off track/ late –

1. UCC/ WIC streaming; 2. Complex discharge/ DTOC; 3. AEC & ICS activity rates



2. Key actions required

Gaps and mitigating actions

1. Streaming patients to UCC/ WIC

   - Delays in agreeing streaming process and capacity have constrained opportunities to divert demand at the front door
   - Streaming and additional funded resources to support this are now in place from w/e Dec 27 and very early signs of increased activity
   - PRH are using diverts back to GPs, and there is agreement to jointly monitor on a daily basis

2. Admission avoidance & complex discharge through ICS

   a. Admission avoidance rate at 33% of forecast
      - Care Coordination Centre to be used as well as SPR as point of AA referral
      - 8-8pm service hours in place from Jan 4

   b. Complex discharge rate is c30% of forecast
      - Care capacity uplift expected from Jan 18
      - All existing and new referrals for care being reviewed to ensure appropriateness and potential to profile care needs accordingly

2. Key actions required

Gaps and mitigating actions

3. Utilising AEC to avoid ED/ admissions

- Unit throughput data outstanding – escalated and data to be provided ahead of SRG Jan 15
- Current operational pressures mean that the AEC has been disrupted by the need to bed patients when hospital full.
- Pathway development work continues on track

4. Reduction in delayed transfers

- Reduction in numbers of delayed patients after Christmas (zero at PRH), however first week in Jan saw a stepped increase
- Daily operational processes and grip enhanced following COO meeting Dec 18. Strengthened further by daily command and control meetings within the acute
- Additional commissioner presence in daily hub meetings to support additional challenge and pace of action/ decision making
- ECIP led workshop on improving complex discharge management being confirmed

2. Key actions required

Gaps and mitigating actions

5. Internal flow improvements

- Day of discharge initiative mapped and 3 areas of focus to reduce TTO lead time are being piloted, with an evaluation planned for end of Jan.
- SAFER and Exemplar Ward project are being piloted on 2 wards and baseline metrics being collected.
- Nursing Director lead to work with ECIP on supporting pace of roll out and embedding progress

6. Non admitted breaches

- Cubicles installed at PRH, process changes to be delivered and impact starting to feed through from Jan 13

7. Over 75s Admission Avoidance Scheme

- Funding approved and signed off by SRG through winter monies
- Delay in formal sign off from WMAS has meant that recruitment and induction has been delayed – scheme live date slipped from Jan 4 to beginning of Feb
- Option to launch with clinical lead providing cover for shifts to be explored

3. Next steps

What we need to do now -

1. Ensure close monitoring

    - Recovery metrics circulated across system weekly - COO's to receive, discuss and action at their weekly meeting
    - SRG & SRG Core Group to receive updates

2. Detailed line by line review of all plans

    - Session being arranged for all action owners to present their plans to PMO/ Chair of UCWG
    - Mid term projects to be scoped and potential impact on recovery to be quantified

3. Maximise the impact of support from ECIP

    - Local lead to join weekly COO meeting & plan of support to be aligned to each priority area and mapped to end of March

4. Remain committed to delivery of trajectory in March

    - Stock take of progress to date and what it means for delivery – refresh breach impact timing
    - Ensure daily operational grip maximises current performance
    - Deliver existing actions on time and bring forward where possible mid term impact

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 5

Emergency Care Improvement Programme Whole System Diagnostic

Emergency Care Improvement Programme

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ECIP – Whole System Diagnostic – Shrewsbury & Telford Local Health Economy

Summary

A whole system review was undertaken between the 9th and 12thNovember 2015. The acute trust that formed part of the whole system review is Shrewsbury and Telford Hospitals NHS Trust (SATH). The Trust was in full support of the review and the preparatory work leading up to our visit.

Shrewsbury and Telford Hospitals NHS Trust provides acute hospital services, including urgent and emergency care, critical care, general medicine including elderly care, emergency surgery, elective surgery, paediatrics, maternity care and a range of outpatient services. Urgent and emergency (UEC) services are provided across two sites with Emergency Departments (ED) at Shrewsbury Royal Hospital and the Princess Royal Hospital in Telford. Shrewsbury and Telford Hospitals NHS Trust is a non-foundation trust. The Trust employs over 5,000 staff.

SATH provides acute treatment and care for a catchment population of around 500,000 people in Shrewsbury, Telford and Mid Wales. The hospital provides healthcare to the population covered mainly by two Clinical Commissioning Groups, Shropshire CCG and Telford and Wrekin CCG. Each CCG was invited to engage in the process. Shropshire Community Health Trust is the community provider in this system and was a key part of the diagnostic visit. Shropshire County Council and Telford and Wrekin are the two Local Authorities.

The whole system review comprised of the following:

1. An Acute Walkthrough of the patient pathway across SATH's urgent and emergency care system, on both sites. The visiting team met with clinical and managerial staff involved in leading and delivering services across the internal pathways.
2. Structured interviews with providers and commissioners outside Acute Trust.
3. A visit to two of the community hospital facilities in Whitchurch and Bridgnorth as well as recovery beds managed by an independent provider.
4. Discussions with Integrated Care Service (ICS) and discharge planning / admission avoidance teams in Telford and Shropshire.
5. A whole system event to present findings and initiate discussion to develop solutions.

Acknowledgements

We would like to thank the teams and individuals we met for their openness and willingness to be challenged.

The visit, with the co-operation of all the staff we met, has allowed us to make a number of observations, which we have developed into 'high impact' priority recommendations.

We wish to assure all concerned, in particular the teams we met, that in our evaluation we have acted independently and trust that observations and recommendations will be viewed in a constructive manner by all concerned.

The ECIP review was conducted by:

- Dr Jyothi Nippani (ECIP Clinician)
- Dr Mitton Ruparelia (ECIP GP Clinician)
- Steve Christian (ECIP Cluster Head of Improvement)
- Elizabeth Sargent (ECIP Clinical Lead for Integration, Health and Social Care)
- Glynnis Joffe (Social Care Lead)
- Karen Campion (ECIP Intensive Support Manager).

Evidence Base – Case for Change

As a starting point, it is essential that everyone across the system understands that poor patient flow leads to a reduction in high quality care, and therefore the requirement to make improvements at pace.

Research into poor patient flow (resulting in crowded Emergency Departments and high bed occupancy) has established links with a number of adverse patient outcomes and evidence suggests:

- For patients who are seen and discharged from an A&E, *the longer they have waited to be seen*, the higher the chance they will die during the following 7 days (Guttmann et al, 2013).

- The longer a patient spends in the Emergency Department (ED), the longer they stay in the hospital (Liew et al, 2003).

- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 (Giles et al, 2004).

- Delays in transfer from ED to higher dependency units increase mortality and length of stay (Chalfin et al, 2007).

- Once a hospital is over 90% bed occupancy it reaches a tipping point in its resilience (Forster et al, 2003).

- Lowering levels of bed occupancy is associated with decreased in hospital mortality and improved performance on the 4-hour target (Bowden et al, (2015).

The key national factors associated with deterioration in 4 hour standard performance

The Economic Team at Monitor have completed analysis to determine the key factors at a national level for the deterioration in performance (figure 1).

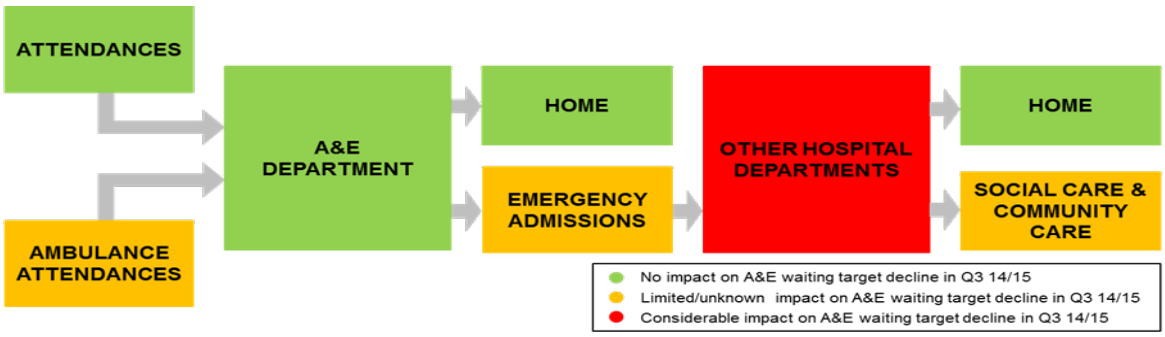


Figure 1 - Drivers of the A&E performance challenges in 2014/15

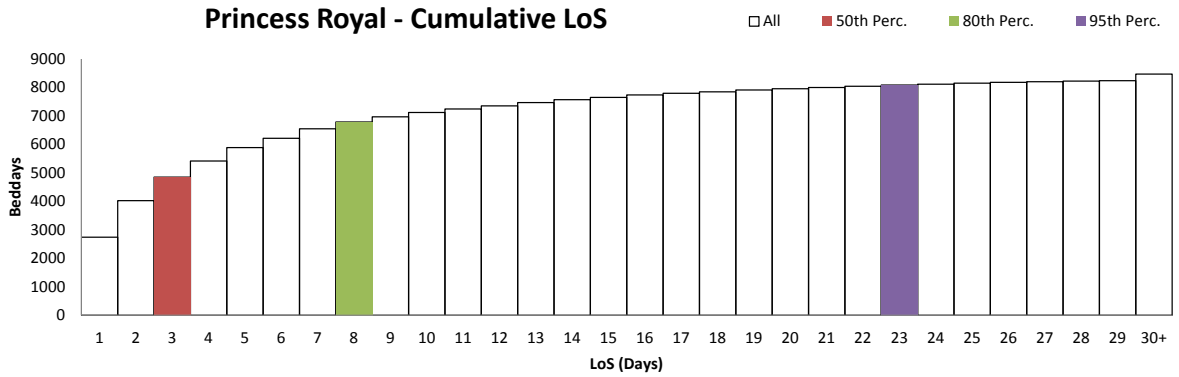
The findings show that the most important cause of the decline was a reduction in acute Trusts' ability to absorb an increase in admissions from EDs. This, in turn, was a result of Trusts running at very high occupancy rates of 90% or above. The data indicates that factors potentially contributing to blockages at other stages in the patient pathway had either a minor or no impact on actual delays. Therefore measures taken by Trusts to improve patient flow through hospital departments other than ED are likely to be highly effective in avoiding another sharp decline in 4 hour standard performance this winter.

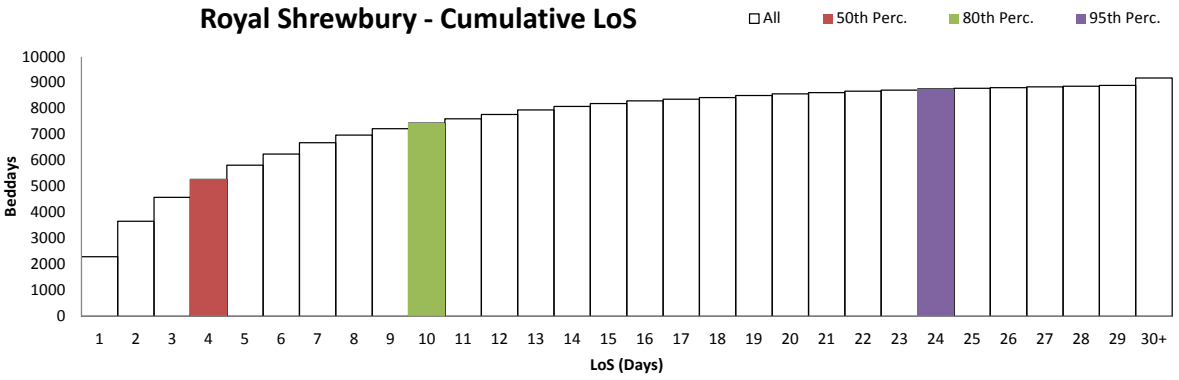
Based on the findings from the analysis (national context) and our observations across the whole system review, the report will detail 8 high impact priorities recommendations that if delivered we believe will improve the system's resilience and ability to achieve the 4 hour standard. However, more importantly, they will improve patient experience and mitigate any potential harm factors arising from the known evidence based risk factors associated with poor patient flow and ED crowding.

Key Information from ECIP Data Pack – Length of Stay

The data suggests that the key focus point for the system will be to drive improvement in Length of Stay (LoS) across the acute Trust. To flag early, this can only be achieved through a whole system approach and working together under a shared vision.

The 8 high impact priority recommendations are focused on initiatives aimed at improving Length of Stay at the acute hospitals. From our observations, we believe that driving the 'basics' should be the focus. We strongly believe that there are opportunities for the system to 'left shift' percentile performance in LoS and therefore support improvement in bed occupancy; and as a result deliver resilience against the 4 hour standard.





The graphs above provide the percentile Length of Stay performance for both acute Trusts at SATH. Whist we don't have a national standard we advise systems that good practice is to work towards the below percentile LoS targets. This is performance we have observed in high performing systems across the NHS.

LoS Percentiles – High Performing Systems		
50th	80th	95th
2	7	21

'High Impact' Recommendations

As a result of our visit, ECIP has identified the 8 high impact recommendations that we believe provide the greatest marginal gains for improvement across UEC and as a result the 4 hour standard. We have purposively focused our attention on specific priorities (rather than a wide range of initiatives) to ensure the improvement remains focused and realistic in terms of delivery.
Later in this report we will identify what we believe from these recommendations are immediate key short term priorities for the system to deliver. However we will continue to work with the health economy over time to deliver all 8 High Impact Recommendations.

1. Development of a system wide vision for UEC and delivery of an effective communication strategy to cascade to all staff.
2. Maximise Ambulatory Care models at Acute Trust to prevent unnecessary overnight hospital stay – this should include support from community rapid response and linking with DARRT service.
3. To enhance the Acute Frailty pathway and along with this develop a system wide vision for Frailty with an overall aim of enabling people to remain in their own home. When a hospital admission is required the acute pathway should allow them to return home in the most timely manner to avoid prolonged hospital stay.
4. To review the current model of care in Acute Medicine.
5. To introduce the SAFER patient flow bundle across all bed based services in acute and community Trusts to ensure consistency across ward process. This needs to be outcome focused with agreed metrics that are monitored weekly.
6. Introduce Discharge to Assess across the health and social care system. This is the planning of post-acute care in the community, as soon as the acute episode is complete, rather than in hospital before discharge. This should be the default pathway, with non-acute bedded alternatives for the very few patients who cannot manage this. Home with care needs to be urgently reviewed and a solution found to ensure domiciliary care is responsive to avoid hospital deconditioning or inappropriate transfer to a community bed based area.
7. To review current processes in managing escalation (i.e. review the effectiveness of frequent teleconferences).
8. To review opportunities to support resilience of the acute Trust EDs.

It must be noted that we observed many aspects of good practice and observed hardworking, committed individuals across the system. The report is focused on further opportunities to complement existing efforts.

1. Leadership and development of a system wide vision

Throughout our visit we did not see any evidence of a shared agreed vision for UEC across the whole health and social care economy. Whilst recognising the significant challenges across the system,

relationships between system Executive teams and senior operational managers did not appear to be that of trusted colleagues. It seems that unacceptable behaviours particularly when the system is under pressure have become normalised, there appeared to be a culture of blame.

This does not mean that there is not a 'can-do' attitude and we met staff across the whole health and care system who were leading on improvement work linked to patient flow. However some members of staff reported a lack of Executive presence and support for their work .The frequent changes in the Executive team in recent years at the acute Trust specifically has not helped with this. The recent appointment of the new CEO at the acute Trust and the Shropshire CCG Accountable Officer brings about an opportunity to develop system leadership, which is positive.

When we spoke to staff across the system it was consistently described to ECIP that the system has a poor track record of sticking to sustainable change, moving on to a new initiative before evaluating and developing the previous service improvement ideas. This is evidenced for example by previous work on the SAFER bundle and Comprehensive Geriatric Assessment at the front door, that was `leading edge ' improvement work at that time bringing significant gains to patients, which for reasons that could not be described on our visit was not sustained. Executive leaders must harness the values and enthusiasm of clinical and operational staff across the health and social care economy.

Recommendations:

- The System Resilience Group (SRG) needs to set a vision for UEC across the health and social care system and communicate that to all levels of staff.
- Executives across the SRG should set shared principles across each improvement initiative and take responsibility in creating a culture of continuous improvement across the system. Across each high impact priority whilst a provider organisation will be responsible, it is paramount that partners engage and work together to find solutions to optimise the recommendations being proposed.
- The system leaders agreed that it would be helpful to develop a set of values and behaviours to underpin the vision and principles. They agreed that these should be developed jointly and allow them to hold each other to account as change is progressed. ECIP could provide support to facilitate this.
- The system leaders need to spend dedicated 'personal' development time as a strategic leadership group. This is something that the ECIP team could help with and facilitate.
- Develop leadership across all levels from the frontline up. The acute Trust in particular had individuals with great ideas and didn't need ECIP to inform 'what good looks like'. The system and providers need to explore change management initiatives to engage the workforce to encourage individuals to be inspired and motivated to lead the change / improvement required.
- System leads must agree the high impact priorities, sponsor each initiative and commit.
- We recognise the challenges the system has in recruiting however it was not apparent that in attempting to tackle this issue the system has approached this as a collaborative. We would advise HR leads from across the system to meet and formulate a recruitment and retention plan to support resilience across UEC.

2. Ambulatory Emergency Care (AEC)

The AEC units at SATH require development to increase the number of emergency patients being referred to AEC, prior to decision to admit into hospital. It is essential that the Trust has one understanding of the purpose and principles of AEC, and this is understood by all service stakeholders, including patients.

We met enthusiastic and inspiring clinical champions for the service across both sites, although they did appear frustrated by barriers being encountered on a daily basis. For example, a clinician overseeing one of the AEC units described a situation, experienced on the day of our visit, whereby a patient was identified as suitable for same day discharge through a process driven AEC approach (and not experience an admission to an inpatient bed). The clinician required a 'next day' MRI scan and a speciality outpatient appointment to deliver such outcome for the patient. The systems were not in place to enable the plan to convert into action, and as a consequence the likely scenario was admission to hospital. The AEC clinician did pursue and not accept initial barriers from clinical support teams and after personal perseverance the right outcome for the patient was reached, and the patient was discharged from the AEC in a safe manner. The process was not timely for the patient nor was it a good use of resources for a clinician to 'chase' the necessary requirements from clinical support teams. Whilst this is a stand-alone example it was 'real time' and the clinical teams we met could describe numerous examples. The process should be systematic and not operator dependent.

Recommendations:

- All patients referred as an emergency (from GP and ED) should be considered for AEC management as a first line unless they are clinically unstable. The number of patients being directly referred to AEC from ED and GP needs to form part of the daily performance reports that are accessible to all clinical and managerial leads. The aim should be to deliver a process were the AEC facility is accommodating at least 35% of the current medical take.
- The time frames for initial assessment and medical review in the AEC facility should be similar to those in the main ED. This should be monitored and reported internally.
- The DAART and community service should be reviewed to ensure clarity of function and consideration of how services fit / support with the development of the AEC and acute frailty services.
- The AEC service should be available for a minimum of 12 hours per day 7 days per week but not overnight.
- Given the recruitment challenges, Advanced Care Practitioners (ACPs) should be pivotal in delivery of the service.
- A weekly project group to deliver continual evaluation and development of the units should be set up with Executive support. The service leads of the units across sites should meet regularly to share learning and experiences. It is appropriate for each site to have different approaches to a model of care (for example different approaches in work force due to availability). However, the principles should be consistent.
- The project group should engage all support service functions (within the hospitals and across community services) to ensure capacity is available to promote 'same day' discharge from AEC. It was not evident that the community services have actively engaged in seeking to understand how they can support this critical function to avoid hospital admission.

3. Acute Frailty Pathway

It was unclear when the Comprehensive Geriatric Assessment (CGA) for patients takes place. There is no frailty pathway. The underpinning aim should be to complete the CGA as soon as possible in the patient journey. CGA is a multidimensional inter-disciplinary diagnostic process to determine the medical, psychological and functional capabilities of a frail older person in order to develop a co-ordinated and integrated plan for treatment and long-term follow up. Effective implementation has been shown to reduce admissions for the over 75s by 33% and for those who are admitted, length of stay is reduced. A 'front door' therapy process to capture the pre admission functional level is a key element of the Acute Frailty pathway.

There is no frailty team although there is the basis of a frailty service available at both ED sites, predominately led by an enthusiastic therapy team with some community rapid response capacity at limited times of the day. The specialist geriatric resource supported a front door service in the past, but this has not continued due to workforce constraints .

We encourage Acute Frailty teams to work towards the following good practice principles:

- Establish a mechanism for early identification of people with frailty (find the patients on arrival)
- Put in place a multi-disciplinary response that initiates Comprehensive Geriatric Assessment (CGA) within the first hour (do the same thing to them every time, urgently)
- Set up a rapid response system for frail older people in urgent care settings
- Adopt a "Silver phone" system (nationally, why do trauma, stroke, STEMI, septic patients get an urgent standard response but frail patients do not?)
- Adopt clinical professional standards to reduce unnecessary variation
- Define and manage 'stranded patients' (Patients in hospital 7 days and over)
- Strengthen links with services both inside and outside hospital
- Put in place appropriate education and training for key staff
- Develop a measurement mind-set
- Identify clinical change champions
- Identify an Executive sponsor and underpin with a robust project management structure

Recommendations:

- The frailty pathway from patients presenting to the ED to discharge requires urgent review and focus. Whilst the therapy team have maintained a front door service, this needs to be supported by a multi-disciplinary response including Geriatricians with agreed professional standards and outcome measures. The review would need to include delivery of a front door assessment model, utilising all members of the multidisciplinary team including general practitioners with special interests, skilled nursing and therapy staff. To support this, we have specialist clinical resources available who could complete a comprehensive 'deep dive review' to ascertain a baseline (gap analysis) and provide practical advice and support to develop current pathways of care.
- Arrangements should be made to include social services, community health services and the voluntary sector in facilitating admission avoidance as part of the service.
- The FFA form is an early functional assessment, which has recently been implemented at the Telford site. This could be used as the assessment notification for both community health and social care services from the front door and would follow the person through their hospital stay. Further functional assessment would then be made when the patient is back in their usual place of residence.

4. Acute Medicine – Variation in AMU

The model of Acute Medicine suffers from a lack of standardised processes. The variation that each team /individual is allowed to bring is too great. AMUs can suffer from this as the senior medical staffing changes frequently (often daily) due to the requirements of a GIM rota and a reliance on drawing from the wider medical consultant team. There is, however, an opportunity to run a short project describing what good looks like for the team delivering the medical take and we advise that SATH, led by Medical Director, undertakes this work, using the apparent nursing teams' frustrations and knowledge to inform medical teams. The SHOP (sick, home, others, plans) model is a way to conduct AMU ward rounds that go to where the patients' needs are. The consultants should see the

sick patients first, followed by those patients who can go home, taking the actions required for them to be discharged. As with AEC, help from other clinical teams and diagnostics needs to mirror ED.

Recommendations:

- Meet as a senior management team (Executive sponsors and clinical leads) to determine the vision for Acute Medicine and commit and work towards the following good practice principles:
  - An average length of stay of 12 hours.
  - All patients with a daytime admission should be reviewed by a consultant within three hours. Evening admissions should be reviewed within three hours by a senior doctor, and a have a 'consultant delivered review' the following morning.
  - Consultants should provide ward cover in blocks of more than one day to provide continuity of care and be present seven days a week and into the late evenings. This will reduce delays and improve outcomes.
  - Consistent speciality in-reach for every patient requiring specialist care should be available five days a week working towards seven days when workforce allows.
  - Short stay beds should be available as part of a wider acute medical unit and should have adequate resources to provide care for patients with an anticipated length of stay of up to two midnights. Patients on the short stay unit should have a face-to-face consultant review twice daily, seven days a week. It was felt that SATH has progressed in this however it is dependent on locum Consultant time and therefore perhaps not a sustainable model and warrants review for a sustainable approach.

5. Ward Processes – Implement SAFER patient flow bundle

We attended and observed inpatient and community ward 'board rounds'. It was immediately apparent there are significant opportunities to improve patient flow across the ward process in both the acute and community environments. We observed high levels of variation in approach. Across our visit we experienced pockets (e.g. ward round approach in respiratory at the acute Trust) of excellent practice. However, this was not consistently applied.

When speaking to staff on the wards the following points were highlighted as current challenges:

- A lack of systematic use of expected date of discharge (EDD).
- A process that encourages sequential planning and acceptance of internal / external waits and delays.
- An acceptance that Board Rounds are not action-focussed and do not hold all members of the MDT to account. The team emphasised that there is variation in Consultant and other MDT daily input / attendance.
- We didn't observe a ward round, but staff we met described a traditional method and that in the main key tasks are still batched until the end of the round which create delays to patient flow.
- Assessment services do not have agreed response standards that are monitored, acted upon and if necessary escalated in a timely and consistent manner.
- Whilst informed that daily senior consultant review of every patient is in place, it could not be evidenced across all areas.

Recommendations:

- We recognise that ward processes can be complex. A good approach to managing complexity is to develop and use simple rules. We would encourage a focused effort in the implementation of the national SAFER patient flow bundle (appendix 1) across all providers

of bed based services. All the principles must be adhered to in a consistent manner to deliver good outcomes for patients. The successful implementation of a patient flow bundle approach requires 'buy-in' at all levels, including all members of the executive team. We have helped a number of Trusts implement the SAFER patient flow bundle and believe this is an area of focus that both the Trust and the system must prioritise and support. The trusts will want to refer to the Ward Round in Medicine Guidance (RCP and RCN 2012)

We would expect the successful implementation of a patient flow bundle to deliver:

- Improved daily patient reviews by decision makers.
- Improved average daily discharge times.
- Earlier time of transfer from assessment units to specialty beds.
- A reduction in the number of unsatisfactory discharges.
- A reduction in the number of delayed patients awaiting sub-acute care.
- Increasingly standardised behaviours across all disciplines.
- Increased ward level 'ownership' and accountability.

6. Interface and Discharge Planning

We recognise the good work that has taken place across the health and social care economy on the development of the Integrated Care Service (ICS) when we met the team in Shropshire. We observed blurred professional boundaries within the teams and good use of skill mix – *the ICS is one of the best examples of this kind of working that we have seen.*

We observed the work teams have been implementing on discharge to assess (D2A) and heard a clear view that community hospitals should be for patients with registered nursing needs and possibly CHC 'potential' patients awaiting assessment as they recover from acute admission. It was acknowledged by most that rehabilitation and reablement should be at home, not in a bed.

Our concerns were around patients who will be placed in the extra beds that are opening over winter as part of the system's resilience plan which the acute trust are putting in place to mitigate against the shortage in domiciliary care capacity. This pathway would not be in the best interests of patients. We understand that there are older people in residential and nursing home beds opened last winter to increase capacity at short notice who are still there awaiting assessment of their onward care needs.

However, the action learning on a ward at the Royal Shrewsbury following our visit also found that some patients, who were waiting for a community hospital bed, could in fact be discharged to their own home, and of the small number that were actually able to leave the hospital needed far less care than their acute based assessments had suggested. The greatest percentage of patients that were highlighted as being able to go home with the Integrated Community Services were then unable to go due to lack of planning within the acute trust.

Far too many decisions about long term care and onward care generally are being made in hospital with no belief amongst hospital staff that home first could work. The CHC pathways are not right with confusing paperwork and far too much of the process happens in the acute hospital setting.

There have been some recent changes in the way the interface teams work at Telford. Social workers are now in a hub with community health professionals available to support patients on their pathway home as needed. Again this did not appear to have filtered through to front line staff in advance of the change, causing uncertainty and a lack of understanding at the front line. It appears that the discharge teams hold most of the decision making in relation to patients that are deemed to have complex needs. The wards described being disempowered in terms of managing discharge.

There appeared to be significant delays in discharge due to availability and provision of equipment.

Staff shared with us some risks around capacity in home based care, which is provided by the private sector. A recent procurement exercise has been undertaken by the joint commissioner with the council and provision should increase from the 1st December 2015. We did not observe assurance that this would be in place and it was not clear who would be responsible for ensuring the commissioning is robust and will deliver. This was a significant concern for system resilience, given the lack of assurance provided at the time of our visit. The system could not articulate a mitigation option, which places greater risk on the reliance of bed based options. This is not in the best interest of patients when home must be the default position.

We also attended the Medically Fit for Discharge meetings at both sites, which involved large numbers of staff in meetings that have no clarity of purpose and are not action focused. Staff attending did not appear to have the necessary detail to pass onto colleagues present.

Patient/family choice was also highlighted as an issue. Clear expectations are not set with families early in the admission. Although we were told that letters had been developed to support the process, communications appeared only to be used by the time the patients had reached the latter part of their stay in hospital. We can share examples of simple information to set expectations with patients on their admission.

Every patient and where appropriate their carers should expect answers to the following four questions to be available to them every day.

- What it wrong with me?
- What is being done to fix it?
- What do I need to be able to do to go home and has anyone asked me?
- When can I go home?

On discharge patients should also know>

- What support will I receive and from whom?
- What can I expect and what should I do if I am worried about something that is happening to me?

Ideally there will be single number that they can ring and we would suggest that the existing Care Coordination Centre is ideal for this purpose.

The system appeared much weaker on prevention of admission before arrival at hospital, although we were impressed by the patient centred services for respiratory patients. We observed excellent practice from Rapid Response although they had limited nonclinical support and appeared to spend large amounts of time trying to source care packages. There is a brokerage service to support this; we were told that this sometimes became quite a bureaucratic process although it should help. We suggest that there is a conversation between ICS and the Council led brokerage team in Shropshire to understand the issues.

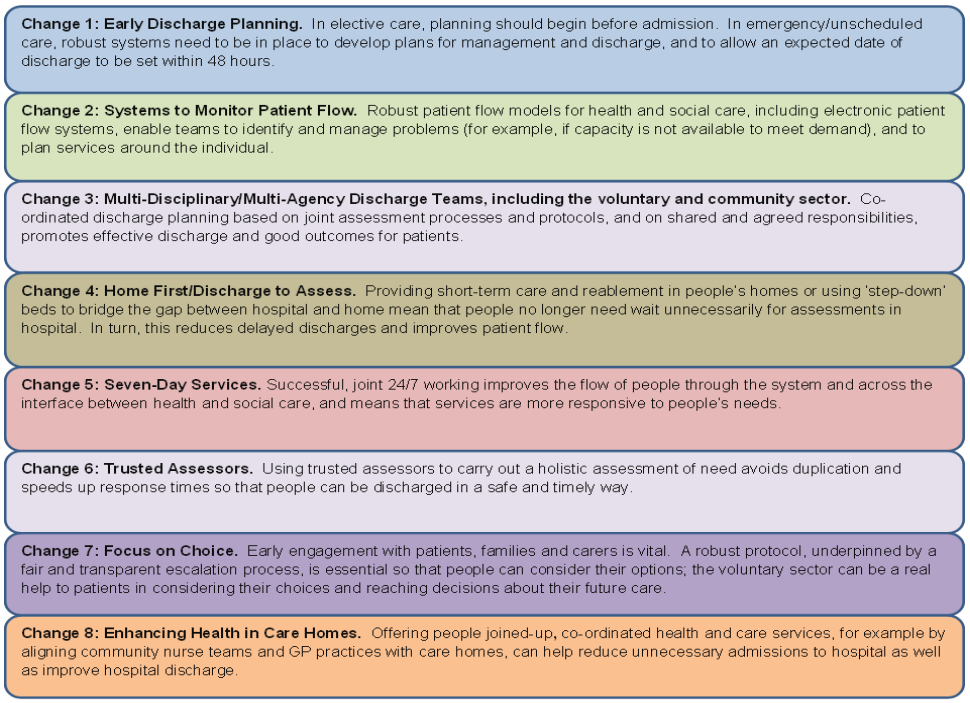
The IDT teams based around GP practices are not as advanced as we usually experience. This is particularly related to the management of patients who may require admission in the future or indeed are frequent attenders. The recent changes in the way community matron's work may bring some improvement. There appears to be a gap of focused medical support keeping patients at home in the community. Admissions from Nursing and Residential homes should be looked at specifically as the evidence base shows that this is an area where prevention of admission can have a significant impact.

The therapists across the community services may be better placed in the ICS team, which is currently struggling with lack of therapy support. It was also not clear what value the Single Point of

Access added and this will require evaluation by the SRG alongside the potential to use the Care Coordination Centre.

Recommendations:

Last winter, the Helping People Home Team (DH, DCLG, LGA, ADASS and NHS England) provided support and challenge to local systems experiencing high levels of delayed discharges.
Their work with 45 economies across England highlighted the importance of working across whole systems to ensure smooth patient 'flow' through health and care services. The work highlighted a number of interventions that were key to supporting improved performance that are listed in the table below. Our priority recommendations are focused on using this framework.



- Early discharge planning should start with Expected Date of Discharge, which should be picked up in the SAFER work stream.
- The ICS should capture unmet need and all referrals for discharge should go through them whether health or social care using the FFA. We are aware that this is work in progress and encourage its introduction as possible.
- There should be a focus on behaviour to drive a 'think home first' system wide approach – the system is currently still too reliant on bed based solutions. This should be led by the system leaders and form part of the vision for UEC.
- The delays in providing equipment needs to be reviewed and understood.
- Delays in provision of equipment should be reviewed

- The MFFD meetings should be reviewed to ensure they are fit for purpose with a view to moving the discussions back to the ward teams.

- The functions of Single Point of Referral should be reviewed, developing possible links with Care Co-ordination Centre

- Robust plans need to be in place to ensure increased domiciliary care is delivered in Shropshire by 1st December 2015.

- All organisations should work together to develop a model that introduces patient information regarding the choice policy at the beginning of the acute episode. This model should be comprehensively communicated with all staff. In many sites, we have seen a positive effect in using welcome cards, ticket home or patient passport concepts to inform the patient and family of next steps.

7. Escalation

We would recommend that the system review the overarching system escalation plan and processes to manage heightened pressures. Many areas are struggling with escalation given that operating at a red/black level has been normalised. There is a need to calibrate the system in order to introduce an effective system wide escalation.

Recommendation:

- The current operational process in managing heightened escalation needs to be reflected upon and an evaluation of the outcomes being delivered through the teleconference meetings should be completed and discussed at the next SRG. From our observation, these processes are not managed appropriately and are causing dysfunctionality in the system thus leading to fractious relationships between providers and commissioners. This is significant enough to impact on patient care. This must be resolved as an urgent priority, working to the principle that such processes are to support the system to address difficult challenges.

8. Emergency Department – Workforce

The trust is struggling with the resilience of the Emergency Departments due to significant number of consultant vacancies. The team described current pressures as unsustainable, particularly across the Consultant on-call rota. If the Trust has not previously, we advise that College support is requested for advice and guidance. The ECIP team has College colleagues as part of our enhanced offer to systems and we would be happy to arrange a facilitated session with the Trust's ED team to review current challenges and explore opportunities that have been borne out by work undertaken / recommended by the College.

Recommendations (to assist not completely resolve):

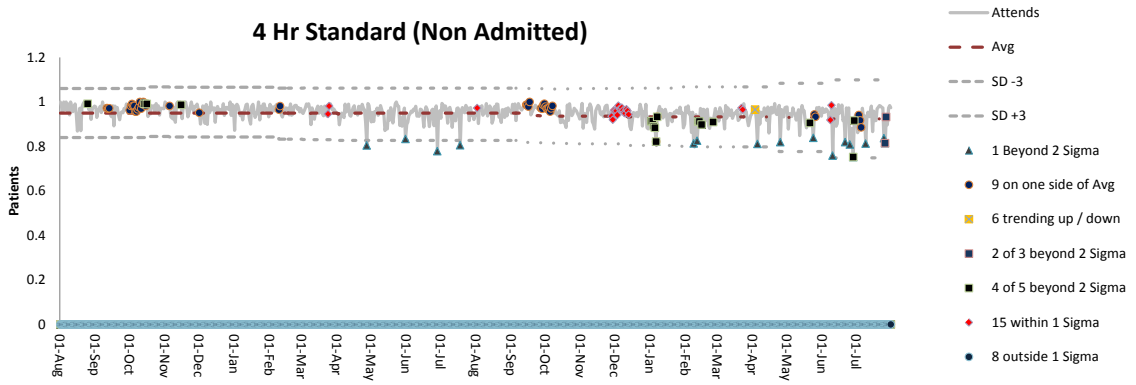
<u>ED Review Clinics</u>

- We were made aware that ED review clinics run 5 days per week across sites. This is unusual, as most EDs no longer run such clinics. The question should be asked, what can be managed in community and alternative plans sought prior to winter to release the ED senior clinical resource to care for on the day unplanned emergency presentations?

Enhance the level of ANP / ENP workforce in ED

- It was encouraging to see the ED utilise the ENP / ANP roles following recent investment. It is apparent that further opportunities are available to enhance this workforce and it would be in the Trust's best interest, given challenges in recruitment across other senior decision making roles in ED, to review options to increase pace to bring additional ENP / ANPs on line. This would also support addressing performance variation across the Princess Royal ED non-admitted pathways' where it was reported that the pathway is causing issues in performance. The Trust should be aiming for at least 98% of patients being seen, treated and discharged within 4 hours across the non-admitted pathway. This needs to be continually monitored locally to understand issues and identify resolution.

Princess Royal Non Admitted 4 Hour Standard Performance:



Urgent Care Centre at Royal Shrewsbury

- We are supportive of the introduction of a co-located UCC. However, from observation and talking to clinical staff the unit is not being maximised (in terms of levels of activity that could be streamed as an alternative to ED). The streaming process needs to be reviewed at the front door. The principles of good practice that underpin a co-located ED/UCC are well described in our Safer Faster Better document. We would encourage you to make reference to this in the future development of the front door model. We would be very happy to arrange a workshop that involved commissioners, acute, primary care and UCC staff to design the most effective model for SATH and wider system.

Priority Recommendations

Of the 8 recommendations above we would wish to highlight the 5 short term priorities for the heath economy to initially focus on and these are listed below: -

- Leadership and the Development of a System Wide Vision
- Ward Processes and the SAFER patient flow bundle
- Ambulatory Emergency Care
- Interface and Discharge
- ED

Next Steps

We hope that this report has been useful. We welcome any feedback on the content/accuracy. We would like to formally thank those involved in our visit for their time and constructive discussions.

Future Support

As you are aware, we have assigned Karen Campion, Intensive Support Manager, to be your ECIP support going forward and Karen will start working with you in December 2015. It is essential we agree what support you would like from our enhanced team function to enable you to make the improvement at pace but in a sustained manner.

It must be noted that the arranged visit was stepped down at the request of the system due to the Virginia Mason visit at the Acute Trust scheduled to take place on the same week (unknown to ECIP at the time). The system requested that the visit to be reinstated at short notice which we gladly supported and assembled a team to conduct the review. Based on the short notice planning, it must be acknowledged that the system did not setup all requested meetings with key stakeholders. For example, we did not meet 111 or WMAS service leads as requested within our initial itinerary. The ECIP support is an offer that will be in place to the system up to 31 March 2016 (as a minimum). Therefore if the system feels that the initial visit did not cover a particular aspect of the UEC pathway we will commit to a visit to review this particular part of the pathway. The report does however focus on the 'high impact' priorities that the ECIP team feel that if delivered, will provide the greatest marginal gains to improve performance across the system. Whist the above highlights that some aspects of the pathway were not reviewed we did however get excellent exposure to services and staff, and remain confident that of our 'high impact' priorities should be the focus for system leads to deliver rapid and sustained improvement across UEC.

We were encouraged by the positive discussions that took place on 7th December with ECIP and system leaders particularly on the issues of leadership and the development of a system vision. We look forward to working with you over the coming months

Yours Sincerely,

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Report to:	Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin, 2 March 2016

Title	Developing our Sustainability and Transformation Plan (including the Deficit Reduction Plan)
Purpose	To update the Joint Health Overview and Scrutiny Committee on the development of a Sustainability and Transformation Plan for Shropshire and Telford & Wrekin
Date	24 February 2016
Previously considered by	Not applicable

Introduction to Sustainability and Transformation Plans

The leaders of the national health and care bodies in England have set out steps to help local organisations plan over the next six years to deliver a sustainable, transformed health service and to improve quality of care, wellbeing and NHS finances.

Called "Delivering the Forward View, the NHS planning guidance for 2016/17 – 2020/21" (copy attached) it sets the framework within which £560 billion of NHS funding will be spent over the next five years.

The planning guidance outlines a new approach to help ensure that health and care services are planned by place rather than around individual institutions. As in previous years, NHS organisations will be required to produce individual operational plans for 2016/17. In addition, every health and care system will be required, for the first time, to work together to produce a Sustainability and Transformation Plan, a separate but connected strategic plan covering the period October 2016 to March 2021.

As part of this, local leaders will be required to set out clear plans to pursue the 'triple aim' set out in the NHS Five Year Forward View – improved health and wellbeing, transformed quality of care delivery, and sustainable finances.

The guidance also outlines nine 'must dos' for every local area in England in 2016/17, agreed by the leading health bodies in England. These include:

- returning the system to financial balance
- introducing a local plan to address the sustainability and quality of general practice
- reducing waiting times for A&E, cancer and mental health
- improving quality – particularly for organisations in special measures.

The guidance is supported by the proposal, currently under consultation from Monitor and NHS England, that hospital trusts make annual efficiency savings of 2%.

Further guidance has been issued by the national health and care bodies setting out the requirements for developing Sustainability and Transformation Plans by June 2016.

The nine "must dos" for 2016/17 for every local system

1. Develop a high quality and agreed STP, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.

2. Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the sustainability and quality of general practice, including workforce and workload issues.

4. Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice.

6. Deliver the NHS Constitution 62 day cancer waiting standard, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the two new mental health access standards: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with learning disabilities, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make improvements in quality particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of avoidable mortality rates by individual trusts.

Key requirement for developing Sustainability and Transformation Plans

Key requirements for the development of Sustainability and Transformation Plans by Easter include:

- Agreeing the "transformation footprint" for each Sustainability and Transformation Plan (in other words, the geographical coverage of the plan)
- Clarifying the local governance arrangements and processes for agreeing and implementing the Sustainability and Transformation Plan – including how patients and communities will be engaged
- An understanding within the footprint of:

- The health and wellbeing gap.
- The care and quality gap.
- The finance and efficiency gap.
- Further guidance on assessing these gaps is expected during the week beginning 29 February 2016

- An understanding of the key priorities to address the gaps identified above

Our approach in Shropshire and Telford & Wrekin

Our recommendation that the local transformation footprint should be Shropshire and Telford & Wrekin (rather than a larger geography) has been accepted so we have begun to establish our planning process, building on the work already underway on NHS Future Fit, Community Fit, our Deficit Reduction Plan, Primary Care Strategy and other supporting programmes.

A presentation will be provided to the JHOSC to outline the emerging approach (copy attached).

JHOSC views on the following issues (reflecting on your local intelligence, and on your review and scrutiny of health and care issues in the area, in the context of national policy and guidance) are particularly welcomed:

- The health and wellbeing gap in Shropshire and Telford & Wrekin
- The care and quality gap in Shropshire and Telford & Wrekin
- The finance and efficiency gap in Shropshire and Telford & Wrekin
- Priority actions to address the above.

STP Programmes: Deficit Reduction Plan

As reported to the Joint Health Overview and Scrutiny Committee in February, work to develop the Deficit Reduction Plan is continuing and expected to conclude later in March. An oral update will be provided to the meeting.

Enclosures:

- Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21
- Developing Sustainability and Transformation Plans to 2020/21
- Presentation Slides

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 1

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 2

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

    - how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
    - their planned contribution to the efficiency savings;
    - their plans to deliver the key must-dos;
    - how quality and safety will be maintained and improved for patients;
    - how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
    - how they link with and support with local emerging STPs.

    The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

    - greater equity of access through pace of change, both for CCG allocations and on a place-based basis;

    - closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and

    - faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

    - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

    - What action will you take to address obesity, including childhood obesity?

    - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, responsible consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

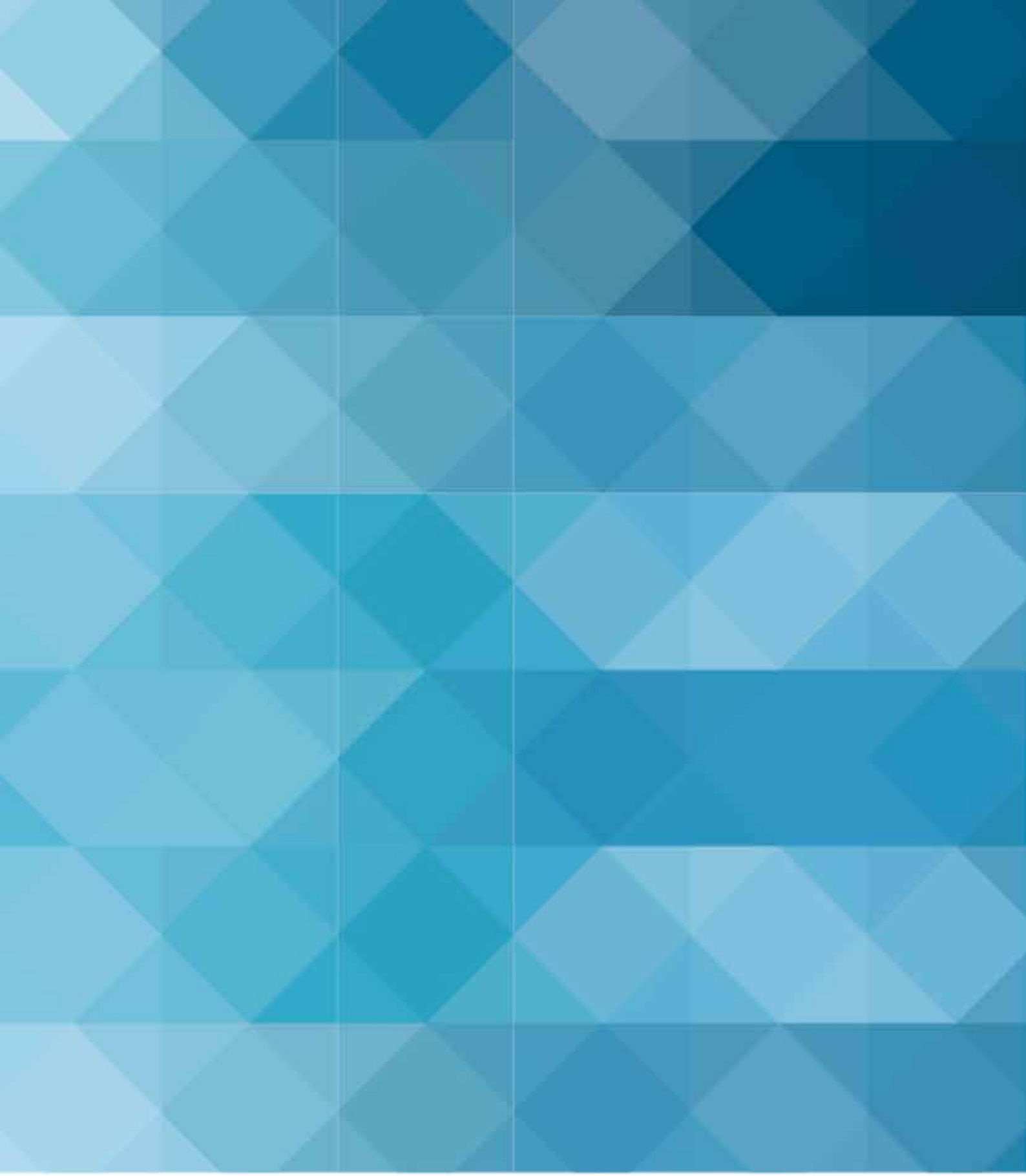
5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.



#FutureNHS

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 2

Developing Sustainability and Transformation Plans to 2020/21

To: CCG Accountable Officers,
Chief Executives of NHS trusts,
NHS foundation trusts and Local
Authorities and LETB Geographical
Directors

By email

16 February 2016

Dear colleague

Re: Developing Sustainability and Transformation Plans to 2020/21

The NHS Shared Planning Guidance asked every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View (5YFV). Sustainability and Transformation Plans (STPs) will be place-based, multi-year plans built around the needs of local populations. They will help ensure that the investment secured in the Spending Review does not just prop up individual institutions for another year, but is used to drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term. STPs are not an end in themselves, but a means to build and strengthen local relationships, enabling a shared understanding of where we are now, our ambition for 2020 and the concrete steps needed to get us there.

We have been encouraged by the speed and enthusiasm with which most areas have already come together to agree their footprints and start the conversations. The boundaries used for STPs will not cover all planning eventualities. As with the current arrangements for planning and delivery, there are layers of plans which sit above and below STPs, with shared links and dependencies. For example, neighbouring STP areas will need to work together when planning specialised or ambulance services or working with multiple local government authorities and, for areas within a proposed devolution footprint that cross STP boundaries, further discussion will be required in working through the implications. Other issues will be best planned at Clinical Commissioning Group (CCG) level.

If we get this right, then together we will:

- engage patients, staff and communities from the start, developing priorities through the eyes of those who use and pay for the NHS;
- develop services that reflect the needs of patients and improve outcomes by 2020/21 and, in doing so, help close the three gaps across the health and care system that were highlighted in the 5YFV (health and wellbeing, care and quality, and finance and efficiency);
- mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver;
- provide a better way of spreading and connecting successful local initiatives, providing a platform for investment from the Sustainability and Transformation Fund; and

- develop a coherent national picture that will help national bodies support what local areas are trying to achieve.

This will require a different type of planning process – one that releases energy and ambition and that focusses the right conversations and decisions. It will require the NHS, at both the local and national level, to work in partnership across organisational boundaries and sectors.

This letter sets out our initial thinking on STPs – please see **Annex A** for further detail. We recognise that you and your teams are also working hard on operational plans, so over the next few weeks and months we will develop an active programme of support for our local and national teams, based on what you tell us you need.

We look forward to continuing to work closely with you to deliver this important work.

Yours faithfully

David Behan, Chief Executive, Care Quality Commission
Ian Cumming, Chief Executive, Health Education England
Sir Andrew Dillon, Chief Executive, National Institute for Health and Care Excellence
Jim Mackey, Chief Executive - Designate, NHS Improvement
Duncan Selbie, Chief Executive, Public Health England
Simon Stevens, Chief Executive, NHS England

Annex A

Stage 1: Before Easter – developing local leadership and collaboration

1. To have a realistic prospect of developing good plans by the summer, we will need to have agreed three things for each of the STP footprints by Easter:

   (i) the governance arrangements and processes needed to produce an agreed STP and then to implement it;
   (ii) the scale of the challenge locally for each of the three gaps; and
   (iii) key priorities identified to address each gap.

2. **Governance arrangements**: Building the relationships and collective leadership needed to make STPs real will take dedicated time, effort and resource. Different areas will be at different starting points. In some areas, local leaders are already working together on established transformation projects. In other areas, relationships and strategies are less mature, requiring intensive focus in the early stages.

3. Each footprint will need to set out governance arrangements for agreeing and implementing a plan. This should include the nomination of a named person who will be responsible for overseeing and coordinating their STP process – a senior and credible leader who can command the trust and confidence of the system, such as a CCG Chief Officer, a provider Chief Executive or a Local Authority Chief Executive. They will be responsible for convening and chairing system-wide meetings and facilitating open and honest conversations that will be necessary to secure sign-up to a shared vision and plan. We would expect to see time and resource dedicated to this system leadership role.

4. STPs will need to be developed with, and based on the needs of, local patients and communities and command the support of clinicians, staff and wider partners. We therefore anticipate robust plans for genuine engagement as part of the decision making process. This doesn't mean beginning from scratch. Where relevant, areas should build on existing engagement through Health and Wellbeing Boards and other existing local arrangements. Health Education England has agreed that they will establish a local Workforce Advisory Board to coordinate and support the workforce requirements for each STP footprint.

5. **The scale of the challenge:** Partners in each footprint area will need to quickly get a sense of the scale of the forecast challenge in their local area, by working out the extent of the three gaps. To accelerate this process, we will provide a method with data to enable local partners to diagnose current and projected gaps in health and wellbeing, care and quality and finance and efficiency, including current and expected delivery on key service priorities such as cancer and seven day services. We will publish more detail on this during the week commencing **29 February 2016**.

6. **Identify key priorities:** An assessment of the three gaps, alongside a consideration of local challenges where patients and populations need to see most improvement, will help each area to identify the key priorities they need to tackle over the next five years to achieve sustainable transformation. Where, for example, Vanguards and

Integrated Care Pioneers are leading the transition to new care models, local leaders will want to set out how the learning from these can be applied in the coming years.

7. There is clearly a lot to do in a short space of time. To help support local and national learning, each footprint will be asked to attend one of four regional 'development days' to share their emerging thinking with one other and with the Chief Executives of the national bodies. This will help us to identify further areas for support and shape the next stage of the process. Ahead of these regional 'development days' we will ask each planning footprint to make a short return on the above three issues (governance, gap analysis and key issues).

8. **National support until Easter:** By March, we will provide each local system with:

   - **Input into assessing each of their three gaps** – this will set out the key health and well-being outcomes the NHS and partners need to improve by preventing illness, diagnosing disease earlier and treating it more effectively; the quality improvement and service change priorities by 2020, such as moving to seven day services and (by the end of March) provide each area with analytical support to help assess its financial gap.
   - **Share information and provide support –** based on what you tell us you need and using some of the tools that Vanguards and other collaborations have found useful as they have developed new systems and relationships. This will include using logic models as a basis for longer-term planning, and information about the core components of the different care models (e.g. multi-speciality community providers (MCPs) and primary and acute care systems (PACS) or devolved arrangements).
   - **Publish advice on engaging individuals, communities and staff** – drawing on exemplar practice from the service and partners and the 'six principles' developed by the People and Communities 5YFV Board.

   In addition we will:

   - ask our regional teams and partners to support the process of building local leadership and effective decision-making, sharing what we've learned from working with, for example, Vanguard sites and others through communities of practice;
   - work with you to identify and enlist a group of respected individuals who have the experience and credibility to mentor and catalyse system leadership where it is needed. This could include people with experience of health leadership roles, as well as local government and the voluntary sector. We will make this offer to all local areas that would benefit from individual support to accelerate progress; and
   - share some further tools, templates and guidance along with some exemplars to support local development of returns. For example we will work quickly with a small number of leading systems as they develop their plans to provide models for what good Easter returns and June plans look like and make these available to everyone.

Stage 2: after Easter – developing the STP

9. After Easter, local area partners will be able to focus on more of the detail of their plans and the actions required to close the three gaps over the next five years. To do this, they should consider their response to the set of questions outlined in the annex to the Shared Planning Guidance, given the results of their gap analysis and continuing engagement with local communities, staff and other partners.

10. The Shared Planning Guidance sets out nine 'must dos'. Many, if not all, of these will require action beyond 2016/17. A good STP will therefore set out how areas will maintain and deepen the progress they will make by implementing their operational plans. This is one tangible way in which 2016/17 operational plans need to be closely linked to STPs, and conceived as the first steps on the way to wider transformation.

11. Strong STPs will set out a broader platform for transforming local health and care services. We will work with the footprints to help us develop the detailed requirements. However, as a minimum, we expect that all plans will:

- describe a local cross-partner prevention plan, with particular action on national priorities of obesity and diabetes and locally identified priorities to reduce demand and improve the health of local people;
- increase investment in the out-of-hospital sector, including considering how to deliver primary care at scale;
- set out local ambitions to deliver seven day services. In particular: (i) improving access and better integrating 111, minor injuries, urgent care and out-of-hours GP services; (ii) improving access to primary care at weekends and evenings; and (iii) implementing the four priority clinical standards for hospital services every day of the week;
- support the accelerated delivery of new care models in existing Vanguard sites; or in systems without Vanguards, set out plans for implementing new models of care with partners;
- set out collective action on quality improvement, particularly where services are rated inadequate or are in special measures;
- set out collective action on key national clinical priorities such as improving cancer outcomes; increasing investment in mental health services and parity of esteem for mental health patients; transforming learning disabilities services; and improving maternity services;
- ensuring these and other changes return local systems to financial balance, together with the increased investment that will come on-stream as set out in NHS England's allocations to CCGs; and
- be underpinned by a strategic commitment to engagement at all levels, informed by the 'six principles'.

12. We must avoid creating distinct plans for each specialty or initiative, and instead grasp the opportunity to achieve greater alignment and coherence between programmes and priorities. Local leaders will also want to ensure that their plans are underpinned by action on the key enablers of change, including harnessing technology and workforce redesign, working closely with their Local Education and Training Boards (LETBs). Local areas should also have considered the fit between

their STP footprint and their local plans for integrated health and social care more broadly, and decided on the high-level model of person-centred, coordinated care that they would look to develop.

13. The aim should be to produce an STP that is based upon strong analysis and insight rather than a glossy brochure. The process of exposing these issues and having real conversations about the potential benefits for patients is as least as important as the final product itself. A robust process will enable STPs to set out the actions that will make a difference for local people rather than abstract principles or vision statements. The examples we publish at Easter will give local areas a better sense of what a good final document looks like, but we are clear that a good process is one that unleashes energy, facilitates real conversations and strengthens local relationships around a shared sense of purpose.

14. **National support after Easter:**

- In April and May, we will host a programme of regional workshops and webinars with subject matter experts to provide practical help with developing plans. We will continue to make available online collaborative tools so that local areas can share information and examples of emerging best practice, based on what you tell us would be most helpful.
- These will be supplemented by a suite of 'how to' materials so that we can develop a shared understanding of what good looks like on topics including implementing the Cancer and Mental Health Taskforce reports, developing and spreading new models of care, workforce redesign and planning for interoperability and digital services.
- Our regional teams and their partners will continue to work closely with local footprints as they develop the detail of their plans, to enable effective communication and learning across the system.

Sustainability and Transformation Funding

15. There will be tangible benefits for areas with good STPs. The Spending Review settlement enabled us to invest £2.139bn in a Sustainability and Transformation Fund in 2016/17. Of this total, £1.8bn of funding has been allocated to the sustainability element of the fund to bring the NHS provider trust sector back to financial balance.

16. Quarterly release of sustainability funds to NHS trusts and NHS foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. It is not a case of recovery followed by transformation. They are not alternatives; we must do both simultaneously.

17. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign-off of a robust STP during 2016/17.

18. The Sustainability and Transformation Fund will grow from £2.1bn in 2016/17 to £2.9bn in 2017/18, rising to £3.4bn in 2020/21, with an increasing share of the growing fund being deployed on transformation.

19. The STPs will become the single application and approval process for being accepted onto programmes with transformation funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

20. Recognising that different systems are at different starting points, the most credible and compelling STPs will secure the earliest funding. We will assess plans in July, and – as the Shared Planning Guidance sets out – we will consider:

    - the quality of plans, particularly the scale of ambition and track record of progress already made in addressing each of the three gaps. The best plans will have a clear and powerful vision across health, quality and finance, owned by all local partners in the system. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new models of care; trusts in special measures and finance. They will systematically borrow good practice from other geographies and adopt national frameworks;
    - the reach and quality of the local process, including community and voluntary sector engagement;
    - the strength, maturity and unity of local system leadership and partnerships, with clear governance structures to deliver them;
    - how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities; and
    - the extent to which systems can already point to tangible, early progress.

21. Part of this process will involve a second series of regional events hosted by the Chief Executives of the national bodies. Taking place in July, these regional summits will be an opportunity to test the plans that local systems have submitted, and agree the actions we will take to deliver them.

22. **Contacts:**

For any queries, please contact the Regional Director from the relevant national body in the first instance or please email england.fiveyearview@nhs.net

23. **Key Dates:**

What	Who	When
Further engagement and support on gap analysis and STP development	National bodies	Week commencing 29 February 2016
Gap analysis / data developed with each footprint	National bodies / Regional Directors / footprints	Throughout March 2016
Short return, including	Each footprint	11 April 2016

priorities, gap analysis and governance arrangements		
Outline STPs presented	Footprints to attend regional events to discuss emerging plans with peers and national bodies	w/c 22 April 2016
Each footprint area to develop plans and build support with their boards and partners	As set out in local governance arrangements	During April/May/early June 2016
Ongoing engagement and support from national policy experts and teams to support priority development	National policy teams and experts	During April and May 2016
Each footprint to submit their STP	To Regional Directors and then the 5YFV Board of national body Chief Executives	30 June 2016
Series of regional conversations between national teams and footprints	The NHS national body Chief Executives, National Directors, partners and footprints	Throughout July 2016

Update on Winter Pressures and the Urgent and Emergency Care System

Annex 3

Presentation Slides

Shropshire and Telford and Wrekin Sustainability and Transformation Plan (STP)

Introduction

The last spending review set out the basis for:

* Implementation of the "Five Year Forward View"
* Restoring and maintaining financial balance to the NHS
* Delivery of core access and quality standards for patients

What we have to do?

* Following the spending review we now have national guidance outlining the requirement to:

  - Develop a Five Year Sustainability and Transformation Plan (STP), based on local health and social care systems and delivering the Five Year Forward View.
  - Develop a one year operational plan for each organisation, consistent with the STP – a year of stabilisation.

* STPs are to be submitted by the 30 June 2016 and will be formally assessed in July 2016.

Context of the STPs

* Planning by individual institutions increasingly supplemented with planning by place for population

* System leadership will be needed and involve:

    - Local health and social care leaders coming together as a team
    - Developing a shared vision with the local community
    - Setting out a programme of activities to make the STP happen
    - Implementation of the plan once it is written
    - Learning and adapting to develop the right solution

* Engaging and iterative process that harmonises the energies of clinicians, patients, carers and citizens and local community partners.

* Must cover all areas of CCG and NHS England spend as well as relevant local authority services reflecting health and wellbeing strategies.

Access to Transformation Funding

* For the first time the planning process will have significant central money attached
* STP will be the single application and approval process for transformation funding for 2017/18 onward
* This protected funding is for initiatives such as the spread of new care models, technology roll out, prevention etc
* The criteria to assess STPs will include:

  - Scale of ambition, track record of progress already made
  - Clear and powerful vision with a coherent story across the system
  - The reach and quality of the local process
  - The strength and unity of the local system leadership and partnerships
  - Confidence that there is a clear sequence of implementation actions

Context of STPs

* A clear overall vision and plan for the area including system-wide financial sustainability
* Agreement of the transformation footprint (Shropshire and Telford & Wrekin)
* Clear plan for the radical upgrade in prevention, patient activation, choice and control and community engagement – how we will close the health and wellbeing gap
* New care model development, improving against clinical priorities and rollout of digital healthcare – how we will drive transformation to close the care and quality gap
* Achieving financial balance around the local systems and improve the efficiency of NHS services – how we will close the financial and efficiency gap

What are we doing in Shropshire and Telford and Wrekin?

* Build on what is already in place (e.g. NHS Future Fit)

* Putting in place the governance and implementation process for the STP – building on what is in place rather than creating a new bureaucracy

* Working in partnership across the local health and care system to develop our approach in the context of emerging national guidance

* Creating a coherent and shared vision across the health and care system

Key questions for the Joint HOSC

Considering your work programme and intelligence:

* What are the main features of the **Health and Wellbeing Gap** in Shropshire and Telford & Wrekin
* What are the main features of the **Care and Quality Gap** in Shropshire and Telford & Wrekin
* What are the main features of the **Finance and Efficiency Gap** in Shropshire and Telford & Wrekin
* What views do you have on the main priorities to address these gaps?

Questions

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