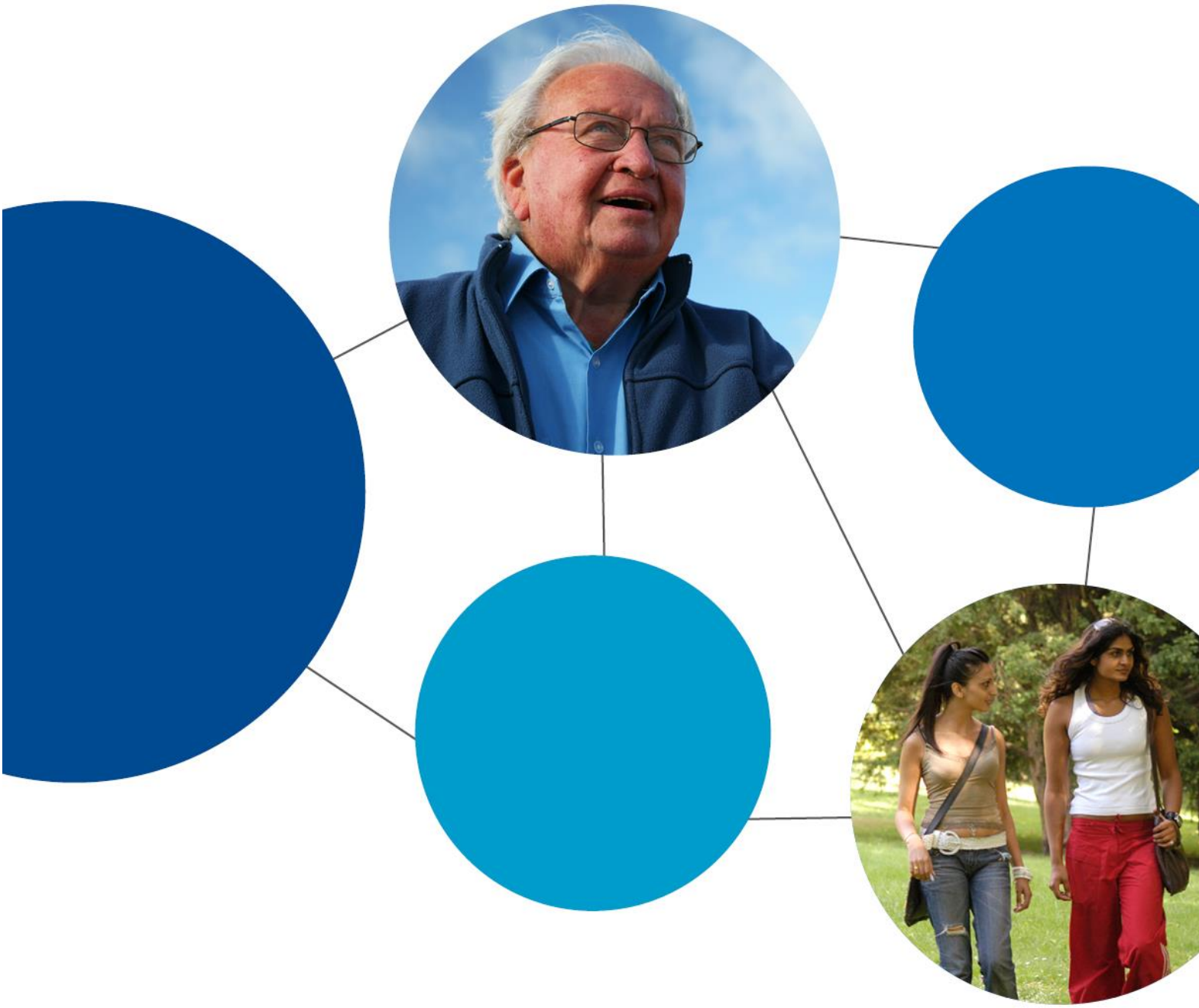
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Pre-Consultation Business Case – November 2017

VERSION CONTROL

Version and file name	Date	Nature of revision	By whom	Amended version shared with
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List of Abbreviations

A&E	Accident and Emergency
ACS	Ambulatory Care Sensitive
AEC	Ambulatory Emergency Care
AGM	Annual General Meeting
AMU	Assessment Medical Unit
AO	Accountable Officer
BAME	Black and Minority Ethnic Groups
BCBV	Better Care, Better Value
BCF	Better Care Fund
BMI	Body Mass Index
BPT	Best Practice Tariff
C&CC	Community and Care Co-ordinators
C&YPS	Children and Young People's Services
CAB	Citizens Advice Bureau
CAU	Children's Assessment Unit
CCG	Clinical Commissioning Group
CDG	Clinical Design Group
CDU	Clinical Decision Unit
CGA	Comprehensive Geriatric Assessment
CHC	Community Health Council
CIP	Cost Improvement Programme
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CRG	Clinical Reference Group
CSU	Commissioning Support Unit
CT	Computerised Tomography
CU	Community Unit
CVD	Cardio Vascular Disease
DAART	Diagnostics, Assessment and Referral for Treatment
DCAG	Departmental Cost Allowances
DfT	Department for Transport
DH	Department of Health
DMBC	Decision Making Business Case
DoF	Director of Finance
DPS	Dynamic Purchasing System
DTC	Diagnostic and Treatment Centre
DTOC	Delayed Transfers of Care
DVT	Deep Vein Thrombosis
EAC	Equivalent Annual Cost
EC	Emergency Centre
ED	Emergency Department
ENT	Ear, Nose and Throat
EPR	Electronic Patient Record

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ETTF	Estates and Technology Transformation Fund
EMIS	GP electronic patient administration system
FBC	Full Business Case
FCHS	Future Configuration of Hospital Services
FFP	Future Fit Programme
FTT	Fit to Transfer
GIA	Gross Internal Area
GP	General Practitioner
GMS	General Medical Services
GPFV	GP Forward View
HCA	Health Care Assistant
HCPG	Healthcare Premises Cost Guide
HDU	High Dependency Unit
HIA	Hospital Acquired Infection
HM	Her Majesty's
HRG	Healthcare Resource Group
HWB	Health and Wellbeing
ICS	Integrated Community Services
ICT	Intermediate Care Team
ICU	Intensive Care Unit
IIA	Integrated Impact Assessment
IM&T	Information Management and Technology
IMD	Index of Multiple Deprivation
INR	International Normalised Ratio
IT	Information Technology
ITU	Intensive Treatment Unit
JHOSC	Joint Health Overview and Scrutiny Committee
LA	Local Authority
LDR	Local Digital Roadmap
LGBT	Lesbian, Gay, Bi-sexual and Trans-sexual
LHE	Local Health Economy
LMC	Local Medical Committee
LOS	Length of Stay
LPC	Local Planned Care
LSOA	Lower Supra Output Area
LTC	Long Term Conditions
MCP	Multi-specialty Community Provider
MH	Mental Health
MIU	Minor Injuries Unit
MLU	Midwifery Led Unit
MP	Member of Parliament
MSK	Musculo-Skeletal
NHS	National Health Service
NHSE	NHS England

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NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
NPC	Net Present Cost
OBC	Outline Business Case
ODP	Operating Department Professional
OP	Out Patient
PbR	Payment by Results
PCBC	Pre-Consultation Business Case
PCI	Percutaneous Coronary Intervention
PCS	Planned Care Site
PDC	Public Dividend Capital
PEP	Programme Execution Plan
PFI	Private Finance Initiative
PICU	Paediatric Intensive Care Unit
POCT	Point of Care Testing
PPG	Patient Participation Group
PRH	Princess Royal Hospital
PtHB	Powys Teaching Health Board
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
RCS	Royal College of Surgeons
RJAH	Robert Jones and Agnes Hunt Hospital
RSH	Royal Shrewsbury Hospital
RTT	Referral to Treatment
SATH	Shrewsbury and Telford Hospitals NHS Trust
SAU	Surgical Assessment Unit
SCHT	Shropshire Community Health NHS Trust
Shropdoc	Shropshire Doctors Co-operative Ltd
SMI	Severe Mental Illness
SOC	Strategic Outline Case
SRO	Senior Responsible Officer
SSP	Sustainable Services Plan
STP	Sustainability and Transformation Plan
T&W	Telford & Wrekin
TBC	To Be Confirmed
TDA	Trust Development Authority
TIA	Transient Ischaemic Attack
UCC	Urgent Care Centre
UK	United Kingdom
VAT	Value Added Tax
VCS	Voluntary Community Sector
VfM	Value for Money
W&C	Women and Children
WAS	Welsh Ambulance Service

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WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent

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2	Futurefit Programme Executive Plan (PEP)
3	SATH Strategic Outline Case
4	Independent Clinical Review Report - Women & Children's Variant Option
5	SATH Internal Clinical Review Report - Women & Children's Variant Option
6	2015 Option Appraisal report
7	SaTH OBC and appendices
8	Futurefit Phase 1 Activity Modelling May 2014
9	Futurefit Phase 2 Activity Modelling December 2014
10	Communityfit Activity Modelling Report 2016
11	End to End Clinical Pathways - Paediatric Asthma Pathway
12	Futurefit Non-Financial Appraisal Evidence Pack 2016
13	Integrated Impact Assessment (IIA) 2016
14	Integrated Impact Assessment Women and Children
15	JHOSC Questions and Futurefit Programme Responses
16	Futurefit Engagement and Communication Strategy
17	Futurefit Executive Summary of evidence of engagement activities
18	Draft Consultation Plan
19	Draft Consultation Documents full and summary
20	Clinical Senate Stage 1 Terms of Reference and Report
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1. Purpose of this Document

Future Fit has been Shropshire and Telford & Wrekin's major health reconfiguration programme for the last 4 years for delivering sustainable acute hospital services. NHS reconfiguration programmes are subject to assurance and approval by NHS England before entering into a public consultation process.

The Shropshire and Telford & Wrekin Clinical Commissioning Groups (CCGs) have sponsored the preparation of this Pre-Consultation Business Case (PCBC) and have approved it for submission to NHS England for final assurance.

The aims of this PCBC are to;

- Make the case for changing acute hospital services in Shropshire and Telford & Wrekin;
- Describe the future model of care and how it has been developed;
- Give detail of the pre consultation engagement that has been undertaken with the public, clinicians, staff and other stakeholders in developing the proposed model of care; and
- Make the case to commence a formal public consultation process.

This PCBC also outlines how the proposals being put forward meet the four mandated Department of Health (DH) tests for service reconfiguration and are affordable in capital and revenue terms. Recently a fifth test has been added around specific assurance as regards the deliverability of changes in bed capacity.

This PCBC describes the proposals for change to deliver high quality, safe, efficient and sustainable acute hospital services supporting the public of Shropshire, Telford & Wrekin and parts of mid Wales delivered via the Future Fit Programme.

It will outline how the system will govern and finance that change and consider the impact on patients across the region.

Once NHS England approval has been given the Future Fit Programme will move into public consultation.

Further information about the NHS England process for assuring NHS service reconfiguration can be found via the following link. https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-assdeliv-serv-chge.pdf.

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2. Executive Summary

2.1 Purpose

This Pre Consultation Business Case (PCBC) describes the proposals for change to acute hospital services for the public of Shropshire, Telford & Wrekin and parts of mid Wales to be delivered through the Future Fit Programme (FFP). It will outline how the system will govern and finance that change and consider the impact on patients.

The Future Fit Programme is targeting the initiation of a fourteen week public consultation starting in November 2017.

2.2 Future Fit programme

The Future Fit Programme for the reconfiguration of acute hospital services was established in 2013 from the outcome of the Call to Action Survey. Over the past 4 years it has been very much a clinically-led and engaging process as solutions have been developed for the health system's pressing need to address the serious shortfall in workforce across a number of specialties. Three hundred clinicians and patients were involved in the original clinical design work and all agree that high quality, safe, efficient and sustainable hospital services can only be delivered if changes are made. Everyone agreed that doing nothing is not an option

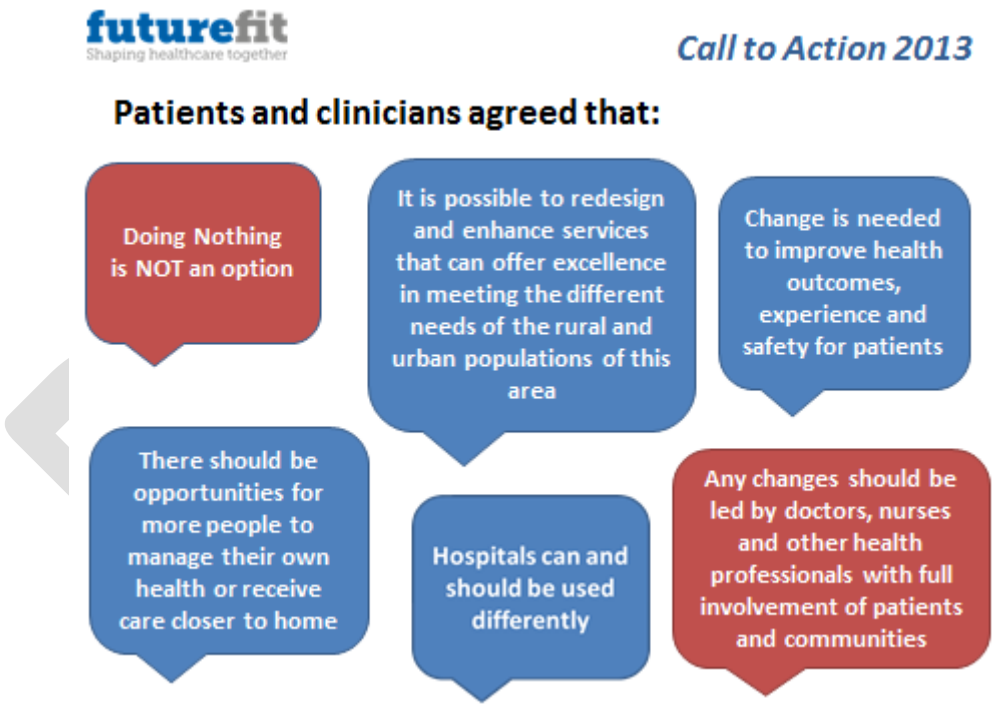


Figure 1: Future Fit Call to Action 2013

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

The new model of care began its development in 2014 and the foundations for this work is described in the Clinical Work stream Models of Care Report in appendix 1. The programme's focus quickly became the reconfiguration of acute hospital services because of the worsening position and vulnerable nature of some of the acute services related to workforce shortages. This has led to the development of the Outline Business Case (OBC) by the Trust which forms the basis of this PCBC. It is the acute reconfiguration of services on which the CCGs would wish to consult at this point in time.

The CCGs absolutely recognise the clear interdependencies of community models of care to delivering the acute business case and have set out in the PCBC the proposals for community solutions that support the acute model. This is not however a consultation proposal or a business case for out of hospital care. The modelling work done however, since the approval of the strategic outline case, provides sufficient confidence in the clinical evidence base, assumptions and opportunity set out in the acute business case for admission avoidance and in the investment required to support people in the community particularly the growing frail older population.

2.3 Rationale

Local acute hospital services have developed over many years with clinicians, managers and staff trying to keep pace with changes in demand, improvements in medicine and technology and increased expectations of the populations served. Nevertheless, all stakeholder partners recognise that the current acute hospital configuration is not sustainable.

Workforce is the primary driver for the proposed changes and the situation has become critical. There are serious recruitment challenges across a number of specialties due to poor employee experience related to duplication of services across 2 sites and the resulting onerous staffing rotas. Linked to this there are high levels of locum cover resulting in premium costs and the potential for sub optimal care. Staffing levels do not meet those recommended for A&E, critical care and emergency medicine and in the case of A&E, currently the Trust does not have on site consultant presence 24/7 at both sites. This is not sustainable and clinical standards and improvements in care and developments in medicine will not progress for the populations served by the Trust without the right workforce in place.

One of the highest users of urgent and emergency care services are frail older people. Projected changes in the population profiles suggest 25% of Shropshire will be over 70 years old by 2036 and in the case of Powys 29%. This is significantly higher than national profile and further contributes to the future sustainability concerns for services provided across the system as more and more demands continue to be placed on healthcare provision.

Investment is desperately required in the facilities and buildings across both acute sites for it to continue to deliver 21st century healthcare. The condition of the existing estate was recorded in detailed surveys undertaken in 2015/16, which showed that significant amounts of the existing Trust estate did not achieve a satisfactory standard and a substantial number of areas were unacceptable, particularly at the Shrewsbury site.

Additionally, the local health system is in deficit, it spends more in a year than the funds allocated to it. To be able to respond to increasing demand and to reduce the deficit is one of the goals of the change programme and will require both the public and those who work within the health system to view the delivery of acute services differently in the future.

The CCGs believe that the proposals set out in this document will result in a number of measurable improved outcomes for patients:

- Improved clinical effectiveness through patients being cared for by the right clinician with access to senior decision makers and enhanced ambulatory emergency care with fewer unnecessary admissions
- Improved experience of care though well-designed appropriate capacity and physical settings promoting more healing for patients and improved patient experience through improved, privacy and dignity
- Separation of emergency and planned care resulting in fewer delays and cancellations
- Better support for people with long term conditions and for people living independently through early access to a consultant opinion, fewer admissions and reduced length of stay and less decompensation in frail older people.
- Equitable access to services through patients waiting less time in A&E , waiting less time for operations and avoiding cancellations and with the potential for repatriation of some services back into Shropshire

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Clinicians, patients and members of the public who participated in the Call to Action back in in 2013 and have continued to support the programme through its work since, recognising all these real and pressing issues and challenges faced locally. Four years later they have become even more critical and whilst recognising these decisions are very difficult, the CCGs believe it is now necessary to draw conclusions from all the work done within the Programme and consult with the public on the proposed changes to acute services.

2.4 What Changes are Being Proposed

2.4.1 Proposed Model of Care

The following principles and practices emerged from the clinical design work across all areas of care and specialties in 2014 as being necessary and fundamental components of an efficient, safe resilient and integrated health and social care system. These principles continue to be reflected in 2017 through the work of the STP partners:

- **'Home is normal'** describes the principle of matching people's needs with the correct level of care,
- **Empowerment** where patients who want to be empowered so they can remain autonomous and independent, even when they are ill; clinicians who want to do the job they were trained to do, and not spend too much of their time trying to navigate a poorly designed and inefficient system on behalf of their patients; communities who want to be empowered so that citizens can help each other to live 'a life well lived' in an environment that minimises isolation, vulnerability and inequality.
- **Sustainable workforce** solutions with consolidation of some services to make posts more attractive by improving the quality of work; development of novel roles to fill gaps created by recruitment issues and new models of care; and working in an integrated and collaborative way to accommodate patient journeys.
- **Needs-led services** in which patient access to care is dependent on the level of care they require Quality, safety and achieving the best outcomes may come before choice.
- **Integrated care** that improves the co-ordination, collaboration and consistency of care across time and care settings
- **Digital-enabled working practices** as a fundamental component of an efficient, safe resilient and integrated health and social care system.

In developing the more detailed delivery solutions for acute service reconfiguration, these have been the guiding principles.

2.4.2 Two Vibrant Hospitals

The proposed changes to the configuration of acute hospital services described in this document are consistent with the acute components of the Future Fit Clinical Work Stream Model of Care 2014. The proposal ensures that the future system secures and invests in two vibrant hospitals with consolidation of emergency care on one site and planned care on the other. Key components are:

- One Emergency Centre comprising:
  - one Emergency Department
  - one Critical Care Unit
- One Planned Care Centre
- Two Urban Urgent Care Centres
- Local Planned Care (outpatients, diagnostics) on both hospital sites

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2.4.3 Key Components

There will be an Urgent Care Centre (UCC) on each site open 24 hours a day 7 days a week for those patients that have an injury or illness that is urgent and cannot be treated by primary care services. It is anticipated that approximately 60% of the patients that go to the current EDs could carry on going to their nearest hospital to receive the urgent care they need under this proposed new configuration of services.

Patients will access the service on both sites as a 'walk-in' or via ambulance if it is considered by paramedic staff to be clinically appropriate. The UCCs will be staffed by a multi-disciplinary team to include GPs, Advanced Clinical Practitioners (ACPs) and nurses, specifically trained in the delivery of accident and urgent care for adults and children.

The new single ED will be fully equipped and staffed to deliver high quality emergency medical and surgical care 24 hours a day, 7 days a week, 365 days a year. Patients who are acutely ill with potential life or limb threatening injuries and require immediate diagnosis and treatment will be taken directly to the ED accessed only via transfer from an UCC or Ambulance. The ED will also serve as a Trauma Unit and will be co-located with a single Critical Care Unit. Ambulatory Emergency care will be available 12 hrs a day 365 days a year.

A new Critical Care Unit will bring together all the Acute Trust adult critical care capacity, with level 1, 2 and 3 patients being managed in the same unit. The planned capacity of 30 beds has been future-proofed for the next decade to allow for projected increases in demand. This unit will support the consolidation of emergency activity and high risk elective inpatient procedures onto one site.

There has been considerable focus on potential changes to Women and Children's services. High risk women and children's services need to be based on the emergency site. This is the clear view of the experts both locally and nationally including the West Midlands Clinical Senate. This means that in-patient Obstetrics and Paediatrics need to be co-located with ED and Critical Care. Most women and children will continue to receive the majority of their care and treatment in the same place as they do now in either option being considered. The services which will remain in their current location include:

- Midwife-led unit and postnatal care
- Maternity outpatients including antenatal appointments and scanning
- Gynaecology outpatient appointments
- Early Pregnancy Assessment Service (EPAS)
- Antenatal Day Assessment
- Children's outpatient appointments
- Neonatal outpatient appointments.

2.4.4 A Preferred Option

The commissioners wish to consult on two options to deliver this proposed model of care: Option 1: the Emergency Centre at Shrewsbury with the Planned Care centre at Telford and Option 2: the Emergency Centre at Telford and Planned Care at Shrewsbury. These are described later in this document as options C1 and B respectively.

In September 2016, the option appraisal process identified a preferred option; the Emergency Centre and Women and Children's Unit at Shrewsbury with planned care based at Telford. This preferred option was chosen because having the Emergency Care site at the Royal Shrewsbury Hospital would mean:

- it can continue to be a Trauma Unit
- fewer people would have to travel further for emergency care
- it would better meet the future needs of our older population, especially in Shropshire and mid Wales
- it offers the best value for money over the long term

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After challenges by Telford & Wrekin Council on the process and a recommendation from the Gateway Review in December 2016, an independent review of the option appraisal process was commissioned by the Programme. The resulting report by KPMG did not identify any material issues that would have resulted in a change in the preferred option and the process was deemed robust. This was supported by the Programme Board in its recommendations to the CCG Joint Committee in August 2017 who then consequently voted unanimously to proceed to consultation with the two options including identifying the preferred option. The details of the process for both the non-financial and financial appraisal are set out in section 11 of this document.

The Programme has demonstrated that the new model of acute care will improve services and outcomes for all patients whilst also tackling the service and workforce challenges facing the Trust. Impact assessments have concluded that in terms of overall health impacts, in either option under consideration, the main changes are expected to sustainably improve the effectiveness, safety and patients' experience of clinical care provided to the whole population. These projected positive overall health impacts achievable under both options are the most significant of all the impacts assessed. It is recognised in this work however that several groups will experience a combination of positive and negative equality effects arising from the projected impacts.

Some of these groups, for example the very young and the older population, may be disproportionately most likely to use the affected services, and therefore benefit the most from the projected positive health impacts. Equally however some may be disproportionately affected by the longer projected journey times from certain localities. Developing plans for mitigation of these impacts will form a key part of the consultation and engagement work of the programme through the next immediate period.

2.4.5 Out of Hospital Care

The acute case assumes a number of non-elective admissions and inpatient bed days will be avoided at the end of a five year period through a 50% reduction in delayed transfers of care, implementation of 7 day working and reducing demand through new community models. For the acute model of care therefore to work optimally and to achieve maximum benefit, all health and social care sectors need to contribute their part to effective and integrated patient pathways which both support reduction in demand on acute services and improve flow through acute services to discharge back to community. This will require investment for appropriate alternative community service provision to acute hospital care. Section 9 describes the approach being taken to ensure that these wider system capacity changes and impacts are delivered to support the activity and capacity assumptions in the PCBC. It describes the proposed community models at their current stage of development.

In approving the Strategic Outline Case in 2016 the CCGs and stakeholders recognised the importance of further developing the community and primary care models necessary to support the acute solutions. There has been good progress in better understanding the challenges in current provision and where there are opportunities for change and they are described at a high level in this PCBC. Through the work that has been done, there is now a level of confidence in the out of hospital care shifts assumed in the OBC for Acute Services and overall affordability. However particularly in rural Shropshire, the public quite reasonably seek assurances around the detail. The options and strategic case for change around community provision will emerge over the coming months and will need to be set out in more detail before the Decision-Making Business Case (DMBC) is approved for Future Fit in early 2018.

2.5 The Department of Health 5 Tests

In order to proceed to public consultation on proposed service reconfiguration the Future Fit Programme needs to ensure it has met the original Department of Health (DH) four tests and the supplementary requirement which was introduced in April 2017. The original DH 4 tests are:-

- Strong public and patient engagement
- Consistency with current and prospective patient choice
- Clear clinical evidence base

- Clinical Commissioners Support

In addition, from April 2017, local NHS organisations have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.

The Programme believes it has met these tests sufficiently at this stage to proceed to consultation and sets out the detail within this PCBC against each. Some of the key points are summarised below:

2.5.1 Strong Public and Patient Engagement

Future Fit was set up in 2013 in response to the Government's 'Call to Action' which asked NHS staff, patients, the public and politicians to come together and agree what changes are needed to make our local NHS services fit for the future.

From the beginning, Future Fit has been led by doctors, nurses and other healthcare staff – the people who deliver our services day in, day out. Many members of public across the county took part in our 'Call to Action' survey and events and accepted that there was a need to make big changes. They have since taken an active part in the design and development of the model of hospital care and been involved in the process we have gone through up to this point.

Over the last four years, we have listened to and involved thousands of local people, including NHS staff, patients and community groups. We have held a series of public roadshows, focus groups, conducted surveys and delivered presentations to a wide range of audiences, from parish councils to senior citizen forums.

The key themes you told us you wanted were:

- Be 'joined up' and responsible for my care
- Help me understand and access urgent care services appropriately
- Assess and treat me promptly and in the right place
- Admit me to hospital only when necessary
- Make my stay in hospital short, safe and effective
- Try to care for me at home, even when I am ill

Examples of public and patient engagement activity are described below:-

- During the life of the Programme, work streams have carried out many public engagement events, workshops, surveys and various engagement activities.

- The Programme has engaged with various groups, including "seldom heard" groups and has attended public meetings to discuss the plans for change.

- Healthwatch Shropshire, Healthwatch Telford and Wrekin and CHC Powys have been engaged and involved in the programme since its inception three years ago. They have provided expert patient views across all the work streams and are active members of the Engagement and Communication work stream and the Programme Board.

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- The Programme Board throughout the Programme has had comprehensive representation from all sponsor and stakeholder organisations. This has included Healthwatch Shropshire, Healthwatch T&W, Powys CHC and separate representation from the individual Patient Groups.

- Without exception, there has been one or more patient and public representatives on every workstream designing the processes and services for the future as well as the supporting the governance and decision-making groups.

- What can be influenced at each stage of the Programme has been identified and a variety of means for people to be involved in the ongoing debate made available, such as focus groups, pop-up events, smaller-scale public activities, as well as, but not limited to, on-line surveys, telephone surveys and social media channels.

- The Future Fit Engagement & Communications Team have implemented a specific plan for the Powys area taking into account the needs of this rural community and the requirements of Welsh regulations and legislation.

- The Programme has been discussed fully with lay members of partner boards, Health and Well Being Boards (HWBB) and Health Overview and Scrutiny committees (HOSC).

2.5.2 Consistency with Current and Prospective Patient Choice

There is no plan to change providers in the Future Fit proposals; therefore the choice of providers is consistent before and after the reconfiguration of services. Patients who choose to receive their acute hospital care in Shropshire and Telford & Wrekin will continue to be able to do so under the proposed new model.

The key change in terms of patient choice under the new model is where in Shropshire patients will receive their care from, as the model consolidates emergency and planned care on separate sites. Some consolidation of specialties on one or other of the current acute hospital sites has already been introduced, for example stroke, acute surgery, obstetrics and neonates and paediatric inpatients.

Currently, some patients have to travel to other Centres outside of the county for more specialist care, for example specialist paediatrics, level 3 neonatal intensive care, and a number of cancer services. This will continue under the new model.

In addition, some patients have to travel outside of the county for the service they need because the current acute trust configuration and the workforce constraints mean that the acute trust is not able to offer a sustainable service locally. It is the ambition of the acute trust that by centralising some services and consolidating their workforce that they are able to repatriate some of this work back into the county.

The aim with the proposed model is to deliver 2 vibrant hospitals with a significant proportion of current activity continuing to be delivered in the future from the same hospital site as now, for example:

- For the majority of urgent care needs, patients will continue to have the choice of using their local hospital as all options include an Urgent Care Centre on each site.
- In the case of cancer care, radiotherapy will remain on the RSH site as now alongside the existing Cancer Centre with an additional Cancer centre developed on the PRH site for some chemotherapy.
- For planned care, diagnostics and the majority of outpatients will remain on both sites as will the current Midwifery led units alongside antenatal and post-natal care facilities.

The table below illustrates the changes to where patients will access their care under the Preferred Option compared to the current configuration of services.

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Situation	I live nearer to the Princess Royal Hospital	I live nearer to the Royal Shrewsbury Hospital	I live in the mid Wales area
I need emergency care – I have a life- or limb-threatening illness or injury ***For example, I have severe blood loss or loss of consciousness***	I would go to the new Emergency Department at the Royal Shrewsbury Hospital ***During 2016-17, almost 120,000 people attended our A&Es. Out of these, almost 45,000 needed emergency care.*** This would be a change to where you go now. You should receive safer, faster, better care. This is because patients with illnesses and injuries that are not life or limb-threatening would go to a 24-hour Urgent Care Centre.	I would go to the new Emergency Department at the Royal Shrewsbury Hospital ***During 2016-17, almost 120,000 people attended our A&Es. Out of these, almost 45,000 needed emergency care.*** There would be no change to where you go now. You should receive safer, faster, better care. This is because patients with illnesses and injuries that are not life or limb-threatening would go to a 24-hour Urgent Care Centre.	I would go to the new Emergency Department at the Royal Shrewsbury Hospital ***During 2016-17, almost 120,000 people attended our A&Es. Out of these, almost 45,000 needed emergency care.*** There would be no change to where you go now. You should receive safer, faster, better care. This is because patients with illnesses and injuries that are not life or limb-threatening would go to a 24-hour Urgent Care Centre.
I need urgent care – I have an illness or injury that is not life or limb-threatening but requires urgent attention ***For example, I have a scald, a suspected fracture or a chest infection***	I would go to the 24-hour Urgent Care Centre at the Princess Royal Hospital ***Over 75,000 of our patients that currently attend our A&Es could be treated at our new 24-hour urgent care centres at either hospital*** There would be no change to where you go now but you should be seen quicker. This is because patients with more serious conditions would go to the Emergency Department at the Royal Shrewsbury Hospital.	I would go to the 24-hour Urgent Care Centre at the Royal Shrewsbury Hospital ***Over 75,000 of our patients that currently attend our A&Es could be treated at our new 24-hour urgent care centres at either hospital*** There would be no change to where you go now but you should be seen quicker. This is because patients with more serious conditions would go to the Emergency Department at the Royal Shrewsbury Hospital.	I would go to the 24-hour Urgent Care Centre at the Royal Shrewsbury Hospital ***Over 75,000 of our patients that currently attend our A&Es could be treated at our new 24-hour urgent care centres at either hospital*** There would be no change to where you go now but you should be seen quicker. This is because patients with more serious conditions would go to the Emergency Department at the Royal Shrewsbury Hospital.
I need planned care ***For example, I have a planned operation***	Most patients would go to the Princess Royal Hospital ***During 2016-17, there were over 50,000 planned operations at our two hospitals*** For most patients, there would be no change to where you go now. You would only go to the Royal Shrewsbury Hospital if you are having a complex planned operation or have a condition that may need the support of the critical care team.	Most patients would go to the Princess Royal Hospital ***During 2016-17, there were over 50,000 planned operations at our two hospitals*** For most patients, this would be a change to where you go now. You would only go to the Royal Shrewsbury Hospital if you are having a complex planned operation or have a condition that may need the support of the critical care team.	Most patients would go to the Princess Royal Hospital ***During 2016-17, there were over 50,000 planned operations at our two hospitals*** For most patients, this would be a change to where you go now. You would only go to the Royal Shrewsbury Hospital if you are having a complex planned operation or have a condition that may need the support of the critical care team.

	Your operation is highly unlikely to be cancelled because of a lack of beds due to an emergency admission	Your operation is highly unlikely to be cancelled because of a lack of beds due to an emergency admission	Your operation is highly unlikely to be cancelled because of a lack of beds due to an emergency admission
I have an outpatient appointment	Outpatient appointments are carried out at both our hospitals. ***During 2016-17, there were over 400,000 consultant-led outpatient appointments at our two hospitals*** For most patients there would be no change to where you go now.	Outpatient appointments are carried out at both our hospitals. ***During 2016-17, there were over 400,000 consultant-led outpatient appointments at our two hospitals*** For most patients there would be no change to where you go now.	Outpatient appointments are carried out at both our hospitals. ***During 2016-17, there were over 400,000 consultant-led outpatient appointments at our two hospitals*** For most patients there would be no change to where you go now.
My 5 month old child is poorly and needs to stay in hospital overnight ***For example, they have a chest infection and are not feeding***	They would go to the Royal Shrewsbury Hospital ***During 2016-17, around 4,000 children had an overnight stay at the Women and Children's Unit at the Princess Royal Hospital*** This would be a change to where your child goes now	They would go to the Royal Shrewsbury Hospital ***During 2016-17, around 4,000 children had an overnight stay at the Women and Children's Unit at the Princess Royal Hospital*** This would be a change to where your child goes now	They would go to the Royal Shrewsbury Hospital ***During 2016-17, around 4,000 children had an overnight stay at the Women and Children's Unit at the Princess Royal Hospital*** This would be a change to where your child goes now
My child is having chemotherapy treatment	They would go to the Royal Shrewsbury Hospital ***During 2016-17, 170 children received care at the Children's Cancer Unit at Telford*** This would be a change to where your child goes now	They would go to the Royal Shrewsbury Hospital ***During 2016-17, 170 children received care at the Children's Cancer Unit at Telford*** This would be a change to where your child goes now	They would go to the Royal Shrewsbury Hospital ***During 2016-17, 170 children received care at the Children's Cancer Unit at Telford*** This would be a change to where your child goes now
I am having a consultant-led birth ***For example, I am having a planned caesarian section***	I would go to the Royal Shrewsbury Hospital ***During 2016-17, over 4,000 women had a consultant-led birth at the Women and Children's Centre at Princess Royal Hospital*** This would be a change to where you go now	I would go to the Royal Shrewsbury Hospital ***During 2016-17, over 4,000 women had a consultant-led birth at the Women and Children's Centre at Princess Royal Hospital*** This would be a change to where you go now	I would go to the Royal Shrewsbury Hospital ***During 2016-17, over 4,000 women had a consultant-led birth at the Women and Children's Centre at Princess Royal Hospital*** This would be a change to where you go now
I am pregnant and have a scan booked with my midwife	I would go to my nearest midwife-led unit ***During 2016-17, over 20,500 women had a maternity scan at one of our midwife-led units*** ***During 2016-17, almost 650 women gave birth in one of our midwife-led units*** There would be no change to where you go now	I would go to my nearest midwife-led unit ***During 2016-17, over 20,500 women had a maternity scan at one of our midwife-led units*** ***During 2016-17, almost 650 women gave birth in one of our midwife-led units*** There would be no change to where you go now	I would go to my nearest midwife-led unit ***During 2016-17, over 20,500 women had a maternity scan at one of our midwife-led units*** ***During 2016-17, almost 650 women gave birth in one of our midwife-led units*** There would be no change to where you go now

Table 1: Changes to where patients will access their care under the Preferred Option Clear Clinical Evidence Base

2.5.3 Clear Clinical Evidence base

The Programme has been clinically led from its inception. The original proposed model of care was derived from two key sources:

i) Reviews of the national and international evidence base relevant to each of the main clinical areas, and;
ii) Clinical consensus derived from the combined experience of over 200 clinicians from primary, secondary care, as well as social care and other services (including ambulance and mental health services).

The programme has undergone a number of independent clinical reviews:

The WM regional Senate Review took place in October 2016. It made a series of 18 recommendations relevant to all options and supported the case for change and the clinical model:

> *"The Panel was of the view that a clear and compelling case for change was made, based on sound evidence presented to it on current performance, improvements seen in other regions by reconfiguration of services with multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy"*

They acknowledged that the decisions the health economy are trying to make are difficult:

> *"We were made aware of the differing current and future demographics pulling maternity and paediatrics toward PRH where it is has recently been built but more elderly around Shrewsbury pulls in the opposite direction. Moving the Trauma unit and therefore other acute and time-dependent services from Shrewsbury might disadvantage residents of Powys but advantage residents of Telford.*
>
> *Decisions are difficult and trade-offs inevitable but the time has come to make them. After all, both sites will get considerable and needed capital investment."*

The Clinical Senate also supported the co-location of Obstetrics and Paediatrics with the Emergency Centre. The variant option of the Emergency Centre at Royal Shrewsbury Hospital but with Women and Children's remaining sited on the Planned Care site at Princess Royal Hospital was not deemed clinically viable. In light of this, local clinicians views and external independent review on this option, the Programme Board unanimously agreed in November 2016 that the co-location of inpatient Obstetrics and paediatrics had to be with the Emergency Centre. Advice was also sought from the Trauma network. The view of the Network was that the preferred site for the Trauma Unit should be Shrewsbury. This reflected its geographical location and an increased risk for the group of patients from Powys if it was sited at Telford.

Advice was also sought from the Trauma network. The view of the Network was that their preferred site for the Trauma Unit would be Shrewsbury. This reflected its geographical location and an increased risk for the small group of patients from Powys if it was sited at Telford. The Network, however, stated that Trauma Unit status could be considered for Telford in Option 2 (Option B) subject to the appropriate standards and specifications set out by the network are met.

In light of the Trauma Network's opinion, the Programme has ensured that due consideration is being given to the mitigation that would need to be considered in any potential relocation of the Trauma Unit from the Shrewsbury to the Telford site.

Whilst ambulance providers recognise that Shrewsbury would be the preferred location for a Trauma Unit, based on access and journey times, for the small number of patients that might need to divert to a Trauma Unit for optimisation and stabilisation and who are not within an hour of a major Trauma Centre, there would be mitigating actions that could be put in place to reduce the risks were the preferred site to be Telford.:

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- Increase in the use of air ambulance; review of dispatch protocols
- Extended flying time to night flights through more night approved landing sites
- Upskilling of workforce; enhanced availability of paramedics and pre hospital care protocols; potential technology advancements over next 3-4 years mobile diagnostics
- Increased access to trauma doctor and/or more critical care paramedics in transit
- Review location of strategically placed land vehicles
- Conveyance to nearest alternative TU: Hereford, Worcester, Wrexham, Wolverhampton

Many of these initiatives are to a degree being progressed now as part of separate ambulance service developments and will mitigate risks for critically ill and injured patients which ever option is finally implemented within Shropshire. In Wales, other reconfiguration programmes are driving the need for development and review of ambulance and air ambulance capacity.

It is the view of the Trauma Network that mitigation plans specific to the risks associated for some trauma patients with long journey times under option 2, should be worked up with West Midlands Ambulance service (WMAS), Welsh Ambulance Service (WAS) and the Emergency Medical Retrieval and Transport Team (EMRTS). This work has begun and will continue throughout the coming months.

These conclusions were reaffirmed by independent clinicians at the Joint Committee held on 10th August 2017, where it was also confirmed that the preferred option of C1, the Emergency Centre at RSH and the Planned Care Centre at PRH should form part of the consultation on the deliverable options.

The programme will continue to be clinically evidence based as it goes forward into consultation and its governance arrangements support that with an active Clinical Design Group of health and care leaders and a wider Clinical Reference Group with a distribution list of over 300 health and care staff from across the system.

2.5.4 Clinical Commissioner Support

Clinical commissioners are the two main sponsors and have supported and funded the programme since its inception in 2014. Without exception, members of the Governing Bodies recognise the case for change and unanimously accept that do nothing is not an option. This is also widely accepted by primary care colleagues.

There is full support for the clinical model of investment to retain two vibrant hospitals with a single emergency centre and a site specialising in planned care. There is also support for the more recent work both CCGs have done in developing out of hospital care.

The geographical split of public and other stakeholder opinion in determining the preferred location of the emergency centre has been mirrored to some degree in primary care commissioners. This has contributed to the requirement for an independent review and for the supplementary impact assessment work that has taken place in leading up to the conclusions of the Joint Committee in August 2017.

The governance arrangements around decision making were reviewed and a Joint Committee established with a strong GP commissioner membership together with independent clinician members. On receipt of the independent review and the further IIA work, the CCG Joint Committee concluded on 10th August 2017 unanimously that both options B and C1 are deliverable, that option C1, the Emergency centre at Shrewsbury and the Planned Care Centre at Telford, is the preferred option and that both should be taken into public consultation in November 2017.

At the Joint Committee the importance of putting in place key areas of mitigation for those populations who would be disadvantaged by any final decision, was emphasised as a key requirement. Specifically that there was appropriate paediatric cover in place at the urgent care centre on the planned care site; that mitigation is put in place for travel and accommodation needs for Women and Children using the EC site and for older people using the planned care site; that carefully balanced ambulance services were put in place; and that the local NHS is really innovative with developing workforce solutions.

The CCG Governing Bodies now fully support a formal consultation with the public on the options deemed deliverable by that Joint Committee including the preferred option subject to the NHSE Assurance process.

Details of the programme's progress made with these original SOC caveats included within the letter of support from the CCGs are provided in the table below.

1.	Sustainability of Clinical Model	Lead Organisation	Comments
1.1	Further clarification to provide assurance on inter-dependencies of clinical specialties and the levels of workforce and capital investment required	SATH/CCG	The development of the OBC and this PCBC set out the key interdependencies for the emergency site in relation to obstetric, paediatric and critical care linkages. Move from a two site medical take to single medical take in delivery model. CCG commissioned external review of Option C2; Stage 2 senate review confirmed clinical model UCC sub group agreed high level workforce assumptions and the model for ambulatory care and paediatrics Best practice guidance used in modelling facilities required and service and workforce redesign. Detail in OBC appendices Further testing of workforce models detail will be done through the clinical design group pre implementation
1.2	Further clarification around the clinical linkages on which the service reconfiguration has been based	SATH/CCG	As above.
1.3	Clarification on the proposed repatriation including Quality Impact Assessments	SATH/CCG	IIAs completed. SATH states that repatriation is in line with STP assumptions. Within sensitivity analysis, this figure has been included within a sensitivity test of affordability to SATH. Further testing of areas for repatriations requested pre DMBC
2	**Neighbourhoods (formerly Community Fit)**		
2.1	Given the inter-dependencies of Future Fit and Community Fit, the CCGs need more assurance of the viability of these assumptions	STP/CCG	The 3 Neighbourhood work streams within the STP have progressed the development of the service offer. Whilst a lot of progress has been made there is more work to do in understanding the delivery model detail. The Optimity work carried out for Shropshire CCG in determining opportunity for shift from acute to community provides confidence in the deliverability of the activity assumptions as does the neighbourhood work within T&W.

2.2	The CCGs require completion of sufficient further work to design the model of community care and to test assumptions about a) the scale of activity shifts and b) productivity improvements anticipated in the SOC	STP/CCG	Community model of care has been progressed considerably via STP Neighbourhood Workstreams. More details in section 9 of this PCBC. The Optimity work carried out for Shropshire CCG in determining opportunity for shift from acute to community has provided confidence in the deliverability of the activity assumptions as has the neighbourhood work within Telford & Wrekin. The implementation detail of these community models is now required. More recent sensitivity analysis by SaTH has examined a number of variables and risks and their impact on affordability including productivity, demographics and repatriation. Section 10 sets out a sensitivity analysis for the acute modelling. Work has been undertaken to further develop the out of hospital model of care and its associated activity modelling and this has been tested against the acute modelling. This is described in Section 11 of the PCBC.
3	**Activity Assumptions**		
3.1	The CCGs require detailed sensitivity analysis on the assumptions used, to be completed through the OBC process	SATH/CCG	Some sensitivity analysis has been undertaken and included in the PCBC in sections 10 and 11
4	**Community and/or primary care alternatives to acute care**		
4.1	These assumptions need thorough testing through the OBC process, including the application of a sensitivity analysis.	SATH/CCG	See above
4.2	This would also need to include the potential impact on primary care and community services in a range of activity shifts, together with an analysis of the change in financial flows away from the acute sector that will enable this activity transfer to take place	SATH/CCG	See above New section added in Section 9 describing the impact on primary care. Forms part of the ongoing work within the STP and the development of the Neighbourhood/Out of Hospital models.
4.3	There is also a need to quantify the impact on ambulance service provision	CCG	Commissioners are leading a piece of work to ensure that this impact modelling is complete by the end of the consultation period. The outputs of this work will be shared with ambulance/patient transport providers for input before final report is concluded. SaTH have had numerous discussions with ambulance trusts regarding the clinical model and approach to

			pathway progression. All discussions have included WMAS, WAS and MSL.
4.4	Further test the detail around the Acute Trust's ambition to repatriate a level of activity from other providers	SATH	See above
5	**Affordability**		
5.1	Affordability of the SOC needs further testing, including the assumptions around investments and efficiency savings and should be supported by robust sensitivity analysis	SATH/CCG	See above. Further sensitivity analysis has been included in the PCBC. Further due diligence work will be required pre DMBC

Table 2: Caveats to the CCG Boards approval of the Acute Trust SOC

In conclusion, therefore, the caveats have to a significant degree been addressed over the past 12 months. More detail has been set out on the community model sufficient to give confidence in the acute assumptions at this stage; there is now more sensitivity analysis done by the Trust. However there remains more work to do prior to any approval of a Decision-Making Business Case (DMBC) which will be expected in early 2018. Notably, further stress testing affordability, specifically around the availability and source of capital; repatriation of services; and detailed modelling of the impact on ambulance and patient transport services will form part of this work.

Notwithstanding this further work this PCBC provides assurance to commissioners that the options being taken into consultation with the public are both clinically and financially deliverable.

2.6 New DH Conditions for any Proposed Bed Closures

Modelling to estimate future acute activity levels and acute bed capacity requirements has been considerable. This work was originally undertaken in 2014 and has subsequently been updated in SaTH's draft OBC (December 2016) and again more recently during 2017. This includes demographic growth, a planned reduction in delayed transfers of care, the move to 7 day working within the Trust and an evaluation of avoidable admissions through implementation of the CCGs out of hospital care strategies.

The table below shows how, under the proposed new model of acute hospital care, the bed numbers and types of beds available across the two acute hospital sites will change to meet the future needs of patients. In summary as can be seen below, whilst the number of beds in future will be more than currently available, the increase is less than projected changes in demography would indicate are required as demographic growth of 2.8% is being addressed through service changes in the community. There is a proposed reduction of 35,738 bed days relating to these schemes this equates to a bed base reduction of 110 beds (37 Telford and Wrekin CCG, 73 Shropshire). This is shown in section 10.1.2.

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	Who will be cared for in these spaces?	Number of beds in the hospitals today	Expected number of beds in the future
Overnight beds	Where patients stay if they need hospital care for more than one day. For example, a patient being treated for a severe chest infection.	**731**	**785**
Day beds	Where patients stay if they have had an operation but do not need to stay in hospital overnight. For example, a minor arm operation or investigation such as Endoscopy.	**91**	**105**
Clinical trolley and recliner chairs	Where patients that need to have some tests carried out and are seen by a hospital doctor but are very likely to go home that day. For example, an elderly patient that has had a fall.	**10**	**49**
Critical Care beds	Where patients who are very poorly are treated and cared for. For example, patients who are on life support.	**23**	**30**
Neonatal cots	Where poorly newborn babies are cared for. For example, a premature baby.	**22**	**22**
Total		**877**	**991**

Table 2a: Proposed Changes in Bed Numbers by Type

The CCGs have in July 2017 reviewed the original assumptions of Future Fit set out in the 2014 modelling and triangulated it through a number of reviews: the recent work in developing community urgent response models within neighbourhood teams in T&W CCG; an independent review by *Optimity* in Shropshire examining the opportunity in out of hospital care; and examining Better Care Better Value Indicators which sets out an "opportunity value of 13% of over 65 year old admissions". Section 10 of this PCBC sets out this triangulation work that provides assurance that there is no material difference in activity assumptions at this point between the Acute Trust OBC and the Neighbourhood/Out of Hospital Community Models, should they be successfully implemented and deliver the benefits as described in this document.

2.7 Financial Impact

The system STP submission in October 2016 demonstrated that if the system takes no action to change, by 2021 there will be a collective deficit of around £130m. Coupled with what is known about difficulties in recruiting staff to current role structures and the limitations of our infrastructure this is not a position that can be supported.

The Financial Case described in Section 12 of this PCBC confirms the affordability of the proposals to the Acute Trust, the CCGs and the system as a whole.

- Shrewsbury and Telford Hospitals NHS Trust
  The Trust's annual audited accounts for 2016/17 demonstrate that a deficit amounting to £5.6m was delivered, achieving its control total as set by its regulator NHS Improvement.

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One of the caveats associated with the CCGs approval of the Acute Trust's Strategic Outline Case in 2016 required detailed sensitivity analysis on the assumptions used to be completed through the OBC process. In considering this the Acute Trust has identified three scenarios:

1. Can the Trust afford the reconfiguration plan, given the attributable risks and assumptions and /or
2. Does the OBC provide an improved way forward than the option of doing nothing, and /or
3. Does the OBC support an on-going improvement in the financial position of the Local Health Economy?

If the current financial model figures are used, the 4 year aggregate Commissioner surplus would fall to £2.5m resulting in a system surplus of £5.7m rather than the £8.7m reported in October 2016. Hence it can be seen that the STP plan aims to deliver a significant change in respect of redefining the model of care in the system whilst at the same time returning to an underlying recurrent balanced position.

The Acute Trust has confirmed that their current underlying financial assumptions will have no adverse financial impact on the CCGs and will not require any additional investment above tariff income.

- CCGs

  In 2017/18 T&W CCG has a cumulative surplus of £5.7m and an in-year control total of break even. At Month 3 the CCG has generated additional year to date surplus of £64k. Delivery of the financial position will be dependent on prudent financial management and QIPP delivery throughout the year.

  The CCG's five year financial plan currently meets all of NHSE's business rules and delivers an in year break even position each year. However, in order to fund increases in activity, demography and service improvements the CCG will need to deliver recurrent QIPP plans in the region of £7m a year. The CCG financial and QIPP plans are aligned to the proposed activity shifts from acute to community.

  Shropshire CCG has a 2017/18 in-year control total for 2017/18 of £19.4m deficit. At the end of the year, the CCG will have accumulated a total deficit (including the £19.4m) of £52m. At Month 5 2017/18, the CCG is on target to deliver its financial control for 2017/18.

  By 2020/21, the CCG is anticipating financial recovery that will enable it to deliver a small in year surplus and to maintain underlying financial stability. In order to achieve this, the QIPP challenge remains high; numbers each year are around 3.5% of total allocation (£16m). Repayment of the accumulated deficit will take a further decade.

- The system as a whole

  Whilst a full refresh of the STP financial plan is still to be completed (this will be conducted during Q3 2017/18, modelling suggests that the recent changes made to the Shropshire CCG plans would not materially impact on the previously reported position. If the current financial model figures are used, the 4 year aggregate commissioner surplus would fall to £2.5m resulting in a system surplus of £5.7m rather than the £8.7m reported in October 2016. Hence it can be seen that the STP plan aims to deliver a significant change in respect of redefining the model of care in the system whilst at the same time returning to an underlying recurrent balanced position.

Judged on this basis it is evident that taking forward the reconfiguration of acute hospital services is significant in improving the financial sustainability of the Shropshire and Telford & Wrekin health system.

2.8 Conclusion

The Future Fit Programme has in collaboration with its sponsor organisations and stakeholders developed a number of proposals for changing the configuration of acute hospital services for the populations of Shropshire, Telford and Wrekin and parts of Powys that rely on the services of Shrewsbury and Telford Hospital NHS Trust, that will both improve the quality and safety of care for the whole population and increase the system sustainability for the next generation.

It has taken over 3 years to get to this point, longer than anticipated and to the frustration of many including the public. During this time services have also become even more fragile. However, the Programme has been able to develop during this time additional assurances around its processes and decision making that must now give confidence to the public and to the regulators that it is time to proceed to public consultation.

In summary, the Programme now believes it has:

- Set out a clear and demonstrable case for change in our acute hospitals that has now become even more urgent
- Set out at a high level the community solutions necessary to support out of hospital care for our dispersed populations whilst also recognising there is more detailed work to do
- Set out affordability for the Acute Trust , for the CCGs and for the system whilst also setting out more work to do to get the necessary assurance for the decision making business case in 2018
- Met sufficiently the 5 key tests for reconfiguration that the DH asks of us
- Set out two options deliverable both financially and clinically
- Set out its preferred option and the rationale for that

The CCGs believe the time is now right to ask the public and all other stakeholders its view on these options and to proceed to public consultation.

This document sets out these assurances to NHSE in more detail and describes the proposals for change on which we would now wish to consult.

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3. Foreword from the CCG Clinical Leads

There are already some very good health services in Shropshire, Telford & Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served. Nevertheless when we look at the changing needs of the population now and that forecast, when we look at the quality standards we should aspire to, as medicine becomes ever more sophisticated, and when we consider the economic and workforce challenges faced particularly by Shrewsbury and Telford Hospitals NHS Trust, but also by our primary and community care providers, then it becomes obvious that there is an absolute need to look at how we design acute hospital services so we can meet the needs of our population and provide excellent and sustainable services for the next 20 years and beyond.

The Future Fit Programme from its inception has been clinically led. Over 300 clinicians, patients and public were involved in developing the 'Model of Care 2014' which first described a new configuration of acute hospital services with one Emergency Centre site and one Planned Care and Diagnostic site.

The many local clinicians, patients and members of the public who participated in the Call to Action in 2013 accepted that there was a case for making significant change provided there was no predetermination and that there was full engagement in thinking through the options.

The Future Fit Clinical Design Group (CDG) has been at the heart of both overseeing and assuring the process by which the delivery solutions for high quality sustainable acute hospital services have been developed. In addition, its multi-stakeholder clinical membership has enabled a whole system overview and assurance of the proposed delivery solutions recognising that effective acute hospital services operate within and are reliant on a wider health and social care system. The programme has ensured continued wider clinical engagement through regular Clinical Reference Group meetings which are held in the evening to facilitate attendance and have between 100-300 attendees. This level of wide clinical engagement will continue and be supplemented by the wide engagement work happening through the STP Neighbourhood/Out of Hospital value streams.

The CDG is confident that the programme over the last 3 years has been clinically led and continues to be so. There is much evidence contained in this PCBC in support of the assertion that there has been no-predetermination of outcome and wide engagement, both clinical and non-clinical, in designing the delivery solution options which have been thoroughly appraised and considered in coming to this stage in the programme.

The CDG fully supports the proposed model of care set out in this document and will continue in its assurance role as the programme progresses to the determination of a final delivery solution and subsequent implementation, subject to appropriate approvals. As joint chairs we look forward to continuing to work with local clinicians both in acute care but also in the developing community model to deliver whole system sustainable models of care for the future for the populations we serve. We welcome the opportunities that the formal consultation period will provide for much wider engagement and input from the public we serve to inform the final decision.

Dr Jo Leahy
Clinical Chair
Telford & Wrekin CCG
Joint Chair Future Fit Clinical Design Group

Dr Julian Povey
Clinical Chair Shropshire
Shropshire CCG

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4. Foreword from the joint Senior Responsible Officers

This PCBC is the culmination of 3 years of collective effort across Shropshire and Telford & Wrekin to reform the local model of acute care so that our local populations consistently receive high quality, efficient, sustainable acute hospital services.

Most acute hospital services have developed over many years, with clinicians, managers and staff trying to keep pace with changes in demand, improvements in medicine and technology and increased expectations of the populations served. Nevertheless, it is recognised that the current hospital configuration is not sustainable. All of this is underpinned by the economic climate in which the NHS must operate.

Our intent is to restructure the provision of safe, high quality acute hospital services into the most efficient and effective configuration.

Over the past three years, patients, clinicians, managers and staff from across health and social care have contributed their time and expertise to the design of the programme and the care pathways within it. This has been underpinned by active and ongoing patient engagement and communication. We thank each of them for their contributions to the programme so far and to the development and assurance of this PCBC.

We will ensure that this programme is led in line with best practice throughout. We will follow the evidence base in concluding our decisions and engage widely with patients, the public and our stakeholders in this process.

David Evans
Chief Officer
Telford & Wrekin CCG

Dr Simon Freeman
Chief Officer
Shropshire CCG

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5. The Strategic Context – Sustainability and Transformation Plan (STP)

The Future Fit Programme for the reconfiguration of acute hospital services forms one of four key transformational service redesign workstreams within Shropshire and Telford & Wrekin's Sustainability and Transformation Plan (STP). This section of the business case summarises the key points from the STP and provides the wider context within which the proposed reconfiguration of acute hospital services is now placed.

It is widely agreed that in order for the local NHS to continue to provide services for the future, changes need to be made now. The challenges faced are similar to those being experienced across the country:-

1. Demand continues to increase
2. Workforce does not have capacity to meet that demand
3. Costs of providing care are continuing to rise

In order to address the increasing financial challenges, changes are needed which take full advantage of recent rapid progress in treatments and technology. In order to meet the needs of the population, Shropshire needs to work as a single health economy, by working together for the benefits of the population.

Causes of poor health are numerous. Joined up care and a systematic approach to tackling issues head on is what is needed. Focusing on needs and delivery of services in "communities" where shared understanding and models for delivery are localised to meet need are shown to be the best way to reduce demand, gain efficiencies and provide a cohesive workforce. This is why the STP focuses on a more joined-up way of working, based on smaller areas called neighbourhoods to prevent ill health and promote the support that local communities already offer.

- **These neighbourhoods** will be used as the basis for providing health and care services for people who need professional help, but not hospital treatment. GPs, social care, community nurses, therapists and mental health workers will increasingly work together to provide a consistent range of services at a local level. These Neighbourhood Care Teams will be the first port of call for people with diabetes and other long-term conditions people who might otherwise have to go to hospital but who don't need emergency services; and people who have recently been discharged from hospital. They will be the link between clinical and community care. Whilst this business case does not set out the implementation of this community model in detail, it recognises the critical nature of getting it right in delivering the assumptions for the acute solutions.
- **For patients who do need hospital care**, as this document does set out in detail, the system proposes to create two centres of excellence, one specialising in emergency care and the other in routine surgery or planned care. Over 300 clinicians have been involved in developing the proposals for hospital services because they know what is best for their patients. The aim is to improve the outcome for patients by using consultants and other resources most effectively. One Emergency Centre will work closely with more local urgent care services. Most assessment, diagnosis and follow-up would be done closer to people's homes. Neighbourhood Care Teams will play an important role in this.

The STP Partnership believes that making these changes will deliver clinical improvements and better outcomes for all patients. Communities themselves would be able to support vulnerable people, with the professional backing of Neighbourhood Care Teams where required. Fewer people would need to go to hospital, and those who do would be discharged quicker.

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5.1 STP Vision, Mission and Values

This STP has set out its vision, mission and values;

5.1.1 Vision

"To be the healthiest population on the planet"

5.1.2 Mission

- Provide the safest care possible.
- Support independent living in older age.
- Be an employer of choice across the region.
- Embed social care, prevention, supported self-care and mental health in all that we do as a system.
- Make exceptional use of technology to improve access, communication, and care co-ordination across our delivery system.
- Make best use of all available resources and deliver value for every £ spent.

5.1.3 Values

- We will share information and resources across organisations in order to build **resilience and social capital across the county of Shropshire.** We will all promote prevention and supported self-care, using available technologies to enhance workforce, patients and citizen's experience of interactions.
- We will work as a single system to deliver **coordinated and integrated care across the NHS, Social Care and the Voluntary Sector.**
- We will work together to develop a **sustainable workforce** that is fit for purpose, is supported by modern technology, and can deliver evidence-based care in new ways that suit user's lifestyles and where they live.
- We will collectively understand available resources, capacity and capabilities to develop a transformed system of care with the appropriate workforce that is **high quality, financially sustainable**, efficient and delivers best practice (or above) all the time. As a system to use evidence from around the world to develop excellence in care and **pioneering services** through the use of high quality research and use of new technologies.

5.2 STP – Priorities

The STP has set out four key priorities going forwards:

5.2.1 Develop and implement a model for Neighbourhood working

- ***Supporting individual communities to become more resilient*** - The causes of poor health are rooted within our communities and as such the solutions need to be community-based. Enhancing the assets and skills of local people and organisations, we will capitalise on the power of this rich source of social support to build individual and community resilience.

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- ***Supporting people to stay healthy*** - People will be supported to lead healthier lives, patients empowered through technology; and self-care promoted in order to reduce the demand and dependency on local public services. Lifestyle patterns are complex and often interlinked and a combination of unhealthy lifestyle choices increases people's risk exponentially. It is estimated that middle aged people with a combination of unhealthy lifestyles are 4 times more likely to die in their next decade than those leading healthier lifestyles.

- ***Developing Neighbourhood Care Teams*** - Preventing unplanned admissions to hospital and proactively supporting discharge from hospital are essential features of neighbourhood working. Professionals will provide a quicker response at times of crisis to assess and treat patients in their own homes and provide short term therapy support to ensure people remain as independent as possible. People with long term health conditions will be supported to live their life to their full potential. Health professionals and other local resources will work together to seek out those who would most benefit as well as ensuring that patients can understand and, as far as possible, manage their own condition.

- ***The community bed review*** - Neighbourhood working will require some access to locally provided beds for patients. At present these are provided through community hospitals, local authorities and care homes. As Neighbourhood working develops, the local provision of beds will be reviewed. The development and use of "virtual wards" will provide the vehicle for this initiative.

5.2.2 To re-evaluate hospital services

- ***Acute reconfiguration Programme -*** This programme is clearly well established and forms the purpose of this business case. The Future Fit model for acute hospital care describes an urgent care network, within which one central emergency centre works closely with two urban urgent care centres and a number of rural services where urgent care is provided on a locality basis. For Planned Care there would be a single site which operates independently from the emergency site which will allow efficient and uninterrupted workflow over 7 days.

- ***Understand our secondary care expenditure -*** Shropshire appears to commission a high level of some treatments in comparison with the rest of England. Orthopaedic and musculo-skeletal (MSK) services is one such area. This service is organised across three hospital sites and through a number of therapy services. The MSK and orthopaedic review has been commissioned to ensure that the service is appropriate and as effective as possible. Other reviews will follow. In this business case it is assumed that there will be no change in acute providers and SATH will continue to deliver orthopaedics with most routine surgery at the planned care site with orthopaedic trauma delivered at the Emergency site.

5.2.3 Continue to develop other services

- ***Services for people with mental ill-health or a learning disability; services for children; and cancer services*** are also developing rapidly. Mental health and Learning Disabilities are core to the development of Neighbourhood teams and will play a key role in the work of local teams. Psychiatric liaison and other specialist services such as Perinatal psychiatry will play an important role in ensuring that admissions to the acute hospitals are minimised. The health and care community is committed to ensuring that these continue to provide high quality care and are developed within the same philosophy as other services.

5.2.4 Make best use of resources

- ***Financial sustainability -*** The health and care community faces very significant financial challenges over the next few years. These have to be addressed whilst safeguarding the quality of services.
- The two CCGs entered the 2017/18 financial year with a combined recurrent deficit of £13.6 m and the Acute Trust commenced the year with a recurrent deficit of £16.5m. The effect of taking forward the acute reconfiguration is to at least generate a balanced recurrent position for the Acute Trust and at the same time secure savings for the CCGs. Judged on this basis it is evident that taking forward the

OBC is significant in improving the financial sustainability of the Shropshire and Telford & Wrekin health system. Further information on the acute financial case is provided in section 12.

- ***Reducing duplication*** - There is potential to further reduce costs without affecting service provision by rationalising organisations, back office functions and estate costs; and by greater exploitation of IM&T

5.3 Benefits to Patients

Achieving the changes described in the STP will deliver improvements in patient safety , clinical effectiveness and patient experience. In particular, changes to the configuration of hospitals will ensure that the concentration of resources dedicated to emergency care and planned surgery will improve clinical quality and enable constitutional standards for waiting times to be met.

The development of Neighbourhood/Out of Hospital work aims to change the emphasis in the relationship between the public and the NHS so that communities are able to support vulnerable people, with the professional backing of Neighbourhood Teams where required. Neighbourhood working also aims to ensure that many people will no longer need to go to hospital and that delays to hospital discharge will be minimised.

The unwarranted variations in clinical outcomes highlighted in the "Right Care" evidence packs indicates that there is a need to address the clinical effectiveness of the delivered pathways. The shared aim is to deliver consistently high standards of care and to learn from best practice elsewhere.

Working collectively to deliver evidence based care and reduce duplication will happen as a result of the workforce developments and transformed systems of care which release capacity to support deliver care in line with constitutional standards more consistently. Developing co-ordinated and integrated care across NHS, social care and the voluntary sector will address the quality concerns when patients experience unecessary steps and delays in their journeys such as those measured through Delayed Transfer of Care data.

Continuing to listen and learn from patient feedback will be key to deliver the benefits that we set out. The development of a systematic approach to engaging and involving local people is an aim in the system 90 day plan. This will be both at large scaleand formal in Future Fit consultation process, but also with wider engagement on the overall system plans.

5.4 Where the Future Fit Programme fits in the STP

Currently we know that our inability to consistently meet NHS constitutional standards around A&E, cancer and 18 week referral to treatment times raises potential challenges to quality of care. Achieving the changes set out in the STP will deliver improvements in patient safety, clinical effectiveness and patient experience. In particular, changes to the configuration of acute hospitals will ensure that the resources dedicated to emergency care and planned surgery will be concentrated and focused to have the greatest impact on improving the clinical quality and reducing waiting times.

The transition of the Future Fit Programme in governance terms into the wider STP plan is much welcomed as part of a whole system approach as it is recognised that the success of the reconfiguration of acute hospital services will be dependent on a robust and supportive community model of care. The activity and capacity modelling assumptions within the new acute configuration of hospital services are in part calculated on the premise that there will be a reduction in demand on acute services which will need to be supported through a redesign of the community model of delivery which will be achieved through the STP work.

6 The Future Fit Model of Care

The Future Fit Programme was established in 2013 as part of a system-wide multi-stakeholder service transformation programme. This section describes the origins of Future Fit and the clinically led process which delivered the clinical model for the system in 2014. In then describes the work to develop this model into sustainable and affordable delivery solutions for acute hospital services described in this PCBC.

6.1 Call to Action Survey 2013

The Clinical Design Workstream, established in November 2013, used the results from the Call to Action survey and subsequent engagement events to develop, agree and establish, via a multi-stakeholder Clinical Reference Group (CRG), an approach to ensure that the future of hospital and community services was considered within the context of a whole system plan. When considering the pattern of services provided in 2013, our local clinicians and many members of the public who responded to the Call to Action accepted that there was a case for making significant change to service provision.

Local clinicians, patients and members of the public who participated in the Call to Action recognised the real and pressing local service issues and challenges faced locally including:

- Changes within the medical workforce
- Staffing within the key acute services (A&E; Critical Care; Acute Medicine)
- Changes in the populations profile and patterns of illness
- Higher expectations
- Clinical standards and developments in medical technology
- Economic challenges
- Opportunity cost in quality of service
- Impact of accessing services
- The quality of the patient facilities and the Trust's estate

6.2 The Case for Change

The Clinical Design Workstream 'Models of Care' Report 2014 (Appendix 1) described the health system challenges as being:

6.2.1 Changes in the population profile

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

6.2.2 Changing patterns of illness

Long-term conditions are increasing due to changing lifestyles. This means health services need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community with consistent support for self-management and care. The increase in the elderly population and the number of people living with long-term conditions coupled with the reduction in funding in the voluntary sector and Social Services results in an increased pressure on acute services such as A&E and acute medicine.

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6.2.3 Higher expectations

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

6.2.4 Clinical standards and developments in medical technology

Increased specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. Every effort must be made to seek to deploy them to greatest effect.

6.2.5 Economic challenges

The NHS budget has grown year on year for the first 60 years of its life. In one decade across the turn of the 21st century its budget doubled in real terms however, the UK economy is now in a different place. The NHS will at best have a static budget going forward and yet the rising costs of services, energy and supplies along with innovations and technological breakthroughs that require more investment mean that without changing the basic pattern of services, costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

It is estimated that without radical changes to the way the system works, the NHS will become unsustainable with huge financial pressures and debts. Current trends in funding and demand will create a gap which projections suggest could grow to £30 billion a year by 2021 if nothing is done to address it.

Locally the Shropshire health economy is challenged and therefore significant change to provide services that are clinically and financially sustainable is required through innovative solutions.

6.2.6 Opportunity costs in quality of service

In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites in their current configuration is increasingly difficult to maintain without compromising the quality and safety of services.

6.2.7 Impact on accessing services

In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include a responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. A network of provision already exists across Community Hospitals that can be part of the redesign of services to increase local care.

6.3 System Principles and Working Practices

The following principles and practices emerged from the clinical design work across all areas of care and specialties in 2014 as being necessary and fundamental components of an efficient, safe resilient and integrated health and social care system. These principles continue to be reflected in 2017/2018 through the work of the STP partners.

6.3.1 Home is normal

Health and social care is currently 'bed based' and risk averse and, although people prefer to remain in their own home whenever possible, they are often cared for at 'levels of care' which are higher than required to meet their needs. Not only is this not what most people want, it is also resource inefficient and increases the risk of health care induced harm. People who are frail have worse outcomes if they are admitted to hospital for more than 3 days.

Patients cared for at home remain connected to their family and carers. Community support remains continuous and the patient is less likely to 'decompensate' by being cared for in a bed based acute environment which is also much more stressful. Individualised care can be delivered more easily by community teams. The potentially difficult and harmful transitions from home to hospital and back again are removed. Performing an accurate and holistic assessment of needs is much more difficult when a patient is not in their usual living environment.

'Home is normal' describes the principle of matching people's needs with the correct level of care, preferably without changing their care setting. Home will not be the right place to care for everyone who is ill. Some of course require high levels of care in an acute hospital bed, but other alternatives must be provided which offer a 'medium' level of care.

6.3.2 Empowered patients, clinicians and communities

Patients want to be empowered so they can remain autonomous and independent, even when they are ill.

Clinicians want to be empowered to do the job they were trained to do, and not spend too much of their time trying to navigate a poorly designed and inefficient system on behalf of their patients.

Communities want to be empowered so that citizens can help each other to live 'a life well lived' in an environment that minimises isolation, vulnerability and inequality.

6.3.3 Sustainability

- Financial sustainability - For the purposes of the clinical design process, it was assumed that there will be no increase in overall budgets over the next 10-20 years and that in the face of an increase in population care needs and life expectancy, in real terms there will be a reduction in investment. Financial austerity is one of the key drivers for radical change and is identified clearly as such as part of the case for change in this Programme. Activity and capacity modelling work completed in 2014 demonstrated that simply continuing 'doing what we do' but with greater efficiency is not sustainable.

- Workforce sustainability – Local clinicians expressed some strong views about potential components of a sustainable solution to the current and impending workforce crisis including:-
    - Consolidate some services to make posts more attractive by improving the quality of work
    - Develop novel roles to fill gaps created by recruitment issues and new models of care
        - Prototype and implement rotating (and split) posts through different care settings
        - More effective succession planning and better role development and continuous professional development

- Service sustainability – New models of care, workforce and commissioning must reflect whole patient journeys and providers will need to adapt, integrate and collaborate to accommodate this whole system planning. Consolidation of some services will improve service sustainability whilst at the same time provide multiple clinical benefits.

  Designing a 'needs led service', in which patient access to care is dependent on the level of care they require, also carries multiple benefits and ensures a more sustainable service. Quality, safety and achieving the best outcomes will come before choice. Services will be rationalised so they are more consistent in their quality and the services they offer.

6.3.4 Integrated care

Integrated care is the means by which continuity of care is delivered across time and care settings. Integration is a means to an end, and is best regarded as a tool to deliver services which are designed around patient need and which improve clinical outcomes.

Effective integrated care that improves the co-ordination, collaboration and consistency of care must be designed and delivered at multiple levels. Whilst one of these levels is the strategic placement of integrated teams to deliver holistic and intensive input when required, at a more basic level integrated care requires effective networking and communication across the whole system. Integrated care records are a necessary precondition to achieve this and their development needs to be given the highest priority.

Integrated care also requires smooth transitions between different levels of care and between organisations providing that care. Providers need to define and plan their transitions as carefully as they do their core service. The clinical workforce needs to 'follow the patient' across organisational boundaries.

6.3.5 Partnership care

Patients often experience their care as fragmented; they find themselves having to tell their story repeatedly to different professionals involved in their care, who then perform multiple assessments on them about the same problem. There is a strong clinical consensus that the success of the new models in improving patients and clinicians experience of care depends on moving from a 'referral based model' to a 'partnership based model' across all care settings. The essence of partnership care is to facilitate direct communication between clinicians caring for the same patient.

Partnership care redefines the roles of generalists and specialists, with generalists (based mainly in the community and including GPs and community care clinicians) responsible for maintaining co-ordination and continuity of care, performing initial assessments and accessing specialist support when required. Specialists will continue to carry responsibility for continuity of care for the most complex cases and for most children with long term conditions.

Successful partnership care will require a high level of trust between partners. Currently there is a perception amongst consultants that offering advice and guidance without seeing the patient carries a level of risk that many are unwilling to take. The process of building trust will be helped through good governance and reliable routes of communication. The principle of a 'named responsible clinician' will also enable partnership care.

6.3.6 Information Technology (IT)

Developments in informatics in 2014 were described as being necessary and fundamental components of an efficient, safe resilient and integrated health and social care system. IT solutions will change working practices in two ways; firstly, by improving communication and information flow across the whole system, and secondly, through the use of assistive technology at individual patient level. The work set out within the Local Digital Road Map (Appendix 28) since the development of the high level clinical model in 2014, builds on this and restates 4 key priorities that will support delivery of the model set out in this business case:

- Paper-free at the point-of-care (by 2020)
- Digitally-enabled self-care
- Real-time analytics at the point of care
- Whole system intelligence to support population health management and effective commissioning, clinical surveillance and research

By 2020 it states that we will have an integrated care record across our economy; patients as co-authors of their record, contributing and interacting with their record, approving access, booking appointments, ordering repeat prescriptions; data sharing agreements in place to enable our vision of a paperless NHS at the point of care; and tele health delivered at scale

The Models of Care report 2014 (Appendix 1) described the proposed Models of Care for the 3 main areas of health care delivery and it is within this Model of Care report that the proposals for one emergency care site and one planned care site was first described:

- Acute and episodic care
- Long term conditions and/or frailty
- Planned care

6.4 Acute and Episodic Care

> *"A single, fully equipped and staffed Emergency Centre (EC), as part of a high acuity unit, with consolidated technical and professional resource to deliver high quality emergency medical care 24 hours 7 days a week. The EC would serve as a trauma unit with a co-located critical care unit. Other adjacencies include facilities for ambulatory care and assessment units with full and immediate access to radiology and pathology diagnostic facilities, blood bank and pharmacy. Access would be via 999 ambulance or co-located urgent care centre with an equivalent UCC on the planned and diagnostic hospital site".*
>
> ***Clinical Workstream Models of Care Report 2014***

This was set within the context of a system of tiered and networked urgent and emergency care services including rural urgent care delivery solutions.

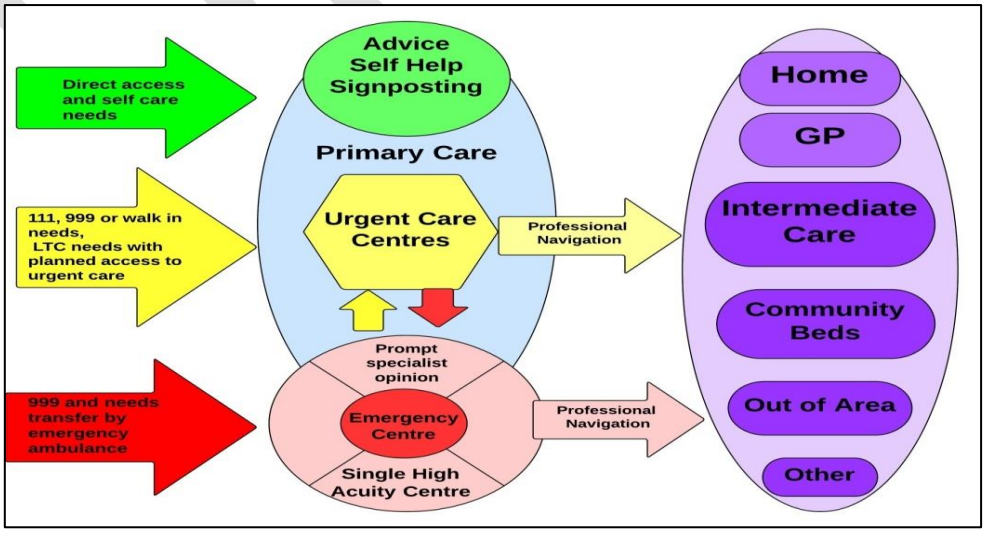


Figure2: Diagram of acute and episodic care model 2014

6.5 Planned Care

A single Planned Care Site which operates independently from the emergency centre (EC) and high acuity unit would consolidate resources in terms of workforce, equipment and finance. It would allow efficient and uninterrupted workflow over seven days.
The greater 'critical mass' of a single Planned Care Site will improve quality and outcomes , help to conserve specialist services within the area and offer the potential to repatriate some services currently located 'out of county'.
Clinical Workstream Models of Care Report 2014

The Models of Care Report 2014 further describes the strong clinical and economic argument for all planned orthopaedic surgery to be consolidated onto one site.

6.6 Rural Urgent Care

The Model of Care 2014 for one Emergency Centre acknowledged the need to provide supporting solutions for rural urgent care. The original Future Fit Model of Care described having a number of rural Urgent Care Centres (UCC) and locating these at each of the existing community hospitals and Minor Injury Unit (MIU) sites with an assumption that there would be a single consistent model applied across the county.

However, concerns were raised about the clinical and financial viability of such centres, and indeed whether the clinical need for them could be evidenced.

In response, the programme model for rural urgent care moved away from a focus on examining existing facilities or infrastructure and specifically evaluating in isolation, the location for rural urgent care centres. Instead they looked at enhancing and developing more integrated local urgent care solutions that will address patient's needs and allow care to be provided in the most appropriate setting, as close to home as possible.

The Programme Board therefore agreed to progress the rural urgent care offer and corresponding local models of delivery through the STP Neighbourhood Workstreams, further details of which can be found in Section 11 of this document. The future model will also be informed by the outcome of the Shropshire CCG review of Minor Injury Units, DAART (Diagnosis, Assessment and Referral to Treatment) and Community Hospital beds.

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7 The Future Fit Programme Plan and Timeline

This section sets out the high level programme plan and progress against to date. The Future Fit Programme has been established since 2013 and has already completed a number of significant phases. Although the original remit of the programme was to focus on acute and community hospitals, in 2015 it was agreed that the primary focus of the Programme going forward would be on the acute hospitals reconfiguration.

PHASE	Key Deliverables	Status
Phase 1 (October 2013 - January 2014)	• Programme Set-up • Determining the High-Level Clinical Model	Complete
Phase 2 (February 2014 - August 2014)	• Determining the Overall Model of Clinical Services • Identification and quantification of the levels of activity in each part of the Model • Determining the Feasibility of a Single Emergency Centre • Public Engagement on the Model of Care and Provisional Long-list & Benefit Criteria	Complete
Phase 3 (August 2014 - September 2016)	• Identification of options and option appraisal • Preparation of Strategic Outline Case(s) • Identification and approval of Preferred Option	Complete
Phase 4 (October 2016 – April 2018)	• Preparation for Public Consultation including submission of Pre-Consultation Business Case and NHSE Formal Assurance • Public Consultation on preferred option(s) • Preparation of Outline Business Case(s) and Decision Making Business Case	Active stage of the work programme
Phase 5 (To be determined)	• Full Business Case(s)	
Phase 6 (To be determined)	• Capital Infrastructure work • Full Implementation	
Phase 7 (To be determined)	• Post Programme Evaluation	

Table 3: Phases of the programme and the current timeline

The design phase, involving patients, clinicians, managers and staff from across the health and social care organisations supporting Future Fit has been completed, and the strategic direction as outlined in a Strategic Outline Case (SOC)(Appendix 3) has been approved by the CCG Boards. This was acknowledged by the healthcare regulators (NHS England and Trust Development Authority (TDA), and pre-consultation public engagement confirmed public support for the strategic direction.

An initial list of more than forty scenarios was refined into a long list of thirteen, from which a shortlist of six options with two obstetric variants was identified. Following more detailed work on each option/variant, the

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Programme Board concluded that those involving any 'new site' component should be excluded from further consideration on the grounds of being unaffordable.

Section 11 describes in detail the approach taken to option development and appraisal. The final 4 shortlisted options are summarised below:

	Princess Royal Hospital	Royal Shrewsbury Hospital
A	**No change**	**No change**
B	EC – UCC – LPC – W&C	PC – UCC – LPC
C1	PC – UCC – LPC	EC – UCC – LPC – W&C
C2	PC – UCC – LPC – W&C	EC – UCC – LPC
	EC – Emergency Centre UCC – Urgent Care Centre W&C – Women & Children's Services	PC – Planned Care Site LPC – Local Planned Care

Figure 3: Final 4 Shortlisted Options

The decision was taken by the Programme Board in November 2016 in response to the findings of 2 independent clinical reviews that Option C2 (Women and Children's Services separate from the Emergency site) was not clinically viable and therefore should be removed from the options list for public consultation.

In August 2017, the Joint Committee approved two options, option B and C1 which were deemed to be clinically and financially deliverable with the preferred option being C1.

The Future Fit Programme has reached the stage where now it wishes to formally consult the public of Shropshire, Telford & Wrekin and mid Wales on the specific proposed changes to acute hospital service and its preferred option.

The key milestones within Phase 4 of the Programme Plan are set out in the table below:

Milestone	Timeline for completion
West Midlands Clinical Senate conduct Stage 2 review	17 – 31 Oct 2016
Shropshire and Telford & Wrekin CCG Boards receive draft PCBC including draft Consultation Plan	8 and 9 Nov 2016
West Midlands Clinical Senate Review Stage 2 Draft Report received	21 Nov 2016
Gateway Review	28 Nov –30 Nov 2016
Programme Board receive Option Appraisal Outcome and made recommendation to Joint Committee for preferred option	30 Nov 2016
SaTH Trust Board approval OBC	1 Dec 2016
SaTH submit OBC to NHSI for approval	5 Dec 2016
West Midlands Clinical Senate Review Stage 2 final Report received	5 Dec 2016
CCG Board Joint Decision Making Committee split decision and referred back to Programme Board	12 Dec 2016
Independent review of Option appraisal and W&C IIA supplementary work commissioned by CCGs	January 2017

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Review of terms of Reference of the Joint Committee to include independent Chair and clinicians	February 2017
Independent Review of Options Appraisal process report received	31 July 2017
Supplementary Women and Children's Impact Assessment Report received	31 July 2017
Programme Board receive the above 2 supplementary pieces of work and review the recommendations to the Joint Committee made in 2016	31 July 2017
CCG Board Joint Decision Making Committee to approve Preferred Option(s)	10 Aug 2017
CCG Boards receive the draft Pre Consultation Business Case	15/16 Aug 2017
NHSE strategic sense check Assurance Panel	30 Aug 2017
CCG Boards receive the draft Pre Consultation Business Case for approval	12/13 Sept 2017
NHSE stage 2 assurance panel	19 October 2017 follow up 16 November 2017
Shropshire/Telford & Wrekin CCG formal public consultation period	November 2017 – March 18 (14 weeks from start date)
NHSI OBC approval period	5 Dec 16 – 31 May 17
Consultation findings and recommendations report received by CCGs	April 2018
Decision making business case for approval	Early May 2018
FBC	(To be confirmed) Autumn 2018

Table 4: Key Milestones of the programme plan

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8 Acute Hospitals Reconfiguration of Services

8.1 Introduction

This section sets out the service challenge facing our local acute hospitals requires the identification of the optimum solution by balancing:-

- The case for change
- Facilities and scheduling of accommodation
- The clinical adjacencies essential for patients to access safe and high quality care;
- The workforce solutions that would ensure safety and sustainability in the medium and longer term;
- IT Solutions that enable this change

8.2 Existing Acute Configuration of Services

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for half a million people living in Shropshire, Telford & Wrekin and Mid Wales.

The majority of the Trust's services are provided at the Princess Royal Hospital (PRH) in Telford and the Royal Shrewsbury Hospital (RSH) in Shrewsbury; providing 99% of Trust activity. Both hospitals provide a wide range of acute hospital services including accident & emergency, outpatients, day cases, diagnostics, inpatient medicine and critical care.

Services	PRH	RSH
A&E	✓	✓
Outpatients	✓	✓
Diagnostics	✓	✓
Inpatient Medical Care	✓	✓
Critical Care	✓	✓
Inpatient head & neck surgery	✓	
Inpatient acute and elective surgery		✓
Surgical Assessment Unit		✓
Ambulatory Care	✓	✓
Inpatient women & children	✓	
Outpatient children	✓	✓
Children's Assessment Unit	✓	✓
Inpatient Oncology Care		✓
Midwife-led maternity services	✓	✓
Day case surgery and procedures	✓	✓
Elective Orthopaedics	✓	*✓
Orthopaedic Trauma	✓	✓
Breast Surgery	✓	

Table 5: Services delivered at RSH & PRH

*RSH activity is provided by Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
Following recent service reconfigurations, inpatient adult surgery (excluding breast) is provided at RSH, with women and children's services (consultant-led obstetrics, neonatology, inpatient and day case paediatrics and

inpatient women's services), head and neck and acute stroke care being provided at PRH. In line with many organisations where the delivery of services is across multiple sites, the Acute Trust is challenged with duplicate costs and inefficiencies inherent in many service structures.

Alongside services at PRH and RSH, the Acute Trust provides community and outreach services including:

- Consultant-led outreach clinics (held in Community Hospitals and the Wrekin Community Clinic at Euston House, Telford)
- Midwife-led units at Ludlow, Bridgnorth Community Hospital and RJAH in Oswestry
- Renal dialysis outreach services at Ludlow Hospital
- Community services including midwifery, audiology and therapies

During 2016/17 Shrewsbury and Telford Hospitals NHS Trust saw:

- 64,153 elective and day case spells
- 55,198 non-elective inpatient spells
- 6,497 maternity spells
- 411,657 consultant led outpatient appointments
- 119,906 accident and emergency attendances

8.3 Configuration of Wider Related Health Services

- The **Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust** (RJAH) is a leading orthopaedic centre of excellence, providing a comprehensive range of musculoskeletal surgical, medical and rehabilitation services both locally, regionally and nationally. The organisation is a single site hospital based in Oswestry, Shropshire, close to the border with Wales and serves both England and Wales, acting as a national healthcare provider.

- **Shropshire Community Health NHS Trust** (SCHT) provides community health services to people across Shropshire, Telford and Wrekin. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, and support to patients with diabetes, respiratory conditions and other long-term health problems. In addition, they provide a range of children's services, including specialist child and adolescent mental health services. Shropshire's four Community Hospitals have a total of 113 beds for those who do not need acute hospital care or have been transferred from an acute hospital for rehabilitation or recovery following an operation or who need palliative care.

  In 2016, SCHT Board reached the view that the Trust and its services needed to become part of a larger organisational model offering the investment and infrastructure for community services to thrive and develop strongly. The Trust's regulator NHS Improvement (NHSI) supports that view. This decision means that the Trust is now progressing a review of options for the future organisational form of its services.

- **South Staffordshire and Shropshire Healthcare NHS Foundation Trust** (SSSFT) - provides mental health, learning disability and specialist children's services across South Staffordshire and mental health and learning disability services in Shropshire, Telford & Wrekin and Powys. They also provide some services on a wider regional or national basis.

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8.4 Acute Hospital Services – The Case for Change

The Acute Trust's Strategic Outline Case 2016 (SOC) (Appendix 3) which was approved by both CCG Boards in 2016 describes in more detail the specific challenges and issues faced by local acute hospital services, as follows:

8.4.1 Medical workforce challenges

Running duplicate services on two sites presents many workforce challenges and can result in a poor employee experience for some of the Trust's medical teams. This compounds an already challenging recruitment environment and leads to difficulty in recruiting the right substantive workforce. The Trust's reliance on temporary staffing increases the fragility of certain specialities.

The current service configuration and the requirement for consultants and other specialist staff to cover both hospital sites can at times limit their ability to provide senior patient reviews. In addition, the Acute Trust is unable to achieve "Royal College standards" in many areas. With the current configuration, it will prove extremely difficult to achieve adequate staffing levels to provide 7-day working across both sites. Furthermore, because teams are spread so thinly services are vulnerable to unexpected absences and the non-availability of staff.

8.4.2 Emergency Department staffing

The Acute Trust does not currently meet staffing levels recommended by the College of Emergency Medicine across all medical roles including Consultant, Middle and Training grades. Research demonstrates that a greater consultant presence in A&E reduces admissions, reduces inappropriate discharges, improves clinical outcomes and reduces risk to patients.

With this minimal workforce and the impact of unforeseen short-term staff absences, A&E staff are finding it increasingly difficult to cope with the increased numbers of attendances, the nature of the patients presenting and increasing numbers of attendances out-of-hours. The Trust is regularly hampered in its ability to provide rapid senior review to patients and this is causing significant numbers of breaches of the 4 hour A&E target at such times. These pressures in A&E; the growing age and acuity of those patients presenting, and the continued bed capacity deficit which routinely prevents timely patient flow, combine to significantly elevate risks in both the immediate term and for the foreseeable future.

8.4.3 Critical Care staffing

In Critical Care, the Trust's staffing levels are again below the recommended standards. The core standards require:

- Care must be led by a consultant in Intensive Care Medicine
- Consultant work patterns must deliver continuity of care
- In general, the consultant/patient ratio must not fall below a range between 1:8 to 1:15 and the ICU resident/patient ratio should not fall below 1:8
- A consultant in Intensive Care Medicine must be immediately available 24/7, be able to attend within 30 minutes and must undertake twice daily ward rounds
- Consultant intensivist led multi-disciplinary clinical ward rounds within Critical Care must occur every day (including weekends and national bank holidays)

Critical Care is covered with a mix of general anaesthetists and the small number of Intensivists available, but consultant presence is still well below recommended levels. Shrewsbury and Telford Hospitals NHS Trust is one

of a very few NHS trusts nationally that have not been able to split its Anaesthetics and Critical Care rotas on both sites. The ability to recruit to posts has been successful on the spilt rota site.

The Anaesthetic and Critical Care team face daily challenges, in particular on call, during which the on call consultant could be required in up to four different places at once. The second on call rota is extremely challenging to cover and often relies on paying higher cost temporary staff or 'acting down' of consultant grades. This can have a negative affect both the quality and financial agendas.

The Acute Trust has continuously attempted to recruit additional Intensivists; however potential candidates consider the absence of formal split rotas and very onerous on-call arrangements deeply unattractive. The workforce challenges mean that the service and the team are highly vulnerable to further vacancies or unexpected absences.

8.4.4 Acute Medicine

In 2004, the Royal College of Physicians recommended that there should be a minimum of 3 acute physicians per hospital by 2008. In the 2012 Acute Care Toolkit, it is recommended that hospitals have at least 1.5 WTE acute physicians available for 12 hours per day for an Acute Medical Unit (with exact numbers based on the anticipated number of patient contacts during the core hours of service).

> *'Involvement of a minimum of 10 consultants in the weekend rota should ensure a sustainable frequency of weekend working, even if the weekend working arrangements are shared between two consultants. For smaller units, it may be possible to operate a rota with fewer than 10 consultants if there is a comprehensive arrangement in place to provide days off in lieu.'1*

The Acute Trust does not meet the recommended staffing levels; this again limits the ability to provide the levels of senior review needed to ensure timely patient assessment and treatment, and move towards more 7 day working.

8.4.5 Non-Medical challenges

The Acute Trust continues to experience recruitment difficulties across a number of non-medical professions such as nursing, operating department practitioners, diagnostic radiographers, domestics and healthcare scientists. These staff groups have historically experienced recruitment challenges in attaining establishment levels, and this has only been compounded by the recent national demand for such roles. Supply and demand data from Heath Education West Midlands suggests that this will not be improved in the short and medium term.

Duplication of services on both sites reduces the ability to support favourable on call rotas which would improve employee experience and the ability for the Acute Trust to be an employer of choice and improve recruitment. In addition there is limited scope to provide cost effective and efficient 7 day working. Currently it is difficult to support the development of advancing and extending practice for non-medical staff as the ability of medical colleagues to mentor, support and clinically sign off training logs is compromised by the need for them to partake in intensive rotas.

8.4.6 Estate condition

Patient care services are primarily delivered from the two main hospital sites in Shrewsbury and Telford. The buildings on the Royal Shrewsbury Hospital (RSH) site comprise several separate developments, ranging in age from 1966 to the current day:

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- The Maternity and Paediatric development at the south of the site adjacent to the main entrance roadway was built in 1967
- The central development of Wards, Outpatients, A&E, Imaging and Support services, which forms the main spine of the site and came into use between 1976 to 1978
- The Cobalt Unit that includes Linear accelerators and Oncology services dating from 1982
- The Renal Unit at the north of the site, which was built in 1991 and extended in 2003
- The Treatment Centre opened in 2005 also at the north end of the site
- Medical and nursing educational facilities in the north east corner of the site, built in 2002
- Residential accommodation in the south west corner of the site, built in 1974 and extended in 1982
- Rooftops accommodation in replacement of some of the old residential accommodation in the south west corner of the site, completed in phases from August 2009 to December 2010
- The Boiler House and Estate Department in the north-west corner of the site, built in 1966 and 1977 respectively
- The new and extended Cancer Centre opened in 2013

The buildings on the Princess Royal Hospital (PRH) site essentially comprise a 2 storey nucleus hospital opened in 1988 with some additions, as follows:

- Extension in 1999 to provide a purpose designed Rehabilitation Unit
- The Management Suite was refurbished in 2013 to create a 28 bed inpatient short stay medical ward
- A new Women's and Children's Centre was opened in 2014
- Staff residential blocks and a small private outpatient clinic in the south east corner of the site built in 1989
- A number of underutilised residential blocks were refurbished in 2013 to provide office accommodation

The condition of the Acute Trust's existing estate at RSH and PRH was recorded in detailed '6 Facet' estates surveys undertaken in 2015/16, which showed that significant amounts of the existing Trust estate did not achieve 'condition B' (satisfactory standard); and a substantial number of areas were 'condition D' (life expired/unacceptable), particularly at RSH (Table 6 & 7 below). The projected cost of the current level of backlog maintenance is £103.9m within the next 5 years, plus £69.3m of functional suitability backlog.

RSH	Ratings and % of Total GIA				
Estates Facet (%)	A	B	B/C	C	D
Physical Condition (%)	17	14	0	29	40
Statutory Compliance (%)	2	27	0	23	48
Quality - Environmental (%)	0	0	0	100	0
Quality - Amenity (%)	13	21	0	36	30

Table 6: Condition of Estates at RSH

PRH	Ratings and % of Total GIA				
Estates Facet (%)	A	B	B/C	C	D
Physical Condition (%)	4	64	9	23	0
Statutory Compliance (%)	0	99	0	1	0
Quality - Environmental (%)	0	100	0	0	0
Quality - Amenity (%)	0	86	0	14	0

Table 7: Condition of Estates at PRH

Note: Women and Children's Centre, PRH – The definitions of NHS ESTATECODE survey criteria stipulate Condition A is only awarded to a brand new building that displays no wear and tear. Generally any estate over 12 months and not in its first year of use is highly unlikely to achieve category A. This is also reflected in the proposed Acute Trust Estates Strategy as any refurbishment work associated with these proposals will be carried out to Condition B standard as it cannot achieve category A.

8.5 Acute Hospital Services – The Proposed Model of Care

From its inception in the Call to Action 2013, to developing the Acute Trust's Outline Business Case 2016, the design of the proposed model of care for acute hospital services and its associated delivery solution options has been clinically-led.

A set of delivery solution options were developed in 2015, however, following a formal options appraisal in 2015 (Appendix 6) it was determined that the proposed solutions were unaffordable for the local health system and as a result the Acute Trust were asked to lead on developing potential delivery solutions which were financially sustainable. The delivery solutions were developed through the Acute Trust's Sustainable Services Programme (SSP).

The 2015 delivery solutions described a 'hot/cold' site model with the majority of activity and beds focused on the 'hot' site which would host the one Emergency Centre. However, revisiting the proposals in terms of affordability led to a revised delivery solution which describes a more balanced-site or 'hot/warm' care model and this is the model contained in the SOC approved by both CCG Boards earlier this year with certain caveats.

The Trust's SSP has ensured that the clinical model delivery solution within the SOC is consistent with the acute components of the agreed Future Fit model of care 2014 which are:

- One Emergency Centre comprising:
  - one Emergency Department
  - one Critical Care Unit
- One Planned Care Centre
- Two Urban Urgent Care Centres
- Local Planned Care (outpatients, diagnostics) on both hospital sites

In designing the clinical model described in the SOC, the following key objectives also had to be met:

- Align to the Future Fit activity assumptions;
- Address the Trust's workforce challenges within emergency and critical care services;
- Be deliverable;
- Be affordable to the Acute Trust and to the local health system.

This led to the development of a proposal which would improve services for patients whilst also tackling the service and workforce challenges facing the Acute Trust and which would lead to:

- Better clinical outcomes with reduced morbidity and mortality;
- Bringing specialists together treating a higher volume of critical cases to maintain and grow skills;
- A greater degree of consultant-delivered decision-making and care;
- Improved clinical adjacencies through focused redesign;
- Improved access to multi-disciplinary teams;
- Delivery of care in an environment suitable for specialist care;
- Improved recruitment and retention of specialist's medical and nursing professionals.

And a balanced-site care model whereby patients would:

- Receive acute medical care within the Emergency Site
- Benefit from planned care with defined separation from emergency care pathways;
- Benefit from improved pathways between primary and secondary care providers.

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Following on from this, more detailed discussions with the wider Acute Trust clinical body and subsequently through the Clinical Design Work stream of Future Fit three key issues were raised:

1. Acute and unplanned medical patients being admitted directly to the non-emergency site (the 'warm' site – the Emergency Site being the 'hot' site):
   - The health system's ability to deliver truly integrated and shared care pathways so that the right patients go to the right site at the right time;
   - The need to maintain sustainability of acute medicine by having Ambulatory Emergency Care on both sites;
   - The ability to recruit clinical staff to work on the 'warm' site.

2. The resultant need to provide 'critical care cover' across two sites, though many clinicians felt that this could be achieved with new roles and new ways of working. Related to this, concern was expressed at then potential number of patients that may need to be transferred to the Emergency Site for critical care.

3. The safety and sustainability of any option whereby Women and Children's services are located apart from the Emergency Centre and Critical Care.

As a result the Acute Trust's senior clinical leaders requested that further work be undertaken to:

- Enable acute and unplanned medical patients to be admitted to the Emergency Site only;
- Deliver Acute Medicine at the Emergency Site only;
- Reduce the number of patients on the Planned Care Site who may need critical care intervention and/or transfer to the Emergency Site for their critical care needs;
- Enable the transfer of patients from the Emergency Site to the Planned Care Site after 72 hours (if clinically appropriate) for their on-going care and treatment. This model is supported in the findings of an audit carried out in August 2016 on acute medical patients.

Consequently, it was proposed that there would be a single site for unplanned admissions which provides improved patient safety and supports the emergency medicine workforce challenges. These proposed changes to the delivery model were debated and discussed at the Clinical Design Work stream and CRG Work streams within Future Fit.

Below is a more detailed description of the core components of the proposed model of care on which commissioners are seeking to consult the public.

8.5.1 Urgent Care

There will be an Urgent Care Centre (UCC) on each site open 24 hours a day 7 days a week providing accident for those patients that have an injury or illness that is urgent and cannot be treated by primary care services. It is anticipated that approximately 60% of the patients that go to the current A&Es could carry on going to their nearest hospital to receive the urgent care they need under this proposed new configuration of services.

Where the Urgent Care Centre is co-located alongside the Emergency Department it will be accessed through a single front door, though patient flows will be managed separately from the ED (ie there will be a separate ambulance entrance for the ED). Patients will access the service on both sites as a 'walk-in' or via ambulance if it is considered by paramedic staff to be clinically appropriate. There will be dedicated facilities for children to ensure that they wait and are treated away from adult areas.

The UCCs will staffed by a multi-disciplinary team to include GPs, Advanced Clinical Practitioners (ACPs) and nurses, specifically trained in the delivery of accident and urgent care for adults and children. Staff on both sites will work closely with the team at the Emergency Department and will ensure patients receive the care they need without delay. Where the ED is not co-located, telehealth links will support the patients prompt diagnosis and treatment

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The UCCs will be open 24 hours a day, 7 days a week. Examples of the type of presenting conditions the Urgent Care Centres will manage include:

- Injuries from tumbles, falls or sport where there is reduced movement or pain from a single limb or joint. This will include patients who have undisplaced closed fractures of the distal part of single limbs/dislocation of fingers and toes;
- Cuts and scrapes that cannot be managed with a simple plaster, or where the edges of the cut are wide apart (usually greater than 3 inches and ¼ inch deep);
- Mild asthma in previously diagnosed asthmatics, such as breathing difficulties in the absence of airway complication where the patient can speak in short sentences;
- Ear, nose and throat problems, such as a persistent nose bleed, sore ear or throat which is rapidly getting worse and cannot wait for the GP;
- Foreign object stuck up nose that IS NOT obstructing the patient's airway;
- Scalds or burns that involve part of a single limb where the skin is red and painful;
- Bites and stings where there is more than expected swelling but there is no swelling in the mouth, tongue or difficulty breathing.

In relation to the service offer of the Urgent Care Centre on the Planned Care site, the following clinical model has been agreed:-

- Children who would normally be observed within primary care or at home, to determine whether they need further treatment or not, could be managed within the service on the Planned Care Site if the team feel competent to do so;
- Children needing further assessment or treatment from the paediatric team however, would need to be transferred to the Emergency Site where the Children's Assessment Unit and Children's Inpatient Service would be located. There will be a clinician trained in Advanced Paediatrics Life Support available for the stabilisation of the critically ill child that may present at the Planned Care Site
- Some adult patients would be seen and their treatment started through the urgent care service at the Planned Care Site;
- Ambulatory Emergency Care service would only be at the Emergency Site but that does not mean patients with Ambulatory Care Sensitive conditions could not be seen in the urgent care service at the Planned Care site. Again, patients needing more detailed assessment or treatment, or those needing admission would be transferred to the Emergency Site.

Mental Health presentations can account for at least 20% of primary care attendances. The UCCs will have 24/7 direct access to the psychiatric liaison team. Local psychiatric liaison teams (RAID) will be responsible for ensuring consistent levels of cover for the UCCs and to the Mental Health Crisis Team. Both UCCs will have access to a Mental Health assessment room that are compliant with the relevant Royal College of Psychiatrics safety standards.

8.5.2 Emergency Department

The ED will be fully equipped and staffed to deliver high quality emergency medical and surgical care 24 hours a day, 7 days a week, 365 days a year. Patients who are acutely ill with potential life or limb threatening injuries and require immediate diagnosis and treatment will be taken directly to the ED. Access to the ED will be gained only via transfer from an UCC or Ambulance. The ED will also serve as a Trauma Unit and will be co-located with a single Critical Care Unit.

There will be full and immediate access to diagnostics (Radiology, Pathology), Haematology (Blood Bank) and Pharmacy. Children and adults will be managed in separate areas within the ED. Within Resuscitation the facility will be designed to manage both the critically ill adult and child with provision for some division should a child be in resus. Capacity has been planned to manage all ED patients within three hours of their arrival, with the majority of patients having no waiting time for assessment.

Patients with mental ill health needs will have access to local psychiatric liaison teams (RAID) who will be able to assess appropriate care requirements as part of the ED clinical team. Facilities will be collocated and shared

with the adjacent Urgent Care Centre and will provide a safe environment that will support the patients assessment.

The Clinical Decision Unit (CDU) will be co-located alongside the ED providing dedicated clinical space for those patients that require further assessment and monitoring prior to a clinical decision being made. The 8 bedded CDU will be incorporated within the Ambulatory Emergency Care Unit to provide greater flexibility in space and response in times of increased demand on services.

8.5.3 Ambulatory Emergency Care (AEC)

The Ambulatory Emergency Care (AEC) Unit located adjacent to the ED will be operational for 12 hours per day. The AEC will support unscheduled care activity for those patients that require admissions for no more than 12 hours (both planned and unplanned). The AEC will also support a shift in activity flows for patients who currently stay between 13 and 72 hours.

8.5.4 Critical Care

The Critical Care Unit will bring together all the Acute Trust adult critical care capacity, with level 1, 2 and 3 patients being managed in the same unit. The planned capacity of 30 beds has been future-proofed for the next decade to allow for projected increases in demand. This unit will support the consolidation of emergency activity and high risk elective inpatient procedures onto one site.

Critical Care Outreach will support the wards on the Emergency Site and the Planned Care Site. The risk of patients requiring Critical Care Outreach on the Planned Care Site will be minimised through the appropriate clinical streaming of patients and early identification of the deteriorating patient.

For those patients that unexpectedly deteriorate on the Planned Care Site, for example, post-surgery, the admitting consultant in conjunction with anaesthetic and ODP support will liaise with the consultant intensivist on the Emergency Site to discuss treatment plan, stabilisation and, if appropriate, transfer.

8.5.5 Unplanned Medicine

Wherever possible, unplanned medical patients will be assessed and treated in the AEC/CDU, with those with additional healthcare needs requiring a stay over more than 12 hours being admitted to the Short Stay Medical wards, with an indicative maximum stay in this setting of 72 hours.

Patients requiring on-going or specialist care will be transferred into the appropriate specialty ward. The introduction of 7 day working and enhanced recovery pathways will promote proactive management of patients throughout the week, supporting timely discharge once the acute care episode has been completed. On this basis, it is envisaged that internal patient transfers and outliers can be minimised, and that a reduction in delayed transfers of care can be achieved.

For those patients that have on-going acute care needs but do not require specialist input such as Cardiology and live nearer the Planned Care Site they can be transferred to receive on-going care in an appropriate environment that meets their clinical needs.

8.5.6 Unplanned Surgery

Unplanned surgical patients (excluding oncology and haematology) requiring admission will be seen at the Emergency Site, with anyone with an anticipated length of stay of under 72 hours being admitted to the Surgical Admissions Unit (SAU). Unplanned surgical patients requiring a stay of longer than 72 hours will be admitted to the appropriate specialty ward. As with medicine the introduction of enhanced recovery pathways will promote proactive management of unplanned surgical patients, supporting timely discharge once the acute care episode has been completed.

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For unplanned surgical patients who do not require admission to the Emergency Site, the Planned Care Site will have a short stay surgical unit.

8.5.7 Planned Care

Planned care where clinically appropriate will be provided on the Planned Care Site, including the majority of day case and short stay surgery. Most planned care admissions will take place between Monday and Friday, with the exception of orthopaedics where there are Saturday morning lists. Only major or complex planned care, including some cancer surgery where there is potential for the patient to require critical care input will be provided on the Emergency Site. Enhanced recovery pathways will facilitate proactive management and timely discharge.

Outpatients and outpatient procedures will be undertaken at both sites.

8.5.8 Women and Children

The model for Women and Children's services is based on that recently developed and effectively implemented as part of the consolidation of services at PRH in 2014. Essential clinical adjacencies have been identified between maternity, neonatology and paediatrics, and between women and children's services and the ED and critical care.

There has been considerable focus on potential changes to Women and Children's services in one of the options. High risk women and children's services need to be based on the emergency site. This is the clear view of the experts both locally and nationally. Therefore only Inpatient Obstetrics and Paediatrics will potentially move. Most women and children will continue to receive the majority of their care and treatment in the same place as they do now in either options being considered.

- Midwife-led unit, including low-risk births and postnatal care (subject to the outcome of the 2017 Maternity Services Review)
- Maternity outpatients including antenatal appointments and scanning
- Gynaecology outpatient appointments
- Early Pregnancy Assessment Service (EPAS)
- Antenatal Day Assessment
- Children's outpatient appointments
- Neonatal outpatient appointments.

8.6 Evidence to Support Change

8.6.1 Learning from experience of reconfiguration of services

In developing the optimum service delivery model, the Acute Trust has taken into account its own learning from experience of recent service reconfiguration as well as those from other acute providers.

The case for the proposed care model is supported by recent service reconfiguration experiences within the Acute Trust including:

- The reconfiguration of Women and Children's services in 2014 onto a single site has delivered improvements in paediatric recruitment and the unit is now the 10th largest paediatric centre in the country;
- Consolidation of emergency surgery onto one site in 2012 has led to improved clinical outcomes.
- A single point of access for Acute Stroke patients was implemented in 2013, which has led to improved clinical outcomes.

It is also supported by the experience of acute providers elsewhere in the country, most notably:

Northumbria - In 2015, Northumbria Healthcare NHS Foundation Trust opened England's first purpose-built, dedicated, specialist emergency care hospital, transforming urgent and emergency care services across Northumberland and North Tyneside. With the opening of The Northumbria hospital, changes were made to the trust's former A&E departments at Hexham, Wansbeck and North Tyneside general hospitals. These became 24/7 urgent care centres, led by highly experienced emergency nurse practitioners who care for walk-in patients with less serious problems, minor injuries and ailments. There are no emergency hospital admissions at the trust's three general hospitals as these are now centralised at The Northumbria.

> In terms of results one year on, Northumbria Healthcare was one of only a handful of trusts nationally to meet the four hour 95% performance standard in 2015/16. This is against a backdrop of a 15% increase in urgent and emergency care attendances. Despite the huge increase in urgent and emergency attendances during 2015/16, since centralising specialist emergency care onto one site at The Northumbria, the trust has recorded an average of a 14% reduction in emergency admissions to hospital.

8.6.2 Best practice guidance

Use of clinical best practice, benchmarking and a review of national guidance on emergency clinical pathways and workforce has been undertaken to inform the proposed model of care, including:

Transforming urgent and emergency care services in England, NHS England, 2015;

Directory of Procedures, Fourth Edition, British Association of Day Surgery;

Directory of Ambulatory Emergency Care for Adults, Version 4, NHS Elect, 2014;

Care of Critically Ill and Critically Injured Children – Quality Standards, v5.1, Paediatric Intensive Care Society / West Midlands Quality Review Service, December 2015;

The repeatable rooms initiative established as part of the NHS P21+ programme.

8.6.3 Compliance with national policy and guidance

The proposals are in line with the following:-

- All pathways being redesigned in consideration of NICE guidance and best practice.
- 'Transforming urgent and emergency care services in England' NHS England 2015
- Review of Operational Productivity in NHS, Interim Report, Lord Carter 2015
- Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21
- Bariatric guidance
- Quality Standards for the Care of the Critically Ill Children. The Paediatric Intensive Care Society 2015.
- Core Standards for Intensive Care Unit. The Faculty of Intensive Care Medicine / The Intensive Care Society 2013
- Transforming urgent and emergency care services in England, NHS England, 2015;
- Directory of Procedures, Fourth Edition, British Association of Day Surgery;
- Directory of Ambulatory Emergency Care for Adults, Version 4, NHS Elect, 2014;
- Care of Critically Ill and Critically Injured Children – Quality Standards, v5.1, Paediatric Intensive Care Society / West Midlands Quality Review Service, December 2015;
- The repeatable rooms initiative established as part of the NHS P21+ programme British Cardiovascular Intervention Society (BCIS)

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8.6.4 Improving patient outcomes

Central to the plans for the delivery of a revised clinical model are the improved outcomes for patients. Research has been undertaken to understand improvements, recommendations and evidence from elsewhere and the opportunities for the SSP specifically around Urgent and Emergency Care, Ambulatory Care and Planned Care.

The core element of the proposed clinical model is that all patients are seen in the right place, at the right time by the right person. If the right place for the patient is the acute setting, then the services that patients access need to be suitable for their needs.

Under the current model of care, patient pathways are not clearly defined and often patients are seen in an inappropriate setting with poor facilities. Furthermore, the current duplication of services has introduced a level of confusion and 'chaos risk' for patients, their families and staff alike. The diagram below has been widely shared in the discussions and development of the model and is recognised by the Acute Trust staff and patients as a reflection of current patient flow:

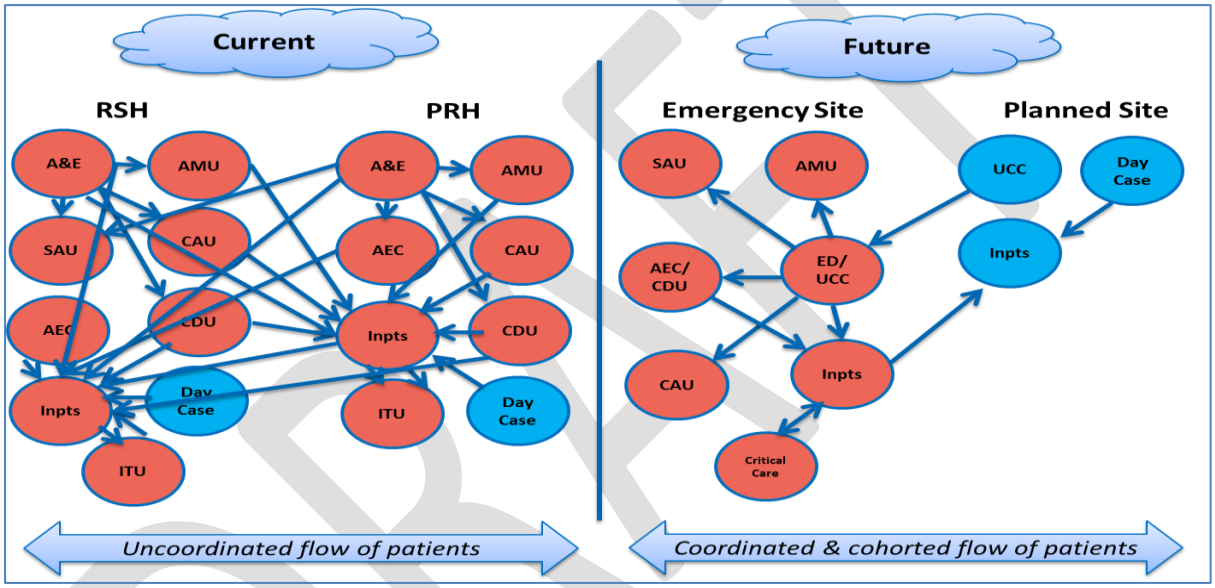


Figure 4: Current and future patient experience and flow

The above merely aims to represent a simplified diagrammatic representation of the change in patient flows these proposals will deliver. The details of individual condition specific pathways will be reviewed as part of the development of the Full Business Case.

This section will describe the new clinical model in terms of the benefits for patients in relation to available evidence.

• What will the Clinical Model offer Patients?

In recognition of the need to design a service that meets the needs of patients and delivers best practice, the model will ensure that:

- When clinically appropriate patients will be seen and treated in ambulatory or day case settings with no overnight admission

- If an overnight admission is required, patients are seen, treated and discharged without delay

The diagram below illustrates the services that will be provided based on the patient's clinical need:

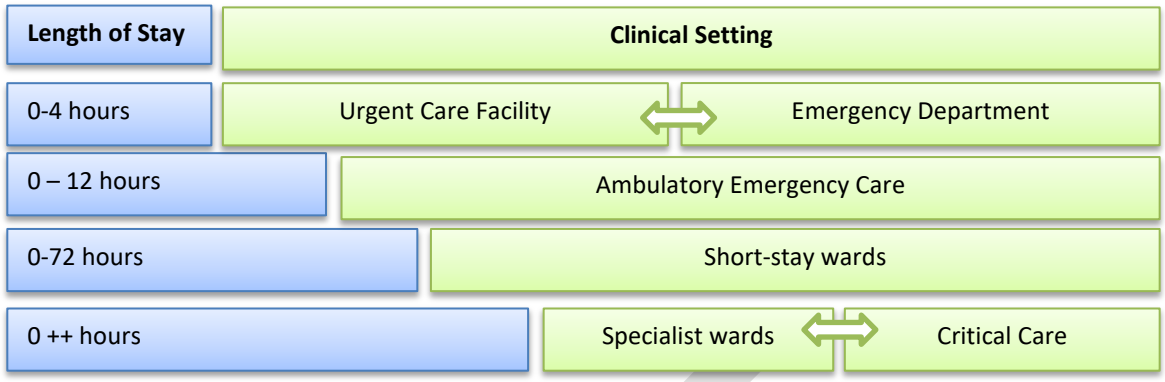


Figure 5: Clinical setting and length of stay

- Seeing Patients in the Right Place

Ambulatory Emergency Care enables around a third of admitted patients to be seen, diagnosed, treated and discharged within the same day to continue their treatment at home or in a community setting.

The current arrangement of the existing A&E departments has a combined workforce and facilities. This, in conjunction with the facilities and hospital flow, creates a scenario where patients are waiting longer than they should for their definitive care potentially having an adverse effect on their clinical outcome; patients run a 43% increased risk of death after 10 days if they are admitted through a crowded accident and emergency (A&E) department. Waiting for admission in A&E is also associated with significantly longer hospital length of stay.

Currently planned care and unplanned care are provided across both hospital sites. Pressures within unplanned services impact daily upon planned care activity. This means medical patients can be cared for within the 'wrong' ward for their needs and that planned episodes of care are cancelled. Both of which have an adverse effect on the patient.

Patients that are being cared for in an area of the hospital that is not related to the speciality to which they should be admitted are classified as 'boarded' patients. There is a direct correlation between an increased length of stay and the number of intra-ward transfers. Boarding patients makes it difficult to ensure they are seen by the right person at the right time as they are in the wrong place. As well as an impact on length of stay, boarding has a statistically significant impact on adjusted rates of mortality, emergency readmission and inpatient discharge timing.

Multiple patient moves within the hospital, particularly if it is an older patient, can increase length of stay and stall patient flow. Research has found that patients can be moved four or five times during a hospital stay, often with incomplete notes and no formal handover. From November 2015 to November 2016, SATH cancelled 514 (25% of all cancelled operations) surgical procedures due to the unavailability of beds. Cancelling a patients operation often has a negative impact on them and their family. Research has shown cancelled operations result in significantly more complications and a lower quality of life in the long run. The most common complications were depression, urinary tract infection, wound infection, and myocardial infarction. Furthermore, cancelling patients also challenges SATH'S delivery of nationally defined access targets.

The Royal College of Surgeons (RCS) recommends separating elective surgical admissions from emergency flows through the use of dedicated beds. Separating the elective flow can result in a separate culture around the unit focused on improving the elective stream, a more predictable workflow, increased senior supervision, earlier investigation, earlier definitive treatment and better continuity of care.

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• Seeing Patients at the Right Time

One of the main challenges in seeing patients at the right time within the Acute Trust, in line with many organisations within the NHS, is the flow of patients through the hospitals, patients being admitted unnecessarily and delayed discharges. All of which contribute to poor flow.

A delay or prolongation of hospital stay after patients are deemed to be discharged from internal medicine departments is associated with increased morbidity and mortality, mainly during the first surplus days of in-hospital stay. Efforts should be made to shorten such hospital stays as much as possible.

As well as patient flow improving access to theatres and wards, appropriate access to care for the critically ill patient is vital. Current flow means on occasions patients that are appropriate to be on a ward remain within the Critical Care Unit as there are no available beds for them. This reduction in available capacity for acutely unwell patients may cause a delay; failure to admit to Critical Care in a timely manner is associated with an increase morbidity and mortality.

Intensive Care National standards advise discharge from Critical Care should take place within 4 hours of patients being declared medically fit to return to the ward. In SATH between April and Nov 2016 over 330 patients have had to wait beyond the 4 hours to secure a transfer to a more appropriate ward bed, 190 of this cohort have had to wait over 24 hours to progress. This exposes the recovering patient to greater physical and psychological harm, potentially compromised same sex accommodation standards and delays in their rehabilitation.

• Patients being seen by the Right Person

As described in section 8.4 the current workforce model creates challenges in making sure patients are seen at the right time by the right person for their clinical need. There is a strong body of evidence to support that early review of patients by a senior decision maker can avoid unnecessary overnight stays.

A key part of supporting the clinical model and the delivery of a medical service where patients have access to the right person is the introduction a 7 day medical workforce. Evidence shows that the length of stay of patients admitted on a Monday or Tuesday is, on average, around 2 days shorter than the length of stay of those admitted on Friday or at the weekend. Several of the factors that contribute to unnecessarily prolonged lengths of stay are more pronounced at weekends, such as variable staffing and service levels in hospitals and variable access to community services.

• Avoiding Hospital Admissions

Much of the evidence supporting the clinical model acknowledges admission avoidance and reduced lengths of stay. Whilst this benefits the health care system, minimising hospital admissions is of great benefit to patients and their clinical outcomes. Hospitalisation can cause various problems for patients including:

- Hospital-acquired infections (HIA'S)
- Confusion, depression and decline in mental function
- Poor nutrition
- Incontinence
- Inability to urinate
- Lack of sleep
- Pressure sores
- Falls

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- Improved Facilities

There is now widespread consensus that a hospital's physical environment can have a big effect on patient outcomes and recovery times. Factors such as space, lighting, use of colour, acoustics, noise levels, smells and the degree of control a patient has over their environment can all have an impact on the wellbeing and mood of the individual,

A patient's environment, especially in Critical Care can have a negative impact on patient outcomes. Intensive care unit nurses must actively consider and manage the environment in which nursing occurs to facilitate the best patient outcomes. ICU design will incorporate access to natural light and the outside environment to aid patient recovery and experience.

A research review on the evidence based health care design confirmed the importance of improving the healthcare outcomes associated with a range of design characteristics or interventions, such as single-bed rooms rather than multi-bed rooms, effective ventilation systems, a good acoustic environment, appropriate lighting, better ergonomic design, and improved floor layouts and work settings. It is now widely recognised that well-designed physical settings play an important role in making hospitals less risky and stressful, promoting more healing for patients, and providing better places for staff to work.

8.6.5 How will the model support the delivery of the NHS Constitutional Standards?

The revised model of acute care and specifically the positioning of emergency care at a single ED (supported by two urgent care centres) and the positioning of the vast majority of planned care at a single site will specifically enable the achievement of constitutional standards as follows:

- Referral to Treatment (RTT) & Cancer
  The concentration of planned care on a single site will greatly enable efficiency of the delivery of care, allow for the ring fencing of beds for surgical capacity and allowed for planned settings of care changes. All of these will contribute positively and significantly to the achievement of waiting times and RTT.

  Cancer will be further enabled by the creation of a dedicated cancer centre on the planned care site as well as the planned care changes described in the previous paragraph.

- A&E
  The proposed reconfiguration will contribute significantly towards a sustainable future achievement of the A&E standard through more effective workforce deployment with a emergency care services consolidated on one site and a different workforce model with new roles with enhanced skill sets and reduced demand on the acute services from a redesigned community/out of hospital model of care which supports more people to manage their health needs closer to home.

8.7 Facility Requirements

8.7.1 Service Planning Assumptions

In planning the facility requirements, the Acute Trust SSP has applied certain key service planning principles. These include:

- The emergency route into the Emergency Site (UCC & ED) will be via a single door. There will be a separate door for ambulance patients to ED;
- Emergency and planned care facilities to be separated from each other;
- Ambulatory Emergency Care is provided on the Emergency Site only
- The balance of services across the emergency and planned care sites has been agreed in detail through iterative dialogue with SATH clinicians; some specialties, such as breast surgery and bariatric

surgery, are exploring how to develop their services on the planned care site as centres of excellence; Cardiology is exploring the development of a Centre of Excellence on the Emergency Site.
- Critical Care – physical capacity will be provided for 30 spaces; work is being undertaken to establish the staffed capacity to be provided from day 1 of the new unit opening;
- Any proposed solution must be affordable and deliverable;

8.7.2 Schedules of Accommodation

The Acute Trust SSP has created a set of baseline Schedules of Accommodation (In OBC appendix 7) that further develop the illustrative space standards set out in the SOC into full generic Departmental Schedules. These baseline schedules represent a target to be achieved as far as is practicable and indicate how the services and functional units are required to be split across the Emergency Care Site and the Planned Care site.

As a consequence of the differences between Option B and C1 and Option C2, it is necessary to define the Emergency Care and Planned Care component parts via two sets of baselines.

The baseline schedules provide an Output Specification against which SATH may evaluate corresponding Input Specification via proposal schedules for each option; once the preferred Option is defined, the objective moving forward through the procurement process is to 'build it or better it'. At this stage the baseline position may still have a value if SATH is presented with more radical or innovative solutions.

The Schedules of Accommodation include reference to source and evidenced standards, both at a room-by-room level and also departmentally where high-level metrics have been applied. The Departmental Summary sheet provides the high-level evidence, whereas the room schedules utilise a 'pick list' of agreed space standards for which there is a separate directory outlining the basis for the Trust's selection.

8.7.3 Construction and Delivery Phase Programme

The detailed construction and delivery phase programme and dates vary depending on which option is chosen. All of the options however comprise:

- An initial programme of site clearance, service diversions, and enabling works
- A main new build stage, followed by initial transition and implementation (including new clinical and workforce models)
- A refurbishment and reconfiguration stage, followed by further transition and implementation (including new clinical and workforce models)

An initial detailed review of the phasing and sequencing has taken place during the development of the OBC, which shows that all 3 options are deliverable.

The overall duration of the delivery and implementation stage for each option is:

- All Options: Obtain all approvals and undertake site enabling works to create a clear site- approximately 2 years

Followed by:

- Option B- 4.5 years, with SSP benefits delivered after 2.5 years
- Option C1- 5 years with SSP benefits delivered after 3 years
- Option C2- 5 years with SSP benefits delivered after 3 years

These results in the implementation of the new clinical model and the associated benefits of the reconfiguration being delivered by the end of the 2020/21 financial year, with all remaining backlog delivered by the end of 2022/23. All of these dates are deemed to include construction, fit-out, and decanting.

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8.8 Workforce Sustainability

8.8.1 The Current Workforce

SATH employs on average approximately 5,300 staff as summarised by the staff groups in the table below:

	2015-16		
Staff Group	Total	Permanently employed	Other (Agency and bank)
	Number	Number	Number
Medical and dental	594	554	40
Administration and estates	1,033	945	88
Healthcare assistants and other support staff	1,171	1,041	130
Nursing, midwifery and health visiting staff	1,593	1,418	175
Nursing, midwifery and health visiting learners	35	35	0
Scientific, therapeutic and technical staff	582	562	20
Social care staff	0	0	0
Healthcare science staff	277	277	0
TOTAL	**5,285**	**4,832**	**453**

Table 8: Summary of 2015/16 Workforce Average Whole Time Equivalent (WTEs) by Staff Group.

8.8.2 The Workforce Challenge

Running duplicate services on two sites presents many workforce challenges and can result in a poor employee experience for some of the Acute Trust's medical and non-medical teams across multiple specialities. This compounds an already challenging recruitment environment and leads to difficulty in recruiting the right substantive workforce to provide high quality safe care.

With the medical workforce, the current service configuration and the requirement for consultants and other specialist staff to cover both hospital sites can at times limit their ability to provide senior patient reviews. In addition, the Trust is unable to achieve Royal College guidance standards in many areas. For non –medical workforce the challenges are similar, senior expertise is split across two sites, the learning environment and provision of workforce development challenging.

With the current staffing configuration, it will prove extremely difficult to achieve adequate staffing levels to provide 7-day working across both sites. Furthermore, because teams are spread so thinly services are vulnerable to unexpected absences and the non-availability of staff.

Current configuration continues to create cost pressures for premium rate working, poor economies of scale and duplication of rotas as well as exacerbating the Trust's ability to resource 'hard to fill' posts.

The recruitment and retention of the required clinical workforce is expected to significantly improve following the reconfiguration of services, as specialist workforce is consolidated into stable and sustainable clinical teams.

8.8.3 The Workforce Plan

The workforce plan incorporates the guidance within the recent publication from the National Quality Board (July 2016) in 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time'. This ensures all opportunities to maximise the contribution of multi-disciplinary teams and the number of care hours per patient per day have been considered. The workforce plan focuses on three main areas for change. These are:

- Efficiencies and improvements as a result of consolidation of services and removal of duplication
- The development of new roles such as Advanced Care Practitioners (ACPs) and Nurse Associates (NAs)
- Change in working practices as a result of technology eg. telehealth and electronic patient records

The new model of acute hospital services will result in WTE reductions of between 225 – 371 depending on which option is implemented. In addition, the plan is to also achieve a reduction in the pay bill relating to non WTE reduction of £4.1m.

To reduce the pay bill the key drivers are:

- Activity and pathway driven changes in workforce e.g. acute intake on one site, strengthened elective provision, improved rota management and removal of duplication, reducing reliance on high cost temporary staffing
- Productivity driven reductions in workforce, leading to fewer WTE to deliver a given quantity of activity e.g. use of technology and improved processes
- Reduction in the cost per WTE of the future establishment e.g. ensuring that staff spend a greater proportion of their time conducting tasks appropriate to their grade through role re-design and the introduction of more junior roles

Workforce plans have assumed that workforce establishment in terms of WTE is reduced but also the average cost per WTE (although this would be focused rather than universally applied).

Staff group	Budgeted establishment 31/03/16	Demand B	Demand C1	Demand C2
Non-Medical				
Registered nursing and midwifery	1415.62	1299.86	1307.86	1323.51
Qualified	262.97	208.90	208.90	208.90
Other	345.81	326.75	326.75	369.91
Support to clinical	1396.02	1311.39	1314.39	1347.39
Non clinical	964.48	874.48	874.48	879.48
Medical				
Consultant	282	290.5	290.5	306
Career/Training grades	366	350	350	372
Total	**5032.9**	**4661.88**	**4672.88**	**4807.19**

Table 9: The Workforce Plan under each of the options

Workforce changes fall into three categories:

- Activity and pathway driven changes
    - Single Emergency Department – recruitment and retention; improved rotas; working environment;
    - Ambulatory Emergency Care/Clinical Decisions Unit – alignment and development of capacity to demand;

- Productivity driven efficiencies
    - Theatres – separation of emergency and planned care;
    - IT enablers – telehealth, paper-light, patient apps and self-check-in;

- New roles
    - Advanced Care Practitioners
    - Advanced Nurse Practitioners
    - Emergency Care Practitioners
    - Extension of Primary Care roles in the Trust

8.8.4 Workforce Transformation Programme

In order to deliver the clinical model within SSP the workforce will increasingly be:

- Treating higher acuity patients on the emergency/ acute site as a matter of routine
- Working more autonomously and delivering a more complex case load
- Working in more flexible ways across traditional professional groups
- Developed to support new roles required
- Smaller in numbers Up-skilled to take on extended roles
- Required to use new technology to deliver clinical care and non-clinical services
- More routine working new patterns of employment e.g. 24/7 on site presence, 7-day working and delivering routine services in the evening and at weekends

As such a phased workforce change programme will commence from year 1 as described in the table below.

Table 10: The Workforce Change Programme

Workforce Change Programme	
Emergency Dept/UCC/AEC/ CDU & Critical Care	
Key service change driving workforce change	Workforce changes
Increased use of urgent care and out of hours services alternatives will mean that a higher proportion of those patients attending the Emergency Department and the Acute Assessment Units (SAU/AMU/AEC) could have higher acuity as a result of major illness/life threatening conditions or exacerbation of an acute episode of a long term condition that cannot be managed within the community environment	• New models of working. e.g. 7-day on site consultant presence in ED & Acute Medicine and 7-day working models • Requirement for rapid access to specialist and technical assessments, diagnosis and treatment across 2 UCC and ED • Shared workforce through ED/AEC/CDU • Increased demand for multi-disciplinary advance clinical practice roles and increase in Emergency Nurse Practitioners • Increased utilisation of new roles e.g. advanced AHP roles, pharmacy ED practitioners, GP with Special Interest Efficient ancillary and administration systems – workforce practices driven by technology
Medical and Surgical bed rebalancing	
Greater focus on 7 day working to deliver consistent standards of emergency and IP services 24hrs ,7 days per week Concentration on provision of Emergency Inpatient	• Enhancing and developing our new models of working • Increase in day case provision • Workforce will become less generalist and increasingly specialist within more than one

services and intense focus on safe acute inpatient care Enhanced rehab /frailty/discharge to assess model on warm site Reduction in admissions and LOS associated with long term condition	specialised care area to meet the demand and enable workforce productivity • Development of new roles crossing professional boundaries at advanced and support level • Introduction of a 'cluster 'approach to working such that surgical/medical workforce cross cover at sub specialty level • Efficient ancillary and administration systems – workforce practices driven by technology
Outpatient transformation	
Outpatients: reductions in outpatient activity and Improved outpatients efficiency, highest impact changes are assumed to be with follow up attendances. Increased utilisation of virtual service models for OP appointments Service users with long term conditions will be managed, within integrated care models that cross over between health primary, secondary and social care models	• A reduction in medical) and non-medical clinical and non-clinical practitioners aligned to OPD acute outpatient services i.e. nursing staff (WTE/Pas) • Conversion of a number medical led OP follow up clinics becoming non-medical led clinics, will occur an increase in demand for advanced and highly competent practitioners i.e. nurses, AHP • Increase in a number of our staff becoming more autonomous workers and therefore becoming increasingly knowledgeable in working within high safety governance models • Increased use of technology- self check in , further development and roll out of tele med app • Efficient ancillary and administration systems – workforce practices driven by technology
Day case	
Increased volume of day surgery	• Scheduling /PAs • Increase in demand in advance assistant roles i.e. specialist nurses, physician associates - delivering and or supporting the delivery of minor surgery • Increase use of technology – telemetry, telescopic instruments •

8.8.5 Training Impact and Implications

The training and learning experience of staff is fundamental in ensuring the Trust continues to develop a high-quality workforce. All workforce changes will align with deanery guidance on training environment and rota requirements and innovations within workforce best practice and role developments will be used as a basis for the Acute Trust's transformation journey.

A phased approach to the development of the existing workforce will be required to ensure alignment of educational lead in time required to ensure that staff are qualified, confident and competent to deliver the care required.

Opportunities to further rotate acute staff through the community will be explored as part of the development of the Full Business Case and through the Neighbourhood Workstreams of the STP.

Summary detail of Acute Trust staff involvement and engagement and the plan to support staff through the transition is given below.

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- Formal Programme structure is in place and is working well including reporting into Sustainability Committee
- Since SATH Trust Board approval of the SOC there has been:
    - 21 separate Task and Finish Groups with clinicians, staff and operational teams
    - 25 technical team meetings
    - 85 small group/ individual meetings that have included the Transformation Team
    - 15 updates and presentations to external groups/ stakeholders
    - 31 roadshows with 172 people 'checking in'
    - 4 overarching Clinical Working Groups
    - 4 Critical Friends Groups
    - 5 Gossip Groups
    - 45 people checked in at fun day/ AGM
- Over 50% of the consultant body has been involved in developing the detail, with many on multiple occasions
- 80% of all areas of the Trust has been visited in the last two weeks with details of the options, the key dates and details of how to get involved/get in touch
- Considerable engagement with all staff groups including operational managers, medical and nursing staff, HCAs, administrative staff, house keepers, radiographers, blood scientists, midwives.

8.8.6 Health Informatics

The Trusts IT Strategy concentrates on providing solutions to meet the clinical and business requirements of the reconfigured services. This service change provides a fantastic opportunity to further the IT development from previous reconfigurations and aid the roll out of a modern, resilient and integrated IT solution that is beneficial to staff and service users. Details can be found in the OBC appendices.

The Trusts plans are also in line with many of the objectives of Local Digital Roadmap (Appendix 28):

- Paper-free at the point-of-care by 2020
- Digitally-enabled self-care
- Real-time analytics at the point of care:
- An integrated care record across our economy
- Patients as co-authors of their record, contributing and interacting with their record, approving access, booking appointments, ordering repeat prescriptions etc.
- Tele Health at scale throughout the duration of the project

The Trust has already rolled out an innovative patient facing app for its cancer patients allowing the patients to be effective members of their own care teams. The service changes outlined in this business case will provide the springboard for further development of patient facing apps that allow for integration across the wider health economy.

The Trust commissioned IT specialists, Channel 3 Consulting, to help with the development of technology solutions to aid future healthcare proposals. The reconfiguration will be a major catalyst for change including looking for opportunities for automation and efficiencies specified in the Carter review. A Paper Light Group has been developed that is responsible for the delivery of the health informatics solutions for the OBC but also a wider remit to ensure that any proposals compliment the solutions required for the wider health economy initiatives. The aim of the work undertaken by Channel 3 was to provide:

- An overview of health informatics and its potential role in the reconfiguration of services
- A new vision for health informatics and the impact of the new service
- High level information around potential technology solutions to support the proposed Emergency Department, Critical Care and Urgent Care configuration

- The next steps required to further develop the vision and solutions

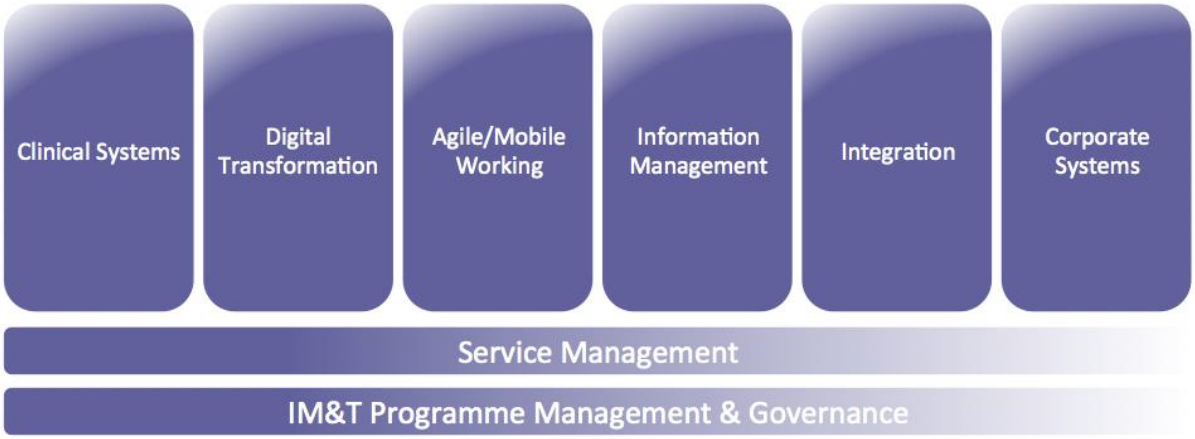


Figure 6: Health Informatics Scope

Elements of the above scope include:

- **Clinical Systems:** Electronic Patient Record, Clinical Decision Support, e-Prescribing
- **Digital Technologies:** Tele-Health, Video Conferencing, Remote Patient Monitoring
- **Agile / Mobile Working:** Community nursing solutions, Tablets, Collaboration Tools
- **Information Management:** Messaging between systems, cross-organisation data sharing

The key attributes and outcomes of the healthcare informatics required to support the reconfiguration within the Acute Trust are illustrated below.

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Key Attribute	How it will benefit the Trust and its patients
Holistic Patient Records	• Enables the Trust to use information more effectively • Supports multi-disciplinary team and cross-site working, which is not possible with paper • Eliminates the need for and costs of paper movement and storage • Better use of resources
Effective Workflow Management	• Standardisation in the delivery of care models • More effective use of resources • Reduce variation • Reduction of unnecessary cross-site transfers • Support for efficient and effective diagnostic and other support services
Streamline Administrative Processes	• Effective administration functions and better use of resources • No paper processes or storage • Fewer communication issues with patients and DNA's resulting in a better experience
Enhance Collaboration	• Enables colleagues to work together across the two sites • Facilitates access specialist support and advice regardless of location • Prevents teams from becoming disjointed • Reduces unnecessary cross-site travel
Agile Workforce	• Enables Clinicians and allied professionals to work flexibly across the two sites whilst remaining available to their colleagues • Ensures that mobility does not result in a disadvantages, in terms of access to information, systems and colleagues
Connected Patients	• To sites working as one – staff will collaborate effectively together and support each other in diagnoses and clinical decision making • Better use if resources, especially clinical specialists working in critical care • Ability to provision ICU/HDU beds on planned care site • Modernisation of Critical Care facility using leading edge monitoring solutions • Maximises the use of acute care to those that truly need it
Partner Integration	• Shared records across different care settings (GP, Community) • Better coordination of care amongst partners, supports prevention and out of hospital care • Non acute care can be managed and coordinated in the community, supported by the Trust but alongside partner providers.
Resilient Infrastructure	• Enables cross-site working and reduction in patient transfers • Support for new technologies • Better use of resources • Secure patient and corporate information • Closer integration of remote sites and partner organisations

Table 11: Required Health Informatics attributes

Inter-operability of the Acute Trust IT system with other provider IT systems will be key to optimising the safety, quality, effectiveness and efficiency of patient care

9. The Developing Community Model to Support the Acute Reconfiguration

For the acute model of care described in this PCBC to work optimally and to achieve maximum benefit, all health and social care sectors need to contribute their part to effective and integrated patient pathways which both support reduction in demand on acute services and improve flow through acute services to discharge back to community.

This section describes the approach being taken to ensure that the wider system capacity changes and impacts are delivered to support the acute reconfiguration activity and capacity assumptions set out in the PCBC. It also describes the proposed community models at their current stage of development through the STP Neighbourhood/Out of Hospital Work streams including associated developments in primary care, frailty, mental health and dementia.

Detail of the acute and community activity and capacity modelling and how they align is set out in Section 10.2.

9.1 Neighbourhoods Vision

The Health and Wellbeing (HWB) Strategy provides our vision: to be the healthiest, most fulfilled people in the country. To achieve this goal we need to replace the ill health paradigm with wellness and deliver place-based integrated health, care and community models that support independence into older age for the majority of our population. Integrated technology and data moving freely across our system will support the placed-based delivery models, backed up by an asset based approach and a one public estate philosophy which maximises the use of community and public assets to the full.

These transformational changes will not only deliver better health outcomes for our communities but will support an investment shift into prevention, maintenance, early detection and treatment and reduce demand for secondary care provision, releasing hospital specialists' capacity to focus on the acutely unwell.

This will only be achievable by working closely with our communities; by helping people take control of their own health and supporting communities to develop social action and resilience. The rural nature of Shropshire provides a potentially positive environment for the wellbeing of the people living and working here. This needs to be better valued and harnessed. Equally the rural nature of the county presents challenges of access and delivery that are a significantly influencing factor on the development of the Neighbourhood's strategy and delivery.

There are already many services in place across Shropshire, Telford & Wrekin that are working towards the Neighbourhood ambition. In particular, the Better Care Fund has seen closer working between the NHS and Councils; however, we think that we can go much further towards an integrated patient centered service.

Together, we have recognised the opportunities for creating new ways of delivering care and front line services and also joining up social action, prevention activities and the currently fragmented care system to develop a wellness focused and person centred system for our local population. We are now developing effective, collaborative relationships around this shared purpose that will enable us to move at scale and pace to deliver fundamental change.

Our neighbourhood care model will remove existing barriers to integration and bring together primary, community and mental health services and learning disabilities with local authority, voluntary and the independent care sector to deliver the right care in the right place and maximise the efficiency and effectiveness of local services. Our vision puts the needs of patients at the centre of our Neighbourhood model. This will operate in a more efficient, focused manner, steering away from bed based services to a more community centred style of care.

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9.2 COMMUNITY MODEL - SHROPSHIRE

9.2.1 Key Population Needs

People in Shropshire have a long life expectancy with low rates of obesity and smoking. They are relatively affluent compared to the national average. However, this relative affluence masks significant inequalities that exist throughout the county. The Joint Strategic Needs Assessment (JSNA) and Public Health Business Case highlight that when taking into account the differences between the most deprived and least deprived populations (based on IMD scores), the most deprived men and women have a higher rate of premature deaths compared to the England average (with a more pronounced impact on men during the time period).

The JSNA highlights falls, respiratory, and lifestyle factors related to obesity and cardiovascular disease as the key population level local health concerns.

Shropshire has an elderly population which is expected to grow at a faster rate than regional and national averages. The utilisation of health and social care resources in Shropshire is driven in the main by the complex needs of the frail elderly residents. Issues for strategic planning for health and care to support the frail and elderly are exacerbated by the rural nature of the county, which poses workforce, transport and cost implications.

Local and national benchmarking has highlighted significantly higher than expected utilisation rates of elective orthopedic hospital services.

Source: ONS population estimates and projections



Figure 7: Shropshire Population

Source: ONS population estimates and projections

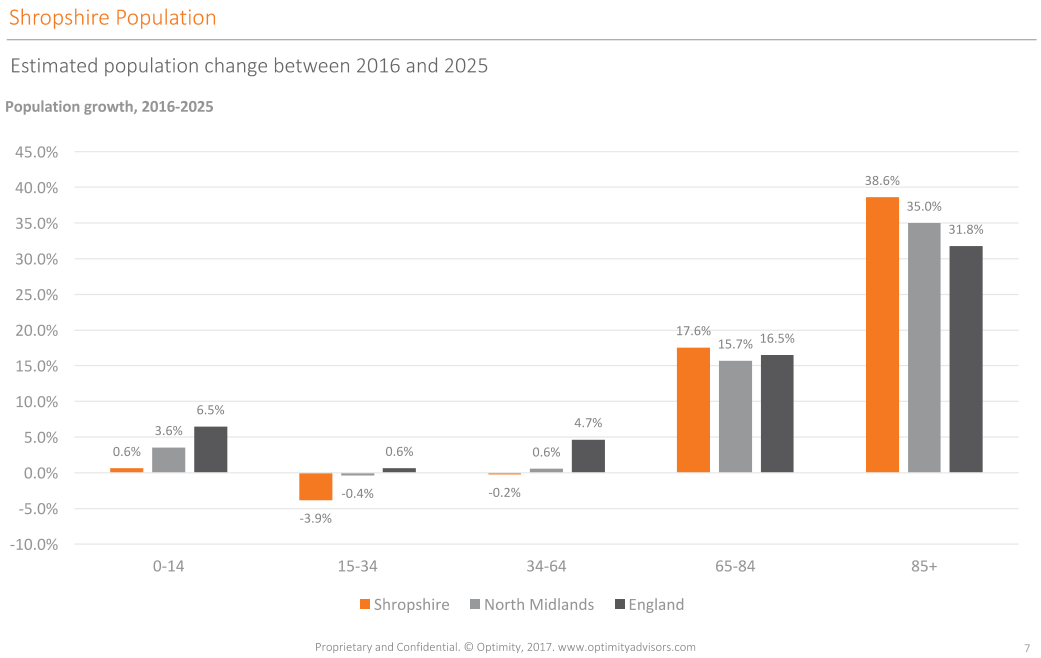


Figure 8: Shropshire estimated population change between 2016/2015

As part of the Out of Hospital Transformation Programme described below a detailed population needs assessment is being undertaken at locality/cluster level to ensure that the final out of hospital design solution is tailored to local need.

9.2.2 Evidence base for The Proposed Community Model of Care

Shropshire CCG commissioned support in May 2017 from a transformation partner to develop an out of hospital transformation solution together with its provider and commissioner partners in Shropshire: (Shrewsbury & Telford Hospital NHS Trust (SaTH); South Staffordshire and Shropshire NHS Foundation trust (SSSFT); Shropshire Community Health Services NHS Trust (SCHT); Robert Jones Agnes Hunt NHS Foundation Trust (RJAH); Shropshire Council; and the 43 GP practices that together make up Shropshire Primary Care.

Previous analysis has shown that there was a large opportunity for improving the way that frail elderly patients are cared for with a significant amount of inpatient activity delivered for patients with conditions that should usually or sometimes be managed in the community/primary care.

Optimity conducted a review of evidence based models of out-of-hospital care internationally and selected six models for shortlisting and presentation for discussion to a group of system stakeholders at a workshop in June 2017. 27 models were included in the review and brief case summaries of the 6 models that were shortlisted were presented to the workshop. These six models were:

- Buurtzorg, the Netherlands;
- Network Mobile Unit, West Skaraborg, Sweden;
- Coordinated Community Care, Oregon, US;
- Geriant Model, the Netherlands;
- Primary Care Home Model, UK; and
- Project Hälsostaden, Ängelholm, Sweden.

Participants saw value in elements of all the models. However Project Hälsostaden, Ängelholm in Sweden appeared to have the most alignment with Shropshire and it was agreed to work together to look at the feasibility of adapting this model to the local needs of Shropshire.

This model is probably closest to the current model that is being developed in Shropshire and consequently would be relatively easy to deliver at scale. The provider model brings in primary, secondary, community and social care under a single organisation.

Some characteristics of this successful model are:

- It is based around a shared vision for improving care for the elderly through consultation with providers.
- Care is organised around the needs of elderly people and feedback is continuously solicited to help improve services and ensure that care adopts a people-centred approach.
- The initiative has a strong focus on improving quality of life for the elderly population. The ambition is add 'life to years, not years to life."
- Responsibility for the provision of all health and social services sits with a single organisation.
- While the ambition is a totally integrated budget, in the early phases some services are contracted with funds transferred from separate regional and municipal budget holders as necessary.
- Care has been reorganised to meet patient needs, with new patient-centred care models tested through a trial and error process.
- A significant effort has been made to encourage collaboration, cooperation and teamwork through fluid communication among the newly formed organisation.
- There is a shared electronic medical record system. Discharge planning is conducted via video link.
- Over 90% of patients have been seen within government waiting time targets and Hälsostaden compared favourably with other hospitals and was ranked among the top ten nationwide.
- Within its first six months of the emergency mobile care teams, in 94% of cases an unnecessary visit to the emergency room was prevented and 73% of unplanned inpatient hospitalisations were avoided. 100% of patients reported that they were satisfied with the care from the emergency mobile team.
- Early economic evaluation shows a return on investment from reduced unnecessary hospitalisations. Readmissions within 30 days are down by 40% from an average of 25% to 15%.

It was agreed that system stakeholders need to look to work together to further adapt the Project Hälsostaden model to the local needs of Shropshire. The opportunities that this model will potentially provide in terms of performance, finance and quality of care for patients are set out in the *Optimity Report July 2017: Shropshire Out of Hospital Transformation* and have been used in triangulating the ambition set out in the original Future Fit modelling for admission avoidance. The following sections set out at a high level the proposed community model that will be further developed.

9.2.3 THE PROPOSED COMMUNITY MODEL OF CARE

The Shropshire community model of care will use place based planning and service integration to reduce demand on acute and social care services by:

1. Building resilient communities and developing social action;

2. Developing whole population prevention by linking community and clinical work – involving identification of risk and social prescribing;

3. Designing and delivering integrated health and social care community services that provide alternatives to hospital care for mild, moderate and severe long term conditions; rapid access urgent and crisis care

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9.2.4 Resilient Communities and Developing Social Action

There is a strong volunteering and community development sector in Shropshire that is well supported by the Shropshire Voluntary and Community Sector Assembly as well as by communities themselves. The **'Communities First, Service Second'** Resilient Communities Workstream is working to support and enable communities to help one another and promote positive, healthy life choices. They support self-care through the 18 place plan areas in Shropshire, with a focus on:

- Further developing place based governance and delivery
- The spread of social prescribing and accredited and assured directories of local activity and services and networks of community connectors
- Connecting and supporting the many volunteering and community services that support people in the place where they work and live (these include C&CCs, Let's Talk Local Hubs, C&YPS Early Help hub).

9.2.5 Whole Population Prevention Programmes

There is continued development of the effective Shropshire Healthy Lives programme with a focus on greater integration with resilient communities and locality based community services.

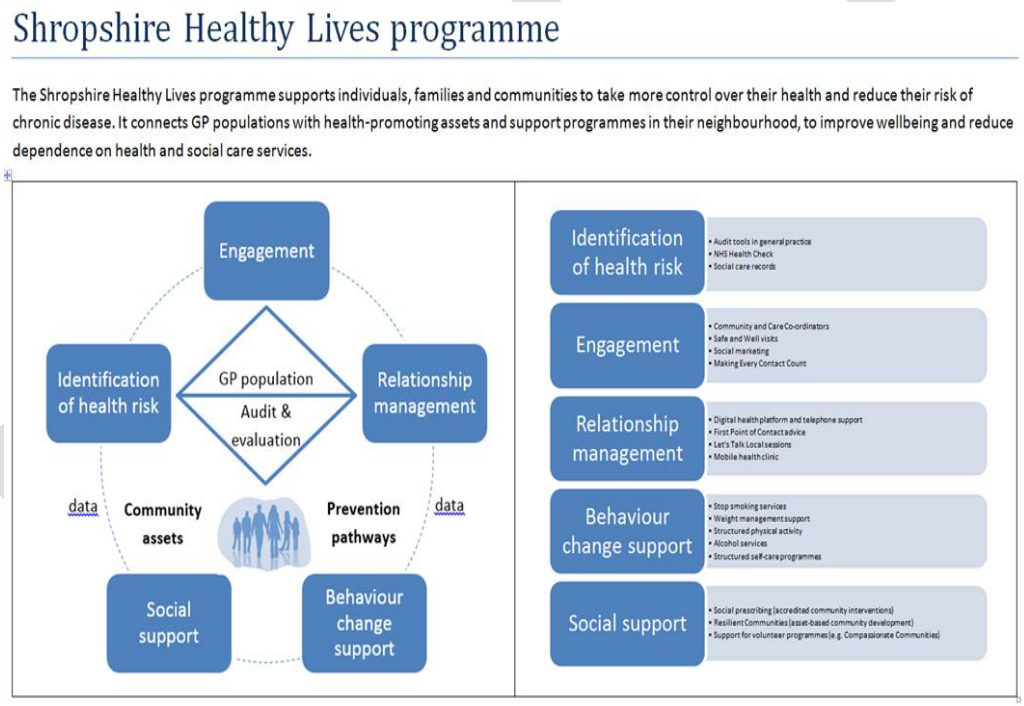


Figure 9: Shropshire Healthy Lives Programme

The programme includes:

- Social Prescribing
- Diabetes and CVD Prevention
- Falls Prevention
- NHS Health Check
- Future Planning , Housing and Fire Service Safe and Well Visits
- COPD and Respiratory Prevention
- Carers and Dementia Support
- Mental Health and Learning Disabilities

The aim is to maximise the impact of preventative activity to reduce the demand on acute and social care services and promote independence in the key areas of: physical activity; smoking cessation; falls prevention and chronic disease management.

The Healthy Lives Programme has been working now for approximately 18 months and has delivered some key prevention work. Social Prescribing is the cornerstone of this work. Key deliverables have included:

- **Safe and Well visits** - Pilot and county area roll out of Fire Service Safe and Well visits. This model is an expansion of the Fire Service Home Safety Check to include the identification of health and wellbeing issues including, home warmth, falls, lifestyle choices (smoking, physical activity), and isolation and loneliness (including carers);
- **Social Prescribing pilot** – Implemented social prescribing in the Oswestry area with referrals from 4 GP practices, Adult Social Care, the VCS, Family Matters, and working towards referrals from mental health services. There are approximately 17 providers offering approximately 50 interventions;
- **Diabetes Prevention protocol** – Pre-diabetes protocol agreed and being tested in 2 demonstrator sites, Shrewsbury and Oswestry. The protocol involves searching GP records for pre-diabetics and offering a 2.5 hour information session along with advice, guidance and information about accessing community support. Five evidence based Expert Patient sessions have been delivered and well received by patients. The demonstrator in Oswestry is linked to Social Prescribing and those who attend the sessions there are offered Social Prescribing to support non clinical approaches to improving lifestyle and addressing social issues;
- **All age Carers Strategy** – The carers strategy has been agreed and is linked to Social Prescribing, Safe and Well visits and dementia companions. The strategy is focussed on working with partners to identify carers and to connect carers to the support they need, as well as ensure that services take carers needs into consideration (eg. Hospital discharge processes);
- **Dementia Companions** – agreement has been reached to implement dementia companions in 2 demonstrator sites (Oswestry and Ludlow), and to link the dementia companions to social prescribing pilot sites;
- **Mental Health** – linking mental health to Social Prescribing to ensure a person centred approach can be delivered through social prescribing; development of a mental health needs assessment for Shropshire; development of a system approach to developing services to support people with mental health needs through a Mental Health Partnership Board;

Systems benefits and outcomes from the neighbourhood initiatives include:-

- Increased engagement of and involvement of local residents in their own care decisions
- Ensure more people remain independent at home
- Avoidance of permanent admissions to residential and nursing homes
- Reduction of emergency admissions to hospitals
- Greater capacity across the system driven by population health need but working on capabilities of individuals
- Additional resource for those rural areas with more limited provision
- Strengthening of existing programmes which might be vulnerable
- Supports the local ambition to the clear ambition to work proactively to develop an integrated care navigation model going forward

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9.2.6 The Shropshire Out of Hospital Transformation Programme

Patients within Shropshire currently have access to a wide range of community-based services including inpatient beds. There are a range of challenges in providing these services under the current operating model. The community beds are in a number of locations, which impacts on efficiency and are on occasion vulnerable to short-term staffing challenges. There are four Minor Injury Units (MIU's) at: Bridgnorth, Ludlow, Whitchurch and Oswestry, each of which has different operating times and offers different diagnostic services. All four of the MIU's offer a walk-in service. There also are three Diagnostics, Assessment and Access to Rehabilitation and Treatment centre's (DAART) at Oswestry, Bridgnorth and Shrewsbury, each offering different adult services. Access to the DAART is via GPs or other health professional referral. The CCG has recently completed a review of these services which has identified that there is a case for change and this is being taken forward through Shropshire's Out of Hospital Transformation Programme.

The objectives of the Out of Hospital Programme are:

- Enable home first principles
- Provide an alternative to hospital care
- Reduce avoidable hospital admissions
- Provide proactive care planning and intervention to prevent patients going into crisis
- Maximise independence
- Promote locality ownership of the commissioning strategy and outcomes

The Shropshire CCG community model aims to deliver preventative services to frail patients, patients with long term conditions and patients with multiple conditions. Care will be delivered closer to the patient's home and so reduce demand on acute hospital services.

The intention is to provide neighbourhood centred care, having services in communities that work with local GP practices based on a single assessment and co-ordinated care approach for older people being identified as being at risk of an avoidable admission.

Shropshire has defined 11 neighbourhood teams within the County as set out in the table below:

Neighbourhood Team	Population
Bridgnorth North	30.543
Bridgnorth South	24,881
Ludlow	23,155
North East	29,175
North West	17,068
Oswestry	34,523
Shrewsbury North	42,555
Shrewsbury Rural	18,223
Shrewsbury South	39,154
South West	20,261
Whitchurch	24,261

Table 12: Shropshire 11 defined Neighbourhood Teams

The neighbourhood centred care will bring together primary, community, mental health, learning disabilities with the local authority, voluntary and independent sector. The team will take a holistic approach to support frailty and patients with long term conditions by promoting resilience rather than dependence.

The CCG's Out of Hospital model of care will build on best practice and research evidence of integration and what works in avoiding hospital admissions, namely:

- Resilient communities and creating social action

- Risk stratification of the population
- A single point of access into services
- Proactive case management of people with long term conditions and frailty
- Integrated working between health, social care and the voluntary sector
- Co-ordinated strategies, underpinned by an integrated information system
- The use of hospital at home and crisis intervention
- Single assessment and co-ordinated care approach
- Digital Technology
- Team-based interventions in community hubs and emergency portals

The community model will be underpinned by effective case management based on improved access to:

- Comprehensive assessments
- Person centred planning
- Collaborative goals that optimise independence and wellbeing
- Services via a community hub
- Crisis response and diagnostics

The focus of the care will be to provide support at the earliest possible opportunity. Services, while maintaining their individual identity will increasingly overlap to provide seamless 'one team approach' care, with consistent professionals from across the services working as a team to provide personalised care, utilising 'assets' in the neighbourhoods such as the voluntary sector, community hubs and activities.

Where a patient needs an acute admission, the Out of Hospital service model will work with the acute hospitals to rapidly assess and discharge the patients that can be safely and effectively stepped down within 72 hours into community care.

The Out of Hospital model will be shaped by local communities, patients and their carers. A period of public engagement has already begun to ensure comprehensive patient engagement so that the CCG knows its communities' perceptions about what would improve their quality of life and incorporating their ideas to create a care model which helps to meet their collective and individual priorities.

9.2.7 Key Elements of the Service

A delivery model blue-print (Appendix 2) has been developed based on the following variables of patient need:

- Severity
- Stability
- Duration
- Urgency
- Self-direction
- Scope of services

The blue-print is predicated on the following:-

- **Rapid Turnaround at the Front Door** - A dedicated MDT based in the Emergency Department who are responsible for the early identification, treatment, risk assessment and planning for frail and long term condition patients.

- **Community beds and Crisis Resolution** – Fully integrated teams to address full spectrum of need in the community setting.

- **Hospital at Home** – Where care needs escalate beyond the core teams, service users will move into a hospital at home element of the service to prevent crisis.

- **Community Services** – Built around general practices with a core Locality Team (including district nurses, allied health professionals, social care and matrons).

- **Non-core enhanced services** – some service users will require input from services outside the core general practice model. This will include service users with more complex and multiple long term conditions who may benefit from access to some of the specialist community teams to manage symptoms or to design exacerbation plans.

Outcome based specifications will be developed by localities for each element of the model to inform the commissioning strategy.

9.2.8 Key Outcomes the Integrated Model will deliver

The following outcomes will be delivered by the model:-

- Maintenance of good health
- Locally determined practice-level management of cohort conditions
- Timely, efficient access to cluster-level core services
- Health crisis prevention through cluster-level case-management
- Admission avoidance through Integrated locality-level crisis resolution
- Efficient and effective treatment and stabilisation of acute need

9.2.9 The Timeline for Delivery

Although the final model of out of hospital care will require a full business case and re-investment of efficiencies generated from reduced levels of hospitalisation, considerable progress has been made within existing arrangements. This includes:

- The social prescribing demonstrator site in Oswestry;
- The single point of access for mental health services being rolled out across the County;
- The planned single point of access and clinical triage for all orthopaedic referrals and the remodelled Shropshire Orthopaedic Outreach Service (SOOS) for later in the year
- Considerable health and social care re-focussing of the ICS service
- The test of concept project in Bishop's Castle that harnessed the opportunity of temporary hospital closure in Bishops Castle for a period of renovation to explore different ways of utilising existing local services differently to meet the needs of patients at home rather than in a hospital bed.

The overall model provides a way of working that is a fundamental change in practice and culture and will take five years to fully embed. The developments described here will however deliver benefits during the current and subsequent years. The phased impact of these initiatives on acute hospital demand is described in Section 10 of this PCBC.

The implementation plan in 2017/18 includes:-

- **Frailty Front Door (Phase 1) – Royal Shrewsbury Hospital** – Six months proof of concept pilot of a dedicated integrated acute and community Frailty Team at the Front Door of the Emergency Department actively working to support frail patients, utilising and more effectively aligning existing resources. Navigation and signposting to rapid community support will be undertaken when the patient is identified as requiring admission avoidance support.

The implementation plan in 2018/19 includes:-

- **Frailty Front Door (Phase 2)** – taking the learning from the evaluation of the proof of concept project described above, design and implement the optimum model and look to expand to the Princess Royal

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Hospital and to include patients with long terms conditions. This improvement will facilitate appropriate triage of patients to either the acute/community/home setting.

The implementation plan in 2019/20 includes:-

- **Core Services** – built around 9 place based areas of general practice with a core Locality Team (including district nurses, allied health professionals, social care and matrons). This element of the service will identify the case management cohort of service users, develop personalised care plans, provide the day to day care and support including wider services as necessary. For stable service users this will be the default range of services.

- **Wider Core Team** – some service users will require input from services outside the core general practice model. This will include service users with more complex and multiple long term conditions who may benefit from access to some of the specialist community teams to manage symptoms or to design exacerbation plans.

- **Hospital at Home and Crisis Intervention** – Where care needs escalate beyond the core teams, service users will move into a hospital at home element of the service which will incorporate the step up element of the intermediate care team with an enhancement to medical cover arrangements (which could include in-reach from acute consultants or alternative medical governance models). The specialist frailty and long term conditions teams will be part of this element of the service, both in terms of care delivery to manage exacerbations and also in an educational role to cascade skills into the core teams.

9.3 COMMUNITY MODEL –TELFORD & WREKIN

9.3.1 The Neighbourhood approach

Neighbourhood working is an approach to developing community centred models, being led by the Council and the CCG together with Primary Care and the people of Telford & Wrekin. The programme has been in development for approximately 12 months and is formed from a collection of initiatives that range from development of peer led roles right through to the design and implementation of NHS services in community settings. This approach evolved naturally in response to a number of issues, one of the most significant of which was to challenge the current deficit based model of care which promotes dependency. In addition budget cuts, coupled with increased demand have created significant financial pressures within the health economy. There has also been a call to reverse the trend that has led to the creation of an acute/hospital dominated local system of care. The schemes are expected to deliver a reduction of at least 2,365 non-elective admissions each year by 2020/21.

The Council and CCG are committed to seizing the opportunities associated with more innovative and creative solutions, co-produced by those to whom the changes affect the most. These solutions will address people's individual goals and support the growth of vibrant and healthy communities which empower people through the promotion of independence. Where possible acute services will be replaced with community based services, delivered in people's homes.

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9.3.2 Key population health needs

The population is 'younger': Telford & Wrekin has an estimated population of 170,200. The population is younger than the national picture, with a greater proportion of the population aged under 20 (T&W 25.8%, England 23.7%).

The population is growing, changing and ageing:

- The proportion of the population who are aged under 20 is decreasing (26.1% in 2010, 25.8% in 2015), as is the working age population (65.2% in 2010, 63.2% in 2015).
- The proportion of the population aged over 65 is increasing (14.3% in 2010, 15.9% in 2015), with 27,200 residents now in this age group.
- The population of the borough is projected to grow at a faster rate than the England population (T&W 13.4%, England 10.2%) and is projected to grow to 196,900 by 2031, an increase of some 23,300 people.
- Over half of the population increase will be in the over 65 age group (12,300 people), with the 85+ age group more than doubling (+117.6%) and the 65-84 age group increasing by a third (33.1%).
- There were a total of 2,075 live births to mothers living in Telford and Wrekin during 2015. Over the past six years the total fertility rate has fallen from 2.00 to 1.82. The National trend is similar, falling from 2.22 to 1.93.

The population is becoming more diverse: and whilst majority of the population's ethnicity is white British, with the borough having lower BME rates in all age groups than England, the highest proportion of BME groups is found in the 0- 24 age group (T&W 13.1%, England 25.4%). The proportion of school age children from a BME background is also increasing (13.7% in 2012, 18.5% in 2016).

Households are more likely to contain dependent children and/or carers: almost 22,000 households contain dependent children, around a third of all borough households. Around 18,000 people provide unpaid care - 1,530 young people aged 0-24 provide unpaid care, around 12,700 adults aged 25-64 and around 3,670 aged over 65. Nearly 5,000 people provide unpaid care for over 50 hours per week

The population has higher rates of poor health:

- Residents report higher levels of bad or very bad health compared to England (T&W 6.2%, England 5.5%), around 10,395 people.
- Life-expectancy at birth is significantly worse than England rates at 78.1 years for males (79.3 England) and 81.8 years for females (83.0 England).
- Early mortality rates from causes considered preventable are declining in Telford and Wrekin, but remain above the England average. The standardised mortality ratio for people aged under 75 is higher than the national ratio for cancer, liver disease and respiratory disease, and similar to the national ratio for cardiovascular disease.
- Across all age groups there are higher rates of people reporting a long term limiting health problem or disability that limits their daily activity (T&W 18.2%, England 17.2%), around 31,000 people.

The population don't always make healthy lifestyle choices:

- 7.9% of all births had a low birth weight (less than 2,500g), similar to the England rate.
- 18.1% (366) of mothers were smoking at delivery, significantly worse than England. Breastfeeding initiation rates have increased a little from 65.1% in 2010-11 to 67.5% in 2014-15, although remain worse than England.
- The prevalence of smoking in those aged 18 & over has decreased to 18.2%, similar to England, having previously been higher. The prevalence of opiate and/or crack use was estimated to have declined and is now lower than England, and the prevalence of drug injectors has declined to a level similar to England.

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- The proportion of children in reception with excess weight increased to 25.5%, worse than the England (22.1%). In Year Six children with excess weight increased to 37.4%, worse than England (34.2%).
- Levels of excess weight in adults are 71.1% and obesity 26.5%, both worse than England.
- 18.7% of residents aged 16 & over are binge drinkers and 28.5% of adults are inactive, both similar to England rates.

Hospital admissions rates for a number of causes are higher than England: For all ages, the Standardised Admissions Ratio of emergency admissions for all causes is worse than national. This ratio is also worse than national for Coronary Heart Disease, stroke, Myocardial Infarction (heart attack), Chronic Obstructive Pulmonary Disease (COPD). The ratio is similar to national for hip fractures and alcohol attributable conditions.

National prevalence rates enable an estimation of the number of residents with other health conditions:

- Around 1,000 children aged 5-10 and 1,400 aged 11-16 with a mental health disorder. Around 17,400 adults aged 16-64 with a common mental health disorder and around 7,700 adults aged 16-64 with two or more psychiatric disorders.
- Around 700 older people aged 65 & over have severe depression. Around 1,800 residents aged 65 & over suffering from dementia.
- Around 4,000 residents have a learning disability. Around 1,400 residents have Autism

9.3.3 The Proposed Model of Care

Neighbourhood working is a complex collection of activities, embracing all aspects of community centred approaches and bringing together existing and new projects into a coherent programme. There is an active steering group and a vibrant working group. Interaction with patients and the community has taken place at project level to define solutions and we are beginning to experience local ownership of the programmes. As the programme has developed, three work streams have emerged which are strongly linked. Each constituent project has clear objectives, timescales and some have already started to see positive outcomes. Much of the work utilises the pathways developed by the Future Fit Clinical Design Group. This programme is also helping to drive the changes across primary care, considering the implementation of new models of care.

Work stream 1: Community Resilience and Prevention



There are two strands to this work which span different geographical areas and populations. The first aims to ensure that Telford and Wrekin has strong and connected communities. This will be achieved through volunteering, peer support, new community based groups and delivery of projects through community organisations. An asset based community development ethos has been employed to support developments and avoid the various statutory organisations dominating changes. This is an all age approach that will affect people at different stages of their life course. Examples include improved networks/connections for people to improve antenatal wellbeing or improved support for people from their community in the end stages of their life.

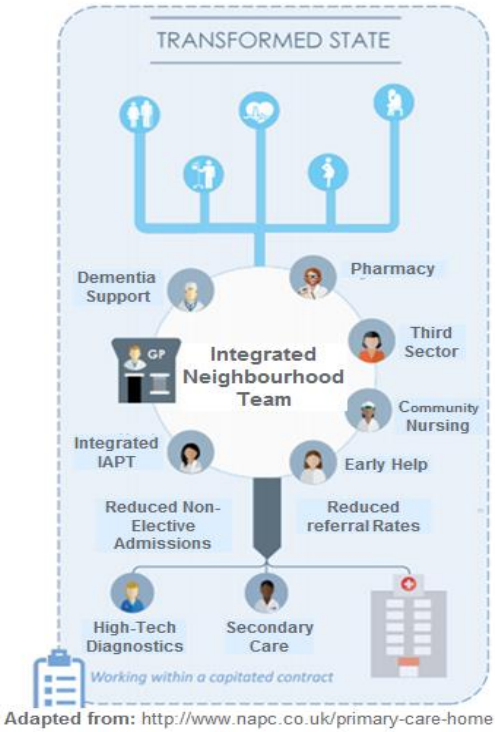
Effective joint working between the CCG and the council means that this workstream will deliver holistic solutions across the full spectrum of care needs of the community.

The second strand aims to support people to stay healthy using a combination of approaches for the whole of the population and some for priority groups. Examples include work on early detection and prevention of cancer and a whole systems approach to reduce excess weight and obesity.

Figure 10: Workstream 1 – Community resilience and prevention

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Work stream 2: Neighbourhood Teams



This work stream will bring together community based health and local authority professionals to proactively support people with long term conditions. The diagram 'transformed state' illustrates the kind of formation the neighbourhood teams will take.

Four neighbourhoods have now formed around groups of practice populations: Newport, South East Telford, Central Telford and TelWell. The constituent practices are listed on page x They have each identified the priorities that would best meet the needs of their population. The main local community providers are fully involved in this work and are helping to articulate the offer to reconfigure services around



neighbourhoods.

Figure 11: Workstream 2 – Neighbourhood Teams

Work Stream 3: Systematic shift of services from acute settings

This workstream has aspirations to review priority specialities and develop plans to enhance prevention, promote self-care, transfer services to the community and define levels of service to remain in the acute setting.

In Telford and Wrekin large shifts of activity have already occurred (over 70% of total outpatient activity) for orthopaedic, pain and dermatology related outpatient activity. This means that opportunities to shift planned care outpatient work is limited but the promotion of prevention, self-help/management and interface services between primary and secondary care are still valid aims and will continue to be promoted within the neighbourhood model. These will be particularly important in the improved management of long term conditions. This work has already started in diabetes and respiratory care.

Figure 12: Workstream 3 – Systematic shift of service from acute setting

The relevant population for projects contained in Community Resilience and Prevention (Workstream 1) will vary. For example some initiatives and changes may be at a place based area such as a street or village level, whereas others may be led by a community of people with shared interests across the whole of Telford and Wrekin.

The Neighbourhood Teams (Work stream 2) will be based around 4 populations that are aligned to patients registered to practices within those neighbourhoods. The table below shows the practices that are part of each neighbourhood.

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Neighbourhood	Constituent Practices	Total Population
Newport	• Wellington Road • Linden Hall	28,187
South East Telford	• Court Street • Hollinswood • Ironbridge • Stirchley • Sutton Hill • Woodside • Dawley	56,592
Central Telford	• Charlton • Donnington • Shawbirch	43,665
TelWell	• Lawley • Oakengates • Trinity • Wellington	56,734

*Population size based on practice registers as at 21st July 2017

Table 13: T&W Neighbourhood Practices

9.3.4 Key Outcomes the Neighbourhood Model will deliver

Communities will be connected and empowered
People will be involved in decision making about services/ issues within communities, be able to develop and tap into networks and have supportive neighbours. Together these and other social connections will all have a positive impact on health and wellbeing, and lead to a reduction in social isolation.

People will stay healthy for longer
The population will have more knowledge and skills to allow them to manage their own health and make healthy lifestyle choices. This will prevent the onset of health problems and prevent any further deterioration of health, fostering community resilience and enabling individuals and communities to take more control over their health and lives.

Clinical outcomes will be optimised for patients
Earlier identification of issues and delivery of best practice will lead to an improvement in health outcomes for patients. This will include improving diagnosis rates and delivering care in the most efficient way across all professionals. It will facilitate the opportunity for patients to manage their own condition, enabling and empowering individuals rather than creating dependency.

Services will be available closer to home for patients
Patients will be able to attend services and appointments locally, where previously they may have had to attend hospital. This will mean that patients only have to go to an acute setting where absolutely clinically appropriate to do so.

People will feel supported during times of crisis (both physical and mental health)
People will know where to go for support both in their community and statutory services. Patients with existing health issues will have care plans in place which clearly articulate what to do if a problem exacerbates. This care plan will have preventative elements, in addition to links and numbers for informal and formal support. Professionals will know how to support people in times of crisis or where to signpost people to for more help. Wherever possible this support will be accessible in a person's usual place of residence.

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People and their carers will be supported at the end of their lives
People who are at the end of their lives will be proactively supported through any changes in need during that time. Their carers will know where to go for help and guidance. People will be able to die in their place of choice with dignity.

9.3.5 Overview of the Neighbourhood Programme

The vision and delivery of the neighbourhood developments as well as priorities are set out below:

- Community Resilience and Prevention

Specific Patient outcomes:

1. People have friends and support networks with their local communities
2. People will have things to do
3. People will have a feeling of being safe and belonging to their community
4. People will have confidence to help others and ask for help
5. People will have centres or connecting points to go to

Wellbeing Care and Support Networks
This programme will be delivered through the implementation of a wellbeing care and support network infrastructure across Telford and Wrekin. The aims of this project will be delivered through supporting a vision of integration of health and social care by identifying and bringing together across 'localities' a diverse range of care and support provision. This will be accessed by the community directly or through being 'connected' by individuals, champions, arts, culture or virtual technology that engage and connect people, families and carers to attend the hubs or communities within the hubs themselves.

Establishment of a Grants Process
The CCG will be reviewing jointly with Telford and Wrekin Council the process for the allocation of grants for projects supporting community resilience. Early project aims will include less emergency admissions for smoking and alcohol related admissions.

Safe and Well Checks
This is an innovative approach working with Shropshire Fire and Rescue Service building on an established process of safety checks already carried out. The vision is for firefighters to discuss health matters such as weight, smoking and mental well-being with people, while they will also seek to refer people to appropriate local support for issues such as unemployment, claiming benefits, and drug and alcohol schemes.

Developing the community role within cancer survivorship
Community based services for people living with and beyond cancer are limited, variable and often difficult to access. A more systematic approach is required to identify the needs of all people living with and beyond cancer to optimise their ability to appropriately self-manage, reduce the risk of recurrence, optimise their health and wellbeing and improve their quality of life.

Neighbourhood Cancer Coordinators will Identify and address the holistic needs of patients; provide live treatment summaries to patients GP's and Consultants Offer of health and wellbeing interventions including tools for supportive self-management, peer support and appropriate follow up within structured Cancer Care Reviews in primary care.

Health Champions
Health Champions are people who, with training and support, voluntarily bring their ability to relate to people and their own life experience to transform health and well-being in their communities.

Champions will be supported to deliver health conversations to friends, family, neighbours and their local community, embed Health Champion's role into existing volunteering, engage with and support existing

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initiatives (e.g. AT sessions at CA, HLH) and start up small community projects e.g. walks, drop in sessions, social groups.

Branches – Mental Health Hub
An initial pilot is already being delivered in the Newport area which will be rolled out as the project develops. Local mental health hubs will provide four functions to support people with emotional and mental health difficulties:

1. A listening service
2. Connecting people
3. Crisis support
4. Post discharge support

Cancer Prevention
This project aims to achieve the Cancer Taskforce ambitions at a Neighbourhood level relating to screening, early detection and provision of support to reduce all cancer risk factors. There will be targeted interventions relating to smoking, alcohol, diet, obesity and physical activity

- Neighbourhood Teams

Patient outcomes:

1. The notion of care 'from cradle to grave' will be reinvigorated through this model
2. Individual professionals will take responsibility for the delivery of as much care as possible, drawing on specialists where necessary
3. Professionals will work together to seek out those who would most benefit from an intervention/support
4. People will share their story once in a way that it right for them
5. People will understanding their condition and how to deal with it, and self-care/ self-manage where possible
6. Carers will be supported

The 'Neighbourhood Working' programme is formed of a collection of projects which will be implemented over five years and lead to a reduction of 2,365 non-electives as described in the outline business case. There are six key projects delivered across Workstream 2 (Neighbourhood Teams) and Workstream 3 (systematic review and transfer of services) and each of these is considered below.

Hypertension
Over the next four years the CCG will increase the 'reported to estimated' hypertension prevalence rates identifying approximately 1,000 extra people. It will also improve the management of hypertension and increase the number of people with hypertension whose BP is <150/90. Together this will lead to better health outcomes including reduced admissions to hospital.

A programme of work has already commenced which was designed using information from The British Heart Foundation, Public Health England's 'Health Matters' and examples of best practices such as 'Bradford's Healthy Hearts'. The work includes the development of a public awareness campaign and calendar of events, raising staff awareness, information and best practice sharing across GP practices, re-designing the hypertension pathway to build in referral to Healthy Lifestyle Advisors and exploring opportunities to use technology.

It is expected that this programme will result in the avoidance of 111 non-elective admissions by 2021.

Wound Care
An innovative complex wound care service will be introduced to improve the clinical outcomes for patients and free up capacity in primary and community care to deliver neighbourhood working. The service includes the introduction of wound care hubs in each of the four neighbourhoods as well as a domiciliary offer for people unable to leave their homes. The hubs will be supported by third sector organisations to address social isolation and increase resilience. A new role of 'wound care practitioner' will be incorporated into the team,

with training delivered by Staffordshire University. Recruitment will begin in the winter of 2017 and the service will take 2 years for full implementation. The design has utilised a range of findings from technical articles on the management of wounds as well as more general references on approaches to wound care management such as those in the BMJ and more recently from the British Healthcare Trades Association. However, this is an innovative approach and both the CCG and provider are keen to contribute to the evidence base through a thorough service evaluation.

Whilst the scheme itself will not result in avoided acute activity the capacity released will support the delivery of the neighbourhood programme resulting in a reduction in non-elective activity of 900 by 2021.

Care Home Team
The CCG reviewed national case studies relating to the formation of multi-disciplinary care home teams with a view to improving the quality of care and reducing non elective admissions. Those of particular interest were Sutton, Salford, Yorkshire and Humber, Walsall and Oxford CCGs.

Taking the best and most relevant aspects from these approaches the CCG are now operationalising their own multi-disciplinary care home team which will include a GP (with Special Interest), social worker, speech and language therapist, nurse and physiotherapist working with a recently appointed pharmacist. Together this team will provide training, clinical advice and rapid interventions as well as a virtual ward for those at high risk of admission. The provider commenced recruitment in September 2017 and a decision on the most appropriate solution for medical support from practices will be concluded by December 2017. Full implementation will take one year and will deliver a reduction in non-elective activity of 278.

One Team
One of the main components of neighbourhood working is the implementation of an integrated team around the neighbourhood population. This is a radically different approach to proactively support patients with long term conditions. It will be a holistic approach, promoting resilience (rather than dependence) and bring professionals together around the patient. In order to support the design of this offer, the CCG commissioned the Strategy Unit to collate a summary of related research and evidence (Jun-2017). This included consideration of key national publications (e.g. Monitor, The King's Fund), initial findings from vanguard sites, Community Fit analysis and summaries of evidence reviews (e.g. multi-disciplinary teams, out of hospital care and reducing unplanned admissions).

The One Team will be formed of community matrons, nurses, physiotherapists, occupational therapists, health care assistants and phlebotomists. In addition newer roles will be introduced such as advanced clinical practitioners, associate nurses & therapists. They will work with a wider virtual team including practice teams, the Early Help and Support function of the Council, specialist teams (e.g. respiratory) and third sector organisations. The main functions will be to provide a single point of contact to clinicians; clinical triage & system navigation; holistic assessment; multi-disciplinary team review of at risk patients and critically support the total needs of patients during exacerbations. A key enabler for the One Team is the development of the 'frailty front door'. This service will direct patients from the hospital to the One Team and also offer diagnostics and holistic assessment to then support people in community settings.

This way of working represents a fundamental change in practice and culture and will take five years to fully embed. The implementation requires a stepped change in community capacity, initial modelling indicates that 30 additional whole time equivalent workforce (WTE) are required to deliver the planned reduction in non-elective. However, positive changes are already underway. The engagement and drive from the practices and main provider means enables rapid mobilisation. The introduction of the wound care service outlined in section 4 will release 10.5 WTE of the increase in workforce needed. Referral to community based non-medical solutions has started and will continue to evolve. The process of aligning current nursing staff to each neighbourhood is underway and will be complete by December 17. Similarly, the Early Help and Support Team are introducing link workers and booked appointments in each of the four neighbourhoods by November 2017.

Overall, our modelling demonstrates a reduction in non-elective activity of 973 by 2021/22.

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- Systematic Speciality Review and Transfer of Service

Patient outcomes:

1. People will be able to access care locally
2. Where possible people will be able to receive treatment from specialists in the community
3. Any treatment will promote recovery and independence

As described above the systematic review and transfer of services forms a key element of the Neighbouhood Working Programme and the key workstreams are described below:

Diabetes
The CCG is working with partners across the STP footprint to implement an integrated '3 tier' service model. The main focus is to provide additional support in primary care and transfer specialist input from acute to community settings. The project has drawn particularly on the NHSE exemplar service specification and the NHS RightCare (optimal) pathway for diabetes. The team have also contacted areas that have operationalised best practice, including a site visit to Nottingham.

Implementation has begun; an incentive scheme has been introduced in practices to improve treatment targets, primary care clinicians have attended the 'Warwick Course', the Diabetes UK profiling tool has been installed in all practices and an additional 400 places on structured education course have been commissioned. IAPT workers will be embedded in teams from November. The wider clinical model has been signed off by the CCG and STP and will be fully operationalised by September 2018 reducing non-elective activity by 28.

Respiratory
The CCG already commissions an established model of care which incorporates most areas of best practice. However, RightCare analysis indicated remaining opportunities through the reduction of non-elective admissions. End to end pathways were reviewed and several areas targeted for further improvement. A range of peer reviewed journal articles have been considered including randomised controlled trials and a meta-analysis. More generally, the work has referred to the 'IMPRESS guidance' and NICE standards.

The team have embarked on a process of rapid implementation, with an aspiration to complete all elements by spring 2018. These elements include: the introduction of Psychological support (Nov-17); enhanced pulmonary rehabilitation including domiciliary visits (Jan-18); pathway refinement for COPD, bronchiectasis and inhaled corticosteroid usage (to be launched in Oct-17); workshops delivered by the British Lung Foundation for those at greatest risk of admission (commenced) and finally the redesign of spirometry services (Jan-18). By the end of the programme the scheme will result in a reduction in activity of 75.

9.3.6 The Timeline for Delivering the Community Model of Care

This will be a long term programme promoting joint working across health and social care. The developments described below will deliver benefits during the current year 2017/18, although it is anticipated that it will take up to five years to fully mobilise. The Neighbourhood approach is an evolutionary process which has been described as a 'movement' and wherever possible bottom up, organic approaches have been encouraged.

This ethos is showing signs of success with momentum and enthusiasm increasing. This gradual implementation of projects will continue, pilot sites will be tested and rolled out where working with the aspiration to have a transformed state by 2022.

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9.4 COMMUNITY MODEL –POWYS

The Integrated Medium Term Plan 2017/18 to 2019/20 sets out how Powys Teaching Health Board (PTHB) will deliver its core purpose of improving health and wellbeing and enabling excellent health services. The plan is underpinned by a commitment to the vision to enable 'truly integrated care centred on the needs of the individual'.

The health board, with its partners, is starting the 2017–2020 period from a strong base. Despite some very real challenges, they continue to experience a strong and successful primary care community. GPs, nurses, pharmacists, optometrists, dentists, therapists, social care, voluntary sector and others are working together to develop innovative services for the people of Powys. There is ambition to do more and the health board is committed to the development of primary and community services as a priority.

9.4.1 Key population health needs

PTHB is responsible for improving the health and wellbeing of around 133,000 people living in Powys. The health board and its coterminous county council cover a quarter of the landmass of Wales, but with less than 5% of the population it is one of England and Wales' most sparsely populated areas. Geography and rurality mean that health and care services are more fragile and access can be more difficult.

Some key population statistics include:-

- 8% projected overall decline in the Powys population by 2039
- The population of children and young people in Powys is predicted to decrease within the next ten years, mainly due to an on-going trend for young people to leave the county in favour of more urban areas, as well as the reduced birth rate across Powys.
- The 65+ age group in Powys is projected to increase by 37% by 2033 and the 85+ population is estimated to increase by 121% over the same time period in Powys.
- Powys has a low income economy with low average earnings, low unemployment and house prices that are disproportionately high. The county has a strong network of small towns and villages with a high level of community commitment including a strong voluntary sector.
- Health inequalities are significant with people living in the most deprived areas of Powys; living more years in poor health than in the least deprived areas. A child born today in the most deprived area lives approximately 10 years (boys) to 14 years (girls) longer with poor health than a child born in the least deprived area. Furthermore Powys is the most deprived county in Wales in terms of access poverty
- The high burden of disease, with 46% of the Powys adults reporting receiving treatment for "any illness" and nearly a third of adults being limited by illness or disability
- High prevalence amongst Powys residents of the risk factors which underpin avoidable ill health, premature mortality, health inequalities and demand on health services. For example, smoking, being overweight or obese and alcohol misuse are risk factors for a wide range of the commonest health problems including cardiovascular disease such as heart attack and stroke, type 2 diabetes, cancers and joint problems such as osteoarthritis
- An unacceptable gap in life expectancy and healthy life expectancy and all age all-cause mortality between the most and least deprived areas in Powys

9.4.2 The Model of Care

PTHB is primarily a commissioning organisation. The largest proportion of its budget is devoted to commissioning NHS services. Much of this care is provided in the community through primary care contractors such as General Practices, Dental Practices, Pharmacists, Optometrists and Nurses in Powys. £2.05M of service

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delivery is also commissioned through the Third Sector. Secondary care services are provided through commissioning arrangements with other health boards in Wales and NHS Trusts in England.

PTHB directly provides non-specialist healthcare services through its network of community services and community hospitals. There is also provision of an increasing range of consultant led outpatient sessions, day theatre and diagnostics in community facilities, bringing care out of the acute hospital setting and closer to home.

Service changes in Powys must be considered within the context of the service changes happening around our borders and beyond, both in England and Wales if we are to deliver truly integrated services. When services are reconfigured, changed, moved, reduced or extended in any one of our commissioned providers there is often an impact on pathways, flows and patient experience for the residents of Powys. The management of change for Powys is therefore complex and must be viewed in terms of our role as both a provider and commissioner.

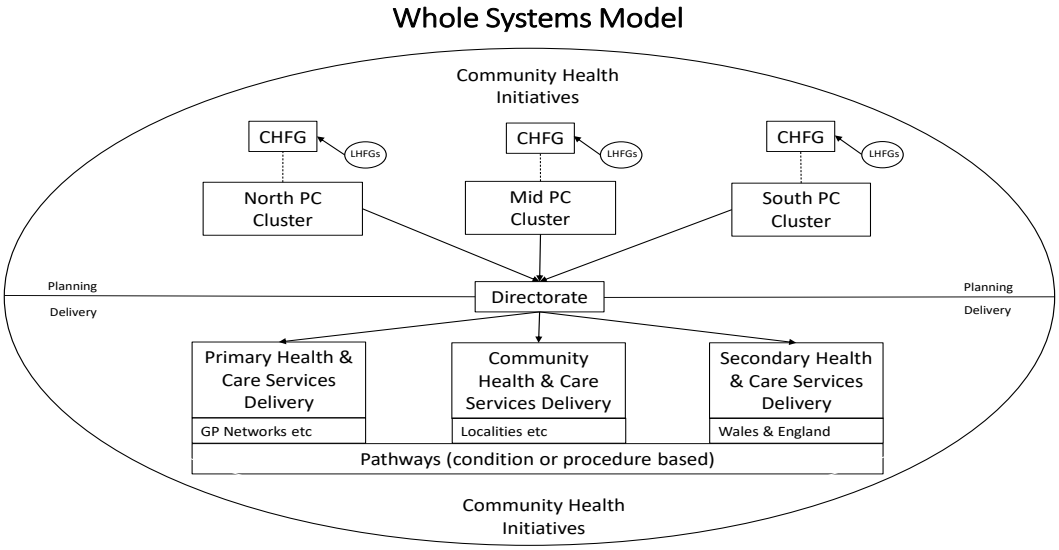


Figure 13: Powys Whole System Model

Vision
Truly integrated care centred on the needs of the individual

Aims and Strategic Objectives

AIM 1 Improving Health and Wellbeing	Improve health now and lay the foundations for maintaining good health for the future Improve the emotional wellbeing and mental health of the people of Powys
AIM 2 Ensuring the Right Access	Increase the capacity and resilience of primary and community care to promote self-care and support care closer to home Implement whole system commissioning to ensure appropriate access to effective services
AIM 3 Striving for Excellence	Deliver continuous improvement in safety, quality and patient and carer experience in all settings Improve the estate to s that it is fit for purpose and progressing to meet service needs Secure innovative ICTG solutions, built on a stable platform Ensure a well governed organisation

AIM 4 Working in Partnership	Implement greater integrated health and care services Develop partnership working, to achieve the ambitions of the health and care strategy and the Powys Wellbeing Plan
AIM 5 Making Every Pound Count	Implement effective financial management to ensure best value for money and achievement of statutory breakeven
AIM 6 Always with our Staff	Develop a sustainable, skilled, engaged and content workforce fit to meet the needs of the population of Powys

Table 14: Powys Community Model Aims and strategic objectives

9.4.3 Key Outcomes this will deliver

- *We seek to be leaders in primary and community care*
  We already have a strong and vibrant primary and community care service with highly committed staff and partners working together. New ways of providing general medical services have already progressed with a greater emphasis on multi-professional care in General Practitioner (GP) practices. We intend to help to transform the way in which people can be supported to self care through the use of new digital technology and good quality supportive individual health care planning and to help broaden the range of services available locally including social networks and support, mental health care provision and outreach services from district general hospitals. The development of integrated community hubs for example has been a key message from stakeholders and partners with regard our future planning. Furthermore, the development of rural regional centres offering an enhanced service provision in county could be developed to help improve access and patient experience, working hand in hand with secondary care providers, utilising new digital and telehealth solutions.

- *We seek to be leaders in commissioning*
  This means that we will increasingly look at the whole system of care to help determine (based on need, quality, patient experiences and cost) what, where, when and how services should be provided. Increasingly we are working with others to jointly commission and during the life of this plan we will increase our joint commissioning with social care, enabling a truly joined up approach. We will be relentless in ensuring we work in the interest of the people of Powys when we commission services and will implement our Strategic Commissioning Framework and Commissioning Assurance Framework in order to achieve the best results possible.

- *We seek to be leaders in integrated care*
  Building on the success to date, we aim to move forward on 'triple integration'. Integrating primary, community and secondary care; physical and mental health care; and health and social care will enable a step change in our offer to the population – seeking to promote a more holistic way of supporting people. The health and social care integration ambition sets Powys apart from others at this stage. We are currently engaging with people on our recently developed integrated health and care strategy, the first of its kind in Wales. This has the potential to be the blueprint for future integrated services managed as a single system with integrated operational management, integrated commissioning, and integrated service provision becoming the norm.

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9.5 Mental Health and Dementia

The strategies and priorities for mental health for the two CCGs are well aligned. Developments for mental health are focused on a number of patient outcomes:

Patient Outcomes:

1. Communities and care systems will have a greater understanding of issues
2. People will have access to early help and support so they can help themselves
3. Services will provide fast track proactive support
4. Services will provide care in a crisis

The Key projects for development from 2017/18 are:-

Key project	What will it look and feel like	How will we do it
Mental health awareness training	Mental health champion on each police shift	Training booked for September
Recovery college	Range of courses to support recovery Joined up employment pathway Improved medicines Management support through health coaches	Nos attending courses Nos of people in employment who have MH issues increases Improved meds compliance- measured on individual basis
Trauma pathway –Telford only	Clear referral pathway with relevant support for people who have had emotional traumas	Patients referred into the correct service for their needs
Physical health CQUIN	Physical health needs of those with severe MH issues is addressed	Improved health outcomes for people with SMI
Clinics linked to Help to Change (Shropshire)	Immediate referral for health promoting behaviour work when attend for MH issues	Psychosis pathway - medication clinics and physical health linking to Help to Change project
Single Access point for referrals	Get to the right place first time then to services or facilitated signposting to third sector	Feedback from patients. Meeting early Intervention psychosis target
Non psychosis assessments in clusters in Shropshire	Care closer to home- Clinics to be held in GP clusters	Clinics up and running
Revised acute care pathway	Prompt access in a crisis from a team that understands your needs and responds	Reduction in Section 136 detentions, reduction in inappropriate admissions to Redwoods and acute hospitals
Frequent attenders at ED	People who attend ED on a frequent basis will be reviewed and an appropriate care package put in place to support their MH needs	Reduction in repeat attenders at ED where MH is an issue
Memory service	Fast track access to quality supportive service in neighbourhoods	Redesign current service

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Dementia crisis support	Advice and support will be available if people have a crisis associated with their dementia	New service specification for current provider
Post dementia diagnosis pathway	People will be supported from diagnosis through to end of life and will know how and when to access support	Dementia companions, dementia friendly communities

Table 15: Mental health and dementia – key priorities for development 2017-18

9.6 Securing Sustainable General Practice

The GP Forward View (GPFV) is identified within the STP as the key delivery vehicle for securing sustainable general practice within the context of the developing Neighbourhood care models described in the preceding sections.

The GPFV workforce objective is described as building capacity and capability in general practice to strengthen the primary care workforce by 2020/21 by increasing workforce, reducing attrition, and increasing recruitment into a more diversified workforce. Specific targets and outputs for both CCGs are:

1. Baseline assessment to identify areas of greatest need
2. Workforce gap analysis to deliver new models of care be undertaken
3. Workforce development plans including multi-disciplinary working and primary care at scale
4. Commitment to develop, fund and implement local plans
5. Initiatives to attract, recruit and retain GPs and other clinical staff
6. Actions to ensure GPs are operating at the top of their license as part of the multidisciplinary general practice team.
7. Actions to extend multi-disciplinary team working and greater integration across community services to optimise out of hospital care
8. International GP recruitment into areas with most need
9. Recruitment of clinical pharmacists in general practice
10. Connections with associated nursing and allied health professional workforce initiatives
11. General Practice provides the building block for Neighbourhood Teams. Providing support is a fundamental part of the model.

The Shropshire and Telford & Wrekin CCGs are embarking on a Primary Care Transformation journey which places primary care at the centre of a multi-disciplinary health and wellbeing offer to the local population. The vision is to develop a neighbourhood based solution to meet need that is based on the principles of:

- **Collaboration** – health, social, community, mental health and voluntary organisations working together
- **Co-ordination** – approaches to delivery of care that are co-ordinated between agencies across a locality
- **Innovation** - embracing new ways of working to offer the best support to the population with clinical and asset based approaches working hand in hand
- **Accessibility** – locality based provision tailored to each area
- **Quality** – Ensuring that transformation leads to better outcomes for patients and reduces inequalities

Both Shropshire and Telford & Wrekin CCGs are working collaboratively to implement the GPFV and are also liaising with the Shropshire Local Medical Committee to provide oversight to progress and impact. Both Telford & Wrekin and Shropshire have plans firmly rooted in wider system change driven by the Sustainability and Transformation plan (STP) and our ambition to further develop integrated working with the local Councils. Our approach to transforming Primary Care will however embrace the differing needs of our local populations across Shropshire and Telford & Wrekin and our neighbourhood models will look different across the County as they will be developed locally.

Each of the CCGs is at different stages in their Primary Care transformation journey. However, the CCGs are committed to sharing approaches and expertise and to apply this to local issues as required. We will build on the emerging collaborations and partnerships between practices, recognising the natural alliances that are forming and the need for locally grown and tailored approaches.

Implementation is supported through a Shropshire wide 2 year GPFV operational plan (Appendix 28) which is aligned with the wider STP delivery plan. The transformation plans include a focus on: workforce, estates, IT, provider collaboration and risks.

9.6.1 Primary Care Workforce

A substantial number of GP's are at or approaching retirement age. In general, the local primary care workforce is dominated by traditional roles with very few nurse associates, Physicians Associates, mental health therapists or pharmacists, although practices are starting to use alternative workforce such as ANPs and clinical pharmacists to provide care that would have historically been delivered by GPs. Workforce is recognised as the most significant challenge to the sustainability of general practice across Shropshire and as such there has been significant focus on this area.

The workload and resilience work stream is re-redirecting workflows and developing care navigation/sign posting. Across Shropshire a number of practices have already benefitted from workflow training and dates are planned for the remaining practices. There has been a collective CCG approach to implementing care navigation on a phased approach with internal signposting to members of the general practice multidisciplinary team and to external providers (i.e. pharmacy, optometry and dental providers). These pathways have been developed in partnership with the Local Professional Networks for Pharmacy, Optometry and Dentistry. This has been possible through national funding.

Two practices have taken up funding from the Local Enterprise partnership (LEP) to up-skill administrative staff. Funding is also available from this source for other members of the MDT in managing people, leadership and the principles of customer service. The CCG's are working with the CEPN's to promote uptake of these courses.

Progress has been underpinned by the investment into Shropshire from the GP Forward View national resilience funding allocation. Prioritised practices have been encouraged to work collaboratively to address specific internal challenges. These include for example lead practices employing pharmacists and / or urgent care practitioners who then provide sessions across a group of practices. Case studies evidencing benefits will be submitted by practices in March 2018.

All our stakeholders are now advocating network working across practices to build greater resilience and the GPFV resilience funding has been used to support the piloting of new workforce models across groups of practices.

In October 2017 Shropshire, Telford and Wrekin produced a comprehensive primary care workforce plan. This includes a description of the current workforce and aspirations for changes across the area, linked directly to the GP Forward View. There is a clear action plan which covers monitoring, introduction of new roles and training.

9.6.2 Primary Care Estates and Technology

Infrastructure is also recognised as a critical enabler for change across Shropshire County to help ease the pressures created by workforce challenges, especially in relation to the use of IT. Through the Estates and Technology Transformation Fund (ETTF), Shropshire, Telford & Wrekin have been awarded funding to implement an Integrated Care Record which will support delivery of the new model of care. Funding has also been awarded to purchase additional computer screens for practices to support the implementation of re-directing workflow and to pilot e-consultation.

9.6.3 Primary Care links with Mental Health

There is also a dependency on the Five Year Forward View for Mental Health (5YFVMH) which is progressing schemes that will deliver additional mental health therapists within primary care teams.

As part of the government's extended commitment to achieving parity of esteem for mental and physical health and implementing the Five Year Forward View for Mental Health (5YFVMH) CCG's will have to ensure that mental and physical health care, including access to psychological therapies, is delivered as part of an integrated approach. The 5YFVMH sets out the ambition that by 2020/21, 25% of adults with depression or an anxiety disorder, will be able to access to IAPT.

Recognising the high levels of unmet psychological needs in people with co-existing physical health conditions, two thirds of this expansion is planned to take place within 'integrated IAPT' services. As part of this expansion, new mental health therapists will be co-located in primary care, as set out in the General Practice 5 Year Forward View.

The need for integration is particularly apparent in people with existing long-term physical health conditions (LTCs) and medically unexplained symptoms (MUSs). Around one-third of people with LTCs, such as diabetes, cardiovascular disease and respiratory disease, will also experience a common mental health problem, with an even higher proportion experiencing poor mental health. Coexisting mental and physical health problems are associated with a poorer prognosis and considerably higher healthcare costs. Integrated care, as well as being reported consistently as preferable to non-integrated care by people who receive it, has also been shown to improve outcomes and be cost effective.

The introduction of the national IAPT programme will be in a number of waves with specialist national support to CCGs in each wave. Telford & Wrekin CCG is in Wave 2. Shropshire CCG is awaiting instruction following a review of these first wave implementers which is due to report in Autumn 2017.

9.6.4 Key Primary Care Developments to-date

- Formal quarterly reporting to Primary Care Committees
- Primary Care Needs Assessment undertaken in 2016
- Review of all PPGs across the County
- Shropshire wide Primary Care Workforce audit process underway. The CCGs are working with NHS England to establish a workforce baseline which will be fed into a Health Education England tool which will assist in workforce planning
- Primary Care Estates Plan being progressed
- Primary Care IT Roadmap approved
- Both CCGs have been successful in bidding for ETTF funds through the GPFV for both estates and IT projects. All projects are being progressed via the development of business cases with milestones towards completion agreed.
- 14/17 practices in Telford and Wrekin are now working in 4 clusters/localities to secure sustainability
- The development of Practice clusters are being progressed in Shropshire
- Practices in both CCGs have been successful in obtaining funding from the NHSE Resilience Fund and are starting to deliver on plans to improve resilience. Bids to the 2017/18 Resilience Fund have been made with decisions expected during August 2017.
- Practices have attended training sessions to understand their referral data better (via the Aristotle system)
- Shared learning from the CQC visits, as and where appropriate, will be commenced
- A new quality and improvement assurance process will be commenced
- Primary Care Communication and Engagement Plan submitted for approval to Primary Care Committee
- Primary Care Financial plan approved by Primary Care Committee
- Social Prescribing Pilots are underway in both CCGs.

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- 24 practices across both CCGs are part of a scheme to provide extended access to General Practice. Pre-bookable and same day appointments are available from 8am-8pm and at weekends. Both CCGs are planning to extend this to cover 100% of their population by April 2019 in line with the GPFV.
- Practices from both CCGs have received funding to provide training to practice managers.
- Staff at many practices from both CCGs are receiving training on care navigation and on improving workflow in practices.
- Both CCGs are implementing plans to introduce e-consultation and Skype consultation in practices.

9.6.5 The Impact of the Out of Hospital Model of Care on Primary Care

The CCGs have considered the impact of the Out-of-Hospital model of care on General Practice. One of the key features is that the model is flexible enough to meet the demands of delivery in both rural and urban populations. There are many similarities between the approaches of the two CCGs. In Shropshire the programme is referred to as the 'out of hospital model of care' and in Telford & Wrekin the approach provides the foundations for neighbourhood working with the primary care offer firmly bedded within this programme of work.

Whilst services will be delivered around practice populations across the whole of the County of Shropshire, the registered GP practice list sizes of our 43 Practices in Shropshire CCG ranges from just over 2,000 patients up to 17,500 patients with an average list of 7,150 patients. This together with the rural nature of much of Shropshire's geography requires the delivery model for the Out-of-Hospital model to be flexible in nature. Shropshire CCG has 3 commissioning localities which are made up of all the GP practices in Shropshire. The GP Forward View recommends new models of care are commissioned around populations of 30,000 – 50,000 and the CCG has worked with practices to define the total population around 9 commissioning Hubs. As far as possible these "hubs" meet the needs of the geographical locations and are mostly consistent with recommended population sizes. However, 3 of these commissioning hubs are under the recommended 30,000 population at 16,000, 18,000 and 27,000. The rural geography of the County is such that making these hubs larger would not benefit the delivery of patient care. The methodology is similar in Telford & Wrekin with 4 localities, 3 of which are within the recommended guidance numbers and one is slightly under at 28,187.

The CCGs are implementing the GP Forward View guidance on the STP footprint and the key areas which link into the overarching Sustainability Transformation Plan and the Out-of-Hospital model of care are around "at scale" working, workforce, improved access both in and out of hours and the development of workload management (10 high impact actions), technology (shared access) and infrastructure (estate). The majority of practices in the County are working on "at-scale" plans which will enable and support the Out-of-Hospital model to be implemented and this includes the delivery model for the 8am – 8pm 7 day a week Primary Care Service. Further work is required to enable the smaller more rural practices to work together. If this is to be successful, the "wrap-around" services and access to diagnostics need to be fully aligned.

Through signposting and care-coordination, the CCGs are working well with the Local Authority and Voluntary Organisations to build local directories of services which are accessed by GP Practices and out of hospital providers. These will be revisited as the new model of care approaches the implementation phase, ensuring that the health and social care teams are all updated with service availability in the local "hubs"/ neighbourhoods. This will be electronic and maintained by the care providers.

The CCGs have risk stratification processes, however, the new Out-of-Hospital model will provide opportunities to fully align how these patients are identified and managed across an integrated team ensuring an every contact counts one team approach.

The model will operate on four levels of population need:

- Whole population
- Urgent care needs
- Ongoing care needs
- Highest needs

The model will be built around general practice with a core locality team including district nurses, allied health professionals, social care and matrons. Teams will work across a broad pathway, supporting the delivery of place based care around long term need and a more urgent care service in both acute and community teams.

The aim will be to support an increasing number of individuals in their own homes, helping them to regain confidence and independence in order to reduce their future need for more intense health and social care input. The principle will be care in the usual place of residence wherever possible, with the support of a community bed option when unavoidable.

There have been expressions of interest from a number of GP practices/locality groups in looking at formal contractual arrangements which fits with the Out-of-Hospital model, however where the Practices are not able to consider this, due to a number of reasons, the CCG's model of care will need to enable a different procurement option for these areas. As the new model of care is refined and engagement increases, the CCG will more fully define these delivery models.

Development of the workforce is a key fundamental to success. There are a number of schemes which sit outside traditional general practice which rely on a GP workforce such as the ED front door model. The CCGs joint Primary Care Workforce plan identifies ways of improving how GPs and the wider workforce can be attracted to Shropshire and these are clearly defined in the joint GP Forward View plan across Shropshire. There is a requirement to ensure a portfolio approach to job roles across Shropshire and these are also defined in the wider STP workforce plans.

CQC ratings for local GP practices are higher than average, excellent and good and they are aware of the CCGs key priorities and the need to make significant changes to address key areas such as emergency admissions, frailty, MSK etc. They are working on their resilience and sustainability plans under the GP Forward View and whilst there is nervousness about the future, there is recognition and a willingness to work towards a model that ensures service provision which meeting the needs of both patients and healthcare workers.

When delivered successfully, the opportunity of ensuring the alignment of activity shift with appropriate resources in the community underpinned by technology and workforce changes will identify early opportunities to address unwarranted variation in identification and management of risk high patients.

9.7 Reducing Delayed Transfers of Care from Hospital (DTOC)

Significant work has been undertaken this year to ensure robust plans are in place to reduce Delayed Transfers of Care (DTOC) to 3.5% or below in all provider organisations by the end of September 2017. Reducing length of stay is key to improving effective flow of patients through the acute hospital. Examples of initiatives in place to support this reduction include:

- The local LHSE has a well-established discharge to assess model in place that is subject to a continuous improvement cycle to ensure that it is embedded within work practices and functions effectively. Trusted assessment is now in place with local NHS and LA partners and plans are in train to expand to independent care providers.

- In Telford, for 6 months a part-time Matron role has been embedded with clinical experience to educate, advise and manage in order to minimise risk and reduce the pathway level as prescribed on the fact finding assessments. The funding to extend this role to a full-time post for 2 years from the BCF has been agreed.

- Local authority partners are working to have a robust 'sufficiency of care plan' in place by 1st October 2017 to ensure continuous service delivery to support hospital discharge through to 1st April 2018. This represents a whole system approach to the delivery of services over the winter period and beyond. The plan is underpinned by the principle of collaboration to drive solutions to manage surge and escalation.

The changes introduced over the last 12 months are already demonstrating reductions in delayed transfers of care and this trend is expected to continue with the additional initiatives coming on stream this winter.

- A system-wide standard has been agreed that the majority of patients (95%) will be discharged from the acute hospital within 48 hours of the organization responsible for discharge receiving the Fact Finding Assessment. Weekly performance monitoring against this standard for both Local Authorities was introduced in July 2017 including the reasons why the standard was not achieved.

- Daily Discharge Hub meetings are now embedded on both acute sites and the chairing of the meetings now rotates across stakeholder partners to ensure that the culture and process of the meetings retains sufficient momentum and action planning.

Both Local Authorities have specific initiatives either planned for this winter or already in place as follows:

9.7.1 Shropshire Council

- **10 additional admission avoidance beds** to support those who would have previously required hospital admission with medical care and reablement in care homes in the community, preventing the need for hospital admission and supporting individuals to regain their independence in their community.

- **20 additional Discharge to Assess beds,** providing early discharge to individuals as soon as they are medically fit, but not well enough to return home. Enabling them to receive a period of continued assessment and reablement, increasing their independence with the intention that they will return home, in turn reducing permanent admissions to residential and nursing care settings.

- **7 day brokerage service** - Ensure the brokering of care 7 days per week, enabling individuals to be discharged within 48 hours 7 days per week as providers can bid on packages and brokerage can accept them, meaning care can start.

- **Additional emergency Admission Avoidance support in the community** through Carer's Trust For All. They will provide emergency only domiciliary care support for the out of hours period. This support is not planned support but designed to be available for urgent situations dealt with by ICS and EDT. Carers Trust 4 All will have access to assistive technology to use in these situations and the pilot will test the use of this equipment in more urgent situations.

- **4 extra care units in Shrewsbury** to be used as reablement support in the community following hospital admission for those individuals who are not ready to return home, but do not require the level of support offered by the step down beds. These properties can be used for individuals and their carers to move into together.

9.7.2 Telford & Wrekin Council

In order to ensure bed availability in times of high escalation, the Council has undertaken a market consultation about developing flexible capacity. This will assist with outcome-focused step-down care from hospital including enablement and recovery. Working within a strategic partnership with care providers to secure additional spaces across the Borough, providers will collaboratively identify an 'agreement to work' within an agreed specification.

- **Implementation of Dynamic Purchasing System (DPS)**
  Implemented in October 2016, the DPS provides a more flexible and innovative approach to purchasing care and support from Providers across the market. From September 2017, the Council and CCG are procuring a new DPS provision for Contingency Intermediate Bed Based Care. Whilst the priority is to

support individuals to return to their own home, there may be cases where intermediate care is required as an alternative to the patient going straight home from hospital.

- **Development of Collaborative Partnership Arrangements**
  - (i) Block contracts for enablement have been in place since January 2017 which has enhanced the supply of enablement packages. The service is provided by 2 leading Providers across 3 identified 'zones' across Telford & Wrekin. This has reduced pressure on bed capacity in both acute hospitals and has provided capacity for home care and support from other Providers in the market. It is planned to increase capacity from 1st November 2017 to support hospital discharge/admission avoidance.
  - (ii) This autumn it is planned to implement block contracts for planned (long term care) in targeted areas where this type of provision is difficult to broker.
  - (iii) From April 2017 the Council and CCG have been developing the concept of 'Wellbeing Care Networks' with the care and support sector including the voluntary sector. The aim is to increase community resilience and provide preventative support to individuals in order to avoid hospital admission.
  - (iv) Individuals will be assisted through a variety of Information, Advice & Guidance e.g. Care Navigators at GP Surgeries and Networks across Telford & Wrekin

9.8 Community Provider Trust Organisational Sustainability Review

Shropshire Community Health NHS Trust (SCHT) has been considering for some time whether they are sustainable – clinically and financially - in their current organisational form. This includes the Trust's ability to deliver high quality services, and capacity and ability to deliver the transformed out-of-hospital community services that are vital to the Trust's own vision, and as described within the Sustainability and Transformation Plan (STP).

These considerations have not come about because the Trust is failing in its performance or finances. The Trust is keen to ensure that its organisational form will enable it to best help community services to thrive and develop strongly for the future. The Trust currently faces key limitations and issues because of its small organisational size, including the challenge of finding efficiencies and making investment in its services, and limited infrastructure in a range of areas from transformation change management, to quality governance, to support for workforce change, to IM&T and estates.

In 2016, SCHT Board reached the view that the Trust and its services needed to become part of a larger organisational model offering the investment and infrastructure for community services to thrive and develop strongly. The Trust's regulator NHS Improvement (NHSI) supports that view. This decision means that the Trust is progressing a review of options for the future organisational form of its services.

Since that decision a Sustainability Board has been established and is meeting regularly. The Board has been working through the stages to arrive at a preferred option, including developing the criteria to be used, and refining/narrowing down the organisational options. The Board has committed to reaching a conclusion as soon as it practicably can, and has recognised the importance for the Trust's services and staff of arriving at a preferred option in a timely way. The ultimate decision maker remains NHSI as our regulator, taking into account feedback and views received.

From the outset, the Trust is committed to keeping their staff informed and engaged in the process, and to make sure they have opportunities for their voices to be heard in the process.

9.9 Conclusion to Community Approach to Supporting Acute Reconfiguration

The acute draft OBC assumes a number of non-elective admissions and inpatient bed days will be avoided at the end of a five year period through a 50% reduction in delayed transfers of care, implementation of 7 day working and reducing demand through new community models.

For the acute model of care therefore to work optimally and to achieve maximum benefit, all health and social care sectors need to contribute their part to effective and integrated patient pathways which both support reduction in demand on acute services and improve flow through acute services to discharge back to community. Through the work that has been done to examine the evidence base and to begin to develop the proposed community models of care, the CCGs have a level of confidence that plans to modernise the out of hospital/community services to support better patient care and experience closer to home are aligned with and complement the proposals in this PCBC to modernise local acute hospital services. There is also confidence in the out of hospital care shifts assumed in the Acute OBC and overall affordability to the system as a whole and the individual stakeholder organisations.

The overall model provides a way of working that is a fundamental change in practice and culture and will take five years to fully embed. The developments described here will however deliver benefits during the current and subsequent years. The phased impact of these initiatives on acute hospital demand is described in the next section of this PCBC.

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10 Activity and Capacity Modelling

This section describes the activity and capacity modelling that has been done to support the delivery of a new clinical model of care. It also describes the triangulation of the acute modelling and the more recent community modelling that has been developed to support the acute reconfiguration.

As a starting point for consideration of the models of care for urgent and emergency care, the original Future Fit algorithm was applied to the Acute Trust's activity data for 2015/16 to determine whether patients need emergency or urgent care services, including mapping different elements of the case mix to different scenarios. This showed 65% of the patients that currently attend the Trust's A&E departments do not have life or limb threatening illness or injury and could potentially be seen and treated by the Urgent Care Service. The remaining 35% of patients could be treated within the Trust's single Emergency Centre (EC).

Thus, around 77,400 of patients seen in A&E during the twelve months from April 2015 to March 2016 didn't need emergency care and under the new model would be seen in the Urgent Care Centre, at whichever site they arrived. In other words, under the proposed new model approximately 80% of patients requiring urgent or emergency care will receive treatment in the same place as now.

The core element of the proposed clinical model is that all patients are seen in the right place, at the right time by the right person. If the right place for the patient is the acute setting, then the services that patient's access need to be suitable for their needs. All unplanned patients would therefore be assessed and admitted to the Emergency Site. If clinically appropriate, patients could be transferred to the Planned Care for their on-going care and treatment. The majority of adult patients having a day-case operation or procedure would be admitted to the Planned Care Site. High risk patients would have their day-case at the Emergency Site, as would children in two of the options.

10.1 Activity and Capacity Modelling - Acute

The activity and capacity modelling has developed from the onset of the Future Fit programme in 2014 to the most recent admission avoidance proposals identified by the CCGs in 2017.

The draft OBC developed by SaTH in December 2016 used 2015/16 activity data and amended Future Fit Phase 2 assumptions as the basis for the capacity requirements. This PCBC has further updated the future activity requirements with a revised baseline of 2016/17, the CCG admissions avoidance plans and a demographic growth of 2.8% (Indicative Hospital Activity Model (IHAM) requirements).

The table below summarises the baseline and projected future activity for SaTH up to 2023/24.

	2016/17 Outturn	Projected
Elective Inpatients and Daycase	51,948	63,026
Non Elective Inpatients	58,946	66,462
Outpatients	435,799	528,735
A&E attendances	119,906	145,476

Table 16: Baseline and projected future activity of SATH

Future capacity requirements were determined by applying a series of throughput and utilisation assumptions to the projected future activity levels. A key principle has been the optimisation of occupancy levels for each ward or bed pool to maximise throughput and efficiency while minimising disruption and inconvenience at times of peak demand. The Trust's overall occupancy levels are planned at 86%.

The major throughput and utilisation assumptions for each of the main areas are summarised below. Key points to note are:-

- The larger bed pools are modelled at an occupancy rate of 89% and the smaller bed pools, such as the acute medical ward, are set at 72%, as advised by Strategic Healthcare Planning (the Acute Trust's healthcare planners). Critical Care is modelled at 60% by applying the Erlang theory. Allowance in the modelling has been applied for 7 day working and an expected reduction of 7 beds.

- Performance currently is significantly below the national A&E 4 hour target, however, the Acute Trust is assured that its bed modelling is accurate because the clinical model focuses on streamlining the current patient pathways and improving the flow of patients through the hospital. The future configuration of services will ensure that patients are cared for in the right ward thus improving the flow. Patients accessing current A&E services will be managed in the future based on their clinical need. That means patients requiring urgent care are seen by a workforce appropriate for their need, such as Advanced Practitioners or GPs; this is based on a 2 hour 'See and Treat' model.

  Seeing these patients in a different and separate facility to the more serious clinical cases will ensure that the ED workforce are consolidated and have the space and capacity needed to respond, without delay, to the clinical needs of the patients. Ambulances will be able to handover care of patients quicker as the staffing levels will be improved through this consolidation and streaming and cohorting of patients.

  Furthermore, 7 day working and a more organised delivery of specialities will ensure senior decision makers are available to view patients and instigate treatment. This will support the delivery of the admitted and non-admitted target for urgent and emergency care. In addition, the availability of senior decision makers 7 days a week will ensure timely discharge, or transfer to the Planned Care Site. The future bed numbers allow for demographic growth and reflect the clinically led modelling work of Future Fit and the commissioning intentions of both Shropshire and T&W CCGs in relation to Neighbourhoods.

These changes will address the core issues that underly poor performance in achieving the A&E standard, namely:

- Consolidation of A&E onto one site so improving A&E workforce resilience, reduce the impact of adverse rotas, and provide an attractive working environment into which new A&E consultants can be recruited
- Space constraints across the sites will be addressed so improving non-admitted performance currently contributing significantly to breaches in A&E
- Remodelled pathways and staffing to improve and sustain early discharge through improved flow

Urgent Care Centres

- UCC capacity required at both sites under all options;
- Adult and children's capacity planned separately;
- Target > 98% see and treat within 2 hours;
- Average 45 minutes in cubicle per patient;
- Adult and children's wait planned to allow average 1:15 hours in waiting area or sub-wait;
- Allowance for 2 visitors per patient.

Emergency Department

- Adult and children's capacity planned separately;
- Target immediate capacity for > 99% arrivals;
- Target maximum treatment time 3 hours;
- Resuscitation average stay of 3 hours with 0% unavailability.

Ambulatory Emergency Care / CDU

- Best practice tariff pathways applied;
- Average length of stay of 7.37 hours based on analysis;
- CDU, AEC and Unscheduled Care Day Case to operate as combined unit;
- Mix of beds (8), trolleys and chairs;
- Operational 12 hours a day over 365 days

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Unscheduled Care beds

- Short Stay Medical
  - 72% occupancy for the short stay medical unit;
  - Up to 72 hours stay;
- All other wards
  - 89% occupancy;
  - A 50% reduction in DTOCs;
  - A 10% reduction in the average length of stay within General Medicine due to the introduction of 7-day working;
  - Beds available 365 days per year;
  - Specialty allocation based on HRG-level case mix analysis;
  - 80% of patients from the Emergency Site with a planned length of stay greater than 72 hours that are clinically appropriate can transfer to Planned Care, of which 20% remain on the Emergency Site to receive care closer to home.

Scheduled Care beds

- Short Stay Surgical
  - 72% occupancy, 365 days per year for the short stay surgical unit;
  - Up to 72 hours stay;
  - Best practice tariff pathways applied.

- All other wards
  - 89% occupancy;
  - specialty allocation based on Treatment Function Code;
  - 80% of patients from the Emergency Site with a planned length of stay greater than 72 hours that are clinically appropriate can transfer to the Planned Care Site.

Women and Children's Beds

- Occupancy modelled at 72%
- Postnatal capacity includes increase in transitional care beds in line with guidance.

Critical Care

- Adult Critical Care
  - Level 1, 2 & 3 pts managed flexibly within the bed pool;
  - 60% occupancy based on a <1% turnaway rate;
  - Demographic growth of 1.25% applied over 10 years.
- Neonatal Critical Care
  - Based on 2014 reconfiguration of Women and Children's services occupancy at 80%.

Clinicians also considered the optimum balance of specialties and services between the Emergency Site and Planned Care Sites. Through a review of the predicted acuity of patients, critical care activity and the application of the single unplanned admission route, a bed base was established.

These modelling assumptions were tested through an audit of all medical patients within the Trust on a particular day. The key audit findings showed that of the almost 300 medical patients audited, 84% required on-going care and were not planning to be discharged in the immediate future. The overall percentage of patients that were be suitable to receive their on-going care on the Planned Care Site was 54% (n=162 patients).

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	RSH	PRH	Both sites
% of pts not for imminent discharge	81	88	84
% of pts not for discharge that can transfer care to PCS	68	61	65
Overall % of pts that can transfer to PCS	55	53	54

Table 17: Audit of admitted medical patients August 2016

From this, it is clear that a very considerable proportion of the overall activity can be managed from the planned care site.

10.1.1 Capacity Requirements

The table below summarises the projected UCC capacity requirements based on the assumptions set out above:

	RSH	PRH	Total
UCC Adult cubicles	7	7	14
UCC Children's cubicles	4	4	8
UCC Adult waiting places	30	30	60
UCC Children's waiting places	15	15	30

Table 18: UCC capacity requirement

The table below summarises the projected ED capacity requirements based on the assumptions set out above.

	Total
ED Adult cubicles	27
ED Children's cubicles	7
ED Resuscitation trolleys	8

Table 19: ED capacity requirement

The table below summarises the projected future capacity requirements based on the assumptions set out above and the current Trust bed base. In summary as can be seen below, whilst the number of beds in future will be more than currently available, the increase is less than projected changes in demography would indicate are required as demographic growth of 2.8% is being addressed through service changes in the community. There is a proposed reduction of 35,738 bed days relating to these schemes this equates to a bed base reduction of 110 beds (37 Telford and Wrekin CCG, 73 Shropshire).

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	Who will be cared for in these spaces?	Number of beds in the hospitals today	Expected number of beds in the future
Overnight beds	Where patients stay if they need hospital care for more than one day. For example, a patient being treated for a severe chest infection.	**731**	**785**
Day beds	Where patients stay if they have had an operation but do not need to stay in hospital overnight. For example, a minor arm operation or investigation such as Endoscopy.	**91**	**105**
Clinical trolley and recliner chairs	Where patients that need to have some tests carried out and are seen by a hospital doctor but are very likely to go home that day. For example, an elderly patient that has had a fall.	**10**	**49**
Critical Care beds	Where patients who are very poorly are treated and cared for. For example, patients who are on life support.	**23**	**30**
Neonatal cots	Where poorly newborn babies are cared for. For example, a premature baby.	**22**	**22**
Total		**877**	**991**

Table: 20a

The table below provides a further breakdown of the proposed bed capacity by site and by type of service.

	RSH Current	PRH Current	Current Total	Emergency Site (RSH)	Planned Care Site (PRH)	Future Total
Medical beds	211	184	395	257	97	354
Surgical beds	170	78	248	169	112	280
Women & Children's beds	-	98	98	109	-	109
Sub Total - General and Acute	**381**	**360**	**741**	**534**	**209**	**743**
Day surgery and cardiology places	53	38	91	-	105	105
Adult critical care beds	14	9	23	30	-	30
Neonatology cots	-	22	22	22	-	22
Total	**448**	**429**	**877**	**586**	**314**	**900**
Occupancy improvement as per national planning assumptions	-	-	-	66	25	91
Total	**448**	**429**	**877**	**652**	**339**	**991**

Table 20b: Projected future capacity requirements

Thus it is projected that the optimum model of care for the future results in 66% of the total beds being required on the emergency site, with 34% on the planned care site.

10.1.2 Better Care, Better Value (BCBV) Indicators

The Better Care Better Value indicators are produced quarterly by NHS Elect to inform planning and to inform views on the scale of potential quality improvements and efficiency savings in different aspects of care. The indicator *Reducing Length of Stay* summarises the opportunity to reduce inpatient length of stay over the median value for each case mix group by 25%.

As a measure of the scope for improving length of stay the indicator looks at the number of bed days beyond the average length of stay for each of combination of Healthcare Resource Group, age, sex and social deprivation. It assumes that a quarter of this figure should be an achievable level of improvement, and expresses this as a percentage of all the Payment by Results (PbR) bed days at SATH with an associated productivity volume opportunity expressed in bed days.

SATH has been performing well in recent years against this indicator as shown below (the indicator value here is expressed as the percentage of all PbR bed days that could be saved):

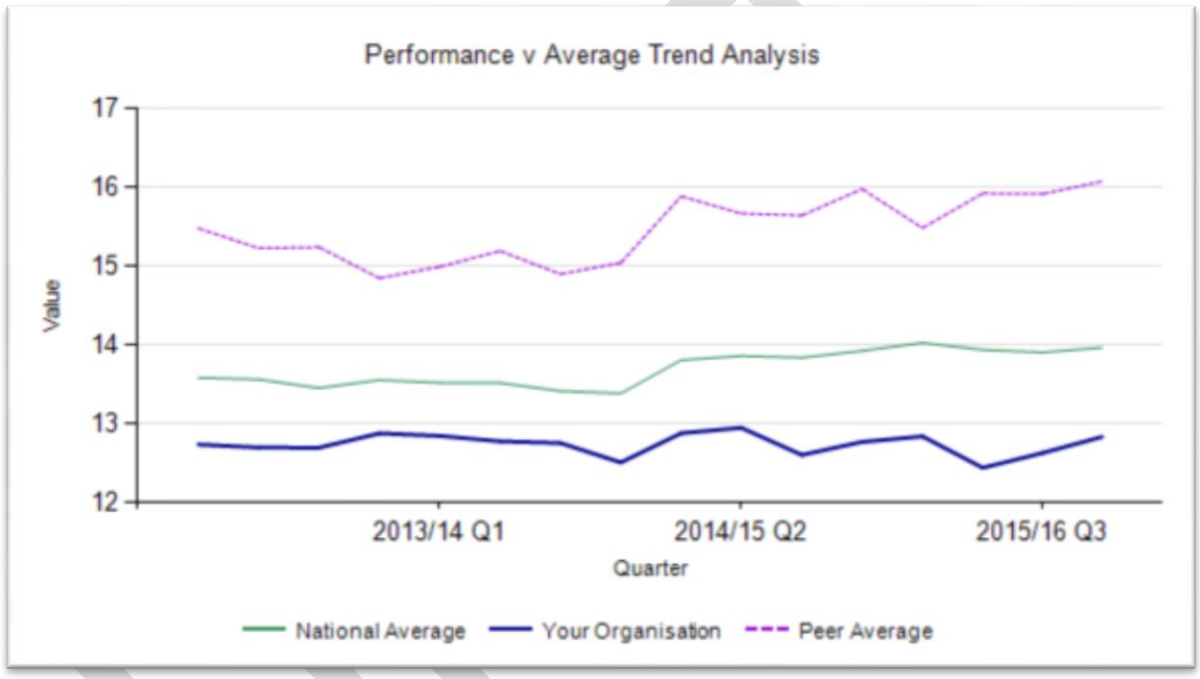


Figure 14: Performance vs average trend analysis

The chart above shows that the Acute Trust consistently has an 'opportunity' value of below 13%. This compares with a national average of between 13.5% and 14%, while the peer group average (of other local Trusts) has been at or around 16% in the last two years.

Despite the apparently more limited opportunity for the Acute Trust for further bed day reduction suggested by the national indicators, SaTH SSP has demonstrated that the proposed model of care changes offer considerable further potential and would see the Trust in the inter quartile range for medicine.

The projected in-patient bed day impact arising from the community schemes are set out below:

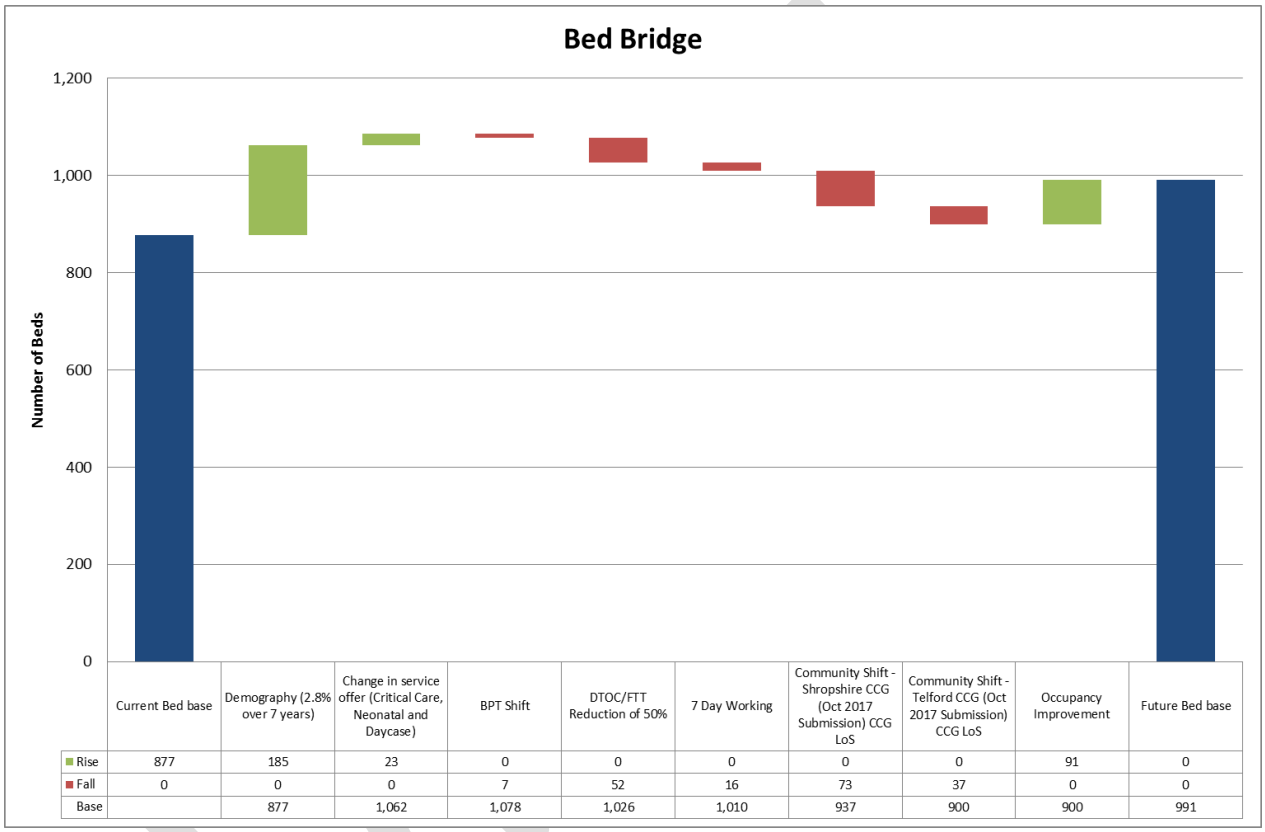
	Bedday Impact of Community Schemes
Shropshire County CCG	23,717
Telford & Wrekin CCG	12,021

Table 21: Projected in patient bed days

Thus it is projected that a total of 35,738 inpatient bed days could be saved.

A sensitivity testing exercise was also undertaken to confirm theatre capacity requirements in relation to existing provision across the two sites. This was based on a detailed analysis of data from SATH's theatre management system combined with the SSP future activity projections. Two scenarios were tested, based on 80% and 85% theatre utilisation respectively. The analysis for both scenarios confirmed that projected theatre activity for each site can be managed within existing capacity, with opportunities to increase throughput and extend operating hours at some stage in the future if required.

The acute hospital reconfiguration proposals are designed to manage future capacity on the assumption that patients that are currently being seen in the acute trust will in the future receive care within the community setting. This equates to a reduction of 5,054 emergency admissions.



	Current Bed base	Demography (2.8% over 7 years)	Change in service offer (Critical Care, Neonatal and Daycase)	BPT Shift	DTOC/FTT Reduction of 50%	7 Day Working	Community Shift - Shropshire CCG (Oct 2017 Submission) CCG LoS	Community Shift - Telford CCG (Oct 2017 Submission) CCG LoS	Occupancy Improvement	Future Bed base
Rise	877	185	23	0	0	0	0	0	91	0
Fall	0	0	0	7	52	16	73	37	0	0
Base		877	1,062	1,078	1,026	1,010	937	900	900	991

Figure 15: Bed Bridge current to 2023/24

The diagram above represents SATH's bed bridge from current bed base through to the proposed future bed base at 2023/24.

The bed bridge starts at the Trust's baseline beds and shows the number of beds associated with demographic growth and changes applied for assumed reductions in delayed transfers of care (DTOC), 7 day working and the adoption of Best Practice Tariff (BPT) pathways, admission avoidance schemes and improvements in occupancy levels.

10.2 Activity and Capacity Modelling - Community

As described in the previous section, the Acute Trust Strategic Outline Case and developing OBC is built on the assumption that a proportion of activity currently taking place in the acute hospital will in future be delivered in community settings. Or expressed another way, improved care capacity in the community will ensure that patients will be maintained in their own homes without the need for admission to hospital.

A Community Fit project was established by the Future Fit Programme Board in April 2015. The first phase of this project was designed to provide insight into the challenges facing the non-acute sector and to encourage stakeholders to consider how these challenges and those originating from Future Fit might be met.

A further phase of Community Fit was described, building on the phase one work and this has been progressed over the last 12 months as part of the STP Neighbourhoods Workstreams. The project used data from 2014/15; the latest complete financial year at the point the project commenced. Data was supplied by each of the relevant stakeholder organisations against an agreed specification and under suitable data-sharing agreements.

The analysis from the first phase of community activity and capacity modelling provided a rich resource to support stakeholders to develop and assess out-of-hospital service design options. In particular it provided information on current levels of service usage, the potential impact of demographic change on service demand, the patterns of service usage across multiple sectors and the activity transfer assumptions from Future Fit.

A further phase of modelling has continued within the STP Neighbourhood workstreams at a clinical pathway/condition level to inform the activity and capacity impact on demand on acute hospital services that the proposed community models described in section 9 would deliver. This work remains ongoing and will be subject to further iterations as the developing community models are further refined. A number of condition specific pathways have also been developed for long term conditions.

Details of this second phase of activity modelling for the populations of Telford & Wrekin and Shropshire are described below.

10.2.1 Telford & Wrekin

- Key Indicators

  - Increase in proportions of expected to actual prevalence of disease (as defined in the practice diseased registers)
  - Reduction in non-elective activity
  - A primary care related indicator to indicate the changes at practice level (detail to be determined)
  - Reduction in permanent admissions to care homes
  - Systematic identification of people who would benefit from care planning
  - Reduction in spend on acute care by neighbourhood (as defined in 'neighbourhood' budgets)

The programme will help to improve health, enhance the support for people in early stages of illness (from the community as well as statutory services) and increase the community based alternatives therefore the number of patients attending hospital will reduce.

- Activity Modelling

One of the most significant reductions will be in the number of unplanned hospital admissions (non-elective activity). The CCG has considered national evidence, local intelligence and current plans to produce high level modelling to assess the impact of change in hospital activity. This local modelling estimates this potential reduction to be 2,365 admissions. This is summarised by schemes in the table below:

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Neighbourhood Scheme	17/18	18/19	19/20	20/21	21/22	Total
Wound Care	30	540	330			*900*
New Diabetes Model of Care		4	24			*28*
Hypertension ID and management	9	34	34	34		*111*
Enhancing Respiratory pathways	32	43				*75*
'Development of One Team' including Social Prescribing and dementia	44	40	40	411	438	*973*
Care Home Support	56	222				*278*
Total	**171**	**883**	**428**	**445**	**438**	***2,365***

Table 22: T&W Modelling summarised by Neighbourhood

This figure is broken down further by intervention, cohort of patients and category e.g. (ACS- Ambulatory Care Sensitive Conditions) below:

	End Of Life **(based on patients who died in hospital)**	***GP Management*** **(Patients with Long Term Conditions)**	***Multi-Disciplinary Team*** **(Complex Patients)**	**All other patients**	**Grand Total**
STARRs (Patient attendances with no procedure)	68	127	28	970	1192
Ambulatory Care Sensitive Conditions	68	108	25	520	720
Ambulatory Care Sensitive Conditions (Zero Length of Stay)	11	7	1	223	242
Non elective admission (Zero Length Of Stay)	8	2	1	94	106
Total	**155**	**244**	**54**	**1807**	**2260**

Table 23: ACS (Ambulatory Care Sensitive Conditions)

Activity for patients not included in the table above who may benefit from care planning in neighbourhood teams (N.B. the split for this activity is artificially low, but has been done to avoid duplication of counting).

	End Of Life **(based on patients who died in hospital)**	***GP Management*** **(Patients with Long Term Conditions)**	***Multi- Disciplinary Team*** **(Complex Patients)**	**All other patients**	**Grand Total**
Cohort Based	35	21	49		105
Total	**35**	**21**	**49**	**0**	**105**

Table 24: Activity of patients who may benefit for care panning in neighbourhood teams

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• Key Assumptions in Modelling

Baseline demographic data has been based on ONS statistics. The impact of the interventions described in work stream 1 has incorporated evidence based national data. This work produced two potential scenarios. The greatest impact assumes a fully implemented community solution delivering the greatest opportunity for enhancing disability free years. Telford and Wrekin CCG aspire to deliver these targets but recognising that many of the schemes are in early development and will take some years before we enjoy full impact. The modelling uses a more moderate set of assumptions.

There is now a stronger evidence base around the impact of care planning and continuity of care. Reductions in non-elective activity will be achieved by better supporting people in the community so they stay well for longer and are able to better cope in a crisis should their condition exacerbate. Activity modelling for work stream 2 has been based on a model developed by a CCG in the South of England utilising evidence derived from the Strategy Unit and Kings Fund work on community interventions. This data has been sense checked against available local data and audits. The information has been based on SUS data and has been stratified by Point of Delivery and by complexity. Further work has then been carried out to split this activity down to HRG level and exclude appropriate HRG chapters. The assumed impact on activity is summarised in below:

Opportunity	*End of life* (based on patients who died in hospital)	*GP Management* (Patients with Long Term Conditions)	*Multi-Disciplinary Team* (Complex Patients)	All Other Patients
Community Urgent Response (Admission Avoidance)				
STARRS (patient attendances with no procedure)	25%	25%	25%	25%
Ambulatory Care Sensitive Conditions	70%	70%	70%	70%
Ambulatory Care Sensitive Conditions (Zero Length of Stay)	70%	70%	70%	70%
Non Elective admission (Zero length of stay)	30%	30%	30%	30%
Neighbourhood Teams (Care planning)				
Cohort based	15%	5%	18%	

Table 25: Admission avoided through "Community Urgent Response"

Further work has also been completed on the frailty pathway. A frail elderly algorithm has been developed and shows that a focus on frailty provision would have the potential to contribute to at least 66% of the total reduction in demand on acute services required to support the Future Fit Acute Reconfiguration capacity modelling.

As implementation of the programme progresses, the modelling will be further refined. The specific interventions will be assessed for the effect on hospital activity. The actual outcomes will be compared to plans and the design of the services changed accordingly. This more detailed work has begun in hypertension, respiratory and some of the mental health related initiatives.

• Cost of Reinvestment in Neighbourhoods

Work undertaken by the Kings Fund and Monitor indicate that the development of new community services will require investment of up to 80% of the savings made from the acute setting. Telford and Wrekin already have a wide range of community delivered services so it is assumed that there will be economies of scale delivered. The modelling has therefore assumed an overall reinvestment level of 70%.

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10.2.2 Shropshire

By 2021/22 the CCG plans to have reduced non-elective admissions by 2,689 spells. The reduction projections are based on the achievement of 80% of the avoidable admissions that present with conditions that can "usually" be managed in a community setting, and 50% of the avoidable admissions that present with conditions that "sometimes" can be managed in community settings.

Further detailed work on the phasing of these savings will be required as project plans develop but based on current information, outline assumptions are as follows:

	17/18	18/19	19/20	20/21	21/22	Total
Frailty Front Door		558				*558*
Risk Profiling and Case Management Approach			875	876	380	*2,131*
SCCG Total	**0**	**558**	**875**	**876**	**380**	***2,689***

Table 26: Shropshire Activity Reduction Assumptions

A breakdown of the projected activity and bed day outcomes is tabled below:

	Year 5 Total Reduction	
Acute Specialty	**Non Elective Admissions**	**Bed Days**
General Surgery	106	742
Urology	49	294
Colorectal Surgery	2	44
Vascular Surgery	30	360
Trauma & Orthopaedics	15	135
ENT	6	72
A&E	29	174
General Medicine	1,803	14,424
Gastroenterology	30	450
Endocrinology	15	360
Clinical Haematology	17	136
Rehab	9	504
Cardiology	166	1,660
Stroke Medicine	25	325
Respiratory Medicine	298	2,980
Nephrology	28	420
Medical Oncology	12	48
Geriatric Medicine	27	513
Gynaecology	13	13
Clinical Oncology (previously Radiotherapy)	9	63
	2,689	**23,717**

Table 27: Emergency Admissions & Bed days (Shropshire Patients only)

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The diagnosis breakdown is charted below by the “usually” and “sometimes” categories as follows:

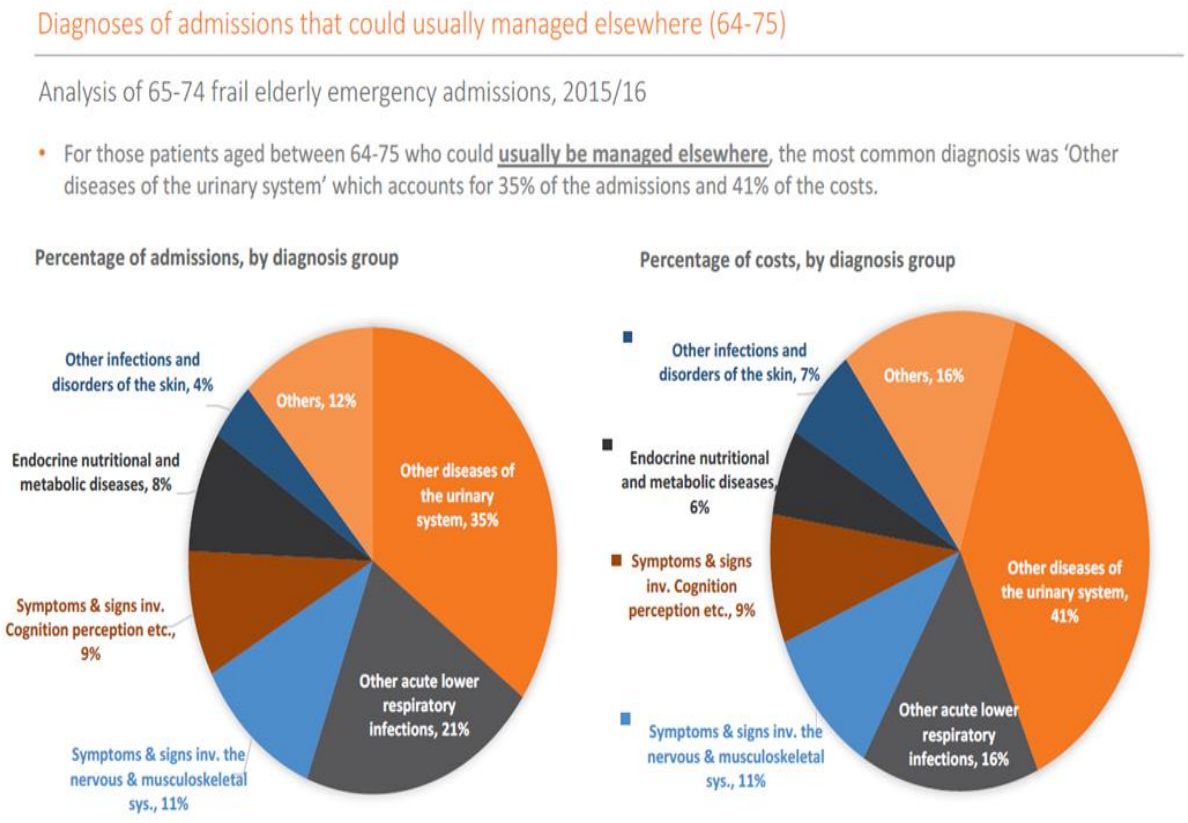


Figure 16: Diagnosis of admissions that could be managed elsewhere (64 -75)

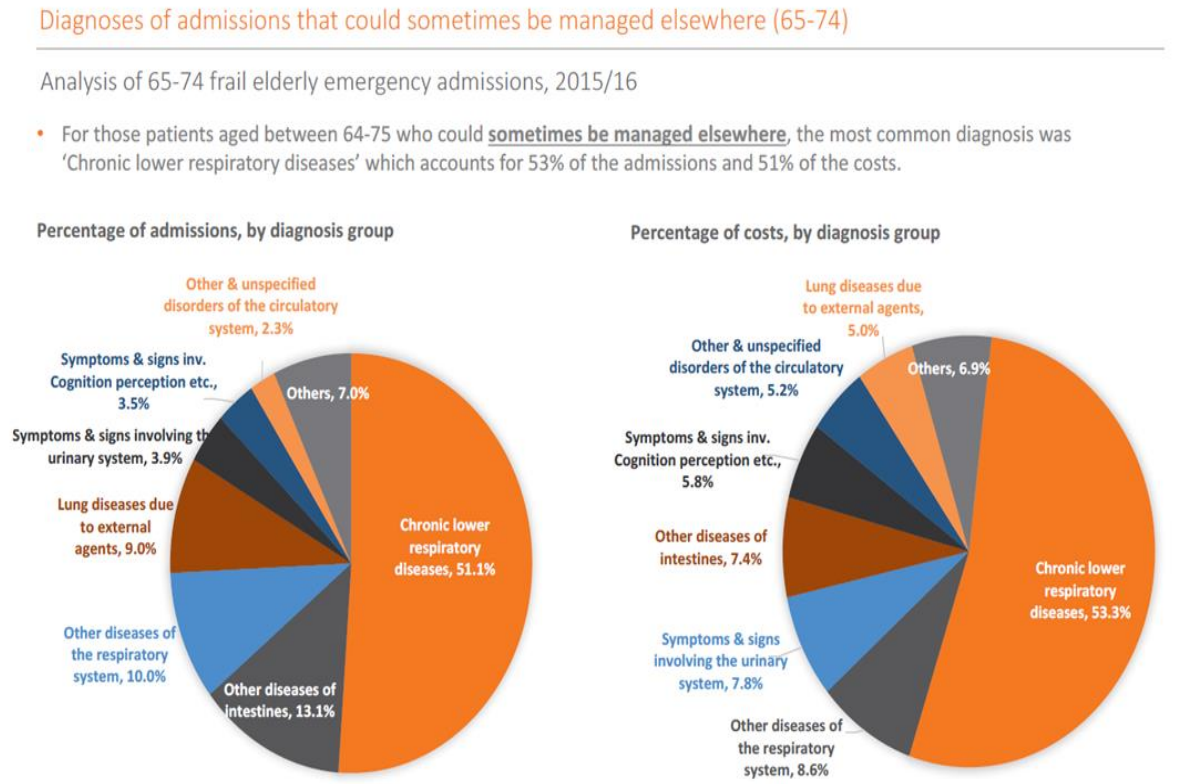


Figure 17: Analysis of the 65-74 frail elderly emergency admission 2015/2016

- Key Assumptions used in Modelling

The CCG's Long Term Financial model (LTFM) builds a picture of its finances for future years by taking a start point position of the current year's forecast outturn and applying assumptions about growth (demographic and non-demographic); other known cost pressures, and a level of QIPP savings that ensure that the organisation moves out of in-year financial deficit over the planning period.

The LTFM includes all aspects of the CCG's spend and, therefore, reflects the impact of the system changes required to support the out of hospital model. Activity in the CCG's LTFM is assumed to grow year on year as a result of both demographic and demand factors. Our modelling includes estimated non-elective admission growth as follows:

Year 0	2017/18	2.60%	STP Jan 17
Year 1	2018/19	2.90%	
Year 2	2019/20	2.60%	
Year 3	2020/21	2.70%	
Year 4	2021/22	2.80%	CCG local assumption
Year 5	2022/23	2.80%	

Table 28: Shropshire CCG Assumptions on growth

As detailed above, our work has indicated that we can achieve a 2,689 reduction in non-elective spells by the end of 2021/22; this is after taking account of these anticipated levels of growth in activity. The LTFM incorporates the impact of the reduction in non-elective spells on the SATH contract plus an assumed level of investment required in community based services to achieve this.

The Kings Fund and Monitor suggest that when developing new community services an investment requirement of up to 80% of the savings generated from the acute setting are required. The CCG has taken a prudent view in its modelling at this stage and set aside funding for the full 80% (£5.4m). It is noted however that there may be some duplication here with existing services and growth assumptions. This will be explored further and figures refined as the business case develops.

- Profiled Overall Activity Impact of CCG Community Interventions

Table 29 below demonstrates the total impact of community interventions on non-elective activity and bed days between 2017/18 and 2021/22.

	17/18	**18/19**	**19/20**	**20/21**	**21/22**	**Total**
Telford and Wrekin CCG						
Wound Care	30	540	330			*900*
New Diabetes Model of Care		4	24			*28*
Hypertension ID and management	9	34	34	34		*111*
Enhancing Respiratory pathways	32	43				*75*
'Development of One Team'	44	40	40	411	438	*973*
Care Home Support	56	222				*278*
TWCCG Total	**171**	**883**	**428**	**445**	**438**	***2,365***
Shropshire CCG						
Frailty Front Door		558				*558*
Risk Profiling and Case Management Approach			875	876	380	*2,131*
SCCG Total	**0**	**558**	**875**	**876**	**380**	***2,689***

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Overall Total	**171**	**1,441**	**1,303**	**1,321**	**818**	***5,054***

	17/18	18/19	19/20	20/21	21/22	Total
Telford and Wrekin CCG	869	4,488	2,109	2,262	2,293	**12,021**
Shropshire CCG		4,911	7,734	7,740	3,332	**23,717**
Overall Total	**869**	**9,399**	**9,843**	**10,002**	**5,625**	**35,738**

Table 29: CCG Community Scheme Specific Impact on Non Elective Inpatients and Bed Days

For Telford & Wrekin CCG, the development of 'Neighbourhood teams' is the aspiration for the second workstream of the Neighbourhood Working programme across Telford & Wrekin.

Implementation has already begun in diabetes care, respiratory and hypertension. Clinical outcomes are already improving and as further improvements are made these are expected to translate into a reduction of emergency admissions from 2017/18 through to 18/19.

A business case has been agreed within the CCG and recruitment is underway for a multi-disciplinary care home team. This will be complemented by a revised model of medical support from GPs. A small team will begin to deliver from January 2018 which will grow with the service fully operational and seeing the full benefits of reduced non electives by April 2019.

A business case to introduce a dedicated wound care service is being considered by the CCG during 2017, with mobilisation from January 2018. The opportunities will be realised over a period of 2.5 years.

The development of 'one team' will bring together virtual teams across local authority, practices and community. This will be supported by initiatives including social prescribing, intermediate care and case management. Roll out will be gradual and the full benefit expected in year 5.

For Shropshire CCG the development of the community model of care is expected to deliver a 2689 reduction in non-elective spells to the period 2021/22.

In 2018/19 the remaining effect of the Frailty Front door project will deliver 558 avoided admissions. During the same period the CCG will be developing its case management offering to primary care with additional community nursing capacity for care planning. For 2019/20 the CCG is committed to delivering a 10% reduction in the current level of emergency admissions in the over 65 population who have 1-3 long -term conditions with a further 10% expected to be avoided in the following year as the case management and community nurse support for care planning is rolled out.

The social prescribing demonstrator in Oswestry, the community pilot being tested in Bishops Castle and the Frailty Front Door initiative are suggestive of improvements in admission avoidance that will inform the further roll-out across the localities.

Work has been undertaken by practices to establish the cohort of patients that would benefit from a case management approach to ensure where appropriate these patients are managed within their place of residence using place based care.

- Reconciliation of Community Interventions Impact on Trust Activity

Table 30 provides a profiled analysis of the impact on Trust activity.

	17/18	18/19	19/20	20/21	21/22	Total
Non Electives	(171)	(1,441)	(1,303)	(1,321)	(818)	(5,054)

Table 30: Impact of CCG community intervention profile on Acute Trust activity forecast

The impact of these reductions on the overall non elective activity forecast is summarised in the table below. The opening baseline for 2017/18 has been restated to reflect the 2016/17 outturn. The impact of the community model has been developed and articulated below only up to 2021/22. As described above, the reason for this is that the community modelling indicates that the required reduction in demand on the acute services as a result of the new community models of care will have been achieved by 2021/22.

	17/18	18/19	19/20	20/21	21/22	22/23	23/24	Total
Opening Non Elective Baseline	58,946	60,425	60,681	61,122	61,594	62,620	64,515	
Demography	1,650	1,697	1,744	1,793	1,843	1,895	1,948	12,570
Impact of Schemes	(171)	(1,441)	(1,303)	(1,321)	(818)	0	0	(5,054)
Outturn	60,425	60,681	61,122	61,594	62,620	64,515	66,462	

Table 31: Profile of total non elective activity

10.2.3 Ambulance

The CCGs have a strong track record of working in partnership with West Midlands Ambulance Services, a collaboration which, for example, shows one of the lowest conveyance rates in the West Midlands. As part of Future Fit and as suggested by the Clinical Senate, after considering the issue with the Ambulance Trust, the CCGs are commissioning an independent modelling exercise to explore the potential impact of service changes on ambulance activity. The exercise will take account of:

- The service re-configuration options
- The impact of Ambulance Response Programme (ARP) on ambulance activity and response times
- Local initiatives to reduce and manage conveyance rates
- Assumptions about the ambulance disposition rate arising from NHS111 and any other demand sources

Key outputs from the modelling will be:-

- An understanding of the impact on the ambulance services of the differing service options
- A sensitivity analysis around the various assumptions to determine which factors provide the greatest source of variation
- Overall impact on the ambulance services in respects of:
- changes in the level of activity
- impact on net travel time
- net impact on resource requirements for a given level of response time

The initial outputs of the modelling will be shared with the ambulance services for comment around the planning assumptions and the nature of the expected impacts on the ambulance services. A final set of outputs from the modelling work will be presented to the CCGs for sign off prior to the end of the consultation period in 2018.

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11 Options Development and Appraisal

11.1 Options Development

Since June 2014, the Future Fit Programme has been engaged in a process of identifying and developing the potential deliver solutions for how the approved Clinical Model could be implemented. This section sets out how the Programme concluded that of two options deliverable in clinical and financial terms, option C1 is deemed the preferred option.

An initial list of more than forty scenarios was refined into a long list of thirteen, from which a shortlist of six options with two obstetric variants was identified. Following more detailed work on each option/variant, the Programme Board concluded that those involving any 'new site' component should be excluded from further consideration on the grounds of being unaffordable.

A previous appraisal exercise was undertaken on the remaining shortlist of options in September 2015. As the results were being considered it became evident that proposals could not go forward to public consultation until the deficit in the local health economy had been addressed. As a result, the Programme Board asked the Acute Trust to set out how it could address its most pressing workforce challenges whilst parallel work was initiated to address the deficit (work since taken up by the STP programme).

The work requested from the Acute Trust by the Programme Board led to the development of revised delivery solutions for each of the programme's configuration options. Those solutions offer a much more balanced split of activity between the sites with a 60/40 split of beds between the Emergency Centre site (EC) and the Planned Care (DTC) site.

These options include provision for local urgent care, diagnostics and outpatients in both Shrewsbury and Telford. The programme continues to explore the potential for local urgent and planned care in rural areas but that is outside the scope of these proposals.

11.2 Options Appraisal Process

The appraisal process in both 2015 and 2016 consisted of three parts and these are each briefly described below. It was endorsed by the Future Fit Programme Board in April 2015 and confirmed (with some minor enhancements) in April 2016. It reflects the guidance set out in the DH Capital Investment Manual and HM Treasury's *The Green Book: Appraisal and Evaluation in Central Government.*

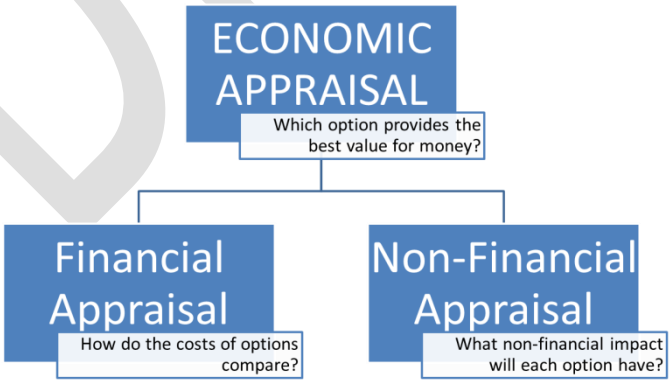


Figure 18: Options appraisal process

11.2.1 Financial Appraisal

At the shortlisting stage there was an overarching affordability criterion which reflected the relatively high level information that was available at that point. That criterion has now been subsumed into the financial appraisal undertaken by the Technical Team using data provided by the Acute Trust.

The financial appraisal covers capital, lifecycle and revenue costs, and is summarised in terms of:

- Net Present Cost (NPC) - the total future costs of the project over a number of years expressed in terms of today's prices,
- Equivalent Annual Cost (EAC) - the average annual impact at today's prices.

The analysis considers periods of both 30 years and 60 years.

11.2.2 Non-Financial Appraisal

The remaining criteria from the shortlisting process– accessibility, quality, workforce and deliverability – provide the framework for this appraisal.

Full descriptions of the options were developed which addressed all four criteria. The criteria were weighted for importance.

11.2.3 Economic Appraisal

This final appraisal combines the outputs of the financial and non-financial appraisals in order to assess the overall value for money offered by each option.

11.3Options

Initially, over 40 ideas were developed by an evaluation panel for how the programme's clinical model could be delivered. This panel then grouped these ideas into 13 scenarios.

At shortlisting, the panel appraised those scenarios and made a recommendation to Programme Board which reflected the five options which had scored most highly. The Board accepted this recommendation and, in addition:-

- Accepted that the 'do minimum' also needed to be included on the shortlist as required by national guidance; and
- Agreed that two 'obstetric variants' should also remain under consideration pending further clarity being gained about the relative location of consultant-led obstetrics services and the proposed Emergency Centre.

The resultant eight options were then developed in terms of physical solutions and associated revenue and capital costs.

At its meeting in August 2015, the Board was advised that:

a) The options involving a new site (D, E1, E2, F) were not affordable, and;

b) The remaining options (B, C1, and C2) were potentially affordable in that they would cover their own costs and contribute to SATH's underlying financial position.

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The Programme Board therefore agreed to recommend to Sponsor Boards that the new site options be excluded from further consideration. At the same time, work was undertaken to test previously excluded options. Board accepted the conclusion that the result of the shortlisting process had been robust.

As a result, the revised shortlist was reduced to four options. This recommendation has been approved by all Sponsor Boards, and it is these remaining options (summarised below) which this report addresses. An appraisal was conducted in September 2015 but the Programme was unable to move forward at that point due the wider financial position in the local health economy.

As a result, the Acute Trust was asked to develop solutions which addressed its most pressing workforce challenges, and to do so within the resource available locally. This 2016 appraisal addresses the same four options but has considered them in terms of the revised delivery solutions developed by the Acute Trust.

Based on the required configuration of services, shortlist options have been worked up in more detail as follows:

	Princess Royal Hospital	Royal Shrewsbury Hospital
A	**No change**	**No change**
B	EC – UCC – LPC – W&C	PC – UCC – LPC
C1	PC – UCC – LPC	EC – UCC – LPC – W&C
C2	PC – UCC – LPC – W&C	EC – UCC – LPC
	EC – Emergency Centre UCC – Urgent Care Centre W&C – Women & Children's Services	PC – Planned Care Site LPC – Local Planned Care

Figure 19: Detailed shortlist options

11.4 Appraisal Panel

The Programme Board agreed in 2015 that the non-financial appraisal should be undertaken by a larger group than used for the shortlisting to enable a wider and more balanced representation. It maintained the approach of asking for nominations from those bodies which are sponsor or stakeholder members of the Programme (except those conflicted by a subsequent scrutiny role). However, instead of a single member from each organisation, the following distribution was agreed. This reflected a request from the Core Group that sponsor members should have a greater representation than stakeholder members and that, given that the focus of the appraisal is exclusively on acute options, there should be additional representation from the Acute Trust.

The full panel was convened on 23rd September 2016 at Shrewsbury Town Football Club, and fifty members were in attendance, along with technical advisors, members of the programme team and observers from the Joint HOSC and Powys Community Health Council.

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11.5 Evidence to support the Options Appraisal

The panel was supplied with evidence which addressed the four non-financial criteria. This was supplied to the panel in advance of the appraisal (both electronically and in hard copy), and presentations of the evidence were made on the day. Substantial time was also set aside to enable panel members to seek clarification about the evidence provided. The Non-Financial Appraisal Evidence Pack is provided at Appendix 12.

11.5.1 Accessibility

The travel time analysis for this criterion was based on actual activity levels at the Acute Trust during 2015-16. This enabled an assessment to be made of the travel time from each full postcode to each hospital site. It models the impact of each option in terms of that historic activity, to show what the impact would have been were the configurations described in each option to have been in place.

11.5.2 Quality

There were two main components in relation to the quality criterion. The first concerned the impact of the options on time critical journeys to EC; the second summarised the impact of each option on the three quality domains of safety, effectiveness and patient experience.

11.5.3 Workforce

Clinical workforce shortages are an increasingly critical element of the programme's case for change. The impact of these shortages were set out in relation to Option A. For the other options, the potential of each option to improve recruitment and retention was summarised.

11.5.4 Deliverability

For this criterion, the estates work required to deliver each option was summarised, drawing on work undertaken by external technical advisors. Outline plans and timescales were presented to the panel workshop.

Beyond physical deliverability, there are also differential issues in terms of the acceptability of each option to the public and other stakeholders, with supporting evidence from a stratified telephone survey.

11.6 Weighting Criteria

The panel was asked to assign a relative weighting to each criterion. To inform this, the panel was presented with the weightings agreed in the shortlisting process and in the 2015 appraisal, and with a weighting derived from the public telephone survey. Panel members agreed to use the same weighting used in the 2015 appraisal:

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Evaluation Criteria	*Shortlisting 2015*	*Appraisal 2015*	*Public Survey 2015*	*Public Survey 2016*	agreed weighting
ACCESSIBILITY	29.0% (2)	25.1% (3)	26.4% (2)	25.8% (3)	**25.1%**
QUALITY	32.3% (1)	31.2% (1)	27.5% (1)	27.1% (1)	**31.2%**
WORKFORCE	27.4% (3)	27.3% (2)	26.4% (2)	27.0% (2)	**27.3%**
DELIVERABILITY	11.3% (4)	16.3% (4)	19.7% (4)	20.1% (4)	**16.3%**
					100.0%

Table 32: Agreed non-financial weightings

11.7 Scoring Options

Panel members were asked to score each of the four options against each of the four criteria using a range of 1-7, where a higher number indicated a stronger performance against a criterion. Following discussion, panel members were given the opportunity to revise any of their scores if they wished to.

11.8 Non-Financial Appraisal Results

The following table summarises the results of the non-financial appraisal. Detailed results can be found in Appendix 12.

TOTALS	*Agreed Weighting*	Total Weighted Scores			
		Option A	Option B	Option C1	Option C2
ACCESSIBILITY	*25.1%*	59.8	45.2	65.1	47.7
QUALITY	*31.2%*	39.0	65.0	91.5	24.7
WORKFORCE	*27.3%*	26.0	67.0	76.8	26.2
DELIVERABILITY	*16.3%*	19.6	40.5	42.4	22.2
	100.0%	**144.4**	**217.6**	**275.8**	**120.8**
	RANK	**3**	**2**	**1**	**4**
	DIFFERENCE	*47.7%*	*21.1%*	*0.0%*	*56.2%*

Table 33: Summary of non-financial scores

A number of sensitivity analyses were undertaken to test the validity of the results. This included breaking down weighted scores in terms of the following groupings:

- Clinicians and non-clinicians (where the former includes social care and public health professionals);
- Geographic groupings (those whose organisations are solely focused on Shropshire, Telford & Wrekin or Powys plus other non-geographic organisations), and
- The type of body represented (commissioners, the Acute Trust, other providers and public or patient representatives which included Local Authority representatives).

The results of the sensitivity analysis were as follows:-

a) Weightings

i) Applying equal weightings to all criteria resulted in the same ranking though with a slightly reduced margin of 19.4% between C1 and B.

ii) Applying the weightings derived from the public telephone survey also resulted in the same ranking though with a reduced margin of 20.2% between C1 and B.

iii) Since C1 outperformed B against all criteria, no change in the weightings could switch the ranking. If the only criterion was Deliverability (a test applied in the previous appraisal) awarding a 100% weighting to deliverability would therefore still result in C1 coming first, albeit by a reduced margin of 4.6%.

b) Scoring

i) The most significant difference in scoring between the leading options relates to the accessibility and quality criteria under which C1 scored 43.9% and 40.9%, respectively, higher than B.

ii) Adding in scores for the Shropshire patient representative who had to leave early (using the average of other Shropshire patient representatives) very marginally increases C1's leading margin to 21.2%.

iii) Adding in scores for the missing GP Federation representative (using the average of other GP panel members) very marginally reduces C1's leading margin to 21.0%.

iv) C2 scored lowest across all groupings, followed by A (except in the case of Powys members where A was ranked 2nd and B 3rd).

v) If the only scores counted are those of the CCG representatives, the outcome switches with B leading C1 by a margin of 5.2%.

vi) If options are assessed in terms of the maximum scores awarded against each criterion, B and C1 come equal 1st.

vii) If options are assessed in terms of the minimum scores awarded against each criterion, C1 comes 1st by a very substantial margin, indicating that the panel regarded it as the 'least worst' option as well as the best.

viii) Finally, to test the impact of extreme scores, scores of zero and 1 were raised to 2 and scores of 7 were reduced to 6. Again, no change of ranking resulted, although C1's margin reduced to 16.8%

c) Change from 2015 Appraisal

i) Option A scored higher than before against all criteria (Access +2, Quality +26, Workforce +16, Deliverability +2);

ii) Option B scored lower on Access (-8), Quality (-35) and Workforce (-8) but higher on Deliverability (+22.5);

iii) Option C1 scored higher on all criteria (Access +12, Quality +17, Workforce +17, Deliverability +34.5);

iv) Option C2 scored lower across the board (except from Powys scorers) and replaced Option A as the lowest scoring option;

v) The increased differential between Option C1 and Option B was most evident in the scores of representatives from provider organisations and those with no explicit geographical affiliation but -

a. Telford and Wrekin scorers also increased their scores for both B and C1 (and more so for C1 than for B),
b. Shropshire scorers decreased their scores for both B and C1 (to a comparable degree), and
c. Powys scorers increased their scores for both B and C1 (and more so for B than for C1).

The 2015 appraisal, in recording the same preference for C1 over other options, noted that the panel appeared to have a concern about increasing the disadvantage of those who already have to travel further, especially for emergency care.

In the present appraisal, it was further noted that some of the disadvantages of the change options (B, C1 and C2) had been mitigated through the more balance site model offered in the revised delivery solutions.

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The significant change in scoring for C2, resulting in it moving from 3rd to 4th ranking, reflects the new clinical evidence that had become available since last year, therefore precluding on clinical grounds the potential for women and children's services to remain at PRH under where the preferred site for EC is RSH.

11.9 Financial Appraisal

The shortlisted options have been fully evaluated in line with the requirements of Department of Health Business Case Guidance and the HM Treasury *Green Book* to assess which option represents potentially the best value for money (VfM).

The economic analysis thus:

- Covers an appraisal period that ensures a full 60-year operational use of new facilities is reflected, using a discount rate of 3.5%;
- Excludes VAT from all cash flows;
- Reflects capital cash flows at current cost levels calculated by discounting outturn cash flows by 2.5% GDP deflator;
- Makes provision where appropriate for a residual asset value to be included at the end of the appraisal period;
- No provision is made for any potential Opportunity Costs;
- Includes lifecycle costs for building and engineering elements based on standard NHS asset lives and replacement cycles, and lifecycle of equipment, with replacement occurring between 5-15 years depending upon the classification of the asset;
- Incorporates cash flows for all revenue costs;
- A quantified assessment of risk has not been undertaken;
- Assumes a price base of 2016/17.

All these cost inputs have been modelled to establish, for each option:

- The Net Present Cost (NPC) of the discounted annual cash flows over the whole appraisal period;
- The Equivalent Annual Cost (EAC), being an annualised equivalent of the NPC.

11.10 Cost Inputs

11.10.1 Capital

A capital cost assessment of the short listed options has been undertaken by Rider Hunt based on NHS Departmental Cost Allowances (DCAGs), applied to the proposed schedules of accommodation.

The costing has been undertaken in accordance with Department of Health guidance for the costing of capital schemes. Separate costs forms have been produced for the individual sites and options with levels of optimism bias, VAT recovery and inflation assessed individually to provide more realistic costings.

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Costs	Option A	Option B	Option C1	Option C2
	£000s	£000s	£000s	£000s
Works		123,554	153,837	145,450
Fees		16,062	19,999	18,908
Non-Works		400	400	400
Equipment		12,867	14,797	13,862
Contingencies		12,355	15,384	14,545
Optimism Bias		28,090	36,795	34,770
VAT		34,048	42,668	40,335
Total at PUBSEC 195 Reporting Level		227,376	283,878	268,270
Total at Outturn (at PUBSEC 214)		**249,613**	**311,636**	**294,497**

Table 34: Capital cost options

Key assumptions are:

- The completion on site of each option has been separately identified;
- The Cost Index at Reporting Level is defined by the Department of Health to provide a consistent means of comparison between different projects: the current PUBSEC Index level is 195 with the costs being updated to the latest index, PUBSEC 214;
- Formal indices are no longer published in respect of equipment costs therefore, the costs are based on relative percentage requirements within new build, refurbishments and backlog areas;
- Professional fees have been included at 13% across all options;
- Planning Contingencies have been incorporated at 10% across all options;
- Optimism Bias has been calculated utilising HM Treasury's and Department of Health standard template and the percentage additions reflect the relative nature of each project. For each option the optimism bias has been assessed for each site separately to make it more appropriate to the works within each site;
- VAT is potentially recoverable on all construction projects and is generally related to the amount of refurbishment work but can also be recoverable against some elements of new build. For all options, recovery has been included at 100% against all fees and this is shown in the cost forms as zero VAT in accordance with the standard NHS forms.

11.10.2 Revenue

Baseline 2016/17 revenue costs and forecasts for each option have been provided by the Acute Trust as part of the analysis supporting the affordability assessment. The economic appraisal uses these figures, with the exception of the provision for inflation, in order to provide a consistent 2016/17 price base. Capital charges are also excluded from the VfM analysis.

Baseline revenue costs for 2016/17 are shown below.

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Expenditure	Revenue Expenditure £000s
Pay	233,691
Non Pay	102,699
Total VfM	**336,390**

Table 35: Baseline Revenue Costs 2016/17

Table below provides a summary of the assessed cost changes expected by 2020/21 under each of the options.

Sustainable services project changes represent:

- Additional staffing (£4.6m under Option A only);
- Workforce reductions comprise of three separate elements, new ways of working and new roles, efficiencies and savings directly related to service change and pathway redesign
- Further reductions in workforce relate to activity changes, duplicate costs and IT;
- Savings are site and option specific;
- Within the development options, there is a net savings range of some £3.2m, between Option C2 (lowest) at £11.4m and Option B (highest) at £14.6m.

(Savings)/Costs	Option A £000s	Option B £000s	Option C1 £000s	Option C2 £000s
Sustainable Services Project Savings	4,600	(14,589)	(14,203)	(11,377)

Table 36: Revenue Cost (Savings) – in 2020/21 at 2016/17 price base

11.10.3 Opportunity Costs and Residual Values

No specific provision has been made for Opportunity Costs since:

- Full lifecycle provision has been made for all facilities including elements refurbished on a light touch basis and those simply retained as they are, as well as New Build and Major Refurbished facilities.
- In respect of Residual Values, provision reflects the assumption that New Build and Major refurbished elements will be maintained to their as built standard and therefore the residual value remains.

11.11 Financial Analysis Outputs

11.11.1 Summary of VfM Analysis – 60 Year Appraisal Period

The economic costs of the proposed options over a 60 year appraisal period is set out in Table 37 below.

	Do nothing	Option B	Option C1	Option C2
	£000s	£000s	£000s	£000s
Net Present Cost	9,356,590	8,555,517	8,659,431	8,705,510
Equivalent Annual Cost	351,473	321,381	324,070	325,794
Economic Value	4	1	2	3

Marginal EAC over 1st Ranked	30,092	0	2,689	4,413
% over Option First Ranked	9.4%	0.0%	0.8%	1.4%

Table 37: Economic Costs of Options - 60 year appraisal period

In Capital and Revenue elements:41 below provides a summary of the marginal EAC of each option, over that for Option B, split between Capital and Revenue elements:

Option	Rank	Capital EAC Variance £000s	Revenue EAC Variance £000s	Total EAC Variance £000s
Option C1	2	2,374	315	2,689
Option C2	3	1,674	2,739	4,413
Option A	0	(10,413)	40,505	30,092

Table 38: Summary of EAC Variance over Option B

From the analysis that has been undertaken it is evident that, in economic terms:

1 The cost of each of the development options (excluding Option A) falls within a relatively tight band range of just 1.4%;

2 Option B is preferred by a margin of 0.8% (EAC £2.689m) over Option C1;

3 The Do Nothing (Option A) is least preferred, by a margin of 9.4% (EAC £30.092m).

11.11.2 Sensitivity Analysis – Appraisal Period

In order to test the robustness of the economic analysis, an appraisal has also been undertaken to assess the VfM position over a 30-year appraisal period.

Cost inputs and assumptions mirror those detailed above with the exception of Residual Value, where it is assumed that 50% of the value of new/major refurbished facilities would be retained at the end of the 30-year period.

	Do nothing	Option B1	Option C1	Option C2
	£000s	£000s	£000s	£000s
Net Present Cost	7,478,605	6,889,470	7,039,144	7,072,871
Equivalent Annual Cost	351,265	323,594	326,332	327,895
Economic Value	4	1	2	3
Marginal EAC over 1st Ranked	27,671	0	2,738	4,301
% over Option First Ranked	8.6%	0.0%	0.8%	1.3%

Table 39: Economic Costs of Options – 30 Year Appraisal Period

This analysis confirms that under a shorter appraisal period:

- Whilst there is less net annual revenue cost impact under Option A, it remains least preferred by a margin of 8.6%;
- Option B again remains preferred by a margin of 0.8%;

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11.11.3 Sensitivity Analysis – Income and Expenditure

A sensitivity analysis has been undertaken relating to demography, QIPP, CIP, repatriation and sustainable services workforce reductions. It has compared initial assumptions and the percentage move required for there to be an impact on affordability on each option.

Element of Sensitivity	Assumptions within Model	Option B1	Option C1	Option C2
Demography	2% pa	58%	85%	89%
QIPP	Net QIPP Loss £10.5m over 4 years	168%	125%	118%
CIP	£31.0m over 4 years (2.1%)	77%	92%	94%
Repatriation	Net gain of £6.0m over 4 years	-19%	57%	68%
SSP Workforce	Option B1 Saving of £14.4m Option C1 Saving of £14.2m Option C1 Saving of £11.4m	66%	88%	89%

Table 40: Sensitivity analysis

11.12 Financial Conclusions

On the basis of the analysis undertaken:

- Option B is preferred from a financial perspective on the basis of the figures provided;
- The VfM margin between all the development options is relatively close with the exception of option A.

Two alternative methods have been used to combine the results of the Non-Financial and Financial Appraisals in order to test for robustness:

- Cost per Benefit Point;
- Weighted for Financial / Non-Financial Factors.

The results are as follows:

	Option A	Option B	Option C1	Option C2
Total Weighted Non-Financial Score	144.38	217.6	275.79	120.83
Benefits Margin below 1st	-47.7%	-21.1%	0.0%	-56.2%
Benefits Rank	**3**	**2**	**1**	**4**
Total EAC (£m)	351,473	321,381	324,070	325,794
Financial Margin above 1st	9.4%	0.0%	0.8%	1.4%
Financial Rank	**4**	**1**	**2**	**3**
Cost per Benefit Point (£)	2,434.40	1,476.92	1,175.04	2696.20
Overall Margin below 1st	107.2%	25.7%	0.0%	129.5%
Overall Rank	**3**	**2**	**1**	**4**
Combined Scores (50:50)	71.9	89.5	99.6	71.2
Overall Margin below 1st	-27.8%	-10.2%	0.0%	-28.5%
Overall Rank	**3**	**2**	**1**	**4**

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Table 41: Overall Economic Results

No material change in the results is caused by the application of the variant weightings from the non-financial appraisal.

A further sensitivity analysis has been undertaken to examine what weighting would need to be applied to the Non-Financial / Financial Results in order for Option B (the second ranked Option overall) to be preferred in Overall Terms to Option C1. This shows that, in order for the combined scores of Options B and C1 to be the same, the relative weightings for financial and non-financial analyses would need to be set at 96.2% and 3.8%, respectively.

11.13 The Preferred Option

The Future Fit Programme Board met on 30th November 2016 and considered the evidence available to it in order to reach a decision and recommendation to the Joint Committee of the CCGs about which options should be taken to public consultation and which option was the 'preferred option'. There were a number of elements to this evidence, shown below:

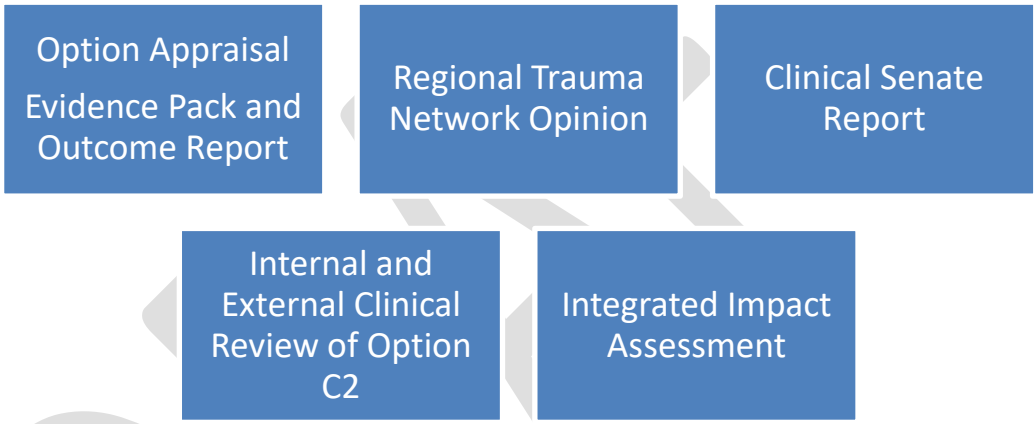


Figure 20: Key evidence considered at the Programme Board in November 2016

11.13.1 Two Clinically and Financially Deliverable Options

There has been a very robust and comprehensive process of evaluating the options and concluding a preferred option through the option appraisal process as described in this section earlier. This has also been independently reviewed by KPMG and deemed robust.

The Programme stakeholders and sponsors believe that there are two deliverable options that they wish to seek views on including any mitigation plans. Throughout the process of long list to shortlist, there has consistently been clinical consensus from all partner organisations that the Emergency Centre at either site are both deliverable options.

The Programme has commissioned the Consultation Institute (CI) to ensure that the consultation process is an accredited process and follows best practice. The CI advice is that the CCGs must consult on all options that are deemed financially and clinically viable. The process of consultation is to seek views on those options and their impacts on the population and any mitigating actions that might need to be considered were they to be implemented. This information can then support final decision making by the CCGs and the development of the final decision making business case.

The WM regional Senate Review took place in October 2016. It made a series of 18 recommendations relevant to all options and supported the case for change and the clinical model: "The Panel was of the view that a clear and compelling case for change was made, based on sound evidence presented to it on current performance, improvements seen in other regions by reconfiguration of services with multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy"

They acknowledged, however, that the decisions the health economy are trying to make are difficult:

> *"We were made aware of the differing current and future demographics pulling maternity and paediatrics toward PRH where it is has recently been built but more elderly around Shrewsbury pulls in the opposite direction. Moving the Trauma unit and therefore other acute and time-dependent services from Shrewsbury might disadvantage residents of Powys but advantage residents of Telford.*
>
> *Decisions are difficult and trade-offs inevitable but the time has come to make them. After all, both sites will get considerable and needed capital investment."*

The Clinical Senate also supported the co-location of Obstetrics and Paediatrics with the Emergency Centre. The variant option of the Emergency Centre at Royal Shrewsbury Hospital but with Women and Children's remaining sited on the Planned Care site at Princess Royal Hospital was not deemed clinically viable. In light of this, local clinicians views and external independent review on this option, the Programme Board unanimously agreed in November 2016 that the co-location of inpatient Obstetrics and paediatrics had to be with the Emergency Centre. Option C2 was therefore excluded as a viable option.

Advice has also been sought from the Trauma Network. The view of the Network is that their preferred site for the Trauma Unit would be Shrewsbury. This reflected its geographical location and an increased risk for the small group of patients from Powys if it was sited at Telford. The Network however stated that Trauma Unit status could be considered for Telford in Option 2 (Option B) subject to the appropriate standards and specifications set out by the network are met.

It is the view of the Trauma Network that mitigation plans specific to the risks associated for some trauma patients with long journey times under Option 2, should be worked up with West Midlands Ambulance Service (WMAS), Welsh Ambulance Service (WAS) and the Emergency Medical Retrieval and Transport Team (EMRTS). This work has begun and will continue throughout the coming months.

In light of the Trauma Network's opinion, the Programme has ensured that due consideration is being given to the mitigation that would need to be considered in any potential relocation of the Trauma Unit from the Shrewsbury to the Telford site. Whilst ambulance providers recognise that Shrewsbury would be the preferred location for a Trauma Unit, based on access and journey times, for the small number of patients that might need to divert to a Trauma Unit for optimisation and stabilisation and who are not within an hour of a major Trauma Centre, there would be mitigating actions that could be put in place to reduce the risks were the preferred site to be Telford.:

- Increase in the use of air ambulance; review of dispatch protocols
- Extended flying time to night flights through more night approved landing sites
- Upskilling of workforce; enhanced availability of paramedics and pre hospital care protocols; potential technology advancements over next 3-4 years mobile diagnostics
- Increased access to trauma doctor and/or more critical care paramedics in transit
- Review location of strategically placed land vehicles
- Conveyance to nearest alternative TU: Chester, Hereford, Worcester, Wrexham, Wolverhampton

Many of these initiatives are to a degree being progressed now as part of separate ambulance service developments and will mitigate risks for critically ill and injured patients which ever option is finally implemented within Shropshire. In Wales, other reconfiguration programmes are driving the need for development and review of ambulance and air ambulance capacity.

The IIA reports have assessed potential impacts for different localities and for specific equality groups for each of the options. The IIA reports are the starting point to developing recommendations for how any negative impacts and effects could be mitigated and positive impacts and effects maximised.

In the first report that focused on acute care, in terms of overall health impacts, in either option under consideration, the main changes are expected to sustainably improve the effectiveness, safety and patients' experience of clinical care provided to the whole population. These projected positive overall health impacts achievable under both options are the most significant of all the impacts assessed. Some of these groups, for example the very young and the older population, may be disproportionately most likely to use the affected services, and therefore benefit the most from the projected positive health impacts.

Equally, however, in both options, it was identified that some may be disproportionately affected by the longer projected journey times from certain localities.

It is worth restating that the purpose of any impacts assessment is not to determine the decision about which option would be selected; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve. The IIA is a live resource that is intended to provide the basis for further assessment as the programme progresses through different stages. This includes the mitigation strategies which will continue to be refined during subsequent consultation.

The Programme governance has an established work stream that has oversight of the draft mitigation action plans that have emerged from the Impact Assessments. The membership of this group is representative of all stakeholder organisations, patient representatives and public health, primary and acute clinicians.

It is proposed to establish a clinical sub group to look specifically at further developing pre hospital care and inter hospital transfer mitigation plans for both options with WMAS, WAS and EMRTS as key membership. This group will report its findings to the Clinical Design Group and on to the Programme Board post consultation and prior to concluding the Decision Making Business Case.

The Programme acknowledges therefore that both options would require risk mitigation strategies and as described above outline plans are in place and these need to be fully developed over the period of consultation before a final decision is made post consultation. One of the purposes of consultation is to further develop those risk mitigation plans with all stakeholders on any of the impacts identified.

Through this process, all mitigation plans will form part of the key decision making papers at the Joint Committee of the CCGs in 2018.

Advice has been provided to the Programme that as Option A (no change) is not financially or clinically sustainable, it should not be consulted on as it cannot be delivered.

11.13.2 Recommendation of a Preferred Option

Following consideration of the evidence described above, the Programme Board made 4 recommendations to the Joint Committee in December 2016:-

1. Having regard to the internal and external clinical review evidence received, C2 be removed as an option for formal consultation on the basis that the expert clinical opinion is that it is undeliverable.

2. The Programme is ready to undertake a period of formal consultation on options A, B and C1.

3. The outcome of the options appraisal and other evidence received identifies that C1 is the preferred option and the formal consultation should be undertaken on this basis.

In addition it was acknowledged that the 2016 impact assessment focused primarily on only the impacts of acute service change and that there are elements of the Future Fit programme that have implications beyond acute services for other types of care such as women and children's. A number of stakeholders felt that the potential impacts of these also needed to be assessed. This was acknowledged by the Programme but not felt sufficient to stop a recommendation on a preferred option and that the further work could be done in parallel alongside wider consultation with the public and other stakeholders.

The Joint Committee met on 12th December 2016 and received the recommendations of the Programme Board together with the supporting evidence and the full Option Appraisal Report and Evidence Pack and the IIA Report in full. The recommendations did not achieve a majority vote with a split vote reflective of the differing position of the two CCGs.

As a result of this position, together with the recommendations from the Gateway Review 2016, agreement was reached to carry out two additional pieces of work prior to proceeding further:

1. An independent review of the process, scoring and methodology of the option appraisal, and;
2. An Integrated Impact Assessment on the potential move of some of Women's & Children's Services under C1 to the RSH.

The Future Fit Programme Board met on 31st July 2017 to receive and consider the outcome of the two additional reports. It concluded by consensus that there has been no material evidence presented in the Independent review of the Option Appraisal or in the W&C IIA Reports that should change the original four recommendations to the Joint Committee as set out in December 2016 and therefore they should be reaffirmed:

- Whilst 'do nothing' is not seen as a deliverable option, it needs to remain in business cases as the baseline. The narrative during consultation will explain why it has been discounted.
- Option C2 is not clinically deliverable and is therefore is not taken forward into formal public consultation as a deliverable option.
- Both Options B and C1 are deemed financially and clinically deliverable and will therefore form part of the public consultation process.
- Option C1 is taken into the consultation process as the preferred Option

The Joint Decision Making Committee of the Boards met on 10th August 2017 to receive these recommendations and unanimously approved all four and that the CCGs should proceed to consultation on this basis.

The Programme and all its sponsor and stakeholder organisations therefore unanimously support the decision to consult on both the preferred option, Option 1 the Emergency Centre and retaining the Trauma Unit at Shrewsbury and Option 2 the Emergency Centre and transfer of the Trauma Unit to Telford.

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12. Financial Case

12.1 Introduction

This section focuses on the financial costs and impact for the Future Fit Programme. In particular:

- The financial case for change;
- Anticipated levels of capital and revenue to fund the change;
- The costs, benefits and overall affordability of the public consultation topic being considered.

The full details of the acute hospital services reconfiguration programme financial plan, including organisational plans, is detailed in The OBC Appendix 7

12.2 The Financial Case for Change

12.2.1 The System as a Whole

Partners in the Shropshire, Telford and Wrekin STP recognise that the health economy needs to address a significant financial challenge over the next 5 years. Our health system currently includes one CCG with a significant deficit (both underlying and historic) and the main acute provider that is also reporting a deficit position. Further, as noted earlier in this case, our main community services provider is actively reviewing options for its future organisational form.

Further, we agree that the current model of care is no longer fit for purpose and therefore in order to develop safe and sustainable services for the population that we serve we have to do things differently. We have demonstrated through our work on the Future Fit agenda that to do nothing is not an option and there is agreement that we will only succeed if we take action collectively.

The challenges we face are similar to those being experienced across the country. Demand on services will continue to rise and, without service change, will outstrip the available funding, putting pressure on all services, especially hospitals, GP surgeries and social care. With a growing number of elderly people in our population, many having more than one long-term health condition, there is a need to reconfigure and transform services to make them both more effective and more efficient.

There is insufficient funding for us to continue as we are and we need to make changes to take full advantage of recent rapid progress in treatments and technology. The reconfiguration of acute hospital services forms part of the system plan to improve services for the local population. Allied to commissioner plans to redefine community based services in order to bring care closer to home, this provides a strong base from which sustainable and effective services will be built.

Our STP submission in October demonstrated that if the system takes no action to change, by 2021 there will be a collective deficit of around £130m. Coupled with what we know already about difficulties in recruiting staff to current role structures and the limitations of our infrastructure this is not a position that can be supported. The table below illustrates the impact of the STP's plans on this position. This includes plans for delivery of both the acute site reconfiguration and community redesign that are detailed in this case.

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	Commissioners	Providers	Total
Structural Deficit	(18.7)	(17.0)	(35.7)
Inflation/Demography cost pressures	(54.8)	(41.0)	(95.8)
Local Health System Deficit	(73.5)	(58.0)	(131.4)
QIPP savings LHE Providers	32.1	(32.1)	0.0
QIPP savings (other)	45.4	0.0	45.4
Provider Trust Efficiency Programme		45.2	45.2
Carter Review Savings		8.8	8.8
Transformation	4.0	(36.0)	(32.0)
Use of Transformation savings		6.5	6.5
Reconfiguration		15.1	15.1
Community Hospitals		3.8	3.8
Orthopaedic Rebasing		3.9	3.9
Repatriation		6.0	6.0
Rationalisation of services		4.0	4.0
External Transfer	1.5		1.5
	5.5	3.2	8.7

Table 42: System Position 4 year aggregate 17/18 to 20/21. (October '16 STP submission):

Figures align with the data used to inform the Acute Trust's outline business case for hospital reconfiguration. Plans submitted to inform the October 2016 position by all three local providers and Telford and Wrekin CCG were not materially altered on finalisation of organisation's plans in early 2017. It is acknowledged however that Shropshire CCG numbers have been updated and this could impact on the position reported above.

Whilst a full refresh of the STP financial plan is still to be completed (this will be conducted during Autumn 2017), modelling suggests that the changes made to the Shropshire CCG plans would not materially impact on the position presented above. If the current financial model figures are used, the 4 year aggregate commissioner surplus would fall to £2.5m resulting in a system surplus of £5.7m rather than the £8.7m reported in October. Hence it can be seen that the STP plan aims to deliver a significant change in respect of

redefining the model of care in the system whilst at the same time returning to an underlying recurrent balanced position.

12.2.2 Affordability

- Telford & Wrekin CCG

In 2017/18 T&W CCG has a cumulative surplus of £5.7m and an in-year control total of break even. At Month 3 the CCG has generated additional year to date surplus of £64k. Delivery of the financial position will be dependent on prudent financial management and QIPP delivery throughout the year.

The CCG's five year financial plan currently meets all of NHSE's business rules and delivers an in year break even position each year. However, in order to fund increases in activity, demography and service improvements the CCG will need to deliver recurrent QIPP plans in the region of £7m a year. The CCG financial and QIPP plans are aligned to the proposed activity shifts from acute to community.

- Shropshire CCG

Shropshire CCG has a 2017/18 in-year control total of £19.4m deficit. At the end of the year, the CCG will have accumulated a total deficit (including the £19.4m) of £52m. At Month 5 2017/18, the CCG is on target to deliver its financial control for 2017/18.

By 2020/21, the CCG is anticipating financial recovery that will enable it to deliver a small in year surplus and to maintain underlying financial stability. In order to achieve this, the QIPP challenge remains high; numbers each year are around 3.5% of total allocation (£16m). Repayment of the accumulated deficit will take a further decade.

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- The Shrewsbury and Telford Hospitals NHS Trust

The Trust's annual audited accounts for 2016/17 demonstrate that a deficit amounting to £5.6m was delivered, achieving its control total as set by its regulator NHS Improvement.

In developing the strategy for an affordable option, the Acute Trust has taken into account the following:

- Projections of income based on the Future Fit Phase 2 modelling including a forecast on demographic changes
- Efficiencies arising from the removal of duplicate rotas, reduction in Junior Doctor intensity payments, co-location of services and the cohorting of surgical specialities
- Increased facilities and ward costs associated with modern and national standards for new wards
- Application of inflation
- Net additional cost of capital
- Repatriation of activity currently being performed for local residents in organisations outside the local health economy
- Increase of tariff payments in line with the current Sustainability and Transformational fund allocation
- Continued CIP delivery

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Analysis demonstrates the affordability of the options at both RSH and PRH resulting in recurrent financial surplus for Options B, C1 and C2. Option C1 however enables the Acute Trust to maximise the potential for repatriation of activity currently being performed for local residents in provider organisations out of the county.

	Do Nothing	Option B	Option C1	Option C2
	£000s	£000s	£000s	£000s
Recurrent 2016/17 Baseline Position	(16,553)	(16,553)	(16,553)	(16,553)
Less SSP Incremental Finance Costs		2,000	2,000	2,000
Recurrent 2016/17 Baseline Position	(16,553)	(14,553)	(14,553)	(14,553)
Revenue Impact				
Demographic Growth	35,584	35,584	35,584	35,584
Increased Cost of Demography	(31,384)	(14,301)	(14,301)	(14,301)
QIPP		(17,295)	(17,295)	(17,295)
QIPP Savings		6,800	6,800	6,800
Inflation	(38,790)	(38,790)	(38,790)	(38,790)
Tariff Uplift	8,221	8,221	8,221	8,221
CIP	30,978	30,978	30,978	30,978
Repatriation Income Gain	3,000	3,000	3,000	3,000
Repatriation Increased Cost	(1,200)	(1,200)	(1,200)	(1,200)
Other Recurring	4,630	4,630	4,630	4,630
SSP Workforce	(4,600)	14,589	14,203	11,377
SSP Additional Non Pay		0	0	0
SSP Incremental Finance Costs		(6,000)	(6,000)	(6,000)
SSP Finance Costs		(5,433)	(8,684)	(7,867)
Recurrent 2020/21 Position	(10,114)	6,231	2,594	584

Table 43: Affordability and key planning assumptions

The Acute Trust has confirmed that their current underlying financial assumptions will have no adverse financial impact on the CCGs and will not require any additional investment above tariff income.

12.2.3 Sensitivity Analysis – Acute Modelling

One of the caveats associated with the CCGs approval of the Acute Trust's Strategic Outline Case in 2016 required detailed sensitivity analysis on the assumptions used to be completed through the OBC process.

In considering this the Acute Trust has identified three scenarios:

4. Can the Trust afford the reconfiguration plan, given the attributable risks and assumptions and /or
5. Does the OBC provide an improved way forward than the option of doing nothing, and /or
6. Does the OBC support an on-going improvement in the financial position of the Local Health Economy?

- Affordability

There are two potential approaches:

(a) Identify specific risks and assumptions operating in isolation and then compare this with the Income and Expenditure position for each option by the year 2020/21 to establish whether there remains at least a balanced financial position.

(b) Take the broad collection of risks and assumptions and apply a likelihood of these sensitivities happening and collate these values into a combined figure and in so doing produce a composite financial assessment of the combined risk, contained within each of the options.

The challenge with (a) is that because it does not allow for the collection of events that may occur over the period 2017/18 – 2020/21 in choosing an individual area it over emphasises the nature of any one factor in judging the financial risk of delivering the project. This factor when combined with the relatively small surpluses generated in the options B and C1, £6.2 million and £2.6 million respectively produces heavily skewed conclusions, as highlighted below.

Dominant downside risks/ assumptions	Financial impact £000's	Option B	Option C1
Assume demographic Income growth is 0.5 per cent less per year	(3,285)	2,946	(691)
Assume Trust delivers 1.5 per cent CIP per year rather than 2.0 per cent	(7,745)	(1,514)	(5,151)
Repatriation Income say 25% lower	(1,500)	4,731	1,094
SSP Workforce savings – 25 per cent lower than expected	(3,600) – (3,550)	2,584	(957)
Blended finance costs 4 per cent not 3.5 per cent	(1,400) – (1,600)	4,829	994

Table 44: Dominant Downside Risk / Assumptions

Dominant upside risks/ assumptions	Financial impact £000's	Option B	Option C
Assume demographic Income growth is 0.5 per cent greater per year	3,285	9,516	5,879
Assume Trust inflation is 0.5 per cent lower per year than the blended rate 2.0	7,460	13,691	10,054
Assume QIPP 10 per cent lower	1.050	7,281	3,644

Table 45: Dominant upside Risk / Assumptions

Risks and assumptions will occur collectively and with varying levels of likelihood. The table below attempts to provide a composite value of risk that recognises this situation.

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Income and Expenditure Element	Scenario	Impact		Likelihood	Indicative Value	
		B1 £000	C1 £000	£000	B1 £000	C1 £000
Demographics Income Growth	0.5% increase in demographic growth	5,497	5,497	25%	1,374	1,374
Demographics Income Growth	0.5% decrease in demographic growth	-5,497	-5,497	10%	-550	-550
Demographics Expenditure Growth	0.5% increase in demographic growth	-2,212	-2,212	25%	-553	-553
Demographics Expenditure Growth	0.5% decrease in demographic growth	2,212	2,212	10%	221	221
Inflation Assumption	Inflation Assumption 0.5% less	7460	7460	25%	1,865	1,865
	Inflation Assumption 0.5% more	-7460	-7460	10%	-746	-746
QIPP Delivery	10% less plan planned levels	1,730	1,730	50%	865	865
QIPP Expenditure Impact	10% less plan planned levels	-680	-680	50%	-340	-340
CIP Delivery	Deliver 2.5% not 2%	7,745	7,745	5%	387	387
CIP Delivery	Deliver 1.5% not 2%	-7,745	-7,745	25%	-1,936	-1,936
Repatriation Income Loss	25% loss of Repatriation Income	-2,500	-2,500	50%	-1,250	-1,250
Repatriation Increased Cost	25% loss of Repatriation Income	1,000	1,000	50%	500	500
SSP Workforce	25% reduction in the level of Workforce savings	-3,647	-3,551	50%	-1,824	-1,775
Finance Costs	0.5% increase in cost of capital to 4%	-1,402	-1,600	60%	-841	-960
					-2,827	**-2,898**

Table 46: Value of Risk

As can be seen from the above based upon these likelihood assessments, the composite risk contained within the draft OBC for both options B and C1 is circa £2.8 million. On this basis if these are adjusted for the risk value Option B surplus reduces to £3.404 million whilst Option C1 produces a marginal deficit of £304,000. Given the nature of this calculation it is sensible to conclude that both options can be regarded as affordable (because they are able to generate a balanced position) however as stated in the draft OBC B is the preferred option considered from a finance perspective.

- Financial Impact compared to the 'Do nothing' Option

The draft OBC describes a deficit amounting to £10.1 million by the year 2020/21 if the Acute Trust were to avoid taking forward the reconfiguration of services. After allowing for a risk adjusted sensitivity assessment, (as laid out in the table above) both options B and C1 allow the Trust to substantially improve its financial position.

- Financial Impact on the Financial Health of the Local Health Economy

The two CCG's enter the 2017/18 financial year with a combined recurrent deficit of £13.6 million and the Trust commences the year with a recurrent deficit of £16.5 million. The effect of taking forward the acute reconfiguration proposals is to at least generate a balanced recurrent position for the Acute Trust and at the same time secures savings for the CCG's. Judged on this basis it is evident that taking forward the OBC is majorly significant in improving the financial sustainability of the Shropshire and Telford health system.

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12.2.4 Sensitivity Analysis – Ambulance

Further sensitivity analysis will need to be undertaken when the outcome of the ambulance impact modelling work has been completed.

12.3 Capital

A capital cost estimate for each of the shortlisted options, B, C1 and C2, has been undertaken by Cost Advisors Rider Hunt. These estimates follow best practice and the guidance within the NHS Capital Investment Manual and are presented on OB forms in the standard format. The work has been split into Baseline works, Estates Implications and Backlog works, and into new build departments and refurbished departments.

The works costs for new build departments are built up using the Healthcare Premises Cost Guides rates per m2 (HPCGs) applied to the building areas shown within AHR schedules, plus appropriate on-costs. The HPCG rates have been adjusted accordingly for number of storeys, and the areas have been adjusted by the addition of 30% to allow for main plant rooms. Communication space is shown separately on the AHR Architects (AHR) schedules and has been priced separately within the cost estimates.

- For the refurbishment areas, a percentage of the new build rate has been taken based on the level of refurbishment indicated on the AHR schedules. There has been no adjustment to the areas of refurbishment for plant space.
- Demolitions have been calculated on a volumetric basis using a typical demolition rate from previous similar projects.
- External works are included based on the areas shown on AHR's schedules, with splits between hard and soft landscaping taken as a percentage.
- Drainage has been priced separately to the buildings based on the total area of new build, and to the external areas based on the total area from AHR's schedules. Additions have been included for attenuation from the Capita (Civil and Structural Engineers) schedules.
- Allowances for items such as ground conditions, retaining walls and cut and fill have been taken from Capita's report and priced using rates from similar previous schemes.
- Prices in the estimates for vertical circulation are for the lifts and escalators only as itemised on AHR's schedules, as the space requirement has already been included in the communication space above.
- Allowances highlighted in the DSSR (Mechanical and Electrical Engineers) reports have been included for services buildings, abnormal services, diversions and connections.
- The capital cost of boilers, boiler houses, energy centres and the like has been excluded from the estimates, as the assumption for OBC is that the new energy centres will be outsourced to a private firm under an "energy supply agreement", similar to the current arrangements the Trust has in place.
- The capital costs of multi-storey car parks have been excluded from the estimates as the assumption for OBC is that the construction and operation of the new multi-storey car parks will be outsourced to a private firm or the Trust will review alternative pricing structures and keep the operation in house.
- The capital cost for the Chemotherapy Day Case Centre at PRH in all options is excluded from the estimate as this is anticipated to be funded through other Public Sector or Charitable organisations.
- The capital cost for the Midwifery-led Unit (MLU) and any other associated legacy Women and Children's accommodation at RSH in all options has been excluded from this estimate as this is funded from the Public Dividend Capital (PDC) obtained from the previous Future Configuration of Hospital Services (FCHS) scheme.

Work has initially been priced at PUBSEC 195, which is the current Department of Health Reporting Level and then updated to PUBSEC 214 which is the current index value for 4th quarter 2016.

Inflation beyond 2016 has not been included in the estimates. The works costs have been adjusted for working in Shropshire based on the BCIS Location Study, 2000 boundaries, currently 0.98.

Additional costs have then been added to the above works costs to include for:

- Fees, which are based on 13% of the works costs, as advised by the Trust
- Non-works costs, which are an allowance based on similar recent developments
- Equipment, which is included at either 12% for Option B or 11% for Options C1 and C2, as advised by the Trust, based on recent experience of similar projects. Equipment costs are deemed to include for all general equipment, and general IT infrastructure, but exclude any specialist medical equipment (such as CT, MRI etc), and any specialist IT requirements (such as EPR or iPads, etc).
- Planning contingency, which is based on 10% of the works cost
- Optimism Bias (based on approved guidance)
- VAT at the current rate of 20%
- VAT Recovery, at an assumed level of recovery based on 100% recovery for fees, and a rate of 20% for refurbishment works.

It is currently assumed that there is no requirement for land purchase.

Costs	Option A	Option B	Option C1	Option C2
	£000s	£000s	£000s	£000s
Works		123,554	153,837	145,450
Fees		16,062	19,999	18,908
Non-Works		400	400	400
Equipment		12,867	14,797	13,862
Contingencies		12,355	15,384	14,545
Optimism Bias		28,090	36,795	34,770
VAT		34,048	42,668	40,335
Total at PUBSEC 195 Reporting Level		227,376	283,878	268,270
Total at Outturn (at PUBSEC 214)		**249,613**	**311,636**	**294,497**

Table 47: Estimated Capital Costs

It is assumed at this stage that the reconfiguration will be capitally funded, using a Public Dividend Capital (PDC) route. The Programme is, however, aware of the potential shortage of availability of capital, and as such would explore alternative funding routes should sufficient capital not be available. Alternative sources to be considered would include private loans, a PFI solution, property-led funding solutions e.g. Joint Ventures, and/or property development solutions.

The Acute Trust are also considering a number of commercial opportunities to reduce the overall capital cost of the proposals, including revenue-led solutions for the construction of new multi-storey car parks, and energy supply contracts to fund new energy plant and buildings; as well as enabling increased revenue opportunities through cafes, restaurants, and retail.

13. Integrated Impact Assessment (IIA)

13.1 Introduction

In support of the decision making process, the Programme commissioned an Integrated Impact assessment report (IIA) on acute services*: Future Fit Integrated Impact assessment November 2016.* The scope of the report and summary of the key findings are detailed below and the full report can be seen in Appendix 13

The Integrated Impact Assessment (IIA) report completed in November 2016 was produced jointly by ICF and the Strategy Unit, Midlands and Lancashire Commissioning Support Unit. The aim of this IIA was to conduct a robust, independent assessment of the potential impacts and equality effects of the options. An IIA includes economic, environmental, health and equalities impact assessments. A three stage process was undertaken to: scope potential impacts; assess key impacts; and, assess equality effects including those identified as having protected characteristics under The Equality Act (2010).

The IIA assessed potential impacts for different localities in addition to for the area as a whole and for specific equality groups. The scope was restricted to assessing the impacts of the changes to acute hospital care. The IIA adopted a 25 year forward view, assessing the impact of the changes over a 25 year timescale.

The IIA also provides recommendations for how any negative impacts and effects could be mitigated and positive impacts and effects maximised.

The purpose of any impacts assessment is not to determine the decision about which option would be selected; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve.

The IIA is a live resource that is intended to provide the basis for further assessment as the programme progresses through different stages. This includes the mitigation strategies which will continue to be refined during subsequent consultation.

Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase. During the consultation phase, experts and local people will also be offered the opportunity to provide any further information that can inform the action plan.

13.2 IIA 2016 - Key Findings and Impacts

The report concluded that in terms of overall health impacts, in either option, (B or C1) the main changes are expected to sustainably improve the effectiveness, safety and patients' experience of clinical care provided to the affected populations.

The projected positive overall health impacts of reconfiguration of acute services achievable under both Options B and C1 are the most significant of all the impacts assessed. However these are partly offset by the projected negative impacts of Option B on **access** to urgent and emergency care of a similar scale.

Figure 21: IIA 2016 – Key Findings and Impacts

- For travel times to access urgent and emergency care, the majority of urgent and emergency care patients (76% - 108,133) would be unaffected. Option B generally has an adverse impact on patients from South Shropshire, Shrewsbury and Atcham, Powys and Oswestry. Option C1 generally has an adverse impact on North Shropshire, Bridgnorth, Lakeside South, The Wrekin and Hadley Chase.

- For travel times to access non-complex planned care, some patients would face longer travel times by car or by public transport to the planned care site. Option B generally has an adverse impact on patients from North Shropshire, Bridgnorth, Lakeside South, The Wrekin and Hadley Castle. Option C1 generally has an adverse impact on South Shropshire, Shrewsbury and Atcham, Powys, Oswestry and (for patients travelling by public transport) north Shropshire.

- In Option B (where the trauma unit would be located in Telford and therefore the majority of planned care in Shrewsbury), it would no longer be possible to access non-complex planned care provision directly by public transport from any area in Telford and Wrekin, and multiple changes would be required from over half of Telford and Wrekin to access planned care at RSH. Shropshire and Powys would be largely unaffected. In Option C1, the impacts are largely reversed.

- The potential equality effects arising out of each impact have been assessed for all the protected characteristic groups defined under the 2010 Equality Act and for deprived groups in the catchment area. In practice there was little variation in the projected equality effects between the options. The projected positive health impacts would have a positive equality effect on several groups. Equally, these groups would potentially experience a negative equality effect arising out of the projected impact on access to urgent and emergency care.

- Three age groups are potentiality more sensitive to changes in local acute hospital services than others: pre-school age children; young adults; and older people. Data is not routinely reported on the proportion of A&E attendances that are made by people with a disability. However the wider evidence- base strongly suggests that disability is associated with higher levels of need for emergency services – particularly mental health and learning disabilities.

- No evidence was identified to indicate that pregnant women and mothers of new born children have disproportionate or differential needs in relation to acute hospital services. However, under one of the options (C1) other women and children's services would be relocated. This was not in the scope of the report.

- However it was noted that one key point of difference between the options concerns young children, women, and the pregnancy/maternity group, who may experience a negative equality effect under Option C1 arising from the relocation of Women & Children care from PRH to RSH.

- There are far fewer equality effects across the projected economic, social and environmental impacts. No single group emerges from the assessment as being significantly more disadvantaged than another.

Section 7.3 of the full IIA Report in Appendix 13 describes strategies for mitigation and priorities for further investigation. Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase. During this consultation phase, experts and local people will be offered the opportunity to provide any further information that can inform the action plan

13.3 Supplementary IIA 2017 – Women and Children's Services

The full report: *Future Fit Integrated Impact Assessment: Additional analysis of potential changes to Women's and Children's services 11 July 2017* can be found in full as Appendix 14 This complements the IIA described above and both documents should be read in conjunction when concluding on any relative impacts analysis on our populations.

The aim of this additional analysis was to conduct a robust assessment of the potential health, access, economic, social and environmental impacts and equality effects of the proposed changes to Women's and Children's services.

13.3.1 Women and Children's IIA Scope

It was agreed by the Programme Board that the proposed specification for the work should be developed and agreed by the IIA steering group in detail to ensure it is fit for purpose. The legacy IIA Steering Group was therefore reinstated for the work and the membership supplemented with the necessary expertise. The Steering Group had GP representation from the CCGs, Powys THB, public health experts from both Shropshire and T&W Council. doctors, nurses and midwives from the Acute Trust Women & Children's Centre together with Healthwatch and other patient representative Groups from the two CCGs and Powys.

It was also agreed that the steering group should commence the formulation of a mitigation action plan for women's and children's services, in anticipation of the final report, which would be further developed throughout the consultation process.

Under Future Fit Option B the current configuration of services for women and children would largely be retained, although the majority of gynaecology day case services would also be delivered at RSH rather than at both sites.

Under Option C1 in-patient services for women and children would be relocated from PRH to RSH. Most out-patient services would continue to be delivered at both sites. The majority of gynaecology day case services would be delivered at PRH.

The assessment of health impacts in the report was informed by a clinical workshop with a wide range of expert stakeholders from across the local health and care economy. A large number of data sources were reviewed as part of this work attempting to examine relative need, access and outcomes for our different populations. Findings from a public survey and equalities activities undertaken by Shropshire CCG, Telford and Wrekin CCG, and Powys Teaching Health Board have also been drawn upon within this report.

In order to gauge current levels of accessibility and measure the impact of any service relocation, a quantitative survey was developed and distributed through a variety of channels across the region.

The objectives of the survey were to provide qualitative data and to gauge current levels of accessibility and to measure how this would be impacted by any movement in services. It was also to understand key influencers and motivations behind choosing where individuals seek treatment.

The survey was for anyone who has used the services for women and children at the Princess Royal Hospital in Telford in the last two years as a patient, relative, friend or carer. Overall 863 responses were received. The analysis can be found in Annex 3 of the Report.

The assessment of **access impacts** was based on statistical analysis of journey times and distances. To aid comparison both car and public transport journey times have been calculated for daytime off-peak travel (between 10am and 4pm). Maps are used to provide a visual representation of journey times. The executive summary of the report describes the net effect on median journey times (so a small number of very long or very short journeys are not skewing the figures) across the whole population whilst the detailed narrative provides additional information on average (mean) journey times, the distribution of all journey times as well as present the impact on journey times and distances for patients within each of the 9 localities.

The assessment of **equality effects** explores the potential disproportionate and differential equality effects of the proposed changes on different groups in the local population, including those groups protected under the 2010 Equality Act. Women and Children are of course are a category within these groups.

It is impossible to summarise and make conclusions from all the analysis of data that has formed part of this work and the full report must be read for individuals from their different perspectives to draw fully on their own conclusions.

The section below draws on the Executive Summary in highlighting some key points in the Report.

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13.3.2 Impact on the Affected Population

The affected population for women and children is described within the report. It is useful to understand the scale of services that formed part of this supplementary IIA relative to the whole in interpreting the findings of the report.

- The total combined catchment population served by the Trust is 542,222.
- There are 223,303 adult women living in this catchment area: 127,807 in Shropshire, 66,836 in Telford and Wrekin, and 28,660 in the affected parts of Powys.
- There are 104,588 children living in the catchment area: 55,462 in Shropshire, 36,945 in Telford and Wrekin, and 12,181 in the affected parts of Powys
- In 2015/16 there were over 640,000 patient contacts within the Acute Trust (Ref SSP Draft OBC 2016)

Within the scope of the activity and services included in the supplementary IIA there were:

48,455 users of Women's and Children's Centre Services in 2015/16

7, 621 used in-patient Women's services (9,647 spells of care)

4,633 used in-patient Children's services (5,840 spells of care).

Figure 22: Impact on affected population

It is primarily these inpatient services that would potentially move from the W&C Centre at Telford onto the Emergency centre site under the option C1.

Demographic differences between the different populations include:

- Telford and Wrekin has a higher proportion of women aged 18-44, BAME women and women living in deprivation than the other two areas. However, in absolute terms Shropshire is home to the largest number of women aged 18-44 (43,670 compared to 29,206 in Telford and Wrekin and 9,163 in the affected parts of Powys).
- Telford and Wrekin has the largest number of BAME women (4,879 compared to 2,556 in Shropshire and 311 in the affected parts of Powys) and women living in deprivation (17,185 compared to 5,408 in Shropshire and 1,354 in the affected parts of Powys).
- In absolute terms, Shropshire is home the largest number of women living in a rural area (73,119 compared to 23,720 in the affected parts of Powys and 4,143 in Telford and Wrekin
- The characteristics of the child population in the catchment area follow a similar pattern to the adult female population, with more children living in rural areas in Shropshire and Powys, and higher proportions and numbers of BAME and deprived children in Telford and Wrekin
- Infant mortality rates in Shropshire (3.1 per 1,000 live births) and Powys (3.8 per 1,000 live births) are slightly below the national average (3.9 per 1,000 live births), while they are higher in Telford and Wrekin (6.5 per 1,000 live births)

13.3.3 Key Findings on Impacts

- It should be noted that the impacts for women and children represent a sub-group of the impacts for the population as a whole. The impacts across the population were fully stated in the 2016 IIA and the scale of impacts for women and children should be reviewed in this context.

- Option B and Option C1 would both have positive health impacts for all users of Women's and Children's services across the catchment area.

- Most **access** impacts are neutral under Option B and negative under Option C1 at the scale of the catchment area as whole, due to higher overall average journey times. However this varies widely for different localities within the catchment area, with some projected to experience shorter journey times, including some who currently have the longest journeys, and others longer.

- Under Option C1 the most positive impacts on **access** would be experienced in Shrewsbury & Atcham, Oswestry and Powys. The most negative impacts would be experienced in Bridgnorth and the three Telford and Wrekin localities: Hadley castle, Lakeside South and the Wrekin. The average journey times though do conceal variations in the projected journey times for women and children who live in different localities

- The projected economic, social and environmental impacts are all either of a minimal scale, neutral or uncertain at the time of writing.

  Detailed evidence on the health characteristics and locality profiles of different groups of women and children are included in the report and are provided in Annex 3 of the IIA report. It includes detailed locality profiles of population characteristics, a description of utilisation rates of services within the scope of this IIA and average travel times in car and on public transport. The reader is commended to read the whole report.

  Activity at any of the SATH sites during 2015/16 are used as *proxy measures of need* by lower super output area and are included as maps. However people across the footprint may use other providers which will not be included. Relative rankings of utilisation using crude population rates together with actual numbers in 2015/16 are then provided by locality.

For paediatric admissions, The Wrekin is the locality with highest population ranking and for actual activity it is Hadley Castle.

For birth inpatient spells, Lakeside South has the highest population ranking with the highest actual number of births from Shrewsbury & Atcham

For neonatal admissions, Powys has the highest population ranking with the highest actual number of admissions for neonates from Shrewsbury & Atcham

For gynaecology day rates, the Wrekin has the highest population ranking with the highest actual number of Gynaecology day cases from Shrewsbury & Atcham.

Figure 23: Activities at SATH sites

13.3.4 Key Findings on Equality Effects

Several groups of women and children would experience a combination of positive and negative equality effects arising from the projected impacts. They may be disproportionately most likely to use the affected services, and therefore benefit the most from the project positive health impacts.

Equally some may be disproportionately affected by the longer projected journey times from certain localities.

There are some potential cross cutting impacts and equality effects. Women and children in different protected characteristic groups (as defined by the 2010 Equality Act) may have differing health and healthcare experiences, which could mediate how they would be affected by the proposed changes. These groups include:

- Pregnant and maternal women: key user group of the affected services; main determinants of healthcare experiences are safety, choice and continuity of care.

- New-born and neonate children: the most likely of any age group to require specialist medical care due to premature birth and/or a medical condition that requires monitoring or specialised treatment.
- BAME women: higher than average rates of maternal mortality and stillbirths (particularly for mothers born outside the UK).

Awareness and understanding of the detail of the proposed changes to Women's and Children's services is currently low amongst the affected population, which is likely to be mediating the concerns and views they currently have.

Perceptions of the existing Women's and Children's services at PRH are very positive, prompting questions about value for money of the proposed changes and a need for reassurance that any relocated services would meet the same standards.

Journey times to access the affected services are shared concern for women and children amongst all protect characteristic equality groups. Equally, specific combinations of characteristics and circumstances may lead to particular differential effects.

13.3.5 Mitigations and Enhancements

Key recommendations for mitigation and enhancement include:

- Reducing unnecessary journeys and transfers;
- Safer care pathway agreements for children; and
- Reducing risk factors before, during and after pregnancy.

The following priorities for further investigation were also identified:

- Work to enhance the availability of urgent services in remote locations;
- Additional data and information requirements to better understand patient experience;
- A strong public awareness campaign surrounding the correct service to access in the case of a medical emergency potentially targeting the population as a whole, with emphasis on current and future services across the sites.
- Build on existing and planned public health interventions and consider a more proactive/aggressive system-wide approach to prevention, bridging deprivation and other equalities gaps which would more effectively and appropriately support the reconfiguration and improve outcomes for women and children.
- Continued Engagement with West Midlands Ambulance Service and Welsh on the proposed model and on Ambulance response times across Shropshire, Telford & Wrekin and Powys.
- Consideration as to whether a review of the location of Breast Services provided by Shrewsbury & Telford NHS Trust is required.

Finally in line with an assessment against NHS best practice guidance, it is the view of the programme at this stage that there has been an appropriate assessment of the impact of the proposed service change on relevant diverse groups; that appropriate engagement has taken place with any groups that may be affected and that possible action and next steps to be taken to mitigate any adverse impacts have been identified.

It must be restated however that the IIA is seen as a live resource that is intended to provide the basis for further assessment as the programme progresses through different stages. This includes the mitigation strategies which will continue to be refined during subsequent consultation.

Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase and the Future Fit IIA Workstream will be responsible for overseeing the development of this plan in advance of the next key programme decision making stage in 2018. During the consultation phase, experts and local people will also be offered the opportunity to provide any further information that can inform the draft action plan.

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13.4 Conclusions from both IIAs

It is important that both IIA's are considered alongside each other and also to note that there are aspects not covered by the two IIA's.

The IIA in 2016 identified that for the majority of people they will continue to go to the hospital they go to now for urgent and emergency care. For travel times to access urgent and emergency care, the majority of urgent and emergency care patients (76% - 108,133) would be unaffected. Option B generally had an adverse impact on patients from South Shropshire, Shrewsbury and Atcham, Powys and Oswestry. Option C1 generally has an adverse impact on North Shropshire, Bridgnorth, Lakeside South, The Wrekin and Hadley Chase.

Much has been made of the potential move of the Women & Children's Centre under Option C1 and any potential impact it might have on disadvantaged groups within our catchment population. The Women & Children's IIA report itself concludes through the engagement work that the public awareness and understanding of the detail of the proposed changes to Women & Children's services is currently low amongst the affected population. Offering assurances to the population is key on what services will be available locally under each option.

The majority of services would remain in the existing Women & Children's Centre in Telford under Option C1 including the majority of Gynaecology day cases. It is only the Inpatient Obstetric and Paediatric services that would need to be co-located with the Emergency Centre (EC).

Most women and children will receive the majority of their care and treatment in the same place as they do now in either option:

- Midwife-led unit, including low-risk births and postnatal care
- Maternity outpatients including antenatal appointments and scanning
- Gynaecology outpatient appointments
- Early Pregnancy Assessment Service (EPAS)
- Antenatal Day Assessment
- Children's outpatient appointments
- Neonatal outpatient appointments.

The majority of children who currently access urgent and emergency care can also continue to come to their local hospital in the proposed configuration of services under either option.

High risk women and children's services need to be based on the emergency site. This is the clear view of the experts both locally and nationally.

When considering both IIA's the question is what impacts should take precedent and be the primary driver in considering the options; Emergency care to the wider population or the location of the obstetric and inpatient paediatric services, or the location of planned care services.

Strong links between access and travel time and outcomes are not always evident. There is clear evidence however received by the programme that the increased travel time of option B for trauma patients would adversely impact on health outcomes for some patients. Expert clinical advice states categorically that there will be worse outcomes for the people of Powys under option B should the trauma unit move to Telford.

Influencing health outcomes is difficult, and what is not always evidenced is that adjacency is necessarily equivalent to better care. For example, in the case of stroke care or in the increased travel time to access primary PCI, the time from onset of symptoms to accessing the most appropriate diagnostics and professional opinion and therefore the most optimal treatment, is more relevant and can result in better outcomes.

It must be remembered in the proposed models that those most at risk will be taken directly by ambulance to the EC or be directed there by their GP for assessment. The Women & Children's IIA sets out the small number

of children who need to be admitted and will need to be safely transferred potentially from the UCC at the planned care site to the emergency site. It is worth noting that the average length of stay for children is a little over 1 day.

Both IIA reports concluded that in terms of overall health impacts, in either option, (B or C1) the main changes are expected to sustainably improve the effectiveness, safety and patients' experience of clinical care provided to the whole population. .

The 2016 IIA describes the disproportionate use of A&E services for some including the very young, the older population, BAME, those with disabilities and those from the most deprived localities. It is worth restating that the majority of these people will continue to use the A&E they do now through the 24/7 urgent care centres. The greatest benefits will accrue to those types of patients who are the higher users of hospital services than the general population. In the case of A&E attendances and urgent care, it must be said that utilisation rates are not necessarily a good proxy for need for acute services, but rather a need for some form of urgent care.

In the W&C IIA Annexes locality profiles, activity and relative admission rates by locality for obstetrics, neonates, paediatrics and gynaecology procedures, are set out and in these cases are perhaps a reasonable proxy for need. The information is comprehensive and shows differences in relative rates across the 9 localities but also actual numbers of patients from localities need to be given due consideration. It is supported by other annexes that include some outcome data for example relative differences in planned and emergency caesarean section rates and in neonatal length of stay that we see in the different localities across the catchment. The dilemma is should these differential impacts influence the location of acute services?

Where there is a difference in access or need suggested by demography, is this a difference to the extent that outcomes will be different and necessitates a change to the plan, or to the extent that further information will be needed and robust mitigations in place and evidenced before implementation?

Other Issues clearly affecting outcomes are Public Health issues – smoking, obesity, accessing community services early in pregnancy and these are unrelated to hospital services. They do need addressing, and should have additional focus, but they are not primarily addressed by inpatient care, but by wider community based Public Health work.

Within the IIA, including the Women and Children's impacts as described and other evidence presented, the link between differences in outcomes and access and deprivation may not be clear.

As the WM senate concluded in their review, dilemmas and trade- offs emerge from studying the two IIA reports and which the decision making bodies will need to consider. They identify clearly, for instance, that some people will travel further under option B than options C1, for some services, and vice versa. However what it doesn't show is the resultant health outcome from these different travel times.

It is worth restating that the purpose of any impacts assessment is not to determine the decision about which option would be selected; rather they act to assist decision-makers by giving them better information on how best they can promote and protect the well-being of the local communities that they serve. The IIA is a live resource that is intended to provide the basis for further assessment as the programme progresses through different stages. This includes the mitigation strategies which will continue to be refined during subsequent consultation.

Subsequent phases of the IIA process will refine the Mitigation Action Plan to be developed during the consultation phase. During the consultation phase, experts and local people will also be offered the opportunity to provide any further information that can inform the action plan.

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14. Patient Engagement and Communication

14.1 Summary of Patient and Public Engagement Activities to-date

Following the 'Call to Action' consultation activity in 2013 it was accepted that there was a case for making significant change, provided there is no predetermination and that there is full engagement in thinking through the options.

Following extensive engagement with key stakeholders, the Engagement and Communications workstream pledged to involve the broad range of stakeholders, including groups, individuals that may be affected by any proposed changes, making best endeavors to engage with as many as possible within the time and resources available.

The Programme did this by working with organisations that have existing networks and, through these stakeholders, seek to support 'Champions of Change'. It encouraged clinicians, young people and, importantly, our NHS staff to take messages out to their teams and feedback responses.

Future Fit has continued the good practice of Call to Action by reaching out and attending groups, events and meetings across the three commissioning areas; Shropshire, Telford & Wrekin and Powys. A cohort of Senior Responsible Officers, Executives and clinicians were (and continue to be) provided with the training and materials needed to get the Future Fit messages out on the ground and to hear, capture and reflect on local people's views.

What can be influenced at each stage of the Programme has been identified and a variety of means for people to be involved in the ongoing debate made available, such as focus groups, pop-up stand events, smaller-scale public activities (such as Local Joint Committee meetings or Patient Group meetings), telephone surveys and social media channels. These have allowed people to be informed of progress and to comment on proposals and developments. The Programme can evidence meeting its statutory duties to engage and involve all sections of society and to gather equality and demographic information.

It was appreciated that many people living in Powys relied on hospital services provided in Shrewsbury and Telford for their care, particularly acute care. The Future Fit Engagement and Communications team has implemented a specific plan for the Powys area, taking into account the needs of this rural community and the requirements of Welsh regulations and legislation.

Working with our voluntary sector colleagues, the Programme has co-created events/methods for specific approaches for those identified as having protected characteristics under The Equality Act (2010). Further accessible engagement has taken place with those with English as a second language.

Local Councillors and MPs are kept informed and updated about the progress of this Programme through regular formal and informal face to face and written briefings.

Throughout the programme we have continued to engage with the Joint Health Overview Scrutiny Committee who have posed questions of the programme which have been formally responded to as well as programme representatives attending their formal meetings every quarter. Additional informal discussions have continued to take place to gather the views of the Joint HOSC chairs. Details of the formal questions received and responses are provided as at Appendix 16.

The evidence gathered shows the Programmes commitment to keeping to principles and objectives set out in our Engagement and Communications Strategy, developed in partnership with our key stakeholders (Appendix 16).

Appendix 17 provides an executive summary of supporting evidence of engagement activities carried out to date, alongside our ongoing Communications and Engagement plan with evidence of some of the supporting materials created to assist people in their understanding of the proposals. It also contains a 'mind map' summarising all activities completed to date.

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14.2 Pre-Consultation Engagement

In planning and developing the Consultation Plan for the proposals contained in this PCBC, the Programme has undertaken a number of engagement activities across Shropshire, Telford and Wrekin and mid Wales. This included:

- Focus groups with patients, families and the public, including seldom heard groups
- Pop-up information stands in town centres, libraries, etc.
- A telephone and online survey
- Responding to written requests for information
- Articles and adverts in local newspapers
- Live radio interviews answering questions from the public
- Flyers and publications
- Facebook and Twitter site
- Future Fit website
- Talks given to a wide range of groups, including Healthwatch Shropshire, Healthwatch Telford & Wrekin, local councils, Powys Community Health Council, schools, colleges and universities
- Briefings to MPs

In addition, The Shrewsbury and Telford Hospital NHS Trust has continually listened to and involved its doctors, nurses and other staff, patients, families and the public in the development of the proposals for formal consultation. This activity has included Task and Finish Groups, technical team meetings, updates and presentations to community groups, weekly roadshows at both hospitals, planning workshops, 'critical friend' groups, 'gossip' groups and an information stand at the Trust's fun day/ Annual General meeting.

A summary of this pre-consultation activity is shown diagrammatically in Figure 26 overleaf.

14.2.1 Political Audiences

A wide ranging group of stakeholders were engaged in the conversations. A range of political stakeholders were visited including Telford & Wrekin Parish Council Forum, Local Joint Committee meetings across Shropshire and Telford & Wrekin Council members and Montgomeryshire Council.

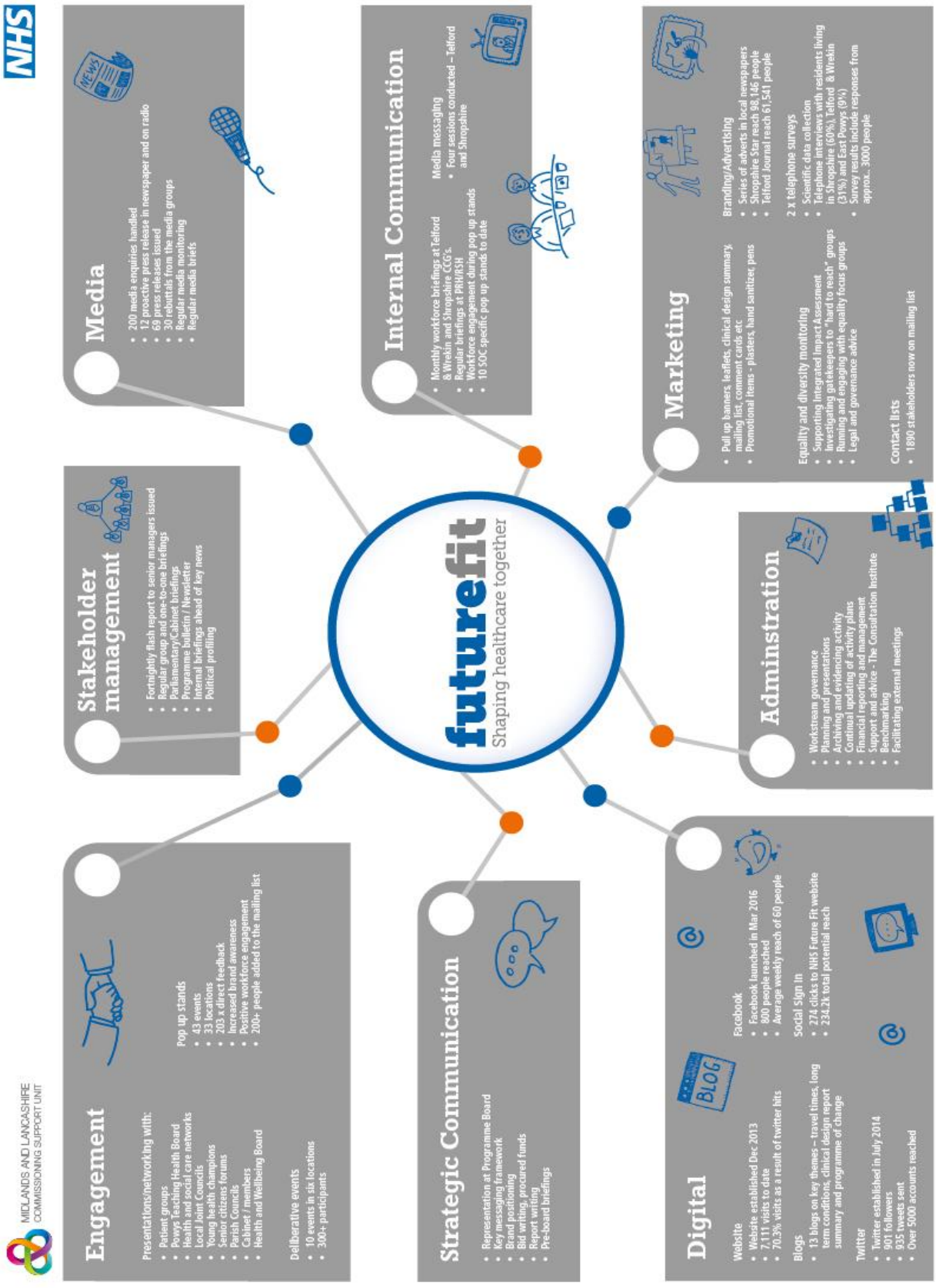
These sessions were formatted around an expert speaker, mainly David Evans (then Senior Responsible Officer for Telford & Wrekin and Shropshire CCGs), Dr Mike Innes (then chair of Telford and Wrekin CCG) and Debbie Vogler (NHS Future Fit Programme Director). At each session a progress update was given including the case for change, the current status and the timeline of events, followed by a question and answer session.

14.2.2 The General Public

It is clear that people across the region are extremely passionate about their healthcare services. The NHS Future Fit team set up its pop up stands at a range of venues across the region with 20 pop up events held over an 11 month period. People in towns in Shropshire, Telford & Wrekin and Powys such as Oswestry, Market Drayton, Ludlow and Bishops Castle, Telford Shopping Centre and Shrewsbury Pride Hill, as well as the two main hospitals and all of the community hospitals had the opportunity to learn more about Future Fit, ask questions and leave their feedback.

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Figure 24: Summary of Future Fit Pre-consultation activity



14.2.3 The 'Informed' Public

The Future Fit Programme also took the time to visit local groups and various 'board' meetings such as Telford & Wrekin Carers Partnership Board, The Shropshire VCS Assembly and the Telford and Wrekin Youth Forum. The approach was adapted for each individual audience and at the Youth Forum an awareness raising session was held in which the young people debated over some common local health 'myths'. They were also given the opportunity to give their suggestions on how the decision could be made on where to site acute services.

- *'Look at pros and cons for each area'*
- *'Look at time travelled to each site from different areas'*

14.2.4 Engaging with the local Health Workforce

On the public release of the Strategic Outline Case (SOC) from the Acute Trust, the Future Fit Programme supported the Acute Trust Transformation Team to engage with members of their workforce, along with the workforce at Shropshire Community Health NHS Trust and with local patient representatives.

The Transformation Team have run pop up stands at both the Royal Shrewsbury Hospital and the Princess Royal Hospital every other week from April 2016 to date. A number of comments were recorded, examples include:

'Having the opportunity for healthcare workers to visit patients at a more local venue would benefit them. It may help reduce patients not being able to attend their appointments resulting in financial impact'

'Give triage nurses the power to send patients to x-ray to speed up waiting times and throughput in A&E'

'Need to make better use of technology, patients deteriorate with travel for fracture clinic, concern for elderly patients who have to travel further'

'Involve staff at the planning level. When Maternity was built a whole department got forgotten and are now squeezed into a section at the other end of the hospital.'

Figure 25: Engagement with the local health Workforce

14.2.5 Working with Groups that are 'Seldom Heard'

A number of pieces of work were commissioned to local agencies to engage with local 'seldom heard' groups. The organisations were able to approach a number of different groups of people including travellers, LGBT, people with drug and alcohol problems, carers, older people and young mothers and many more. They gave an overview of the principles of NHS Future Fit and then gathered their feedback, some examples of which are given below:

'Why, in 2016 where the population is now much greater, can the transferring of services back to Shrewsbury be justified? There will be an increased risk of death owing to the greater travel time. They pointed out that PRH was built because there was a need for a Telford Hospital.'

'Newport, Chelmarsh and Muxton moms were less concerned about the distance travelled and seemed to consider that once the patient was in the ambulance they would be well looked after, their emphasis was on the highest quality medical service.'

'Members of the lesbian and gay community expressed similar concerns to other groups, whilst they thought the location of an Urgent Care Centre in both towns was a positive move, they were concerned if the Emergency Centre was based in the other town.'

Figure 26: Working with groups that are "Seldom Heard"

14.2.6 Working with Healthwatch

Healthwatch Shropshire, Healthwatch Telford and Wrekin and Powys CHC have been engaged and involved in the programme since its inception 4 years ago. They have provided expert patient views across all the workstreams and are active members of the Engagement and Communication workstream and the Programme Board.

They provide advice and guidance as a critical friend and have supported the programme with public engagement in the form of events, focus groups and workshops. They have supported in getting messages out to the general public. They have carried out independent studies, working with seldom heard groups to understand the impact of the proposals as well as general surveys on how people like to be consulted, understanding their preferred communication methods. They uphold the programme to high standards, best practice and provide legislative guidance.

Powys Community Health Council has an enhanced role within Wales to sign off the consultation plan to ensure that the process is robust and fit for purpose. They have final agreement on whether the proposals will go ahead so the programme is engaging with them throughout the process to ensure that the correct due process is followed.

14.2.7 Social Media

As well as face to face engagement, online channels have been developed. Twitter and Facebook have been used to promote the case for change and posts which have highlighted the current use of our emergency services have proved the most popular.

14.3 Outcomes of Work Undertaken

Over the last four years, the Future Fit Programme has been able to raise local awareness, not only of the programme as a whole but more specifically the reasons why local health services need to change. In engaging with this wide range of stakeholders, the Programme has ensured that, as far as possible, the case for change has continued to be argued, that people are aware of the proposals and that they will also have the opportunity to be 'consulted' when the programme launches its 14 week formal consultation period.

In engaging with 'seldom heard' groups the Programme has ensured that those people are made aware of the changes and that their specific needs will be listened to as part of the consultation. By making connections now we can go back to the groups during the consultation to ensure their views are fed into the final decision making.

The comments and views that have been gathered have also been a barometer of the local opinions of the proposals. From listening to their feedback and utilising different methods of communication, the Programme has been able to develop different communication strategies, develop new marketing materials and adapt its approach for different stakeholders.

The Programme will continue to do this throughout the period of engagement prior to the formal consultation. The increased promotion and activity on social media means that audience reach has grown considerably and provides the Programme with a quick and easy way to engage with local people. Our aim is to grow our audience and in turn increase programme awareness.

The below provides a summary of the key themes of what the public and patients told us during the engagement activities and how they have influenced our plans.

You said	We did
Rural urgent care engagement exercise as part of pre consultation engagement you said: • **Each geographical area in Shropshire has different requirements for urgent care services** • **People want an emphasis on services and that current buildings are not being used to their maximum potential**	Without dismissing the importance of NHS buildings, we need to focus on the services that provide urgent care to local people. We need to integrate services/teams and work closely with the third sector. We need to feed innovative ways of utilising existing buildings and establish a confidence in local urgent care services. The above has become the foundation of our neighbourhoods workstream as part of our sustainability and transformation plan. The learnings and some of the people who partook in this exercise and fundamental to this workstream and we are developing the approaches that were initially explored in the NHS Future Fit engagement exercise.
People expressed a concern and a desire for two vibrant hospital sites	The Strategic Outline Case was developed with this key point in mind. It moved away from a hot/cold site to two warm sites that will lead to two vibrant hospital centres.
People wanted to retain the majority of A&E services for their locality	There will be an Urgent Care Centre based at Telford and Shrewsbury which will be open 24 hours a day, seven days a week. 60% of people who attend our current A&E departments in Shrewsbury and Telford would continue to go to their local hospital to receive the urgent care they need.
Clinicians have fed back that C2 is not a sustainable or desirable option	Clinical feedback on C2 option was reflected in a number of reports which led to C2 being scored lowest in the recent option appraisal and recommendation from the Programme Board to the Joint Committee that this option be removed from the formal consultation list.
In our initial call to action you said that public feedback was a key component in the decision making process	As part of all option appraisals undertaken to date a comprehensive stratified telephone survey has been undertaken and reported upon. Rich data including how current services are currently used and how they should be used in the future was reported on. This scientific process ensured the population was represented and data was shown in both geographic and personal characteristics.
Leadership will listen to public opinion and assurances provided throughout the process	On a number of occasions we have delayed the timeline to undertake pieces of work to ensure our processes are robust and meet statutory guidelines.

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	For example the timeline was delayed to allow necessary work to be undertaken on the county deficit reduction plan. This happened following strong public feedback.
Patients should inform what buildings and services will look like under the new proposals	We have undertaken sample surveys of patient's recent experiences of local hospital services; how they accessed the service they required in current facilities and how they navigated the current service provision. This work has fed directly into the Outline Business Case and option development.
People who are high users of services but not easily heard through traditional engagement methods will need to be heard and engaged with.	We have undertaken a number of engagement exercises working alongside voluntary partners such as Impact, Fresh, RAFT, Healthwatch and engagement partners Participate. We have heard directly from people with protected characteristics such as young mothers with children, young people, older people, drug and alcohol addiction dependents, travellers and the homeless. As well as people from BAME communities we learnt about how current services are accessed, information that will feed into the IIA, that specific impacts regarding travel distances weren't necessarily the most important but that getting the right care was. This information fed directly into option development and the SOC.
We want to have a say about formal consultation	We conducted a series of focus groups across the county to understand what local people, patients, councillors and other statutory bodies, discussing a proposed process of consultation and learning about what priorities people have for the consultation and what tactics we should be using to engage effectively. This work is currently ongoing, however has fed directly into the final consultation plan, for example we will factor in a mid-week review period to allow us to take stock of responses so far, emerging priorities and ensure there are no gaps. We will ensure patient representatives are part of this review.

Table 48: Summary of key themes from patients and public

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14.4 Expected Challenges to the Proposals

Consultation process criticism	People are confused with what consultation actually means. They have had 4 years of pre-consultation engagement with several promises to go to consultation. The recent timeline of consultation starting in the autumn of 2017 is supported by the majority of the public, politicians and key stakeholders.
The option appraisal process and outcome	In 2016, the Programme received an informal challenge from Telford & Wrekin Council who proposed a potential Judicial Review challenge on the options appraisal process. An independent review of the options appraisal process in 2017 found no material flaw in the process followed or the way it was enacted, however, Telford & Wrekin Council has confirmed that they will continue to campaign to save their local emergency and women and children's services.
The model proposed	The original model proposed had received some criticism that it was designed to accommodate austerity cuts rather than clinical preference. However this has grown over recent months with recent economic and political environments changes. In particular both the Acute Trust and Shropshire CCG currently have large deficits.
Threat of legal challenge	Be fully prepared to respond to any parties that challenge the recommendation(s); outline the robust nature of the process undertaken and seek legal advice where appropriate
The make-up of the Programme board (e.g. where do people live)	The Programme has received specific queries and FOIs in relation to the place of residence of Programme Board and Appraisal Panel members (and potentially will receive for CCG board members for the Joint Committee).
Continued changes to the Accountable Officer post at Shropshire CCG	There have been a large number of changes in leadership in the local health economy. In particular Shropshire CCG had four Accountable Officers in the space of 18 months. Following appointment to the substantive post in 2017, there is more certainty and assurance.
Confidence in the process- should the Programme Board not be able to reach a decision, or the decision is postponed	The Programme has already received criticism from the media and local campaigners/partners for perceived delays in reaching a decision. "Just get on with it" has been a phrase repeated often, particularly by the media and politicians. Although, the public may be against the model there is a belief that the Programme does need to move forward to consultation. Any further delays will represent a risk to the programmer's reputation.

Table 49: Expected challenges to the proposal

14.5 The Consultation Plan

The Programme will ensure that we use varied methods of communicating information about the consultation. There will be a variety of ways that stakeholders can be involved, making the best use of digital channels, local media and face to face conversations to ensure that people have their say and that is then fed into the consultation report. The focus will be to utilise those identified stakeholders to help us disseminate the message through to members of the public and to those who are typically hard to reach, as well as targeted methods to engage and meet people where they, as opposed to them have to come to us.

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This approach is formed on the basis of work already carried during the pre-consultation period of engagement which ran from November 2013 to August 2017.This process involved deliberative events, pop up events, social media, regular newsletters, and regular briefings to local stakeholders, alongside a communications and media programme and a proactive media programme based on the four principles of NHS Future Fit Patient representatives have contributed at every stage of the programme, attending work stream meetings and events, and have helped to shape the proposals.

The Programme has ensured that all key stakeholders have fed into this document. Advice on the needs of local people has been taken, wherever possible their advice is reflected in the methodology used for consulting.

Consultation procedures included in the proposed process are, in the seventh week, to cease proactive activity to assess the level of response received so far. This pause will assess if there has been sufficient response from seldom heard or minority groups for example, so that if necessary, activities can be adapted to target groups of people whose views have not yet been heard. The Programme will also adapt methods and channels of consultation used so far, making the best use of the most popular channels and that the available resources are directed accordingly. If the consultation period falls over a holiday period or particularly inclement weather conditions, adjustments will be made to the time period to accommodate those times when people are less likely to want to be involved.

Once the 14 week formal consultation period has finished the responses will be collated, coded and summarised into a report to be presented to the CCG Boards for their due consideration. No decision will be taken until full consideration has been given by the decision making board of the consultation outcomes. The report will be made publically available at around 4-6 weeks after the consultation period has ended.

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15 Future Fit Programme Governance and Assurance

15.1 Background

Following analysis of the Call to Action programme in 2013, Shropshire CCG, Telford and Wrekin CCG, Shrewsbury and Telford Hospitals Trust (SaTH), Shropshire Community Health Trust and Powys THB committed to work collaboratively to undertake a clinical services review, engaging fully with their patient populations, to secure long-term high quality and sustainable patient care.

The review programme under the banner of Future Fit focused on acute and community hospital services in Shropshire and Telford & Wrekin. It involved all communities who use those services, particularly across Shropshire, Telford & Wrekin and mid Wales and developed a clear vision for excellent and sustainable acute and community hospitals - safe, accessible, offering the best clinical outcomes, attracting and developing skilled and experienced staff, providing rapid access to expert clinicians, working closely with community services, focused on those specialist services that can only be provided in hospital.

From the outset the Programme was established as a collective endeavour because all who are party to it - sponsors and participants - recognise that this is the only way that the scale of the challenge and opportunity for this whole geography can be met.

Over the last 18 months the primary focus of the Future Fit Programme has been on the reconfiguration of acute hospital services. Progressing the community reconfiguration of services including community hospitals is now the responsibility of the STP Neighbourhoods value streams.

15.2 Programme Objectives

The key objectives of the programme are:

- To agree the best model of care for excellent and sustainable acute hospital services that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin, and Mid Wales;
- To prepare all business cases required to support any proposed service and capital infrastructure changes;
- To secure all necessary approvals for any proposed changes; and
- To implement all agreed changes.

15.3 Programme Sponsors

The Programme Sponsors are the Boards of:

- Shropshire Clinical Commissioning Group
- Telford and Wrekin Clinical Commissioning Group
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health Trust
- Powys Teaching Health Board

15.4 Programme Owners

The joint Programme Owners and Senior Responsible Officers (SROs) are:

- David Evans, Chief Officer, Telford and Wrekin CCG
- Dr Simon Freeman, Chief Officer, Shropshire CCG

15.5 Programme Execution Plan (PEP)

A Programme Execution Plan (PEP) was agreed for the Future Fit Programme in 2013 which sets out the systems and processes by which the Programme is planned, monitored and managed. The PEP has been regularly reviewed and is currently being revised in light of the transition to the STP governance structure. The latest version of the PEP is provided at Appendix 2 and is currently being updated to incorporate STP Governance changes. The PEP is owned, maintained and used by the partner organisations to ensure the successful day-to-day operational management and control of the Programme and the quality of the outputs.

The purpose of the PEP is to:

- Define the Programme and the brief;
- Define the roles and responsibilities of those charged with delivering the Programme;
- Set out the resources available and the budgetary control processes;
- Identify the risks relating to the Programme and the risk management processes;
- Define the programme management and issue control arrangements;
- Set out the approvals processes;
- Define the administrative systems and procedures;
- Set out the controls assurance processes.

The PEP is a live document and is progressively developed by the Programme Board as the project progresses, and is formally reviewed and updated at the conclusion of each Phase of the programme set out in 13.6.

15.6 Programme Scope, Phasing and Timeline

The scope of the PEP covers all the phases of the programme from set up to post implementation evaluation, as follows:-

PHASE	Key Deliverables	Status
• **Phase 1** **(October 2013 - January 2014)**	• Programme Set-up • Determining the High-Level Clinical Model	Complete
• **Phase 2** **(February 2014 - August 2014)**	• Determining the Overall Model of Clinical Services • Identification and quantification of the levels of activity in each part of the Model • Determining the Feasibility of a Single Emergency Centre • Public Engagement on the Model of Care and Provisional Long-list & Benefit Criteria	Complete
• **Phase 3** **(August 2014 - September 2016)**	• Identification of options and option appraisal • Preparation of Strategic Outline Case(s) • Identification and approval of Preferred Option	Complete
• **Phase 4** **(October 2016 – April 2018)**	• Preparation for Public Consultation including submission of Pre-Consultation Business Case and NHSE Formal Assurance • Public Consultation on preferred option(s) • Preparation of Outline Business Case(s) and Decision Making Business Case	Active stage of the work programme

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• **Phase 5** (To be determined)	• Full Business Case(s)	
• **Phase 6** (To be determined)	• Capital Infrastructure work • Full Implementation	
• **Phase 7** (To be determined)	• Post Programme Evaluation	

Table 50: Phases of the Future Fit Programme

15.7 Programme Governance

15.7.1 Future Fit Programme Governance

The Future Fit programme now forms one of the 4 service redesign workstreams within the Shropshire and Telford & Wrekin Sustainability and Transformation Plan (STP) coming under the Acute and Specialist Services Workstream. However, until such time as the Future Fit programme moves to operational delivery phase (post OBC approval by CCG Boards) the programme will retain its Programme Board as the main vehicle for decision making, making recommendations for approval to CCG Boards and reporting delivery progress.

The Future Fit Programme Board oversees the programme on behalf of the Programme Sponsors and has authority to take all decisions relating to the management of programme, with the exception of matters which are statutorily reserved to individual sponsor and/or stakeholder bodies. The programme is led by a Programme Director who is supported by a Senior Programme Manager and Programme Team.

Historically eight workstreams have supported the delivery of the programme deliverables as follows:-

- Clinical Design
- Activity and Modelling
- Workforce
- Finance
- Assurance
- Engagement and Consultation
- Impact assessment
- Feasibility study

This number has now reduced following the conclusion of some of the key pieces of work to deliver the programme milestones and more recently the transition of some workstreams into the STP. The structure of the Future Fit programme and how it is supported by both the STP and the dedicated Future Fit Workstreams and enabling groups is set out in Figure 31 below. This is a transitional structure with the principles where possible not to duplicate workstreams. The Acute service reconfiguration activities will be subsumed fully into the STP governance arrangements post consultation process and final decision making on the preferred option.

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Future Fit Governance Structure:

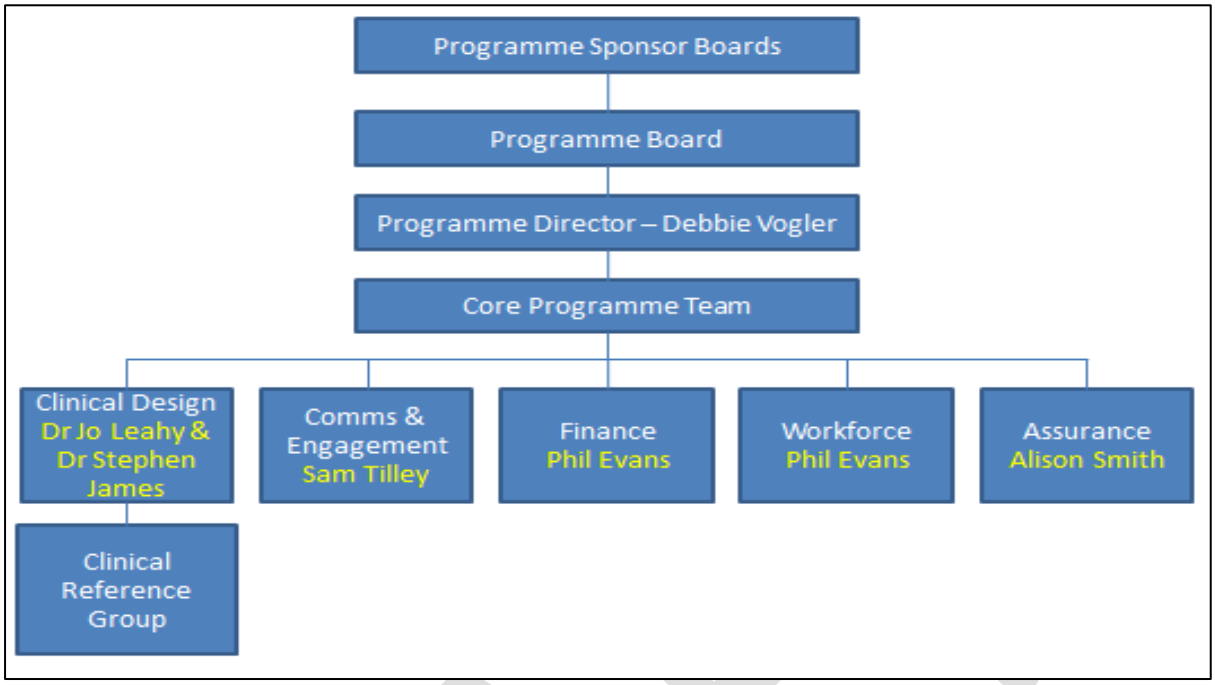


Figure 27: Future Fit Programme Governance Structure

15.7.2 Acute Trust Sustainable Services Programme (SSP) Governance

The outcome of the 2015 Future Fit Options Appraisal was that the proposed options were unaffordable and the Programme agreed that the Acute Trust would lead on developing sustainable and deliverable delivery solutions for the agreed model of care. The Acute Trust's Sustainable Services Programme (SSP) via its Transformation Team led on this piece of work.

The Acute Trust recognises that the successful delivery of its Sustainable Services Programme (SSP) is a significant task which requires robust project management and a real commitment from everyone involved to ensure its success. It has therefore ensured there are thorough arrangements in place for the on-going management of the project, and is committed to ensuring its successful outcome.

The Acute Trust has successfully managed this element of the project to date and delivered a SOC approval. It is managing the Sustainable Services Programme as a single project which is managed internally, complemented by external advisors where appropriate. A governance structure is in place with defined roles for individuals; and a series of groups, teams and boards. This provides a clear and auditable route for decision making and the escalation of risks and issues.

A partnership approach is being employed by the Future Fit Programme Team and the Acute Trust SSP Team to deliver the required programme outputs to timescale. Key members of the SSP are members of the Future Fit governance structure to ensure co-ordination of the work programme to deliver the agreed phases of the Programme.

The management of both the Future Fit programme and the Acute Trust SSP project is based on Prince2 and best practice, amended to suit the needs of the programme. The Acute Trust have given a commitment that adequate time, resource, and expertise is allocated to the project to ensure its successful delivery.

The current SSP Governance Structure is shown in figure 32 below:

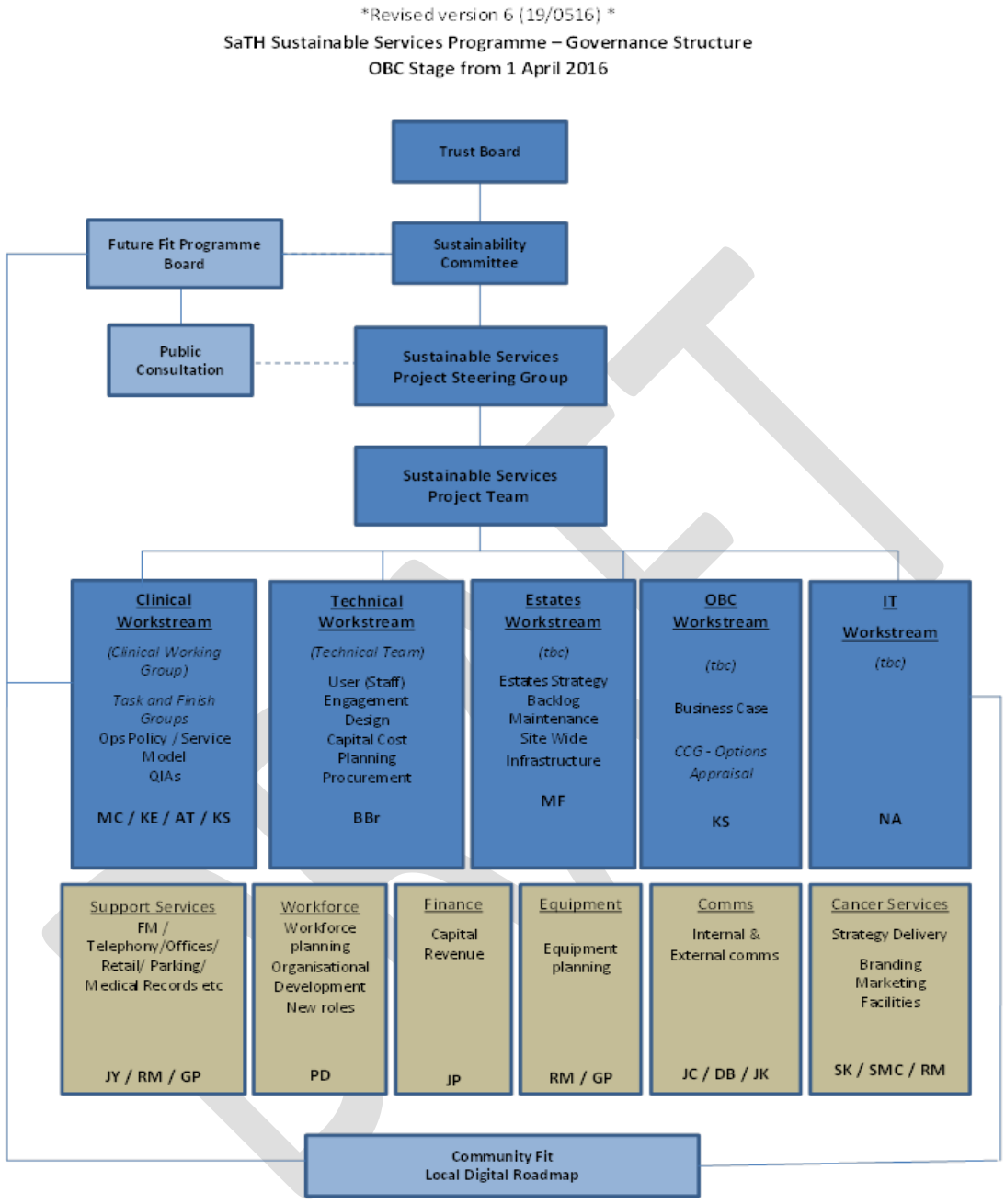


Figure 28: SSP Governance Structure

15.7.3 Where Future Fit sits within the STP Programme Governance

The Future Fit Programme governance structure is in transition to the STP governance structure which is overseen by a Partnership Board of Chief Officers from all NHS providers and commissioners and the two local authorities supported by a Programme Delivery Group of senior officer leads from each of the value streams and enabling groups. The Future Fit Programme now comes under the remit of the Acute and Specialist Services value stream.

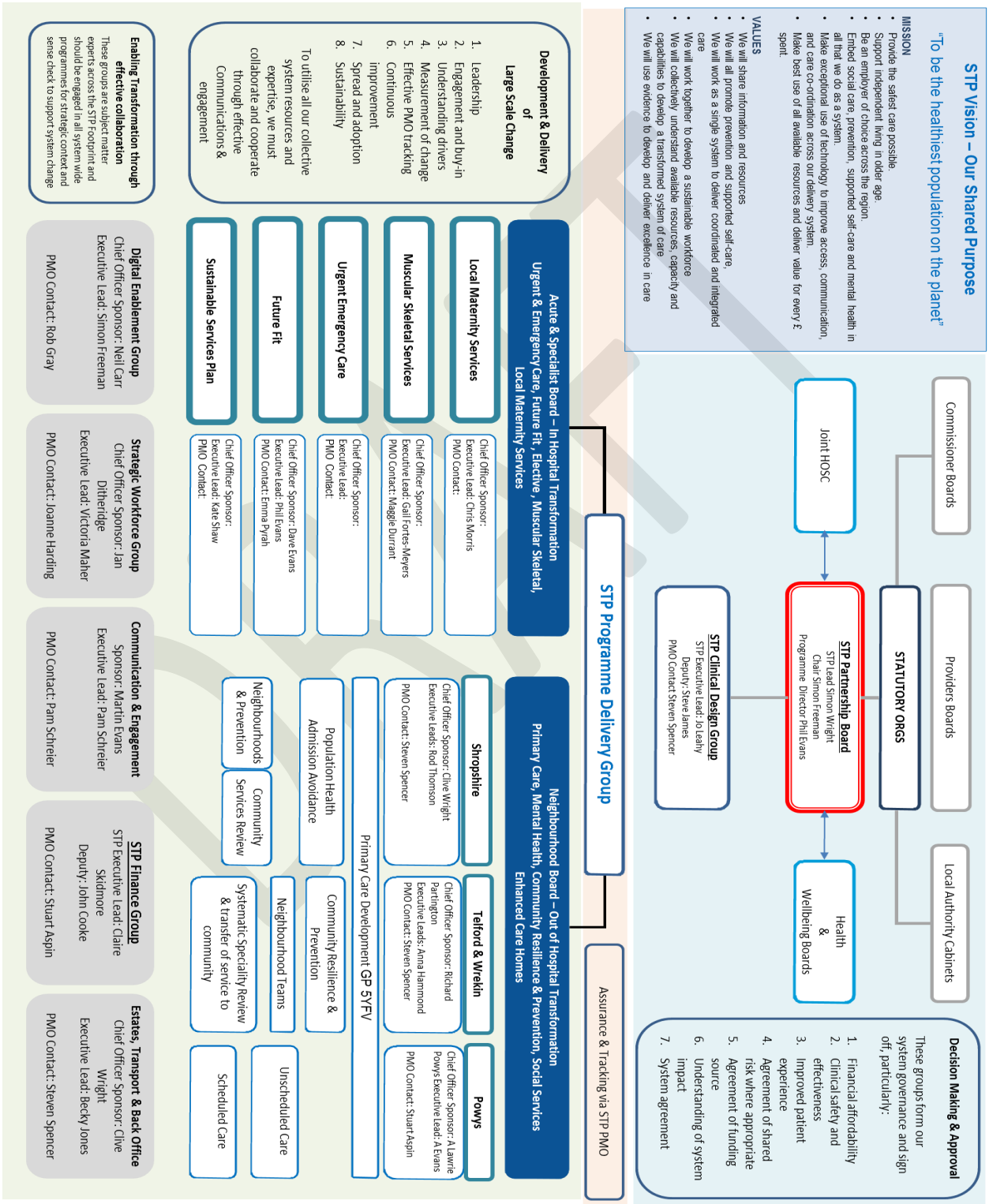


Figure 29: STP Governance Structure

The PEP and STP workstream and enabling group's terms of reference are being developed to reflect this change in governance structure.

15.8 Future Fit Programme Decision Making

The Programme is a collective endeavour because all who are party to it - sponsors and participants - recognise that this is the only way that the scale of the challenge and opportunity for this whole geography can be met. From the outset, all parties to the programme recognised that complex and difficult decisions lay ahead and that in that decision making there will be several potential trade-offs which cannot be avoided.

It is the role of leaders on the programme to reach these decisions, and to do so transparently and objectively. To support leaders in this collective decision making the PEP includes an agreed 'moral compass', code of conduct and set of guiding principles designed to help navigate through when it gets difficult and when the 'trade-offs' have to be decided jointly. Decisions associated with the programme are made by consensus

Table 50 below sets out the actions required from sponsor Boards and other organisations in relation to key programme decisions:

	Key Decision Documents	Programme Board	CCGs	Other Sponsors	Joint HOSC	Health & Wellbeing Boards	Assurance
1	Programme Execution Plan/Case for Change	Approve	Approve	Approve	Consider	Endorse Case for Change	Gateway 0
2	Evaluation Criteria & Process	Approve	Approve	Endorse	Consider	n/a	Gateway 0
3	Clinical Model of Care	Approve	Approve	Endorse	Consider	Endorse	Senate
4	Benefits Realisation Plan	Approve	Approve	Endorse	Consider	Endorse	Gateway 0
5	Selection of short list of Options	Approve	Approve	Endorse	Consider	Receive	Gateway 0
6	Selection of Preferred Option	Approve	Approve	Endorse	Consider	Receive	Senate, Gateway 0
7	Consultation Document	Approve	Approve	Respond	Consider	Respond	Gateway 0
8	Decision Making Business Case	Approve	Approve	Endorse	Consider	n/a	Gateway 1
9	Outline Business Case(s)	Approve	Approve	Relevant Board to Approve	n/a	n/a	Gateway 2

Table 51: Key Programme Decisions

Decisions to date in the Future Fit Programme have been made by a Joint Committee of the CCGs, latterly with three independent voting members, the terms of reference of which are shown in Appendix 29. This covers decision making up to and including going to consultation. The CCG Governing Bodies in October 2017 will

receive a proposal to extend this approach to the receipt and impact of consultation responses and the final decision.

Future Fit is currently in Phase 4 of its programme of work. Details of the planned milestones and timelines associated with the key components of this phase are given in the table below:

Milestone	Timeline for completion
West Midlands Clinical Senate conduct Stage 2 review	17 – 31 Oct 2016
Shropshire and Telford & Wrekin CCG Boards receive draft PCBC including draft Consultation Plan	8 and 9 Nov 2016
West Midlands Clinical Senate Review Stage 2 Draft Report received	21 Nov 2016
Gateway Review	28 Nov –30 Nov 2016
Programme Board receive Option Appraisal Outcome and made recommendation to Joint Committee for preferred option	30 Nov 2016
SaTH Trust Board approval OBC	1 Dec 2016
SaTH submit OBC to NHSI for approval	5 Dec 2016
West Midlands Clinical Senate Review Stage 2 final Report received	5 Dec 2016
CCG Board Joint Decision Making Committee split decision and referred back to Programme Board	12 Dec 2016
Independent review of Option appraisal and W&C IIA supplementary work commissioned by CCGs	January 2017
Review of terms of Reference of the Joint Committee to include independent Chair and clinicians	February 2017
Independent Review of Options Appraisal process report received	31 July 2017
Supplementary Women and Children's Impact Assessment Report received	31 July 2017
Programme Board receive the above 2 supplementary pieces of work and review the recommendations to the Joint Committee made in 2016	31 July 2017
CCG Board Joint Decision Making Committee to approve Preferred Option(s)	10 Aug 2017
CCG Boards receive the draft Pre Consultation Business Case	15/16 Aug 2017
NHSE strategic sense check Assurance Panel	30 Aug 2017
CCG Boards receive the draft Pre Consultation Business Case for approval	12/13 Sept 2017
NHSE stage 2 assurance panel	19 October 2017 follow up 17 November 2017
Shropshire/Telford & Wrekin CCG formal public consultation period	November 2017 – March 18 (14 weeks from start date)
NHSI OBC approval period	5 Dec 16 – 31 May 17
Consultation findings and recommendations report received by CCGs	April 2018
Decision making business case for approval	Early May 2018
FBC	(To be confirmed) Autumn 2018

Table 52: Programme Milestones

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15.9 Programme Assurance Processes

The Programme has been in existence for 3 years and during that time has been subject to a number of internal and external assurance processes, details of these and a summary of the outcomes are described below.

15.9.1 Future Fit Programme Assurance Workstream

The Programme is supported by a number of Workstream groups, one of which is Assurance. The purpose of the Assurance Workstream is to develop and ensure the effective implementation of a comprehensive Programme Assurance Plan in order to provide assurance to the Programme Board, sponsor Boards, the Joint Health Overview and Scrutiny committees and other external parties regarding the governance, management and decision making within the programme. A copy of the Assurance Workstream Terms of Reference and the Programme Assurance Plan are provided in the PEP

15.9.2 Independent Clinical Review of Option C2

- West Midlands Clinical Senate Reviews

For significant service change, it is best practice to seek the clinical senate's advice on proposals in advance of any wider public involvement or formal consultation process or a decision to proceed with a particular option. The Senate review involves assurance of the evidence provided by commissioners against the DH four tests and NHS England's best practice.

The West Midlands Clinical Senate was asked to provide informal advice and expert 'critical' challenge to the service models being developed in the Future Fit: Shaping Healthcare Together programme as part of NHS England's Stage 1 assurance process in 2014. The Clinical Senate Review panel concluded that there is an unsustainable health model across the Shropshire, Telford and Wrekin's health and social care economy which warranted a need for fundamental change and improvement.

The panel agreed that the remodelling and redesign of the whole health and social care economy should be commended and the approach taken reflects the scale of changes proposed and the challenges faced. However, the Clinical Senate Review Panel also recognised clinical and financial risks which required further exploration and clarification before the NHS England stage 2 review.

a) Stage 1 Review

The West Midlands Clinical Senate was asked to provide informal advice and expert 'critical' challenge, to the service models being developed in the Future Fit programme as part of NHS England's Stage 1 assurance process in 2014. The Clinical Senate Review panel concluded:

> *"there is an unsustainable health model across the Shropshire, Telford and Wrekin's health and social care economy which warranted a need for fundamental change and improvement".*
> **West Midlands Clinical Senate Review Stage 1 2014**

The panel agreed that the remodelling and redesign of the whole health and social care economy should be commended and the approach taken reflects the scale of changes proposed and the challenges faced. However, the Clinical Senate Review Panel also recognised clinical and financial risks which required further exploration and clarification before the NHS England stage 2 reviews.

A copy of the full action plan for the Stage 1 review is provided at Appendix 20.

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b) Stage 2 Review

The West Midlands Clinical Senate undertook its Stage 2 review in October 2016. The aim of the review was to assess and confirm the clinical quality, safety and sustainability of the Future Fit Programme preferred models namely, options B, C1 and C2 for reconfiguring acute hospital services in Shropshire and Telford & Wrekin (which also serves parts of Powys). The panel considered benefits and risks in terms of:

- Clinical effectiveness
- Patient Safety and management of risks
- Patient experience, including access to services
- Patient reported outcomes

The review report was received by the Programme on 30 November 2016 and the Senate panel concluded that:

> *"A clear and compelling case for change was made, based on sound evidence presented to it on current performance, improvements seen in other regions by reconfiguration of services with multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy.* A *significant amount of progress has been made since the first NHS England stage 1 review in January 2015, and the Future Fit programme were commended for the work done to date. However, there is further work to be done. The evidence suggests that the Future Fit Team must now make the important decision of stating the preferred option; this will allow the programme to move forward in terms of planning, allocation of resources and having open and transparent engagement with staff, patients and the general public".*

The Panel made 18 recommendations which have been translated into a programme action plan in order that they are addressed. A summary of the recommendations together with the progress against them are set out in table 53 below.

Emergency and Urgent Care

Key finding: *The panel was of the view that the modelling work undertaken (CSU 2014; FF2015.16; SaTH 2016) was based on the former method of triage by the ambulance service and gave the numbers for those calls classed as RED1. The current method of ambulance response programme (ARP) reduces the number of calls formerly categorised as RED1 but significantly increases the calls classed as RED2, which may require a blue light transfer to hospital. Further modelling may need to be undertaken to ensure an accurate picture of future activity if they are to move to a single site ED for the county. The panel was particularly concerned with regards to the provision for patients seen at the non EC UCC in terms of what was in place to ensure safe stabilisation and transfer of patients to EC should the need arise.*

Stage 2 review issue/recommendation	Response
1. *The Future Fit Programme should collaborate with the ambulance services to map out the non-EC UCC functions and patient pathways. There is also a need to further understand and update travel and clinical activity modelling*	Complete: Patient pathways mapped. Discussions on non EC UCC concluded and function agreed with commissioners. IIA reports show detailed and updated travel impacts and proposed mitigation.
2. *A task and finish group should be set up to work with emergency and non-emergency transport providers to ensure transport alignment*	In Progress: Ambulance activity modelling commissioned and terms of reference developed. Engagement of WMAS, WAS and MSL Confirmed. Task and Finish Group established.
3. *A clear narrative should be developed for 111/GP Out of Hours and GP/Community referrers to differentiate the patients to each of the UCC*	Complete: Patient pathways identified for UCC's. Adult ambulatory care pathways led by primary care agreed and shared. Paediatric risk management agreed. Narrative to be included in consultation information.
4. *A clear and consistent message should be*	As above. More work to do on public engagement.

developed in terms of the functions of the EC and in particular UCC services in relation to the service specification, workforce (skills and expertise) and diagnostics available	Plans for consultation documentation incorporate clear messages of what is changing and what isn't.
5. *Consideration should be given to developing an Integrated Decision Hub which will act as a single point of information and direction for patients*	Current Care Coordination Centre review completed by commissioners. Now exploring future options and opportunities for enhancing a single point of access/clinical hub model.
Transport and Ambulance Services **Key finding:** *From the evidence provided, the panel was clear that more analysis and modelling is required to assure the Future Fit Programme that it will deliver the access to urgent care services required to meet the population needs, and that any inequities arising from whichever model is finally implemented are clearly articulated, understood and explicitly taken into account in any final decision making.*	
Stage 2 review issue/recommendation	Response
6. *The Future Fit Programme should review, test and if necessary refine or modify the proposal following the planned public consultation*	The additional IIA for Women and Children's together with the December full IIA report clearly sets out impacts on the population and on the discrete groups within the protected characteristics. The IIA is an iterative process and will be complemented by the feedback from the consultation.
7. *Modelling should be done in conjunction with the Air Ambulance service for this area and evidence their opinion regarding the Future Fit models*	Underway: Both ambulance services have been involved in the clinical pathway developments. In terms of activity modelling and impact on any SLA, this work is outstanding and a Commissioner led Task & Finish Group has been established
Information Management **Key finding:** *From the evidence provided the panel was clear that the aspirations for IT were ambitious and were a significant element in the implementation and delivery of the Future Fit Programme*	
Stage 2 review issue/recommendation	Response
8. *An IT strategy and delivery Plan is developed and potential risks and mitigations are explicitly identified in these plans*	Complete: IT strategy in place through the Local Digital Roadmap and the individual IT strategies of the stakeholders Underway: Delivery Plan - Resource has now been identified and work on the delivery plan has commenced. Risks and Mitigations - Have started to identify risks as part of an Assurance Framework process which feeds in to the STP Partnership Board
Community **Key finding:** *The evidence submitted to support the Future Fit community transformation sets out general principles and direction, significant detail is required before the panel can give an informed opinion in terms of clinical quality, safety and sustainability of the model and how the required commitments from other stakeholders will be developed and delivered.*	
Stage 2 review issue/recommendation	Response
9. *Community service alignment across the system should be revisited. The panel advises that clarity is needed with regards to the current community capacity, the role of community hospitals, pathways for the frail elderly and how care would be joined up with statutory and other community providers*	Significant work done since the senate review in November 2016. In Progress: via STP Neighbourhood Workstreams and specific commissioned pieces of work for Shropshire CCG (Optimity Review, Community Services Review) plus system-wide Frailty Programme agreed. The 'Communities First, Service Second' Resilient

	Communities Workstream is working to support and enable communities to help one another and promote positive, healthy life choices. They support self-care through the 18 place plan areas in Shropshire. The social prescribing demonstrator site in Oswestry is acting as a pathfinder for the development of an assured directory of local voluntary and community services. Further work has been undertaken by health and social care providers to enhance the Shropshire Integrated Community Service (ICS) under the Better Care Fund.
Sustainability and Transformation Plan (STP) **Key finding:** *From the evidence presented the panel was clear that the Future Fit Programme was part of the five key change programmes of the STP.*	
Stage 2 review issue/recommendation	Response
10. The panel was of the view that further alignment work should be undertaken to ensure work streams are fully aligned with the STP	In Progress: It has been agreed that Future Fit will fully transition into the STP governance structure once the programme moves into operational delivery phase. For those Future Fit workstreams that have transitioned to the STP, further clarity has been secured to ensure they maintain their remit to support the Future Fit Programme.
Boundaries and Public Behaviour ***Key finding:*** *From the evidence presented it was apparent that there may be challenges in communicating to the public what the purpose of each site was should either option be implemented and, recognising that behaviour may take some time to change how the transition would be managed so that people received the right care in the right place from the outset.*	
Stage 2 review issue/recommendation	Response
11. Analysis is undertaken by the Future Fit Programme Board to set the proposed changes within a broader health economy context	Complete: Sensitivity analysis undertaken. Review of 2016/2017 position underway. Accident and urgent care, outpatients and diagnostics will be maintained at both sites. Repatriation activity included in draft OBC.
12. The Future Fit Programme Board undertakes public engagement and consultation to understand how they can support both parents and patients to realise the implications of future reconfiguration so that misunderstandings are minimised at the point of implementation	Not yet due: The supplementary IIA work for W&C supported this issue. A number of focus groups were held with those that had used W&C services within the last 2 years. Will also form part of formal consultation exercise.
Workforce **Key finding:** *The panel was of the view that there are a series of workforce assumptions within the Future Fit Programme with regard to job roles, recruitment, retention, training, supervision, sustainability and succession planning for clinicians, ANPs, AHPs and ACPs which needs to be further clarified and supported with Health Education England and Deanery (West Midlands).*	
Stage 2 review issue/recommendation	Response
13. A cultural shift may also be required and the panel felt that more detailed work needs to be done to ensure that the workforce, across the board, including GPs are able and willing to deliver the	In Progress: via the STP Workforce Workstream GP commissioners are supportive of the neighbourhood work that has emerged.

proposed model	
Clinical Co-Dependencies	
14. *The panel was of the view that the Future Fit Programme should consider and make explicit the clinical relationships and dependencies of hospital-based services on each other and evidence this where this has been considered*	Complete: Relationships and dependencies described and included in draft OBC.
Patient Outcomes and Metrics **Key finding:** *To demonstrate success a more structured approach is needed to be able to evidence the desired outcomes with appropriate metrics.*	
Stage 2 review issue/recommendation	Response
15. *The Future Fit Programme should ensure that a clear baseline of what good would look like and how progress will be measured against this. This should include patient and staff experience as well as patient benefits and the quality of new services*	Complete: Current and future outcomes included in draft OBC. Further work will be needed at FBC level
16. *The Future Fit Programme should consult with Town Planning for the Shropshire and Telford & Wrekin area to ascertain potential new developments and assess the impact for future health and care services*	Complete: Assumptions on demography and growth have formed part of the IIA work.
Public Health	
17. *The Future Fit Programme should develop detailed plans in conjunction with key stakeholders of how the public health agenda will be delivered to health service users who are non-CCG residents of Shropshire and Telford & Wrekin*	In Progress: Forms part of the STP Neighbourhood Model Powys included within the STP workstream.
18. *The Future Fit Programme should continue to build on the Equality Impact Assessment once the preferred option has been finalised through engaging with people that will ultimately be affected i.e. parent(s), patients and carers*	Comprehensive IIAs have been done. IIA Workstream to be reconvened with responsibility for ensuring a robust mitigation plan is developed and agreed before the end of the consultation period. Not yet due.

Table 53: West Midlands Clinical Senate Review Recommendations

In November 2017, the Clinical Senate provided written confirmation that it considers sufficient progress has been made by the Programme in responding to the recommendations for further work made following its Senate review in October 2016.

15.9.3 NHSE Gateway Reviews

A Health Gateway 0: Strategic Assessment took place in February 2015. The primary purposes of this stage is to review the outcomes and objectives for the programme (and the way they fit together) and confirm that they make the necessary contribution to government, departmental, NHS or organisational overall strategy. The final report and action plan is provided in Appendix 22, the key points are listed below:

- The Review Team's delivery confidence assessment was AMBER.
- In interviews with a range of stakeholders they found a high degree of evidence to support the sentiment of working collaboratively. While there are differences in view as to the appropriate scope and priorities of the Programme there was an almost unanimous view that radical change was required.
- The Review Team believed that successful delivery of the Programme is feasible. However, they identified a number of issues which required management attention. In particular, the CCGs needed to formalise their collaborative working by committing at the earliest opportunity to an approach that will facilitate a shared and binding decision being taken on the future configuration of services following public consultation.

This latter point was not resolved of course until early 2017 and after the December 2016 Joint Committee failed to deliver a majority decision.

The next stage NHSE Gateway review was undertaken from 28-30 November 2016 and the team included in the scope of the review the governance arrangements within the STP and the transition of the Future Fit Programme workstreams into it.

The Review Team's delivery confidence assessment was RED/AMBER and they made 6 key recommendations. These are listed below together with the Programme response.

Table 54: NHSE Gateway Review Recommendations

Gateway Review Recommendation	Response
1. Progress an independent review of the non-financial and financial appraisal process with Terms agreed by the Programme Board. Depending on the outcome of this review, the SRO should then consider a re-run of the financial and non-financial evaluation with independent facilitation and independent validation when preparing the OBC.	Complete: Independent Review completed by KPMG and report submitted to Programme Board on 31.7.17. No material issues identified and therefore recommendation of the JSROs was that there was no need to re-run the evaluation. JC unanimously accepted programme Board recommendation to proceed with preferred option.
2. Produce clear and unambiguous communication messages for each target audience endorsed by all programme board members.	Complete: Consultation documents in draft for feedback from reading group in July ahead of documentation being received by the CCGs' and Programme boards in August.
3. Engage external expertise to lead a formal long-term programme of stakeholder relationship development aimed at conciliation and building common purpose across the patch.	In Progress: Terms of reference agreed. NHSE funding secured. Senior Comms and Engagement lead and SRO for STP in place. Plan being developed by Comms and Engagement Lead.
4. The SRO should refresh the approach to risk and ensure that there is active risk management, ownership and control.	Complete: The approach to risk management has been strengthened. The Assurance Workstream undertook a thorough review of the register in June 2017 and was presented to Programme Board July 2017.
5. Ensure the consultation plan and approach is agreed and jointly owned by the key stakeholders, and assured throughout**.**	In Progress: Documents drafted and dates for key meetings of Programme Board, JHOSC and CCG Boards in place to ensure system-wide sign off in September 2017. Consultation Institute supporting accreditation of process
6. Ensure that the STP Partnership Board agrees a definition for Future Fit programme closure and identifies the governance and project arrangements (under the Acute Services and Specialist Board) to succeed it.	Complete: Transition date for Programme Board agreed as post consultation when the Programme moves into operational delivery phase. STP Programme Director took responsibility for FF Programme from September 2017.

15.9.4 Independent Review of the Options Appraisal Process

On 30th November 2016 the Future Fit Programme Board approved by general consensus a preferred option: Option C1. This was one of four 4 recommendations which were at that point then made to the Joint Committee of the two CCGs on which options it should proceed with into an NHS England Assurance process and subsequently on into a public consultation.

On 12th December the Joint Committee of the two CCGs met to receive these recommendations and was not able to reach a majority view on this preferred option. The matter was therefore referred back to the Programme.

As a result of queries raised by the Gateway Process in November 2016 and by, Telford & Wrekin CCG and Telford & Wrekin Council since the option appraisal process concluded in September 2016, an independent review of the process, scoring and methodology was commissioned and conducted by external auditors KPMG. KPMG were selected to provide an independent view on the options appraisal process which culminated in late 2016 which was designed to select the preferred option on which to conduct formal public consultation. In undertaking this review they compared written evidence to best practice guidance produced by both NHS England and NHS Wales.

In order to satisfy the requirements of NHS England guidance on service change, reconfiguration proposals must meet four 'key tests', as set out in guidance most recently updated in 2015: strong public & patient engagement; a clear clinical evidence base; consistency with current & prospective need for patient choice; support for proposals from clinical commissioners. Proposals must also demonstrate affordability. These tests formed the basis of this review.

KPMG were provided with three objectives:

- Review of Shortlisting Process Methodology
- Review of the Design of the Evaluation for Shortlisted Options
- Review Enactment of the Evaluation for Shortlisted Options

The full KPMG report *Independent Review: Future Fit Programme Options Appraisal process July 2017* can be found as Appendix 24. Having received and noted the findings of this report, the JSROs recommended to the Programme Board on 31st July 2017 that no material issues had been identified in the shortlisting process, neither in the design of the evaluation options process nor in its enactment.

Some minor points were noted under each objective where improvement could have been made in retrospect; these are fully noted in the detailed sections of the report. Headline findings against each of the objectives are summarised below.

A) Shortlisting Process Methodology

- The shortlisting process undertaken incorporated all four key tests, as per NHS England guidance: commissioner support, clinical evidence, public engagement and patient choice.

- Issues of affordability and alternative provision were also addressed, although only at a high level at this stage.

- Plans to address these issues, in addition to implementation of a governance model capable of delivering reconfiguration while incorporating divergent views, should have been articulated more clearly at this stage

B) Design of the Evaluation of Shortlisted Options

- The design of the process for evaluating the shortlisted options was found to incorporate all four key tests set by NHS England.

- The design was approved unanimously by clinical commissioners, emphasised the need for clinical evidence to support proposals and incorporated patient engagement into weightings and option design.

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- The design of the evaluation of shortlisted options was agreed by the Programme Board in advance and reflected both the evaluation criteria used for shortlisting and NHSE guidance around producing a balanced assessment.

C) Review of Enactment of the Evaluation for Shortlisted Options

- The conduct of the non-financial appraisal panel was largely in line with the process designed and agreed by Programme Board.

- The same applies to the financial analysis, which was presented to Programme Board in parallel to the panel evaluation report

D) Other Areas of Attention

Various points were highlighted in the reports where the Programme could be more aligned with best practice. The majority of these have been captured by three overarching areas for attention, set out on page 8 of the Report:

- Clarity around funding availability and affordability and assurances around the proposed funding solution for the programme, including the mix of sources if PDC is considered unlikely to be sufficient and an analysis of what development and reconfiguration could be achieved with lower levels of funding, should the current total costs prove unaffordable.

- Clarity around community models to address urgent and planned care with reconfiguration of community care, and specifically those elements directly impacting on local acute care flows, needing to be rapidly described and costed.

- Clarity around governance and conflict resolution. This was primarily around reconstitution of the joint committee with three independent voting members, including an independent chair.

Each of these areas have already been identified by the Programme and Sponsor organisations as key issues that require a resolution prior to the approval of the Pre consultation Business Case by CCGs.

Assurance of whether these areas have been sufficiently addressed at this stage in the process will be tested though the NHSE Stage 2 Assurance Process. This fits well with the KPMG recommendation that these issues are addressed by the Programme before moving to public consultation.

15.9.5 Health Overview Scrutiny Committees (HOSC)

HOSC is a committee formed of members of the local authority with public representation with delegated powers of oversight and scrutiny of the local health economy. They also have powers to refer proposals to the Secretary of State on behalf of the Local Authority.

The local authorities in Shropshire and Telford & Wrekin have established a Joint HOSC which meets quarterly. The Programme has been in regular dialogue with the Joint HOSC and responded to a number of sets of questions posed of the programme by HOSC members. Details of the questions and programme responses are provided at Appendix16. The Joint HOSC have been supportive of the proposed model of care and the process of public engagement and communication the programme has undertaken. Both Joint HOSC chairs were observer members of the Non-Financial Appraisal on 23rd September 2016.

The JHOSC received the draft PCBC and consultation documents at its meetings in September and November. They requested further clarification in the PCBC and the Consultation documents on workforce, finance and the acute and community modelling. The Programme has responded to this feedback through further detail provided in the relevant sections of the PCBC and Consultation documents.

15.9.6 Internal Audit

An internal audit review of the governance arrangements in support of the Future Fit Programme was completed in October 2016 as part of the 2016/17 internal audit plan for the CCGs. The internal auditors view was that there has been a clear governance structure in place to support the Programme but that there were some operation improvements required as a result of the Future Fit governance arrangements being at a transitional stage into the STP governance arrangements. For this reason the auditors attributed the programme a 'moderate assurance' level.

15.9.7 Risk Register

The NHS Future Fit Programme has developed a risk register in line with best practice. (Appendix 26) It sets out the areas that could adversely impact on the development and/or implementation of the 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 a RED/AMBER/GREEN rating and a summary of how the risk is being mitigated by the programme. Where further action is needed this is also set out. The risk register is formally reviewed and updated monthly by the workstreams. Risks rated RED either before or after mitigation are reported to the Programme Board.

Risks are grouped under a number of key areas:

- Engagement
- Alignment
- Business continuity
- Resources
- Programme Effectiveness

a) Engagement

There are a number of risks to the successful implementation of the programme around effective engagement

Inadequate engagement could lead to lack of support for the clinical delivery model. The inability to adequately define the urgent care offer to the public leads to lack of support for a single Emergency Centre. Understanding the distinct difference between an EC and UCCs and how people will use the services in future remains a challenge; people remain convinced of a deficit model of losing an A&E. A significant educational programme over the coming months on how to access urgent and emergency care appropriately now and in the future will be required.

A failure to gain support from key partners for the preferred option for the emergency centre and proposed delivery models has been most apparent with T&W Council since the option appraisal outcome has become known. The Council continue to challenge on the processes of non-financial appraisal on the basis of fairness even after an independent review of the process found no material issues. Whilst no final decision has been made yet and will not until after the public consultation, such objections to plans ultimately could lead to a Judicial Review challenge or Secretary of State referral. These could all delay the programme implementation timeline even if unsuccessful.

In terms of an effective IIA process, failure to identify and engage key stakeholders across the protected characteristics may also lead to failure to meet assurance tests and due process. There are concerns raised that the impact of option C1 which appears to be the preferred option on non-financial analysis, is not sufficiently mitigated for the deprived and younger populations of Telford & Wrekin. Equally there are concerns about mitigation that would be needed to be put in place for Option B for critically ill and injured people from Wales. A work stream focusing on mitigations including pre hospital care providers is in place.

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Misrepresentation of programme and information by campaign groups such as Shropshire, Telford & Wrekin Defend our NHS, is placing an enormous burden on resources to manage responses. It is essential that the building blocks are in place to resource (people, budget, facilities) the plan appropriately. There are risks to funding consultation plans appropriately given the financial position of one of the CCGs.

b) Alignment

There has been some confusion with the public and stakeholders over recent months of the scope of Future Fit due the emergence of STP planning processes and to a number of separate but interdependent programmes which are at different stages of development. For example the transition of Future Fit governance into the STP process; concerns around very limited public engagement on STP and lack of transparency of emerging plans; the distinction between Community Fit and Future Fit and the numerous programmes in Wales impacting on Powys healthcare.

Lack of clarity on plans for out of hospital services has had an impact on public support for acute and community hospital proposals. Understanding how community solutions and neighbourhood models will support the acute model of care is critical and less well developed than the acute model and therefore plans are less detailed and not yet at an OBC level with engagement also at an earlier stage. This has now been addressed to a degree with further narrative in consultation documents and in the PCBC.

Structural and organisational change in health and social care could delay the Programme beyond agreed timeline. There has been interim leadership changes across the two CCGs. Questions remain of the viability of the smaller NHS providers. The need to address short term financial risks in individual sponsor organisations and particularly Shropshire CCG could compromise programme progress and/or outcomes.

c) Business Continuity

Staffing in the two current emergency departments remains very fragile. Sufficient consultant capacity which adversely affects patient's safety and patient flow is continually reviewed. The need to implement interim plan for sustaining A&E services over the interim period is a real risk. This currently has an elevated risk score of 20 because of recent resignations in consultant posts. Locum cover has currently been secured and in place. Mitigation plans include the closure of a department overnight. This could compromise the programme with a potential challenge of predetermination should the plan need to be implemented prior to a preferred option decision.

d) Availability of Resources

The revenue affordability to the Local Health Economy of the capital requirement of circa £300m and any investment required in whole system change, could adversely impact on the identification of the preferred option. One option requires considerably less capital than the other. The LHE deficit set out in the STP could undermine the viability of the business case should sufficient transitional support and the availability of capital be a challenge. The Trust has developed alternative sources of capital to mitigate this risk should sufficient PDC only become available to part fund the scheme.

e) Programme Effectiveness

Programme resources are lean. Any loss of key programme personnel or continuity of leadership in sponsor organisations remains a risk to the programme in terms of potential disruption and/or delay. Shropshire CCGs necessary focus on turnaround could be a concern in maintaining executive focus on the programme. The Programme is also running at significant pace. Failure to secure necessary NHS approvals at key milestones could delay the programme.

15.9.8 Acute Trust SOC and OBC External Auditor Review

In 2016 the Acute Trust commissioned an external audit review to analyse the effectiveness and robustness of its processes in developing the Sustainable Services Programme Business Case. The scope of the review included:

- Reviewing the process undertaken in respect of developing the Business Case itself, including reviewing the internal and external governance arrangements; the approval processes and project management arrangements;

- Reviewing the approach to developing the assumptions underpinning the Acute Trust's Business Case, including referring back to any external advice sought and third party benchmarks (and specifically in respect of backlog maintenance assumptions);

- Identifying the Trust's risk management processes and identified risks on filing against the Business Case's relevant milestones.

The findings from the review identified that the development of the SOC and OBC adhered to the guidance and contents as set out in the Green Book with only a few minor omissions which could be rectified to ensure the final OBC is fully compliant. The review confirmed that the appraisal process was appropriate and the assessment criteria used was consistent with that employed on other similar NHS projects. The Acute Trust's approach to risk management and information was found to detail an appropriate level of consideration given the stage of the project. The review recommended that the Trust continue to identify record and assess project risk regularly throughout the project. The Deloitte's report can be found as Appendix 27.

15.9.9 How the New Model supports the NHS Outcomes Framework Domains

NHS Outcomes Domain	Evidence of how the model will support delivery
Domain 1 – preventing people from dying prematurely	• Emphasis and investment on preventing ill health and self-care • Involvement of local communities in supporting vulnerable people are key components of the STP • Neighbourhoods work on community resilience, prevention of ill health and the creation of Neighbourhood care teams • Patients are seen and treated in the right environment for their need and by the right clinical teams and individuals in a kind, timely and efficient way • Better clinical outcomes with reduced morbidity and mortality • Ensure a greater degree of consultant delivered decision making and care
Domain 2 – enhancing quality of life for people with long term conditions	• More local services; less hospital visits • Integrated service delivery – health and social care; physical and mental health • Build resilience and social capital through Neighbourhoods • Neighbourhood care teams at locality level delivering integrated care pathways across the NHS and Social Care • Investment in digital health
Domain 3 – Helping people to recover from episodes of ill health or following injury	• To create one emergency care centre and one warm site mainly for planned care – to provide clinical sustainability and ability to deliver constitutional standards • More appropriate use of hospital care • Centres of excellence developed with more centralisation of expertise onto single sites • Be cared for in their nearest hospital as much as possible for

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	their acute service needs – Urgent Care, Ambulatory Emergency Care, Outpatients, Diagnostics and some inpatient specialties • Benefit from planned care with defined separation form emergency care pathways • Benefit from an ambition of improved pathways between primary and secondary care providers • Development of ambulatory emergency care reducing Length of stay
Domain 4 – Ensuring that people have a positive experience of care	• Improved patient flow through the acute care pathway and onto home or community/primary care and support • 7 day working implementation with consistency of access • Shorter waiting times in A&E and for inpatient treatment • To create one emergency care centre and one warm site mainly for planned care will allow clinical sustainability and ability to deliver constitutional standards • Treating people in the most appropriate setting • Timely and appropriate planned care and the delivery of the RTT performance targets through the separation of planned and non-elective activity • Delivery of care in environment for specialist care • Improved patient and visitor environments at both hospital sites that protect privacy and dignity and deliver a better user experience • Less focus on bed based pathways and more on care closer to home
Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm	• The delivery of safe, high quality and sustainable urgent, emergency and critical care for all patients in response to their clinical need • Treating people in the most appropriate setting • Sustainable workforce and availability of senior decision makers • Separation of emergency and planned care • Improved clinical adjacencies through focused redesign • Bring specialists together treating a higher volume of critical cases to maintain and grow skills • 7 day working and consistency of access to care

Table 55: How the model supports the NHS outcomes framework domain

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16 Summary of Response to the 5 Department of Health Tests

In order to proceed to public consultation on proposed service reconfiguration the Future Fit Programme needs to ensure it has met the original Department of Health (DH) four tests and the supplementary requirement which was introduced in April 2017. The original DH 4 tests are:-

- Strong public and patient engagement
- Consistency with current and prospective patient choice
- Clear clinical evidence base
- Clinical Commissioners Support

In addition, from April 2017, local NHS organisations have to show that significant hospital bed closures subject to the current formal public consultation tests can meet one of three new conditions before NHS England will approve them to go ahead:

- Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it.

The Programme believes it has met these tests sufficiently at this stage to proceed to consultation and has set out the detail within this PCBC against each. Some of the key points are summarised below:

16.1 Strong Public and Patient Engagement

Public and patient engagement has been integral to the Future Fit programme from its inception in 2013. It has continued to be an underpinning process supporting the development of the models of care and options for delivery solutions over the 4 years and enacted at a number of levels. The involvement of patients and the public will be described throughout the document:

- During the life of the Programme, work streams have carried out many public engagement events, workshops, surveys and various engagement activities.

- The Programme has engaged with various groups, including “seldom heard” groups and has attended public meetings to discuss the plans for change.

- Healthwatch Shropshire, Healthwatch Telford and Wrekin and CHC Powys have been engaged and involved in the programme since its inception three years ago. They have provided expert patient views across all the work streams and are active members of the Engagement and Communication work stream and the Programme Board.

- The Programme Board throughout the Programme has had comprehensive representation from all sponsor and stakeholder organisations. This has included Healthwatch Shropshire, Healthwatch T&W, Powys CHC and separate representation from the individual Patient Groups.

- Without exception there has been one or more patient and public representatives on every workstream designing the processes and services for the future as well as the supporting the governance and decision making groups.

- What can be influenced at each stage of the Programme has been identified and a variety of means for people to be involved in the ongoing debate made available, such as focus groups, pop up stand events, smaller-scale public activities, as well as, but not limited to, on line surveys, telephone surveys and social media channels.

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- The Future Fit Engagement & Communications Team have implemented a specific plan for the Powys area taking into account the needs of this rural community and the requirements of Welsh regulations and legislation.

- The Programme has been discussed fully with lay members of partner boards, Health and Well Being boards and Overview and Scrutiny committees;

16.2 Consistency with Current and Prospective Patient Choice

There is no plan to change providers in the Future Fit proposals; therefore the choice of providers is consistent before and after the reconfiguration of services. Patients who currently receive their acute hospital care in Shropshire and Telford & Wrekin will continue to do so under the proposed new model.

The key change in terms of patient choice under the new model is where in Shropshire patients will receive their care from, as the model consolidates emergency and planned care on separate sites. Some consolidation of specialties on one or other of the current acute hospital sites has already been introduced, for example stroke, acute surgery, obstetrics and neonates and paediatric inpatients.

Currently, some patients have to travel to other Centres outside of the county for more specialist care, for example specialist paediatrics, level 3 neonatal intensive care, and a number of cancer services. This will continue under the new model.

In addition, some patients have to travel outside of the county for the service they need because the current acute trust configuration and the workforce constraints mean that the acute trust is not able to offer a sustainable service locally. It is the ambition of the acute trust that by centralising some services and consolidating their workforce that they are able to repatriate some of this work back into the county.

The aim with the proposed model is to deliver 2 vibrant hospitals with a significant proportion of current activity continuing to be delivered in the future from the same hospital site as now, for example:

- For the majority of urgent care needs, patients will continue to have the choice of using their local hospital as all options include an Urgent Care Centre on each site.
- In the case of cancer care, radiotherapy will remain on the RSH site as now alongside the existing Cancer Centre with an additional Cancer centre developed on the PRH site for some chemotherapy.
- For planned care, diagnostics and the majority of outpatients will remain on both sites as will the current Midwifery led units alongside antenatal and post-natal care facilities.

16.3 Clear Clinical Evidence Base

The Programme has been clinically led from its inception. The original proposed model of care was derived from two key sources:

iii) Reviews of the national and international evidence base relevant to each of the main clinical areas, and;
iv) Clinical consensus derived from the combined experience of over 200 clinicians from primary, secondary care, as well as social care and other services (including ambulance and mental health services).

The programme has undergone a number of independent clinical reviews:

The WM regional Senate Review took place in October 2016. It made a series of 18 recommendations relevant to all options and supported the case for change and the clinical model:

> *"The Panel was of the view that a clear and compelling case for change was made, based on sound evidence presented to it on current performance, improvements seen in other regions by*

reconfiguration of services with multi-site Trusts, the potential long-term benefits, and alignment with national NHS strategy"

They acknowledged that the decisions the health economy are trying to make are difficult:

"We were made aware of the differing current and future demographics pulling maternity and paediatrics toward PRH where it is has recently been built but more elderly around Shrewsbury pulls in the opposite direction. Moving the Trauma unit and therefore other acute and time-dependent services from Shrewsbury might disadvantage residents of Powys but advantage residents of Telford.

Decisions are difficult and trade-offs inevitable but the time has come to make them. After all, both sites will get considerable and needed capital investment."

The Clinical Senate also supported the co-location of Obstetrics and Paediatrics with the Emergency Centre. The variant option of the Emergency Centre at Royal Shrewsbury Hospital but with Women and Children's remaining sited on the Planned Care site at Princess Royal Hospital was not deemed clinically viable. In light of this, local clinicians views and external independent review on this option, the Programme Board unanimously agreed in November 2016 that the co-location of inpatient Obstetrics and paediatrics had to be with the Emergency Centre. Advice was also sought from the Trauma network. The view of the Network was that the preferred site for the Trauma Unit should be Shrewsbury. This reflected its geographical location and an increased risk for the group of patients from Powys if it was sited at Telford.

Advice was also sought from the Trauma network. The view of the Network was that their preferred site for the Trauma Unit would be Shrewsbury. This reflected its geographical location and an increased risk for the small group of patients from Powys if it was sited at Telford. The Network, however, stated that Trauma Unit status could be considered for Telford in Option 2 (Option B) subject to the appropriate standards and specifications set out by the network are met.

In light of the Trauma Network's opinion, the Programme has ensured that due consideration is being given to the mitigation that would need to be considered in any potential relocation of the Trauma Unit from the Shrewsbury to the Telford site.

Whilst ambulance providers recognise that Shrewsbury would be the preferred location for a Trauma Unit, based on access and journey times, for the small number of patients that might need to divert to a Trauma Unit for optimisation and stabilisation and who are not within an hour of a major Trauma Centre, there would be mitigating actions that could be put in place to reduce the risks were the preferred site to be Telford.:

- Increase in the use of air ambulance; review of dispatch protocols
- Extended flying time to night flights through more night approved landing sites
- Upskilling of workforce; enhanced availability of paramedics and pre hospital care protocols; potential technology advancements over next 3-4 years mobile diagnostics
- Increased access to trauma doctor and/or more critical care paramedics in transit
- Review location of strategically placed land vehicles
- Conveyance to nearest alternative TU:Hereford, Worcester, Wrexham, Wolverhampton

Many of these initiatives are to a degree being progressed now as part of separate ambulance service developments and will mitigate risks for critically ill and injured patients which ever option is finally implemented within Shropshire. In Wales, other reconfiguration programmes are driving the need for development and review of ambulance and air ambulance capacity.

It is the view of the Trauma Network that mitigation plans specific to the risks associated for some trauma patients with long journey times under option 2, should be worked up with West Midlands Ambulance service (WMAS), Welsh Ambulance Service (WAS) and the Emergency Medical Retrieval and Transport Team (EMRTS). This work has begun and will continue throughout the coming months.

These conclusions were reaffirmed by independent clinicians at the Joint Committee held on 10th August 2017, where it was also confirmed that the preferred option of C1, the Emergency Centre at RSH and the Planned Care Centre at PRH should form part of the consultation on the deliverable options.

The programme will continue to be clinically evidence based as it goes forward into consultation and its governance arrangements support that with an active Clinical Design Group of health and care leaders and a wider Clinical Reference Group with a distribution list of over 300 health and care staff from across the system.

16.4 Clinical Commissioner Support

Clinical commissioners are the two main sponsors and have supported and funded the programme since its inception in 2014. Without exception, members of the Governing Bodies recognise the case for change and unanimously accept that do nothing is not an option. This is also widely accepted by primary care colleagues.

There is full support for the clinical model of investment to retain two vibrant hospitals with a single emergency centre and a site specialising in planned care. There is also support for the more recent work both CCGs have done in developing out of hospital care.

The geographical split of public and other stakeholder opinion in determining the preferred location of the emergency centre has been mirrored to some degree in primary care commissioners. This has contributed to the requirement for an independent review and for the supplementary impact assessment work that has taken place in leading up to the conclusions of the Joint Committee in August 2017.

The governance arrangements around decision making were reviewed and a Joint Committee established with a strong GP commissioner membership together with independent clinician members. On receipt of the independent review and the further IIA work, the CCG Joint Committee concluded on 10th August 2017 unanimously that both options B and C1 are deliverable, that option C1, the Emergency centre at Shrewsbury and the Planned Care Centre at Telford, is the preferred option and that both should be taken into public consultation in November 2017.

At the Joint Committee the importance of putting in place key areas of mitigation for those populations who would be disadvantaged by any final decision, was emphasised as a key requirement. Specifically that there was appropriate paediatric cover in place at the urgent care centre on the planned care site; that mitigation is put in place for travel and accommodation needs for Women and Children using the EC site and for older people using the planned care site; that carefully balanced ambulance services were put in place; and that the local NHS is really innovative with developing workforce solutions.

The CCG Governing Bodies now fully support a formal consultation with the public on the options deemed deliverable by that Joint Committee including the preferred option subject to the NHSE Assurance process.

Details of the programme's progress made with these original SOC caveats included within the letter of support from the CCGs are provided in the table below.

1.	Sustainability of Clinical Model	Lead Organisation	Comments
1.1	Further clarification to provide assurance on inter-dependencies of clinical specialties and the levels of workforce and capital investment required	SATH/CCG	The development of the OBC and this PCBC set out the key interdependencies for the emergency site in relation to obstetric, paediatric and critical care linkages. Move from a two site medical take to single medical take in delivery model. CCG commissioned external review of Option C2; Stage 2 senate review confirmed clinical model UCC sub group agreed high level workforce assumptions

			and the model for ambulatory care and paediatrics Best practice guidance used in modelling facilities required and service and workforce redesign. Detail in OBC appendices Further testing of workforce models detail will be done through the clinical design group pre implementation
1.2	Further clarification around the clinical linkages on which the service reconfiguration has been based	SATH/CCG	As above.
1.3	Clarification on the proposed repatriation including Quality Impact Assessments	SATH/CCG	IIAs completed. SATH states that repatriation is in line with STP assumptions. Within sensitivity analysis, this figure has been included within a sensitivity test of affordability to SATH. Further testing of areas for repatriations requested pre DMBC
2	**Neighbourhoods (formerly Community Fit)**		
2.1	Given the inter-dependencies of Future Fit and Community Fit, the CCGs need more assurance of the viability of these assumptions	STP/CCG	The 3 Neighbourhood work streams within the STP have progressed the development of the service offer. Whilst a lot of progress has been made there is more work to do in understanding the delivery model detail. The Optimity work carried out for Shropshire CCG in determining opportunity for shift from acute to community provides confidence in the deliverability of the activity assumptions as does the neighbourhood work within T&W.
2.2	The CCGs require completion of sufficient further work to design the model of community care and to test assumptions about a) the scale of activity shifts and b) productivity improvements anticipated in the SOC	STP/CCG	Community model of care has been progressed considerably via STP Neighbourhood Workstreams. More details in section 9 of this PCBC. The Optimity work carried out for Shropshire CCG in determining opportunity for shift from acute to community has provided confidence in the deliverability of the activity assumptions as has the neighbourhood work within Telford & Wrekin. The implementation detail of these community models is now required. More recent sensitivity analysis by SaTH has examined a number of variables and risks and their impact on affordability including productivity, demographics and repatriation. Section 10 sets out a sensitivity analysis for the acute modelling. Work has been undertaken to further develop the out of hospital model of care and its associated activity modelling and this has been tested against the acute modelling. This is described in Section 11 of the PCBC.

3	**Activity Assumptions**		
3.1	The CCGs require detailed sensitivity analysis on the assumptions used, to be completed through the OBC process	SATH/CCG	Some sensitivity analysis has been undertaken and included in the PCBC in sections 10 and 11
4	**Community and/or primary care alternatives to acute care**		
4.1	These assumptions need thorough testing through the OBC process, including the application of a sensitivity analysis.	SATH/CCG	See above
4.2	This would also need to include the potential impact on primary care and community services in a range of activity shifts, together with an analysis of the change in financial flows away from the acute sector that will enable this activity transfer to take place	SATH/CCG	See above New section added in Section 9 describing the impact on primary care. Forms part of the ongoing work within the STP and the development of the Neighbourhood/Out of Hospital models.
4.3	There is also a need to quantify the impact on ambulance service provision	CCG	Commissioners are leading a piece of work to ensure that this impact modelling is complete by the end of the consultation period. The outputs of this work will be shared with ambulance/patient transport providers for input before final report is concluded. SaTH have had numerous discussions with ambulance trusts regarding the clinical model and approach to pathway progression. All discussions have included WMAS, WAS and MSL.
4.4	Further test the detail around the Acute Trust's ambition to repatriate a level of activity from other providers	SATH	See above
5	**Affordability**		
5.1	Affordability of the SOC needs further testing, including the assumptions around investments and efficiency savings and should be supported by robust sensitivity analysis	SATH/CCG	See above. Further sensitivity analysis has been included in the PCBC. Further due diligence work will be required pre DMBC

Table 56: Caveats to the CCG Boards approval of the Acute Trust SOC

In conclusion, therefore, the caveats have to a significant degree been addressed over the past 12 months. More detail has been set out on the community model sufficient to give confidence in the acute assumptions at this stage; there is now more sensitivity analysis done by the Trust. However there remains more work to do prior to any approval of a Decision-Making Business Case (DMBC) which will be expected in early 2018. Notably, further stress testing affordability, specifically around the availability and source of capital;

repatriation of services; and detailed modelling of the impact on ambulance and patient transport services will form part of this work.

Notwithstanding this further work this PCBC provides assurance to commissioners that the options being taken into consultation with the public are both clinically and financially deliverable.

16.5 New DH Conditions for any Proposed Bed Closures

Modelling to estimate future acute activity levels and acute bed capacity requirements has been considerable. This work was originally undertaken in 2014 and has subsequently been updated in SaTH's draft OBC (December 2016) and again more recently during 2017. This includes demographic growth, a planned reduction in delayed transfers of care, the move to 7 day working within the Trust and an evaluation of avoidable admissions through implementation of the CCGs out of hospital care strategies.

Modelling to estimate future acute activity levels and acute bed capacity requirements has been considerable. This work was originally undertaken in 2014 and has subsequently been updated in SaTH's draft OBC (December 2016) and again more recently during 2017. This includes demographic growth, a planned reduction in delayed transfers of care, the move to 7 day working within the Trust and an evaluation of avoidable admissions through implementation of the CCGs out of hospital care strategies.

The table below shows how, under the proposed new model of acute hospital care, the bed numbers and types of beds available across the two acute hospital sites will change to meet the future needs of patients. In summary as can be seen below, whilst the number of beds in future will be more than currently available, the increase is less than projected changes in demography would indicate are required as demographic growth of 2.8% is being addressed through service changes in the community. There is a proposed reduction of 35,738 bed days relating to these schemes this equates to a bed base reduction of 110 beds (37 Telford and Wrekin CCG, 73 Shropshire). This is shown in section 10.1.2.

	Who will be cared for in these spaces?	Number of beds in the hospitals today	Expected number of beds in the future
Overnight beds	Where patients stay if they need hospital care for more than one day. For example, a patient being treated for a severe chest infection.	**731**	**785**
Day beds	Where patients stay if they have had an operation but do not need to stay in hospital overnight. For example, a minor arm operation or investigation such as Endoscopy.	**91**	**105**
Clinical trolley and recliner chairs	Where patients that need to have some tests carried out and are seen by a hospital doctor but are very likely to go home that day. For example, an elderly patient that has had a fall.	**10**	**49**
Critical Care beds	Where patients who are very poorly are treated and cared for. For example, patients who are on life support.	**23**	**30**
Neonatal cots	Where poorly newborn babies are cared for. For example, a premature baby.	**22**	**22**
Total		**877**	**991**

Table 57: Proposed bed numbers and types of beds available across the two acute hospital sites under the new model

There is a proposed reduction of 35,738 bed days from the current position. This equates to a 'gross' bed base reduction of 110 beds (37 Telford and Wrekin CCG, 73 Shropshire). This is shown in section 10.1.2. The acute bed base however remains relatively unchanged although there is an increase in ambulatory care beds/day cases/chairs in the new model and a proposed increase in future critical care capacity.

The CCGs have in July 2017 reviewed the original assumptions of Future Fit set out in the 2014 modelling and triangulated it through a number of reviews: the recent work in developing community urgent response models within neighbourhood teams in T&W CCG; an independent review by *Optimity* in Shropshire examining the opportunity in out of hospital care; and examining Better Care Better Value Indicators which sets out an "opportunity value of 13% of over 65 year old admissions". Section 9 of this PCBC sets out this triangulation work that provides assurance that the original assumptions of 4,200 avoidable admissions is a reasonable assumption at this stage and that whist there may be more opportunity for avoiding further admissions, particularly in further development of the frailty model, there is no material difference in activity assumptions at this point between the Acute Trust OBC and the Neighbourhood Community Models, should they be successfully implemented and deliver the benefits as described in this document.

16.6 Affordability

The system STP submission in October 2016 demonstrated that if the system takes no action to change, by 2021 there will be a collective deficit of around £130m. Coupled with what is known about difficulties in recruiting staff to current role structures and the limitations of our infrastructure this is not a position that can be supported.

The Financial Case described in Section 12 of this PCBC confirms the affordability of the proposals to the Acute Trust, the CCGs and the system as a whole.

Based on the likelihood assessments described in Section 12.2.3 of this PCBC, the composite risk contained within the draft OBC for both options B and C1 is circa £2.8 million. On this basis, if these are adjusted for the risk value, Option B surplus reduces to £3.404 million whilst Option C1 produces a marginal deficit of £304,000. Given the nature of this calculation it is sensible to conclude that both options can be regarded as affordable (because they are able to generate a balanced position), however, as stated in the draft OBC Option B is the preferred option considered from a finance perspective.

The Acute Trust has confirmed that their current underlying financial assumptions will have no adverse financial impact on the CCGs and will not require any additional investment above tariff income

Whilst a full refresh of the STP financial plan is still to be completed (this will be conducted during Q3 2017/18, modelling suggests that the recent changes made to the Shropshire CCG plans would not materially impact on the previously reported position. If the current financial model figures are used, the 4 year aggregate commissioner surplus would fall to £2.5m resulting in a system surplus of £5.7m rather than the £8.7m reported in October. Hence it can be seen that the STP plan aims to deliver a significant change in respect of redefining the model of care in the system whilst at the same time returning to an underlying recurrent balanced position.

Judged on this basis it is evident that taking forward the reconfiguration of acute hospital services is significant in improving the financial sustainability of the Shropshire and Telford & Wrekin health system.

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17 Conclusions

The Future Fit Programme has in collaboration with its sponsor organisations and stakeholders developed a number of proposals for changing the configuration of acute hospital services for the populations of Shropshire, Telford and Wrekin and parts of Powys that rely on the services of Shrewsbury and Telford Hospital NHS Trust, that will both improve the quality and safety of care for the whole population and increase the system sustainability for the next generation.

It has taken over 3 years to get to this point, longer than expected. During this time services have also become even more fragile. However, the Programme has been able to develop during this time additional assurances around its processes and decision making that must now give confidence to the public and to the regulators that it is time to proceed to public consultation.

In summary, the Programme now believes it has:

- Set out a clear and demonstrable case for change in our acute hospitals that has now become even more urgent
- Set out at a high level the community solutions necessary to support out of hospital care for our dispersed populations whilst also recognising there is more detailed work to do
- Set out affordability for the acute Trust , for the CCGs and for the system whilst also setting out more work to do to get the necessary assurance for the decision making business case in 2018
- Met sufficiently the 4 key tests for reconfiguration that the DH asks of us
- Set out two options deliverable both financially and clinically and
- Set out our preferred option and the rationale for that

The CCGs believe the time is now right to ask the public and all other stakeholders its view on these options and to proceed to public consultation.

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