futurefit
Shaping healthcare together

NHS

Report of the Clinical Reference Group Meeting

held on Wednesday 29th January 2014 at the Albright Hussey Manor Hotel

1. The Clinical Reference Group (CRG) met for the first time in November 2013 as part of the *Call to Action* process and, through that, had already made an important contribution to developing a clinical vision for the future of the NHS in Shropshire and Telford & Wrekin. The group debated and agreed the case for radical change and the key areas where new approaches and models of care are needed.

2. Following the *Call to* Action process a formal programme – FutureFit – has been established to manage the next phase of work. As part of this, CRG members were invited to attend a second meeting at the end of January 2014 in order to

   - Receive the finalised 'case for change';
   - Endorse the overall programme vision and principles, and;
   - Develop a high level service model for three key areas of care –
     a. Long Term Conditions / Frailty
     b. Acute Episodic Care
     c. Planned Care

3. The meeting was attended by 40 clinicians representing both English and Welsh commissioners, all provider Trusts and social care from both Local Authorities (see Appendix 1 for the full list). The meeting was supported by the Strategy Unit of the Central Midlands Commissioning Support Unit.

4. Dr Mike Innes and Dr Bill Gowans, clinical leads for the programme, facilitated the meeting and began by reminding members that if our aim truly is to build services for the future, there is a compelling case for radical change.

5. Peter Spilsbury, Programme Director of FutureFit , then highlighted some key challenges for health and care services today, drawing on recent analysis from Birmingham, Black Country and Solihull of services for people aged 65 and over (excluding primary care) :

   a. 47% of total health and care funding is spent on acute hospital care;

   b. Zero day length of stay admissions make up 12% of the total cost of emergency admissions (31% in number terms);

   c. Admissions over 27 days make up 15% of the total cost (4% in number terms);

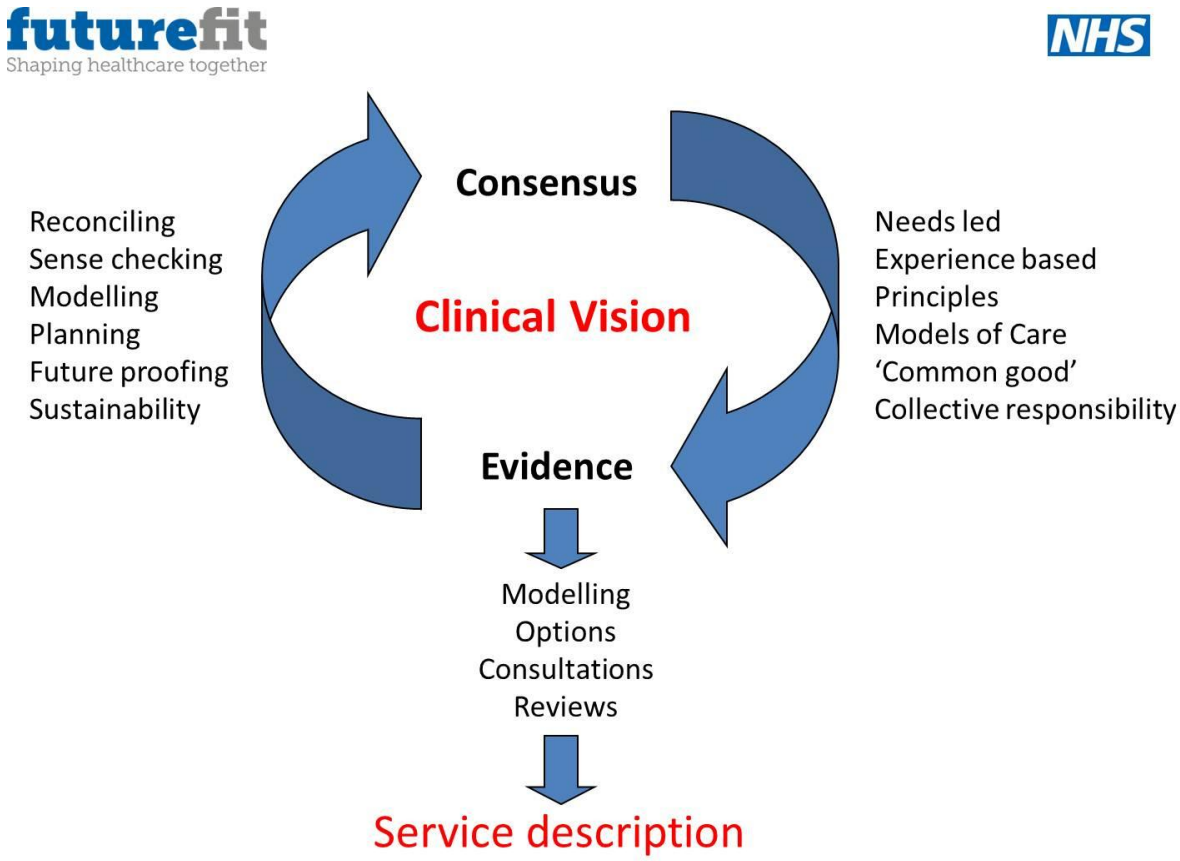
   d. The top 2% of service users incur 26% of the total cost (at £54k each p.a.) and the next 8% incur another 37% of the total cost (at £19k each p.a.);

   e. Although it is recognised that health care systems around the world are organised very differently and are subject to very different drivers, the UK appears to be an

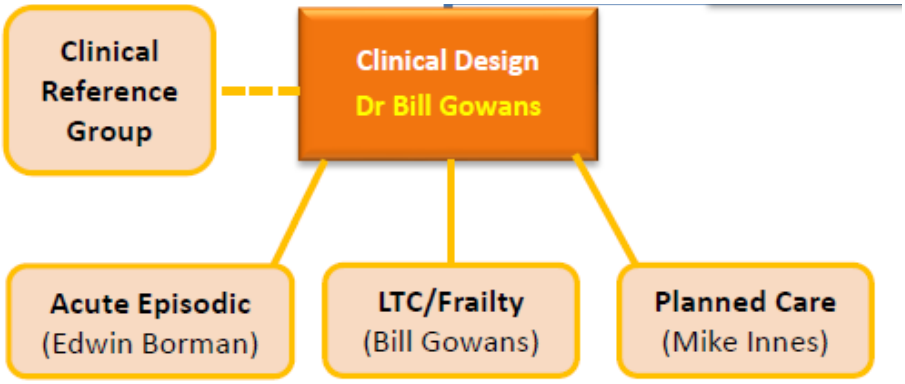
outlier in terms of the proportion of non-qualified admissions, non-qualified continuing stay days and readmissions (Oak Group);

f. For 47% of non-qualified days patients could have been at home (14% without any support).

6. In the light of these challenges, Dr Gowans said the case for change had been accepted, and copies of this as approved by the Programme Board were circulated (see Appendix 2). He went on to set out the process through which the programme will now work to develop a radical new service description based on clinical vision, evidence and consensus.



7. The structure of the Programme was explained, including the clear position for the CRG.



8. Dr Innes continued by highlighting that clinical leadership has been embedded in the core principles of the programme and that CRG members are key to this leadership through:

    a. Attending periodic CRG meetings;
    b. Acting as ambassadors for the programme;
    c. Participating in programme workstreams, and;
    d. Working in clinical model sub-groups.

    He then set out how the meetings of the CRG are aligned with the overall Programme timeline:

Key Tasks	Date
Phase 1a - Programme Set-Up	**End Jan**
CRG reviews framework for clinical models	**End Jan**
Phase 1b - High Level Vision & Overall Service Model	**End Feb**
CRG reviews clinical models and activity modelling	**End March**
Phase 2 - Development of Models of Care	**End Apr**
CRG engagement re: potential options	**End May**
Phase 3 - Identification and Appraisal of Options	**End Sept**
Phase 4 - Public Consultation & OBC	**Oct '14 to Jan '15**
Phase 5 - Full Business Case(s)	**End Jan '16**
Phase 6 - Implementation	**tbc**
Phase 7 - Evaluation	**tbc**

9. Peter Spilsbury then explained the process for modelling potential changes in acute and community hospital activity and capacity.

    Two groups (focused on acute and community hospitals, respectively) are currently working to consider the impact of commissioner activity avoidance strategies, provider efficiency strategies and demographic change. This work considers the potential for change in the light of the existing evidence base. In addition to this, work is now beginning to set out a radical clinical vision and to estimate the activity and capacity impacts of this.

    Once both pieces of work are complete they will be sense checked and reconciled to see what, if anything, is the difference between them and how any such gap might be bridged. The results of this will then provide a basis for determining a range of options for the configuration of hospital services.

10. The work to establish a radical clinical vision is to be based on clinical principles which emerged at the previous CRG meeting. These were re-presented to the meeting by Dr Innes who asked members to identify the things that should be measured, in due course, to assess whether or not radical change in line with these principles has been delivered.

    The measures proposed are recorded in the table below and are now being used to inform the development of the Programme's Benefits Realisation Plan.

HOW TO MEASURE SUCCESS
• Clinical outcomes • healthy life expectancy • increase in disease free life/total life expectancy • Improved QALY/clinical outcomes for specific high morbidity conditions (eg COPD) • Patient experience re genuinely integrated care • Friends and family test • complaints • higher patient satisfaction • reduction in hospital admissions for patients with LTC • have we changed the pyramid? • support in the community • predictable LOS • reduced influenza admissions • reduction in non qualified acute bed days for 65+ • admissions avoidance/improved ambulatory care • Responsibility of actions (healthy living?) • Everyone understands what each (service?) needs to do and agrees • pilots for specific projects • reduction in zero and 27+ day unplanned stays/big reduction in zero LOS • more streamlined use of resources - people working well together • reduction in inappropriate A&E attendances • better coordination of health and social care • clinically and financially sustainable acute services/smaller acute hospital making a profit • No. of clinical vacancies filled • some measure of staff satisfaction rate/recruitment rate/staff morale and wellbeing

11. The frameworks through which clinical models will be developed was summarised by Dr Gowans, and members were then asked to:

    a. Sense check the structure of the framework;
    b. Review the draft content, and;
    c. Discuss and note any proposed changes, additions, etc.

    Members undertook this work in groups, recording comments on copies of the framework. These comments are now informing the ongoing design process through the work of the three sub groups:

    a. Long Term Conditions / Frailty
    b. Acute Episodic Care
    c. Planned Care.

    Transcribed comments are recorded in Appendix 3.

12. Finally, the joint working principles agreed by the Programme Board were circulated (see Appendix 4). These principles – described as 'Our Moral Compass' - include explicit acknowledgement of a number of unavoidable trade offs.

    The role of leaders, including clinical leaders, in reaching decisions on these trade offs in a transparent and objective manner was emphasised, and members were encouraged to reflect on what responsibility each person has for the success of the FutureFit process.

13. After being reminded of the dates and agendas of the next two CRG meetings, Dr Innes and Dr Gowans thanked members for their attendance, and the meeting dispersed.

APPENDIX ONE – Attendees and Apologies

Attendees	Apologies
Mike Innes	Peter Clowes
Nicholas Tindall	Nigel Russell
Matthew Whitcombe	James Hudson
Dave Evans	Jo Banks
Louise Warburton	Karena Tansey
Andy Raynsford	Gilly Scott
Hannah Kelly	Colin Stanford
Chris Beacock	Claire Strickland
Edwin Borman	Georgina English
Kevin Eardley	Adam Pringle
Alison Trumper	Prof. James Richardson
David Hinwood	Vicky Hincks
Dianne Lloyd	Tim Hughes
Andrew Tapp	James Swallow
Andrew Cowley	Karen George
Bruce McElroy	Mark Cheetham
Louise Gill	Quentin Shaw
Bill Gowans	Sarah Bloomfield
Geoff Davies	Paul Taylor
Kieran McCormack	Shailendra Allen
Michael Matthee	Julian Povey
Caron Morton	Roger Davies
Mary McCarthy	Ian Rummens
Maher Moselhi	Andy Inglis
Sal Riding	Adam Pringle
Steve James	Probal Moulik
Tim Lyttle	Cathy Smith
Julia Visick	Mahadeva Ganesh
Sharon Boyle	Emma Lawrence
Narinder Kular	Alison Parkinson
Cath Molineux	Simon Smith
Alastair Neale	
Emily Peer	
Yvonne Rimmer	
Stephen Chandler	
Richard Smith	
Carole Hall	
Steve White	
Matt Ward	
Jo Leahy	

APPENDIX TWO – The Case for Change

The Case for Change

Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
- A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care

They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

This then is the positive case for change.....

.....the opportunity to improve the quality of care we provide to our changing population.

The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

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

Changing patterns of illness - Long-term conditions are on the rise as well, due to changing lifestyles. The means we 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.

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 towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

Clinical standards and developments in medical technology - 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. We must seek to deploy them to greatest effect.

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. But now the world economy and the UK economy within that is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

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 is increasingly difficult to maintain without compromising the quality and safety of the service.

Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities - In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our 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. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.

Call to Action

In November 2013 we ran a major consultation exercise with public and clinicians under the national Call to Action for the NHS. The response was very clear in saying that the public wanted full engagement in thinking through options for the future and that nothing should be predetermined. Nevertheless, in the light of the factors described above, there was real consensus between public and clinicians about the following:

- An acceptance of there being a case for making significant change;
- A belief that this should be clinically-led and with extensive public involvement;
- A belief that there were real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;
- An agreement that hospitals are currently misused. This is not deliberate but as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives;
- A belief that it is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of the rural and urban populations of this geography - but if we are to succeed we must avoid being constrained by history, habit and politics.

APPENDIX THREE – Comments on the Model Frameworks

A. LONG TERM CONDITIONS/FRAILTY

- Prevention: education, addressing unemployment culture (ill health is currently incentivised), recognising ill health, incentivising good health, meeting undifferentiated need, role of communities/councils, family history. Need cultural change – education, parenting, lifestyle choices, balance of carrot/stick, people taking responsibility for action
- Diagnosis: acting early, early recognition, screening, clear understanding and stratification of the condition, genetic marking, education/shared care
- Maintenance: self care, recognition of symptoms, who to contact, more practice targeting of groups, positive role modelling, reduce DNAs (part of education and patient responsibility), empowering patients to self care/manage, understand motivational drivers
- Exacerbations/reablement: delay statutory body input, rapid return to normal activity, integration with OOH, small hospital/lots of staff across health economy
- Dying: discuss death and planning
- Need to ensure support across all areas
- Majority of LTC can be avoided
- Identification and accurate stratification
- Preventing illness
- Role models
- Prevention agenda delivered throughout health system (incl. A&E)
- Diagnosis in primary care as default
- Direct access to tests as part of pathway
- Prompt transition to 'staying well'
- Integrated record
- Proactive care – transitional service, generalist/holistic care as default but rapid access to specialist advice to avoid admission
- Role modelling/parental education
- Education and communities taking responsibility
- Very early identification with early advice on prevention
- Greater employer support
- One stop clinics (does my GP know enough (warning signs)? Value of 2nd opinion. Danger of overfamiliarity)
- Big investment in diagnostics for LTC
- CAB in general practice
- Integrating health and social services and others at primary care level
- Patients need to trigger input they need
- Generic skilled teams or groups with internal referrals

- Refer sideways not always upwards – bigger range of options in community, APCS for frailty
- Stop sending people to hospital to die

B. ACUTE EPISODIC

- Self help:
  - education,
  - access to information,
  - Public Health campaigns,
  - care at home,
  - first aid (for all kids),
  - signposting
- Advice:
  - appropriate to biological, psychological & social need
  - consistent information across primary and secondary care with easy access,
  - for LTC professionals
- Urgent:
  - Triage via primary care (fit to walk/sit), high level triage (fit to lie),
  - rapid access and assessment,
  - urgent investigation,
  - risk management,
  - direct access to specialist services,
  - someone who knows my condition,
  - right person at right time,
  - similar access/criteria for urgent,
  - Simplify points of access
- Emergency:
  - hospital now with focused care and all required facilities,
  - clear pathways,
  - direct access,
  - all required people and resources immediately available
- Getting home:
  - communication,
  - electronically,
  - planned
- Senior clinical decision makers first
- New technologies for the next generation
- Prevention – shift to the left – lower acuity of care by catching patients earlier.
- Information through community groups & facilities, school nurses, voluntary groups, practice leaflets & websites, internet access, expert patients, radio & TV

- 7 day, 24/7 care including diagnostics
- Patient directed to most appropriate unit for that condition
- Economies of scale for assessment
- Easy access to services
- Joint discharge planning
- GP first – easy access to specialists
- Easy, rapid outpatient access
- Patients getting care/point of services
- Single portal of access/numbers of access/variety of access
- Consistent info with local specifics
- Use new technologies (NHS Choices/Portal), local A&E website, phone before you walk
- All must be consistent
- Triage is key (patient/e-triage for less severe, clinician-delivered for more severe).
- New types of triage – one stop shop, e-Triage, telemedicine.
- Triage when breached ceiling of care.
- Home visiting service?
- Consistent management irrespective of site of access (+ education)
- Use of clinicians, AHPs, pharmacists
- Simple diagnostics = clinician + test; complex diagnostics = specialist and specialist tests

C. PLANNED CARE

- (I have a problem…) What is the effect? Is it important? What is the prognosis?
- [add column for diagnostics pathway]
- (leave me clear….) Understand how to maintain my health
- (choices) Diagnosis – disease process, consequences, effects on other elements of my health
- To reduce variation throughout county, provision of care should be made more appropriate: E.G. OA knee pain – paracetamol or in another …… knee arthroscopy
- Angina – GTN spray or hospital admission for investigation
- What are the family implications?
- How do we increase patient responsibilities?
- Specialist commissioning in county/out of county planned care provision
- Communication with patient …..(?) health
- Right care based on pathway
- Evidence based delivery of care
- Model built around pathway – based close to home, comprehensive
- I want to know what is going to happen to me when …
- Is what I am experiencing normal for this stage?
- Seeing the right person first

- Commitment to show compassion
- Teamwork
- Signposting patients to correct source of advice for reassurance or diagnostic pathways.
- Clear guidance about referral pathways.
- Patient education signposting
- Effective communication between different part of pathway – seamless, not duplicated
- Rapid understanding of prognosis/disease process/comorbidity/risk stratification……
- Systems/processes wrapped around the patient
- Experts in appropriate areas
- Patient information to support decision making – expert advice
- Patient choices to be communicated across the system
- Boundary free – i.e. all one Trust, and budget for all healthcare
- Facilitation of information for clinicians too
- What is my responsibility as a patient in managing my own condition as I move between primary and secondary care (duty of care, backup, IT system)?
- Clearly defined capability of institutions
- Access to advice or clinician appointment/to diagnostics/to specialist opinion or therapy/to ongoing care

APPENDIX FOUR – Principles for Joint Working – 'Our Moral Compass'

Given the 'Case for Change' and the goals and objectives of the Programme, it is recognised by all parties that complex and difficult decisions lie ahead if this Programme is to succeed in delivering the improvements to care and to health that we seek for the populations we serve. There are several potential trade-offs which cannot be avoided. In every one of these there will be a balance to be found, but one which can never satisfy every individual interest:

- The 'common good' (for all who look to services in this geography for their health care) versus the individual or locally specific good (the preferences of sub groups);
- The present versus the future;
- Organisational interest versus public interest;
- One priority versus another when resources are limited.

It is the role of leaders to reach decisions on these, and to do so transparently and objectively.

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. But working collectively, whilst still acting as separate statutory organisations, requires agreement on what we have called a 'Moral Compass' - ways of working designed to help navigate through when it gets difficult and when the 'trade-offs' have to be decided jointly.

We have agreed the following principles for our Programme - we will hold ourselves to account against them, and would ask others to do the same:

- We are concerned with the interests of all of the populations in England and Wales who use hospital services provided within the territories of Shropshire and Telford and Wrekin. We desire to maximise benefit for that whole population. Whilst our decisions seek to deliver the greatest benefit to the whole population we serve, we will always consider the consequences of any options for either specific local populations or for the needs of minority and deprived groups and will be explicit about how we weight these and our rationale for so doing.
- Participant organisations will individually sign up to the single version of the Case for Change and, at the appropriate point, to a single shared strategic vision and high level clinical model that arises out of the Programme and its response to the Call to Action and other engagement processes. This will be in addition to the collective sign-up represented by the Programme Board agreeing the Programme Execution Plan.
- The Programme will agree, in advance of its key decision–making on the selection of options, an objective set of criteria that will be employed, and these will also be signed-up to by

individual constituent organisations at that stage. These will explicitly address the basis for considering the trade-offs referenced earlier.

- We will make shared decisions on which innovations to roll out at scale, recognising that any one might not always favour all parties and that some sacrifice for the common good will be necessary.
- We will openly consider all options that can enhance our ability to reach collective decisions on key issues, including governance arrangements which are designed to bind our respective boards together.
- We will work collectively with our stakeholders, including politicians, to invite agreement from them to the case for change, the clinically –led model and the principles for decision making.
- We recognise that we will need to find ways that can meet our programme objectives within current levels of overall expenditure. We cannot add costs, instead we need to redistribute resources to achieve a better overall outcome for the populations we serve.
- We will ensure that we develop a shared financial model so that any plans or changes can be assessed on whether they deliver authentic economic benefit i.e. we will not plan to deliver savings in one part of our system if the inevitable consequence is (unplanned) cost increases in another.
- We will develop ways to share the financial risk when implementing major change…we recognise that national payment formulae may not support what we are agreeing to do and we will adjust for that where appropriate.
- We will share all information necessary to allow the Programme to deliver our objectives and will do so in line with the laws and guidance on Information Governance.
- We will share organisational plans and be transparent re budgets.
- We will deliver our individual contributions to the work of the Programme to the highest quality possible and on-time.
- We will all use a single version of documents pertaining to the Programme and these will be prepared for us by the Programme Office. We will coordinate consideration of key documents so that we avoid the issues (of fact and perception) that can arise when key considerations or decisions are taken sequentially rather than simultaneously.
- We will work together to ensure that public and patient engagement in our Programme is extensive, timely and meaningful and that we engage in the formulation of options as well as in response to recommendations on them - we want this Programme to be characterised by co-production with patients and public.
- The response to Call to Action told us that the public, whilst wanting full engagement at all stages and no predetermination of outcomes, want and respect clinically-led development of strategies and options. We will ensure that this happens.
- Whilst partnership and collective working on the Programme is essential, so too at times will be the need for organisations to pursue their own objectives (e.g. in relation to competition amongst service providers). Where this is felt by any constituent to be the case, then we

agree to making that explicit to our partners, to explain our position, and to work with the Programme to enable continued collective decision making to continue.

- The response to the Call to Action asked us to avoid being constrained by history, habit and politics and to look to do 'the right thing'. We will explain any decisions we make clearly and in that light.
- Being part of the CSR Programme represents a clear commitment, and we will take collective responsibility for making progress towards a shared vision for improved services and health.