Future Fit Clinical Reference Group meeting notes
Wednesday 22nd October 2014

The Future Fit programme's Clinical Reference Group met at the Albright Hussey Hotel, Shrewsbury. In attendance were 62 people, comprised of clinicians, key stakeholders and patients. (Appendix 1)

The evening was structured into 5 parts:

1. Introduction
2. Floor Discussion – 'How do we make the clinical model work?' and phase 2 of the modelling.
3. Table Exercise and Floor Discussion - 'What else should we prototype?'
4. Introduction of Clinical Alliance
5. Closing

Part 1 - Introduction

Edwin Borman welcomed attendees and set out the objectives for the evening:

- Review the programme and clinical vision
- Discuss the level of change required
- Prioritise the things we need to do now
- Agree a way of managing the changes

Mike Sharon provided an update on current programme progress, including the longlist that has been agreed and the challenges now faced.

Mike Innes reminded members of the core components of the clinical model and the agreed system principles.

Part 2 - Floor Discussion – 'How do we make the clinical model work?' and phase 2 of the model.

Bill Gowans made a presentation entitled **'How do we make the clinical model work?'** He highlighted that the model needs support from the people in the room (in addition to others), integrated care pathways, changing the way people are looked after, improved IT provision and working together across the 'silos' of division between Primary, Secondary, Community and Mental Health care, as well as input from Social Services and other provisions across the area.

Bill Gowans then took the group through phase 2 of the modelling process. In the discussion that followed, a number of questions were raised:

- **Double counting**: The latest figures have been revised to exclude this.

- **Reducing LTC prevalence:** It was acknowledged that 'people will still get something' but interventions should delay onset and so reduce overall impact. There is also evidence that some interventions can have an in-year effect (e.g. smoking cessation). The modelling looks at trends and assumes social change. The potential benefits of both national and local interventions (e.g. minimum unit pricing for alcohol) were noted.

- **Reducing Length of Stay (LOS):** The vast majority of admissions <7 days will need acute medical care but, after 7 days the majority would benefit from intensive rehabilitation. If there was a 7 day LOS standard for acute care, bed days could reduce by some 40% although the biggest challenge would be to reduce the long tail of the relevant activity. Mark Cheetham suggested that the 3 main reasons for >7 day LOS are social care waits, patients who are seriously ill, and complex cases with various episodes. Kevin Eardley highlighted that many patients do not need to be in an acute hospital. David Sandbach

reported comparing LOS in SaTH with other organisations and suggested that differences could be accounted for by what is available in the community. Peter Clowes highlighted the problem of access to care packages and placements.

Bill Gowans differentiated 'doing it now' from 'future planning' and highlighted examples of learning by doing (e.g. ICS, RSH UCC, discharge to assess). He asked what else should be prototyped. Prior to group discussion a number of issues were raised:

- **Provider stability:** David Evans invited members to exclude this concern for the purposes of the current exercise, adding that commissioners will subsequently need to work with providers on a sustainable payment mechanism. Mike Sharon added that the starting point is how to provide the right care then to look at any problems and how they can be dealt with. There is no assumption that services would cost more or less: the programme is simply looking for the right thing to do clinically. Paul Tulley said there is a difference between things that might cost more and things that would not but would need a new way of distributing resources.
- **Workforce:** There is a need to increase engagement and involvement in all settings. In addition, when testing the feasibility of prototyping we need to include all elements of the plan (especially workforce) not just bricks and mortar.
- **Alignment of plans:** 'We need to do a load of stuff now' – because we need to know what's going to happen. We need to align changing clinical practice to work alongside Future Fit plans – they need to be strategic, lined up, and need to work alongside current plans.

Part 3 - Table Exercise and Floor Discussion - 'What else should we prototype?'

Each table then had 40 minutes to discuss '**What else should we prototype?**' and were tasked with generating ideas, prioritising them, and present their top 3 to the room for floor discussions.

Points raised on Tables included:

Table	Key Issue	Expansion/Detail
1	Integrated IT	Integrated patient care record accessible and contributed to by all clinicians and care givers Sharing Information – clinical/when appointments are/that a consultant has read letters Facilitates partnership care and communication – phone call Time saved Increased quality of information Better/safer
	7 day working	Reduce bed days Quality/safety Avoid decompensating Therapies
	Delayed discharges	Access to social care packages Planning discharge prior to admission for planned admissions Mobilisation of local communities to support this
2	Bring back 'Winter Nine'	Live whole system demand and capacity management driven through clinical leadership at organisational and system level and supported by live whole system dashboard to deliver audit, live

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		management and predictive planning Co-location of professional, patient and workforce management systems to promote collaboration, co-responsibility and whole pathway care
	Shared care record owned by patient	Cloud based Available to all involved in care
	Put in support for patient self-management	Direct access for advice/having a menu of options Use peer support/voluntary sector Single point of access
	'Paramedic Pathfinder'	Use algorithms for assessment and alternative destinations Identifying knowledge of where secondary care expertise is located
	Integrated rehab service	Expand ICS Combine services into clusters
3	Prototype rural UCC	Testing hypothesis at UCC – UCC/OOH/DAART would enable higher active patients to be managed in attached community beds
	Enhanced flow by direct referral horizontally	Intelligent navigation of patients when need more than one option
	Rehabilitation facilities to decompress SaTH	Using an intensive rehab model to manage >7 day stay LOS patients to test if it can be done – either in SATH through re-designation of beds and / or by transfer to community facility Extends the Discharge to Assess model to much higher intensity patients
	Therapy led stroke initiative design	E.g. preventing contracture and reducing surgery through higher intensity and longer duration of therapy after stroke Allowing county wide therapy to design services and make area more attractive to work in
	Neonatal health input/part of ICS	Reduce LOS team Reduce readmission
4	Pre front door	Prevention – multi agency, whole economy approach Universal us together prevention Further downstream - core pledges Have core package – together intervention based on specific areas
	Prototype education programme linked to easier and earlier intervention	
	Discharge flow through	Personal health budget prototype Outcome of facilitated discharge and personal choice Whole system approach – is patient fundamentally safe? Give control back to patient – test hypothesis that they will choose appropriate and cost effective care Team coordinates
	Re-invent what social care looks like	
5	Urgent Care Centre	Reinventing cottage hospital? Telemedicine – OPD/LTC Access to imaging and diagnostics Respiratory monitoring Supervision/observation
	'Telehealth' at home	Early transfer out – community beds/nursing homes
	Integrated therapists	Vertical integration Integrated cluster systems
6	Transformation of IT system	SaTH – clinical portal – access by GPs?
	Ideal referral letter	Summary which is succinct Care package/rehab/family care

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		Pre admission/discharge planning (Owned by GP?)
	Discharge packages - Pump prime	
	7 day week working – Therapies in SaTH	
	Integration of DAART with acute medicine at RSH	Frailty ++
	Fit to transfer	Dialogue with GP to assist with transfer
	Mobilization of local communities to set up support for local people	
8	Emergency fund available with hours for private social care	
	Self-management (in general)	
	Ban smoking on all NHS premises	
	Psychological input for chronic conditions – chronic pain and M.V.S	
	Telemedicine for early supported discharge following admission – especially for respiratory disorders	
	Therapy supportive discharge for stroke/frailty/cancer	
	Prototyping local planned centre	
	Give primary care access to the SaTH clinical portal	
	Make an integrated record	
	Look at transitions in care and reduce them	
	Hire a community psycho-geriatrician	
	Train GPs in A+E	
	Pilot an emergency care service to take patients to UCC (Use third sector like Blood Bikes)	
	Set up clinical forum for staff in Shropshire across all sectors	
	Fund 7 day admission to hospices	
	Train GPs to do ultrasound	
9	Specialised teams for complex needs	Agreed care plans Social care MDT Therapies Mental Health
	Scrap PbR now!	
	Involve GP federation	
	Link MIU's with A+E – virtual?	
	Use community pharmacy	Prevention/medicating LTC Medication optimisation
	'Telehealth'	
	Joint working paediatrics	Involve school nurses
	CAU inside A+E	
	'Hospitals without walls'	
	Frailty	Intermediate properly staffed including voluntary sector
	Virtual organisation	
	Single healthcare record	
	'What is really necessary?'	

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Questions and discussion points raised in floor discussion:

- Live demand and capacity system + pathfinder (WMAS)
- Acute care in the community
- Integrated care record and partnership care – prototype hospital portal accessible to GPs and patient access to records via the cloud
- Rapid diverse response social care building on community action
- Scrap PbR – virtual hospital for exacerbations, with wide pallet of offers
- MDT with partnership care team
- Co-locate acute medical service with DAART
- Stroke rehab + raise the bar on mobility
- Ground level triage / capacity management
- Integrate community + 1 care offer with 'team around the practice'
- Self-management options – care plan
- Whole system risk strategy analysis for complex patients (relates to psychology + mental health)
- Telemedicine monitoring to support care in community
- Prototype fiscal flows
- 7 day working especially avoiding decompensation of frail
- Ban smoking on all NHS grounds
- Rural urgent care centre especially high acuity admission avoidance
- Pathways: decrease variability and increase IT at front end to avoid inconsistency
- Personal health care set to provide/enhance ESD patient determined level of care
- Fit to discharge – responsibility of community care clinician

Key areas for further investigation/discussion and analysis.

- Integrated IT system is the first priority, but it would be helpful to share more than clinical information across the system – including letter chasing, utilising phone calls between Primary Consultants and GP's. This will increase efficiency and safety, and the systems are already in place in other parts of the country. Several clinicians shared stories of patients being shocked at the lack of access to records that clinicians had in primary, secondary and emergency care settings. There were concerns raised about the accessibility of this to patients in groups without access to the internet, or who are not technologically capable.
- Emergency fund to buy social care, to keep people out of A+E for social issues better dealt with elsewhere. Examples were shared about provision in other parts of the country for this, but the lack of staff able to work on it, resulting in a failing or less than ideal situation.
- Provision of a virtual hospital for stroke and other conditions; utilising MDT, agreed care plans and day centres as a step down facility post discharge. The provision of day centres and MDT being very small to add communication and movement – this provision would have a MDT team, including a community geriatrician, and GPwSI team.
- Integration of care – some patients have experienced being treated acutely but not having on-going community based care afterwards. Need to increase ownership of MDT teams.

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- Use community pharmacies more – utilise knowledge, link in with GPs by 'telehealth' and optimisation of other systems.
- Ban smoking from all NHS property.
- Look at pathways and use of them – why people do or don't use them, monitor using CCC and make more use of clinical support staff at CCCs. If patients start on wrong pathway it is very hard to re-address.
- Personal Healthcare budgets – look at risks for discharge, ensuring patients getting appropriate level of care.
- Fit to transfer patients – can the prioritisation of patients be changed, looking at if they can be cared for under a community physician – patient stays within SaTH but beds are utilised elsewhere.
- Emergency fund provision would decrease admissions and put resources back into the community, especially with the development of a 'Care Conclusion' team. Aware that there are pockets of very good systems in place across the area, and we have to concentrate on developing those area wide.
- Changes in Policy – Local and National.
- Improving cycling routes and provision across the area, but this needs to be community based and locally run – this feeds back into the increased engagement and sense of responsibility that needs facilitating.
- Changing alcohol unit minimum prices – awareness that national policy changes would be helpful as locally cannot change, and that this would have a wider impact. It was shared that BMA have written a letter to EU asking them to take formal action – minimal unit price has been a dream for a while. It hasn't gone through because of the trade agreement SITA which could mean that companies could have precedent for potential loss of earnings. Local health groups have an opportunity to help with this.
- Monitor length of stay across service.
- Marry services up so that no duplications across area.
- Supporting patients to self-manage their long term care.

Examples and further discussion of these ideas in practise were also given:

- There is already an integrated IT sharing system in place across path' labs in the county.
- WMAS has developed a Mental Health Car service staffed by paramedics, Police officers and social workers.
- Provision is available in South Powys where service users can utilise their cottage hospital which works alongside community nurses/physiotherapists/occupational therapists/community geriatrician amongst others – a 'true MDT'. This is deemed to be successful as care is provided around the clock, but day time care – where there is a greater need – is provided by someone else, to be complimented at night by the evening care provided. This enables issues to be picked up on and actioned. Another example was given of the day cottage hospital in Wellington where patients can go in the day 5/7 and have access to Occupational Therapy/Physiotherapy/Medical Practitioners there during the day with self/other care at home during the night.
- There are a small number of patients that take up a lot more time than others, an increase in communication and integration would mean that these patients would be more widely known and be able to be treated by an MDT that are aware of all of the patients issues.
- Example given of Bolton area geriatric care, where care is physically split into 3 types of beds/centres for different types of post-operative needs – recovery and rehabilitation and re-enablement being examples. The breakdown of length of stay in this scenario is also a factor and broken up into acute (less than 3 day), 3-14 days and longer than 14 days as well as other services such as rehabilitation.
- There needs to be a great deal of staff involvement and engagement.

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The overwhelming feedback from the prototyping exercise was the importance of work to increase the integration of, and communication between, services and care providers; as well as improving the IT and technological provision across all of the services and areas involved.

Part 4 - Introduction of Clinical Alliance

Bill Gowans introduced the group to the formation of a Clinical Alliance, to further increase the clinical insight into the Future Fit programme and maximise the transfer of learning and exploring. This will be utilised and recruited to before Christmas. A number of members indicated a willingness to be involved and expressions of interest will be sought by email.

Part 5 - Closing

Edwin Bowman closed the evening with a summary of key points.

- We have worked more together in the clinical reference group than the health economy has done for a very long time in this health economy.
- The artificial barriers between the different NHS organisations must be broken down so we can work together in a very different way.
- The overriding message was integration – fascinating to see more working together for more than a long time. It has been a pleasure to see working together, and make this a thing to achieve over 5 years – all ideas need collaboration work and the key message is that we do work together in a very different way.
- 190k patient presentations are going to have to interact with their healthcare differently – they are going to come into a new environment that hasn't been developed yet – not as now – otherwise the new system will only work as well as the current one, which isn't working.
- Work doesn't finish here, please take one idea and take back to colleagues – what would be have to do to make that happen, what could we do to make that happen, and how can we help – clinical engagement – keep the momentum up.
- The work doesn't finish here but start here. We are going to have another clinical reference group in January.

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Appendix 1 – Attendance Record

Name	Organisation	Please Sign In
Alison Blofield	*South Staffordshire & Shropshire Healthcare NHS Foundation Trust*	**ATTENDED**
Amanda Walshaw	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Andrew Tapp	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Andy Raynsford	*Powys Local Health Board*	**ATTENDED**
Anthea Gregory-Page	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Bill Gowans	*Shropshire Clinical Commissioning Group*	**ATTENDED**
Carole Hall	*Healthwatch*	**ATTENDED**
Caron Morton	*Shropshire Clinical Commissioning Group*	**ATTENDED**
Cath Molineux	*Shropshire Community Trust*	**ATTENDED**
Colin Stanford	*Shropshire Clinical Commissioning Group*	**ATTENDED**
David Beechey	*Healthwatch*	**ATTENDED**
David Evans	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
David Frith	*Midlands and Lancashire CSU*	**ATTENDED**
David Sandbach	*Patient Representative*	**ATTENDED**
Debbie Jones	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Edwin Borman	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Ellen Nolan	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Emma Lawrence	*Shropshire Community Trust*	**ATTENDED**
Frank Hinde	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
George Rook	*Healthwatch*	**ATTENDED**
Gill Clements	*ShropDoc*	**ATTENDED**
Gilly Scott	*Shropshire Community Trust*	**ATTENDED**
Graham Shepherd	*Patient Representative*	**ATTENDED**
Ian Rummens	*Shropshire Clinical Commissioning Group*	**ATTENDED**
Jill Dale	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Julia Visick	*Shropshire Clinical Commissioning Group*	**ATTENDED**
Karen George	*Shropshire Community Trust*	**ATTENDED**
Karen Taylor	*Shropshire Community Trust*	**ATTENDED**
Kevin Eardley	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Lisa Perkins	*ShropDoc*	**ATTENDED**
Lorraine Eades	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Malcolm Locke	*RAID*	**ATTENDED**
Mark Cheetham	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**

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Martyn Rees	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Mary McCarthy	*Shropshire Clinical Commissioning Group*	**ATTENDED**
Matt Ward	*West Midlands Ambulance Service*	**ATTENDED**
Mike Innes	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Mike Sharon	*Midlands and Lancashire CSU*	**ATTENDED**
Mike Teague	*Patient Representative*	**ATTENDED**
Peter Clowes	*Shropshire Clinical Commissioning Group*	**ATTENDED**
Sharon Boyle	*Shropshire Community Trust*	**ATTENDED**
Simon Smith	*South Staffordshire & Shropshire Healthcare NHS Foundation Trust*	**ATTENDED**
Steve McKew	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Yvonne Rimmer	*Shropshire Community Trust*	**ATTENDED**
Andrew Roberts	*Robert Jones and Agnes Hunt Orthopaedic Hospital*	**ATTENDED**
James Briscoe	*South Staffordshire & Shropshire Healthcare NHS Foundation Trust*	**ATTENDED**
Louise Warburton	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Paul Tulley	*Shropshire CCG*	**ATTENDED**
Michael Matthee	*(Shropshire GP)*	**ATTENDED**
Rachel Hotchkiss	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Bruce McElroy	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Jo Leahy	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Stefan Waldendorf	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Fran Beck	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Jane Pannikar	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Nigel Russell	*Chair Shrewsbury Locality*	**ATTENDED**
Emily Peer	*Ass MD SCHT*	**ATTENDED**
Jo Banks	*Shrewsbury & Telford Hospitals NHS Trust*	**ATTENDED**
Stuart Wright	*Shropshire CCG*	**ATTENDED**
Richard Smith	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Jim Milligan	*Telford & Wrekin Clinical Commissioning Group*	**ATTENDED**
Neil Harper	*Strichley Medical Practice*	**ATTENDED**
		62 ATTENDEES
+ Mikayla Williams, Stephen Williams - note taking		