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Summary of Key Programme Products

October 2015

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Introduction

The purpose of this document is to record the initial achievements of local clinicians, patients and partner organisations in their work together on the NHS Future Fit programme.

It sets out the foundations on which subsequent stages of the programme can build.

Local clinicians were mandated to do this work – and to continue engaging the public in it – as a result of the *Call to Action* process in 2013.

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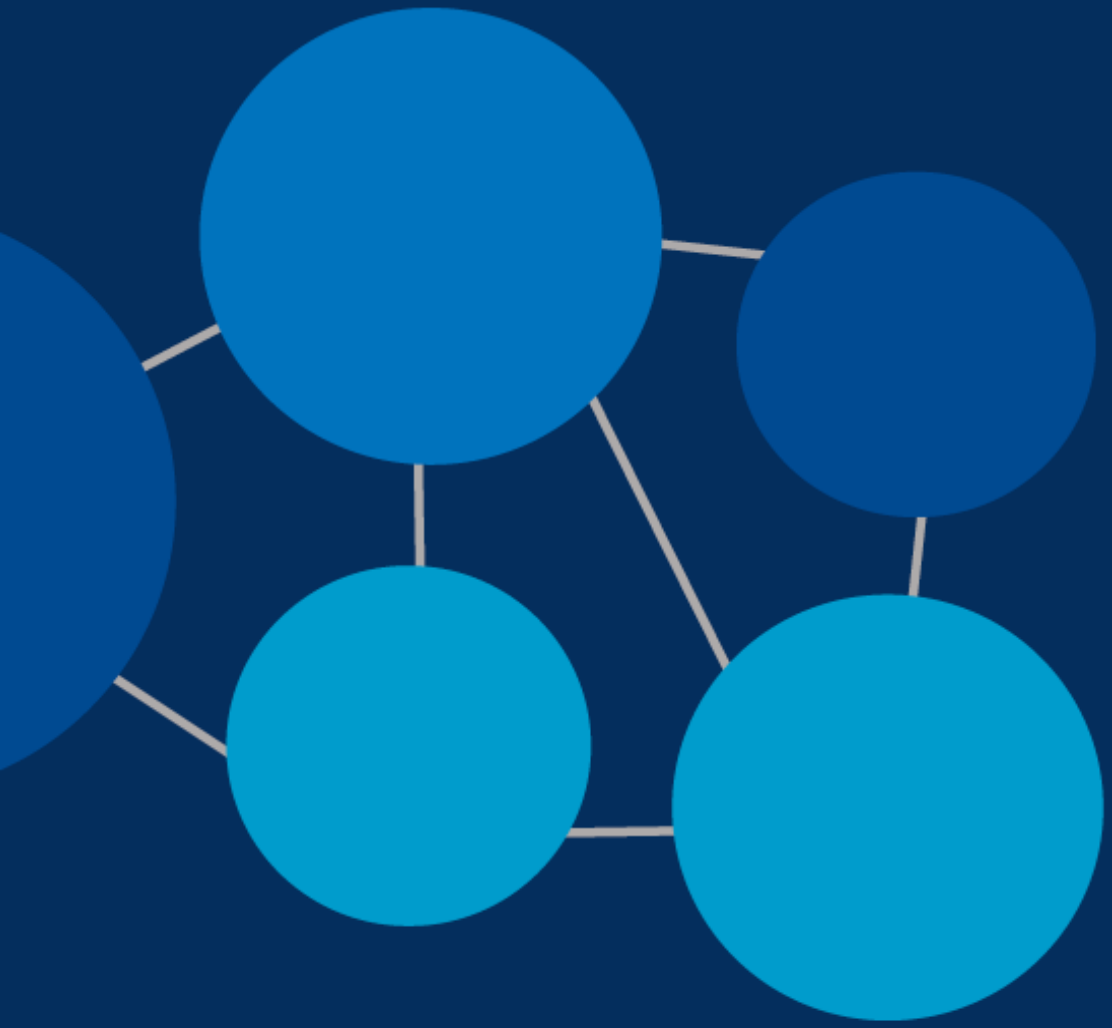

Call to Action

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Call to Action Public Survey

- c.3,000 responses (not stratified)
- Access then quality were key public priorities
- Key themes were:
  - More/improved local services/more care out of hospital (28%)
  - Improve hospitals (16%)
  - Resources (14%)
  - Improve/more staff education (10%)

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Call to Action Conclusions

There was real consensus between public and clinicians that:

- There is a case for making significant change;
- The process should be clinically-led and with extensive public involvement;
- There are real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;
- Hospitals are currently misused as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives;
- It is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of both rural and urban populations, and;
- Proposals should not be constrained by history, habit and politics.

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Summary of Programme Progress to Date

Date	Deliverable
November 2013	• *Call to Action* process identified public and clinical support for making significant change
January 2014	• Full Case for Change developed and programme initiated
May 2014	• NHSE Stage 1 Strategic Sense Check
June 2014	• Clinical Model developed through workshops with c.300 clinicians plus patient representatives • Long list of 13 options developed by stakeholder group
August 2014	• Conversion of Clinical Model into activity and capacity implications completed ('Phase 2' modelling)
January 2015	• WM Clinical Senate Stage 1 Review completed - *…there is an unsustainable health model ……which warrants a need for fundamental change and improvement*
February 2015	• Short list of 6 delivery options plus 2 obstetric variants agreed
August 2015	• Option development completed • Proposed reduction of shortlist to 3 options/1 obstetric variant
September 2015	• Option appraisal completed

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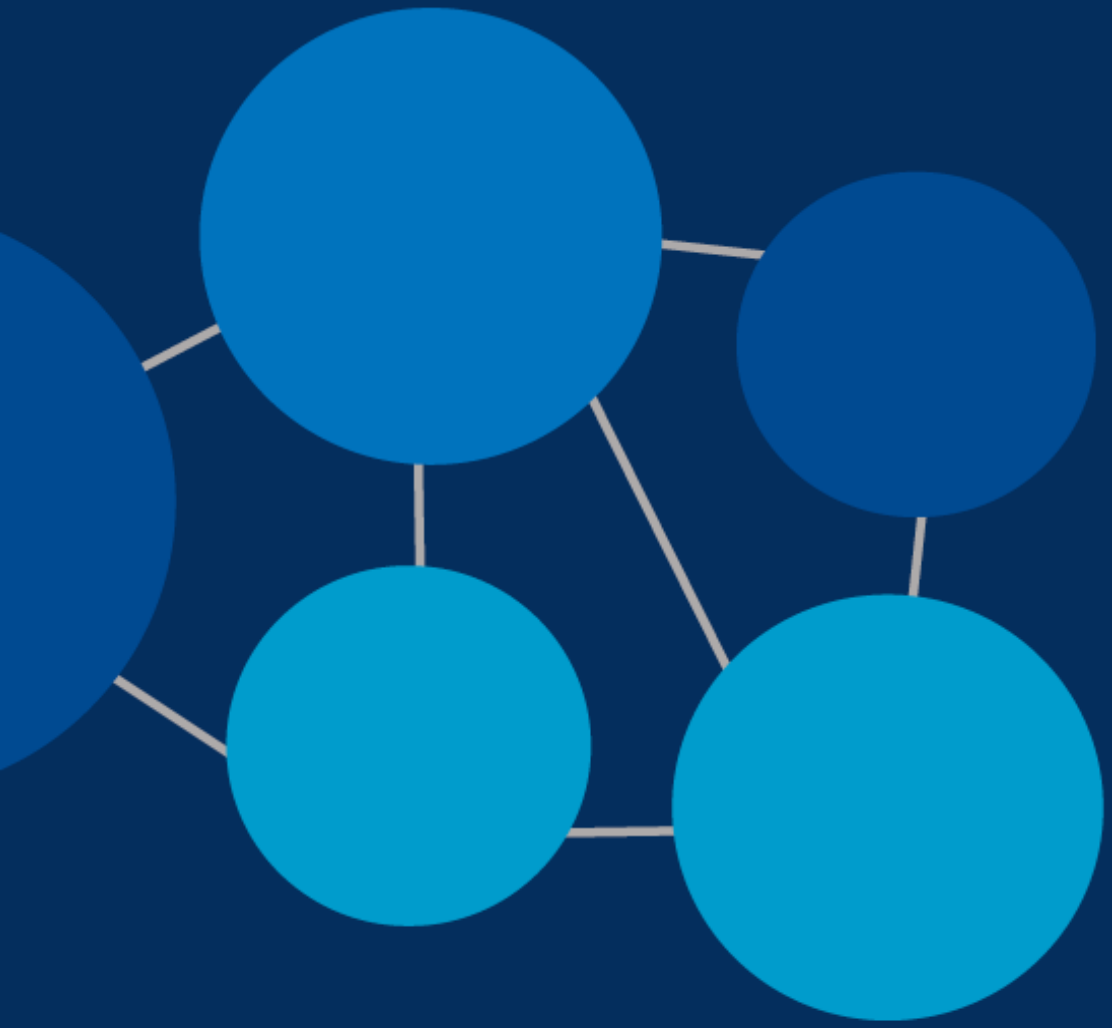

Phase 1

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Key Products by Phase

- **Phase 1** (October 2013 - January 2014)
  - Programme Set-up
  - Determining the High-Level Clinical Model
- **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
- **Phase 3** (August 2014 - September 2015)
  - Identification of options and option appraisal
  - Preparation of Strategic Outline Case(s)
- **Phase 4** (tbc)
  - Preparation for Public Consultation, 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

Case for Change

Challenges

- Availability of key workforce groups
- Changes in our population profile
- Changing patterns of illness
- Higher expectations
- Clinical standards
- Developments in medical technology
- Economic challenges

Opportunities

- Achieve better clinical outcomes
- Highly attractive services to rebuild staff morale
- Better adjacencies between services
- Improved environments for care
- Better match between need and levels of care
- Reduced dependence on hospitals as a fall-back
- Co-ordinated and integrated system of care

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Case for Change

Since the Programme began, the economic challenges facing the NHS have increased and workforce risks have escalated.

All West Midlands Emergency Departments	ED Consultant Hours per week (max 24x7 = 168)	
Hospital Site	Number	%
Queen Elizabeth Hospital, Birmingham	119.0	70.8%
University Hospital, Coventry	119.0	70.8%
County Hospital, Stafford	117.3	69.8%
City General Hospital, Stoke	112.0	66.7%
New Cross Hospital, Wolverhampton	97.0	57.7%
Birmingham Children's Hospital	92.9	55.3%
Manor Hospital, Walsall	88.0	52.4%
Good Hope Hospital	86.0	51.2%
Heartlands Hospital, Birmingham	86.0	51.2%
City Hospital, Birmingham	82.0	48.8%
Sandwell General Hospital	82.0	48.8%
Queen's Hospital, Burton	81.0	48.2%
Worcestershire Royal Hospital	79.0	47.0%
Russells Hall Hospital, Dudley	77.0	45.8%
George Eliot Hospital, Nuneaton	70.0	41.7%
Warwick Hospital	68.0	40.5%
The County Hospital, Hereford	65.0	38.7%
Alexandra Hospital, Redditch	60.0	35.7%
Royal Shrewsbury Hospital	**58.0**	**34.5%**
Princess Royal Hospital, Telford	**49.0**	**29.2%**
Solihull Hospital	40.0	23.8%
AVERAGE	82.3	49.0%

Emergency Department Activity and Consultant Cover by site	2013/14 ED Attendances	Consultant Hours in ED / wk (max 24x7 = 168)	Attendances per Consultant Hour per week
University Hospital, Coventry	121,966	119.0	20
City General Hospital, Stoke	114,043	112.0	20
Heartlands Hospital, Birmingham	111,600	86.0	25
New Cross Hospital, Wolverhampton	108,390	97.0	21
Queen Elizabeth Hospital, Birmingham	94,705	119.0	15
Russells Hall Hospital, Dudley	94,654	77.0	24
City Hospital, Birmingham	79,989	82.0	19
Good Hope Hospital	77,885	86.0	17
Manor Hospital, Walsall	71,035	88.0	16
Sandwell General Hospital	67,662	82.0	16
Worcestershire Royal Hospital	63,527	79.0	15
Warwick Hospital	53,915	68.0	15
Princess Royal Hospital, Telford	**53,323**	**49.0**	**20.9**
George Eliot Hospital, Nuneaton	51,993	70.0	14
Alexandra Hospital, Redditch	50,993	60.0	16
Birmingham Children's Hospital	49,683	92.9	10
The County Hospital, Hereford	48,504	65.0	14
County Hospital, Stafford	46,923	117.3	8
Solihull Hospital	43,313	40.0	21
Royal Shrewsbury Hospital	**41,960**	**58.0**	**13.9**
Queen's Hospital, Burton	40,111	81.0	10
TOTAL	1,486,174	1728.2	351.1
AVERAGE	70,770	82	16.5

Communications and Engagement

MIDLANDS AND LANCASHIRE COMMISSIONING SUPPORT UNIT

midlandsandlancashirecsu.nhs.uk

ENGAGEMENT

Deliberative events
- Ten
- Six locations
- 300+ participants
- Key learning's
  - Came to learn more
  - Majority agreed changes are needed to healthcare delivery
  - Quality of healthcare rated above average
  - 187 questions raised
  - 53 ideas captured

Stakeholder engagement
- **Supported creation of clinical design report**
- **Supporting clinical reference group**
- Key messages conveyed via:
  - Public meetings
  - Presentations
  - One-to-One's
  - Group workshops
  - General awareness raising

Pop up stands
- Fifteen
- Thirteen locations
- High public interaction
- 144 x direct feedback
- 174 x join mailing list
- Increased brand awareness
- Positive workforce engagement

Delivered to 45+ audiences including:
- Patient groups
- Powys Teaching Health Board
- Health and social care networks
- Local Joint Councils
- Young health champions
- Senior citizens forums
- Parish Councils
- Cabinet / members
- Health and Well Being Board

STAKEHOLDER MANAGEMENT

MP/Parliamentary candidate profiling
MP briefings
- Regular group and one-to-one briefings
- Parliamentary/Cabinet briefings
- Programme bulletin / Newsletter
- Distributed to internal and external stakeholders

MEDIA

Proactive press
- 27 press releases issued

Reactive press
- 109 media enquiries handled
- 75 of which from Shropshire Star and BBC Radio Shropshire
- Seven rebuttals against Shropshire Defend Our NHS – active campaign group

Media briefings
- Short-listing press conference and subsequent coverage

Media monitoring
- Monitoring editorial and online content
- Track positive/negative sentiment

STRATEGIC COMMUNICATION

- Programme Board
- Workstream governance
- Key messaging
- Brand positioning
- Bid writing, procured funds
- Report writing
- Risk register, creation of identifying risks
- Relationship management profiling
- Creation of strategy, co-created with patients

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INTERNAL COMMUNICATION

Staff briefings
- Two workforce briefings - Telford CCG
- Two workforce engagement events at PRH and RSH
- Workforce engagement during pop up stands

Media messaging / FAQs session
- Two sessions – Telford and Shrewsbury
- Ten attendees

DIGITAL @

Website
- Established in December 2013
- 7,111 visits to date
- Pages with most hits – Home, Events and News
- 70.3% visits as a result of twitter hits

Social Sign In
- Run pre-scheduled twitter campaigns
- 75 pop up stand campaign posts
- 274 clicks to NHS Future Fit website
- 234.2k total potential reach
- 148 re-tweets/shares
- 32 likes

Twitter
- Established in July 2014
- 661 followers
- 668 following
- 777 tweets sent

Blogs
- Nine blogs on key themes

ADMINISTRATION

- Governance and Workstream
- Planning
- Evidencing communications and engagement
- Continual updating of activity plan
- Financial reporting
- Budget management
- Support and advice - The Consultation Institute
- Benchmarking
- Facilitating external meetings

MARKETING

Branding/Advertising
- Series of adverts in local newspapers
- Shropshire Star readership – 98, 146
- Telford Journal readership – 61,541

Contact lists
- 1860 stakeholders on contact list
- 405 public on mailing list

Marketing/promotional materials
- Marketing material - pull up banners, leaflets, clinical design summary, mailing list cards
- Promotional items - plasters, hand sanitizer, pens

Telephone survey
- Scientific data collection
- Telephone interviews with residents living in Shropshire (60%), Telford & Wrekin (31%) and East Powys (9%)
- Exploring the use of hospitals and perceptions of plans to improve future healthcare delivery in Shropshire, Telford & Wrekin and East Powys
- The survey results include responses from 1015 people

Equality and diversity monitoring
- Supporting Integrated Impact Assessment
- Investigating gatekeepers to "hard to reach" groups
- Running equality focus groups

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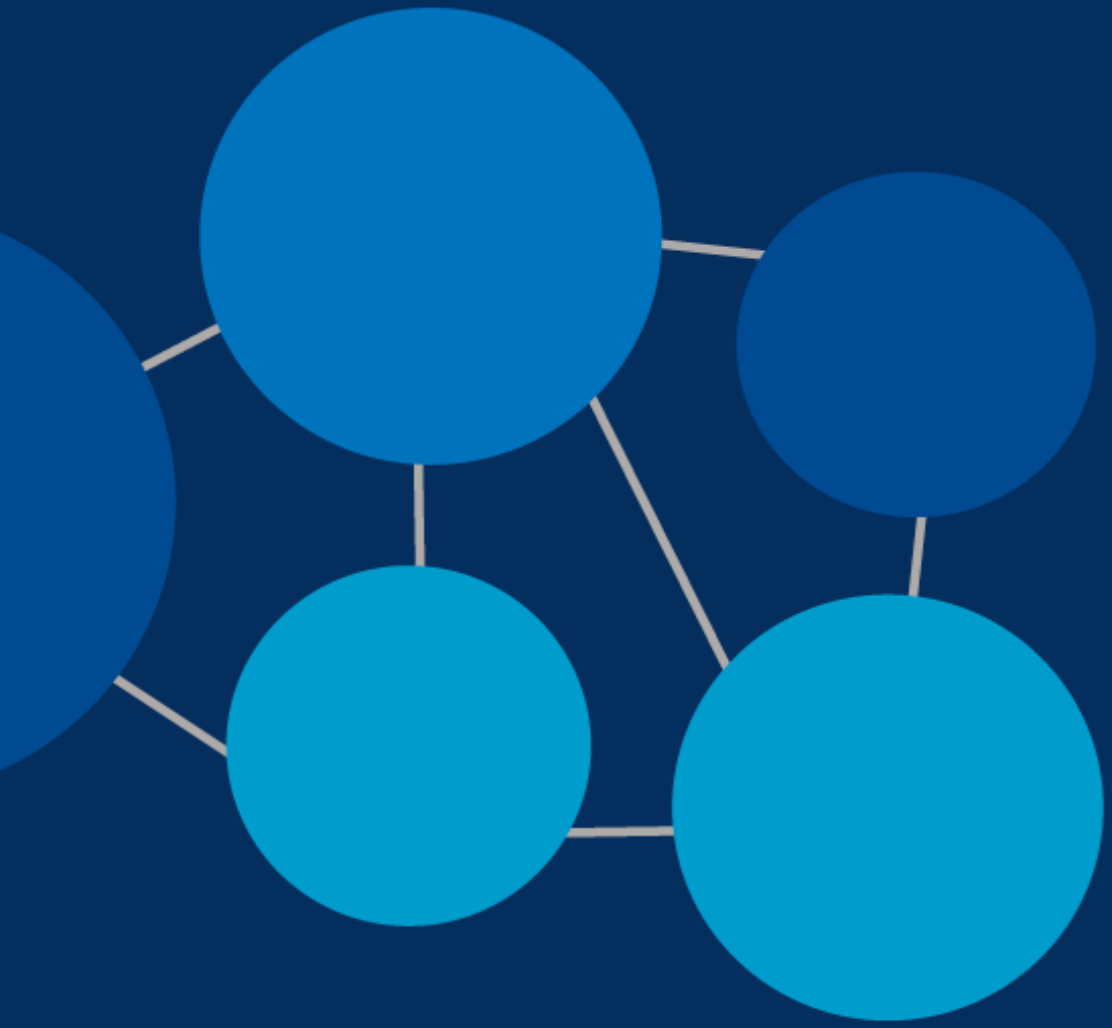

Phase 2

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Phase 2 (February 2014 - August 2014)

- **Determining the Overall Model of Clinical Services**
  - c. 300 clinicians worked together in sub-groups, cross-cutting theme groups and Clinical Reference Group to develop and endorse a new Clinical Model.
  - Model reviewed by WM Clinical Senate which confirmed unsustainability of current configuration
- **Identification and quantification of the levels of activity and capacity in each part of the Model**
  - Clinicians (with patients and managers) undertook 2 phases of modelling
  - Phase 1 modelled the impact on acute & community hospitals of implementing commissioner and provider efficiency strategies but with no major service change
  - Phase 2 involved clinicians agreeing key activity assumptions based on the implementation of the Clinical Model.
  - The resulting activity and capacity impact was then modelled & assumptions revisited to test potential for further efficiencies.

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Phase 2 (February 2014 - August 2014)

- **Determining the Feasibility of a Single Emergency Centre**
  - A study was commissioned to test the feasibility of delivering a single emergency centre and a planned care centre at PRH, RSH and a potential new site
- **Public Engagement on the Model of Care and Provisional Long-list & Benefit Criteria**
  - Extensive pre-consultation engagement activities were undertaken with patients to inform the development of the Clinical Model, a long list of site scenarios and the criteria against which scenarios should be assessed.
  - An evaluation panel was formed of nominated representative of Programme Board Sponsors & Stakeholders which:
    - Generated 40 ideas for the configuration of services
    - Proposed a long list of 13 scenarios for acute/community sites
    - Identified five evaluation criteria

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Clinical Model – design principles

Home is normal

Empowerment for patients and clinicians

Sustainability

New ways of working

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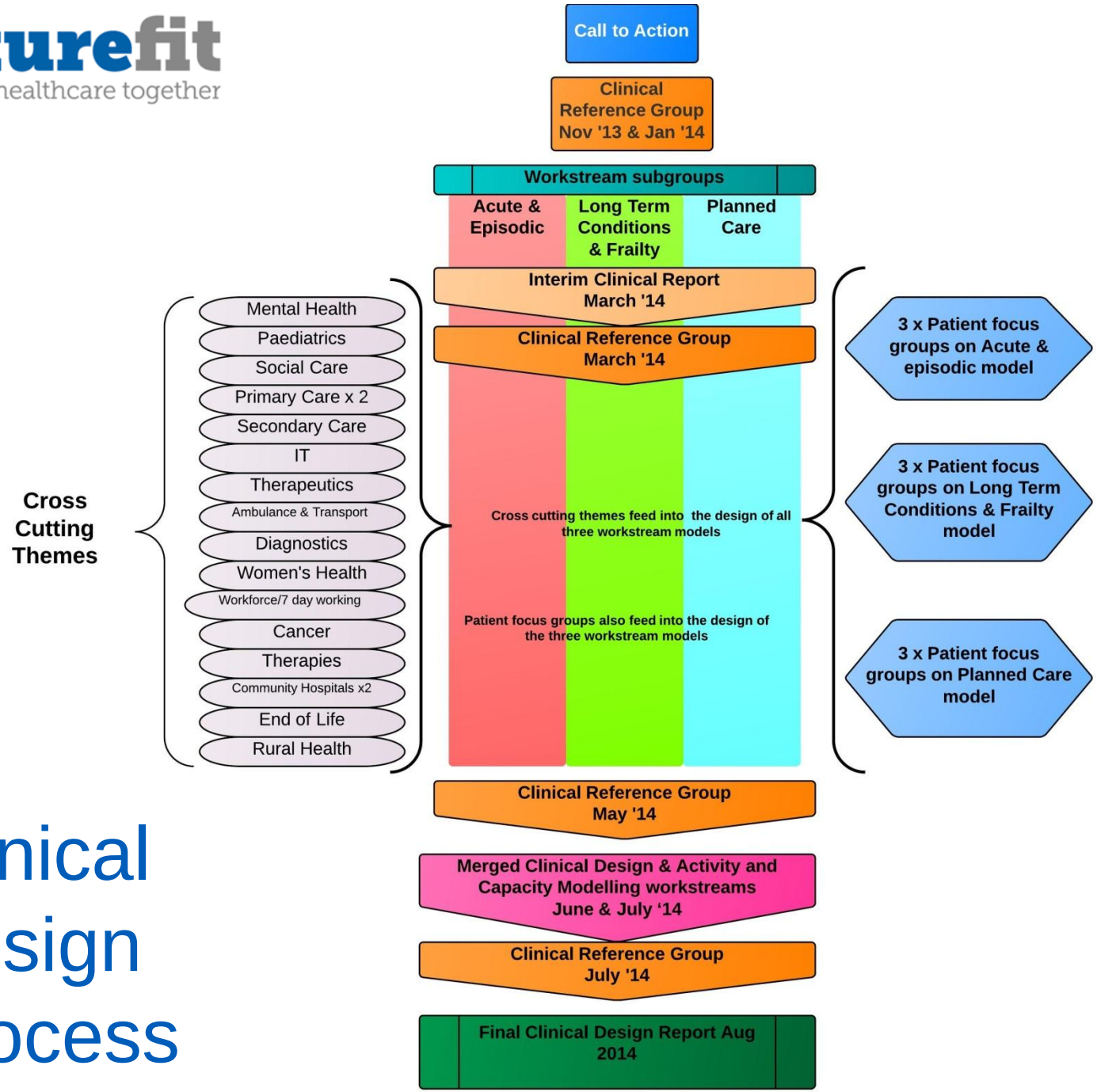
Clinical Design Process



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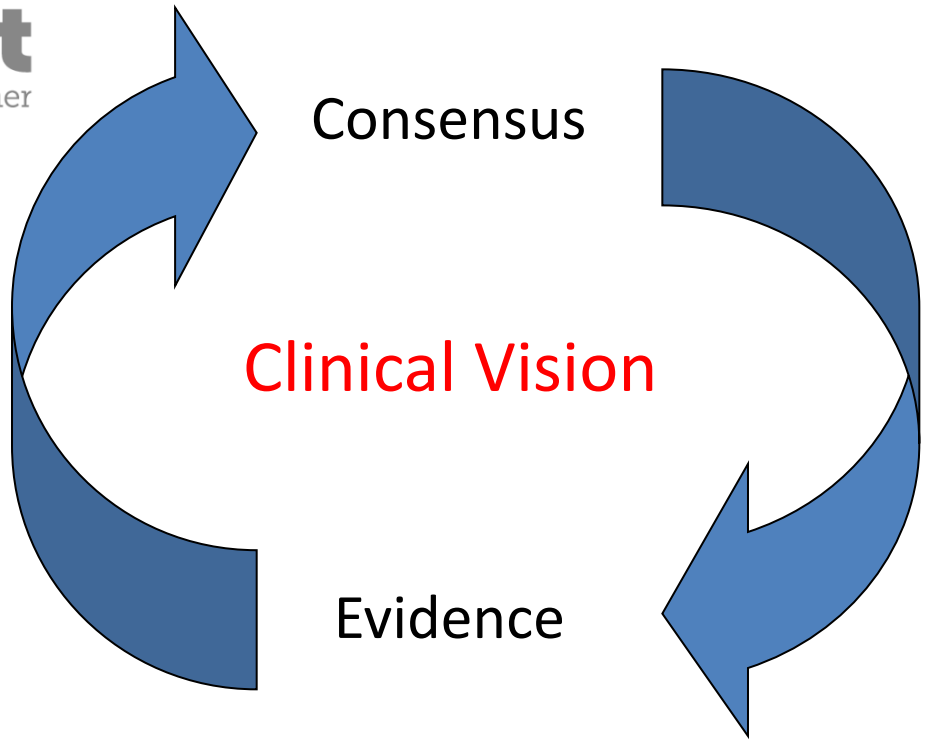
Clinical Design Process



Reconciling
Sense checking
Modelling
Planning
Future proofing
Sustainability

Needs led
Experience based
Principles
Models of Care
'Common good'
Collective responsibility

Modelling
Options
Consultations
Reviews

Service description

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Emergency and Urgent Care Model

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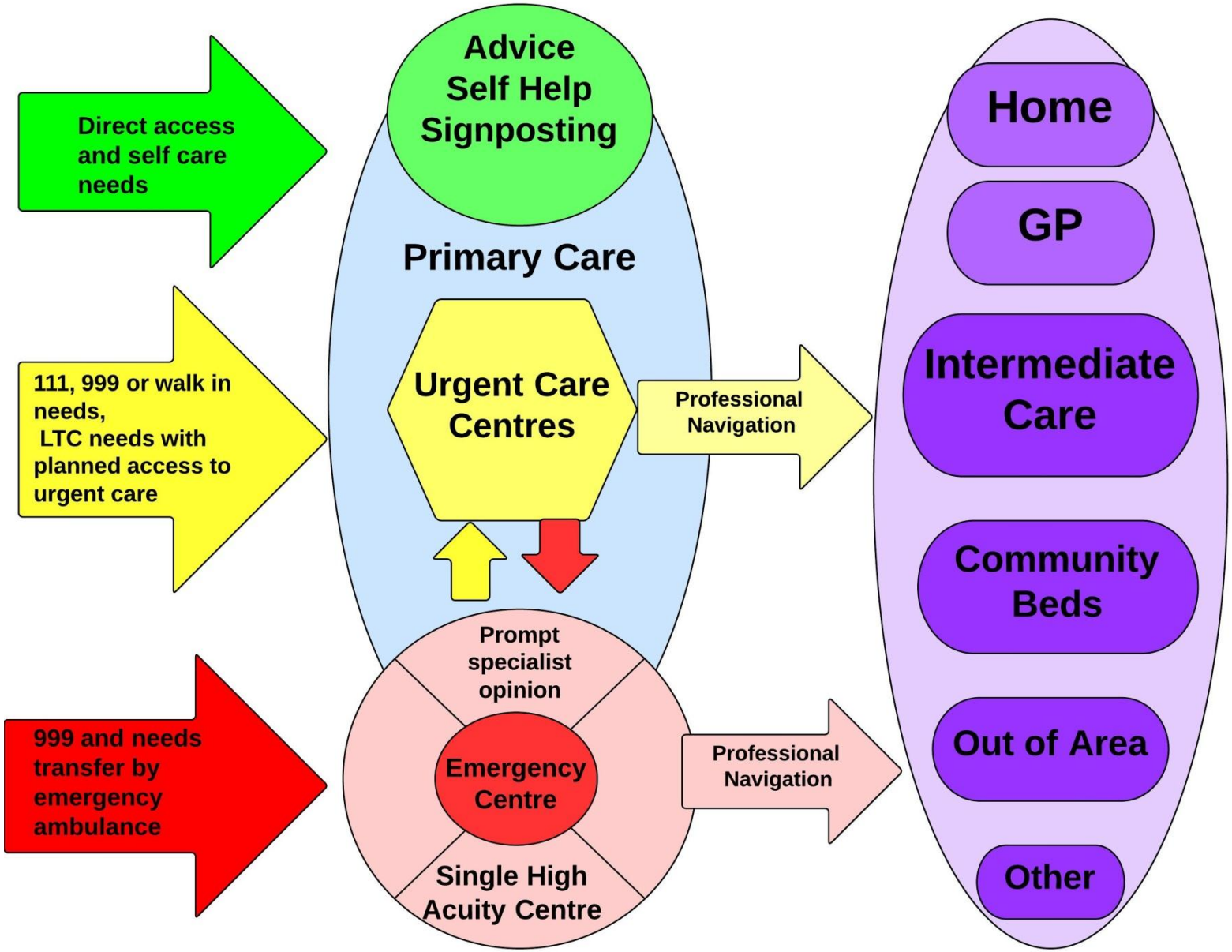

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Emergency and Urgent Care Model

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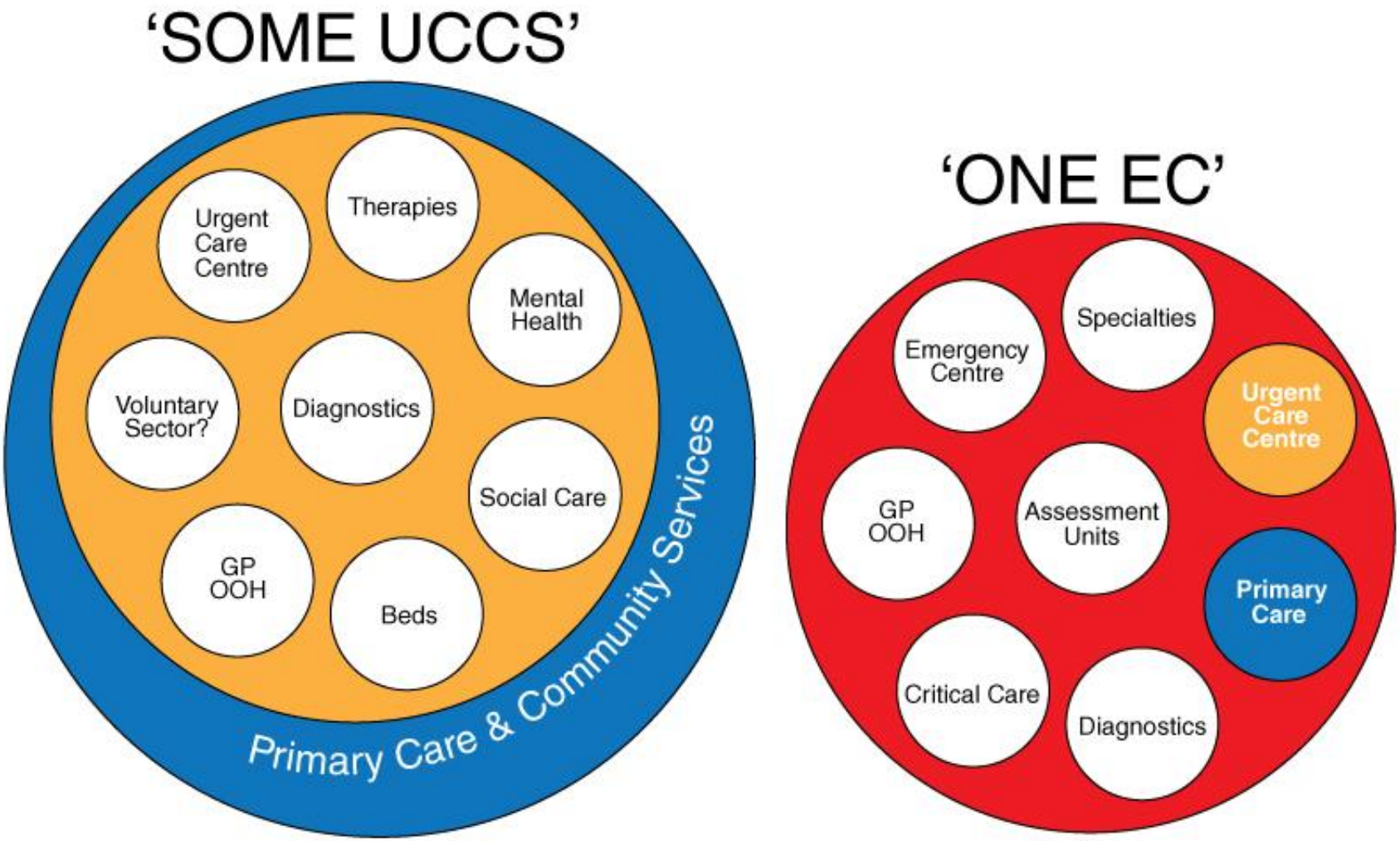

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Planned Care Model

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Planned Care

- Patient
- Peer worker
- Specialist Nurse
- Therapist
- GP
- IT

System Navigators

PATIENTS

- Education
- Information
- Prevention

FACILITATED SELF MANAGEMENT

- IT/Map of Medicine
- Expert Patients
- Voluntary groups

INFORMED DIRECT ACCESS

Diagnosis known (simple)

Diagnosis unknown (complex)

PRIMARY CARE

Skill mix
Unit size

Self Help

- Guided self care

Low Intensity Input

- 'Some' centres for day case/minors
- Basic diagnostics (Xray/USS)
- Access to therapies
- Co-located with Urgent Care Centres
- Facility for remote consulting for pre and post-intervention care

Medium and High Intensity Input

- Interventions ONLY
- Centre for intermediates/day cases (may or may not be co-located with high input centre)
- One centre for majors (co-located with but separate from emergency centre)
  - HDU
  - Diagnostics (USS/CT/MRI/Nuclear etc.)
- Referrals out of area for cardiac, neuro, etc.

Communication

Information/Education

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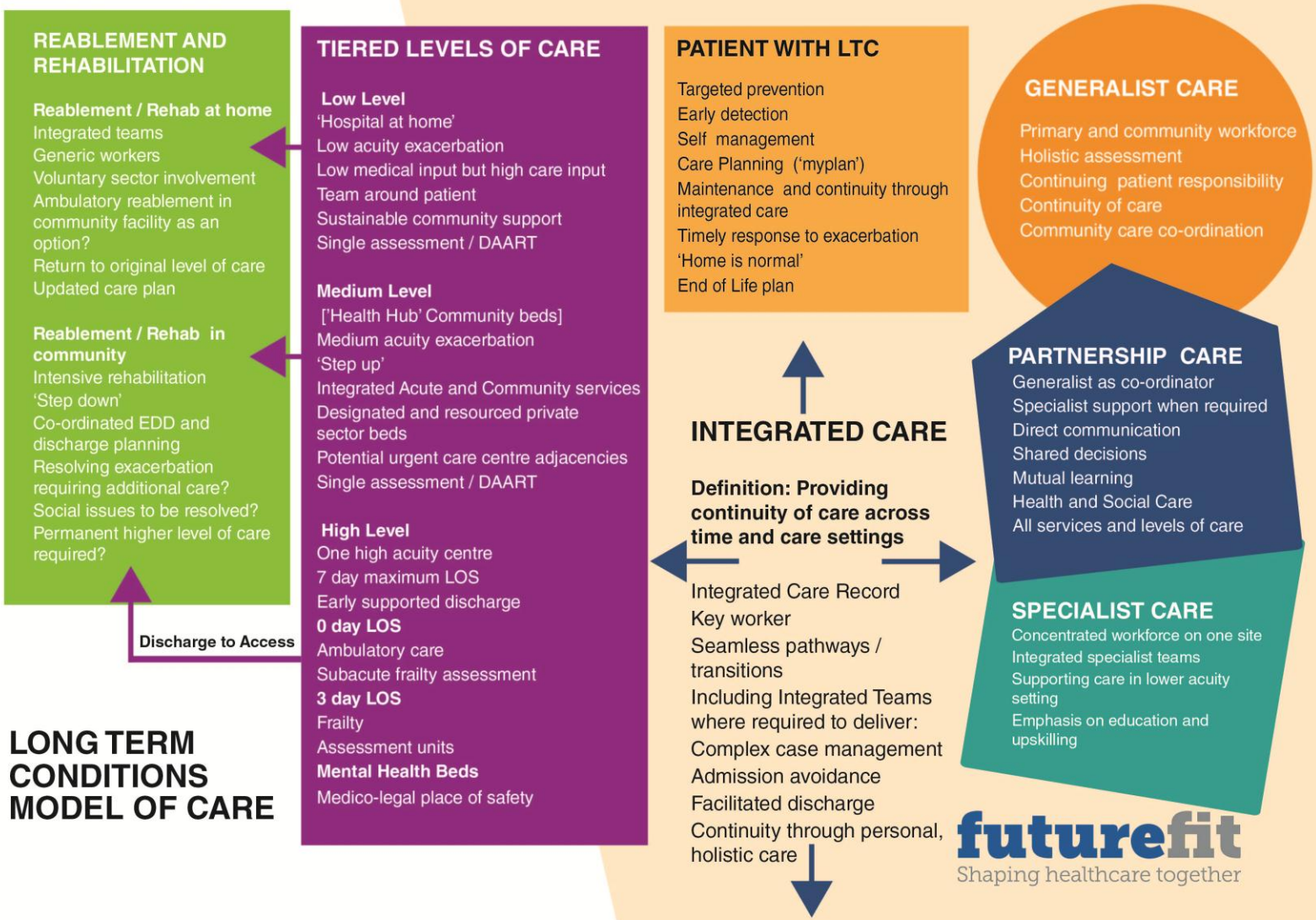
Long Term Conditions Model



LONG TERM CONDITIONS MODEL OF CARE

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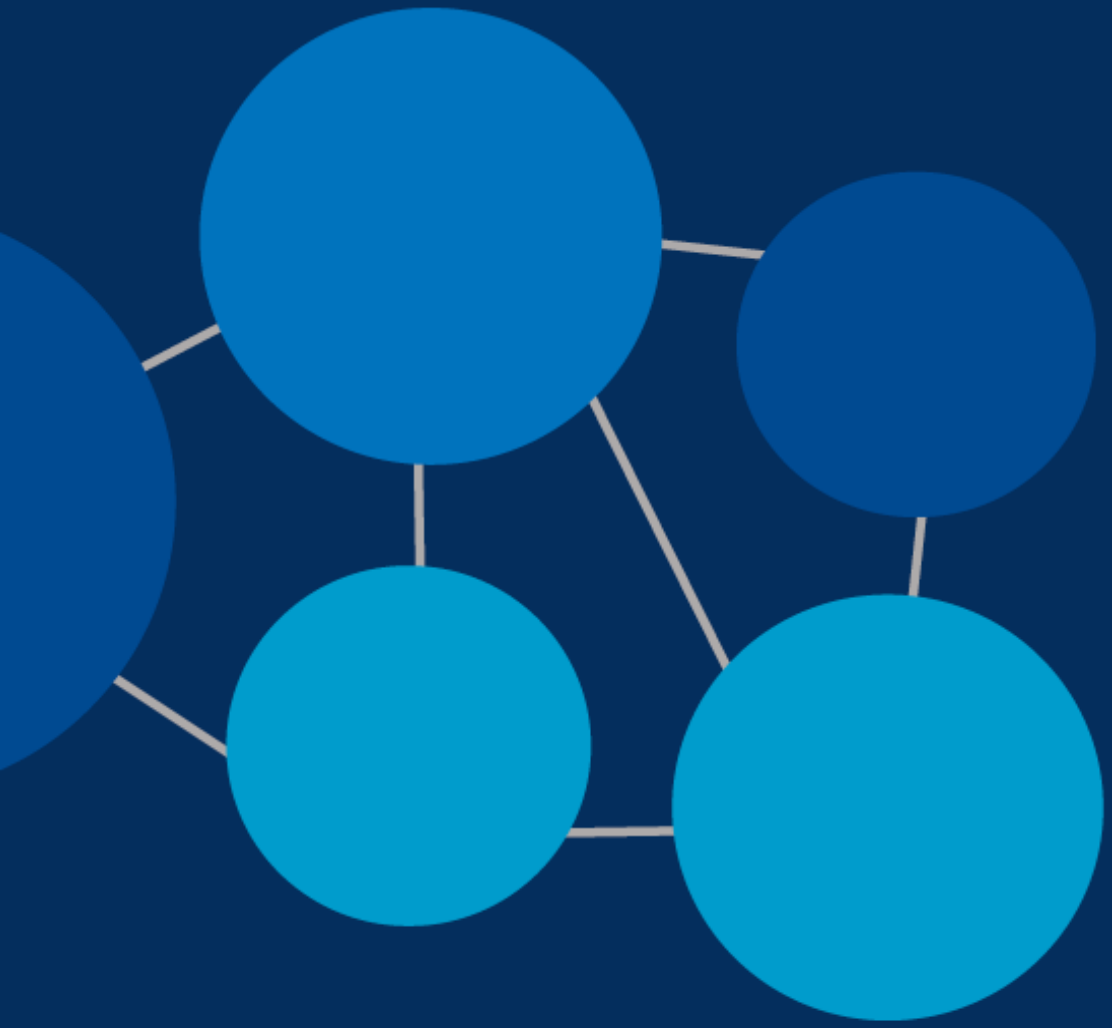
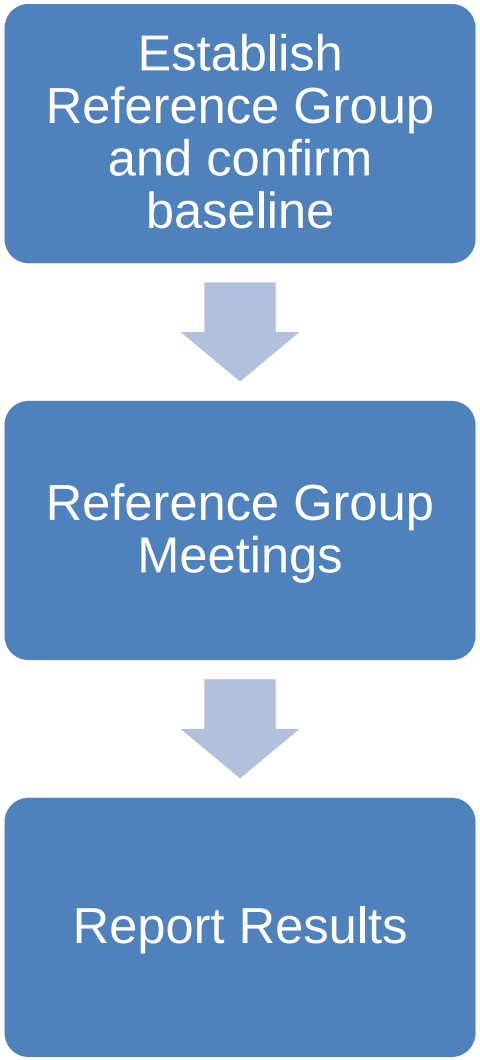


Activity and capacity modelling

Activity & Capacity Modelling Process



Workshop	Content
1	Review and confirm objectives and scope Agree conceptual model & model components Set inpatient parameters (admission avoidance)
2	Set inpatient parameters (LoS Reduction)
3	Set demographics parameters Set A&E parameters
4	Set outpatient parameters
5	Review initial results Adjust parameters

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Overview of Modelling Approach

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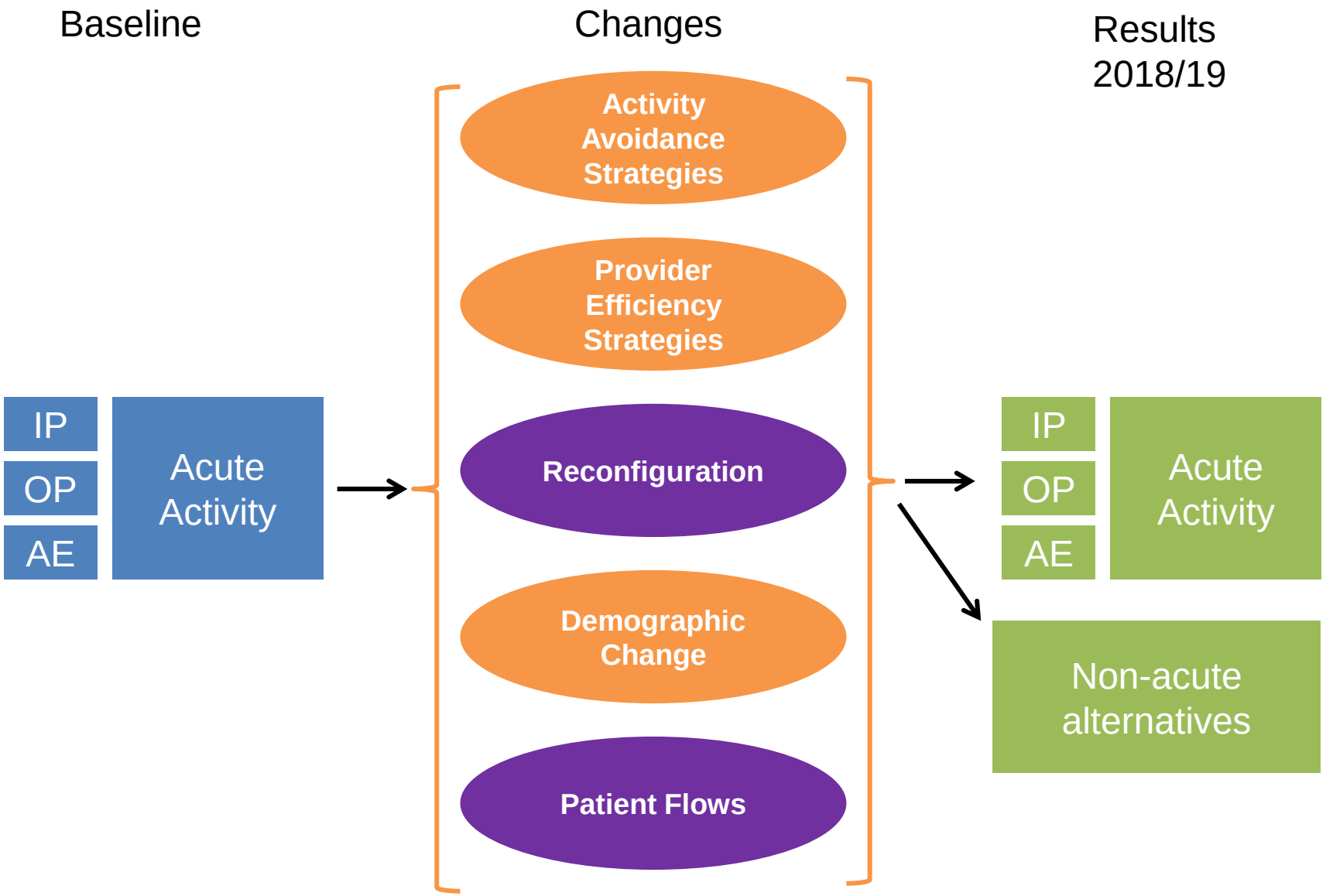

Activity & Capacity Modelling

Long Term Conditions & Frailty

- c10,000 NEL admits associated with frailty or LTCs in 2012/13.
- Phase 1 - admits fall by 8% by 2018/19 (after demographic change **which ADDS 5%**), largely through improvements in primary care management and through better use of community hospitals.
- Phase 2 - a further 24% avoided by reducing the prevalence of the key risk factors that give rise to LTCs (e.g. smoking, cholesterol, blood pressure) and through greater integration of community and primary care.

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Long Term Conditions
Emergency Admissions and Bed Days

NHS

	Baseline 2012/13	After Phase 1 Modelling	UCC Avoided	Reduced Prevalance	ICS Avoided	Final 2018/19
Circulatory	4,115	4,174	125	856	406	2,787
Diabetes	365	331	7	64	27	233
Cancer	1,133	1,165	2	130	153	880
Dementia	65	44	0	5	13	27
Respiratory	1,486	1,521	45	163	186	1,126
Other LTC	747	744	26		77	641
Frailty	2,044	1,207	18		159	1,030

Activity & Capacity Modelling

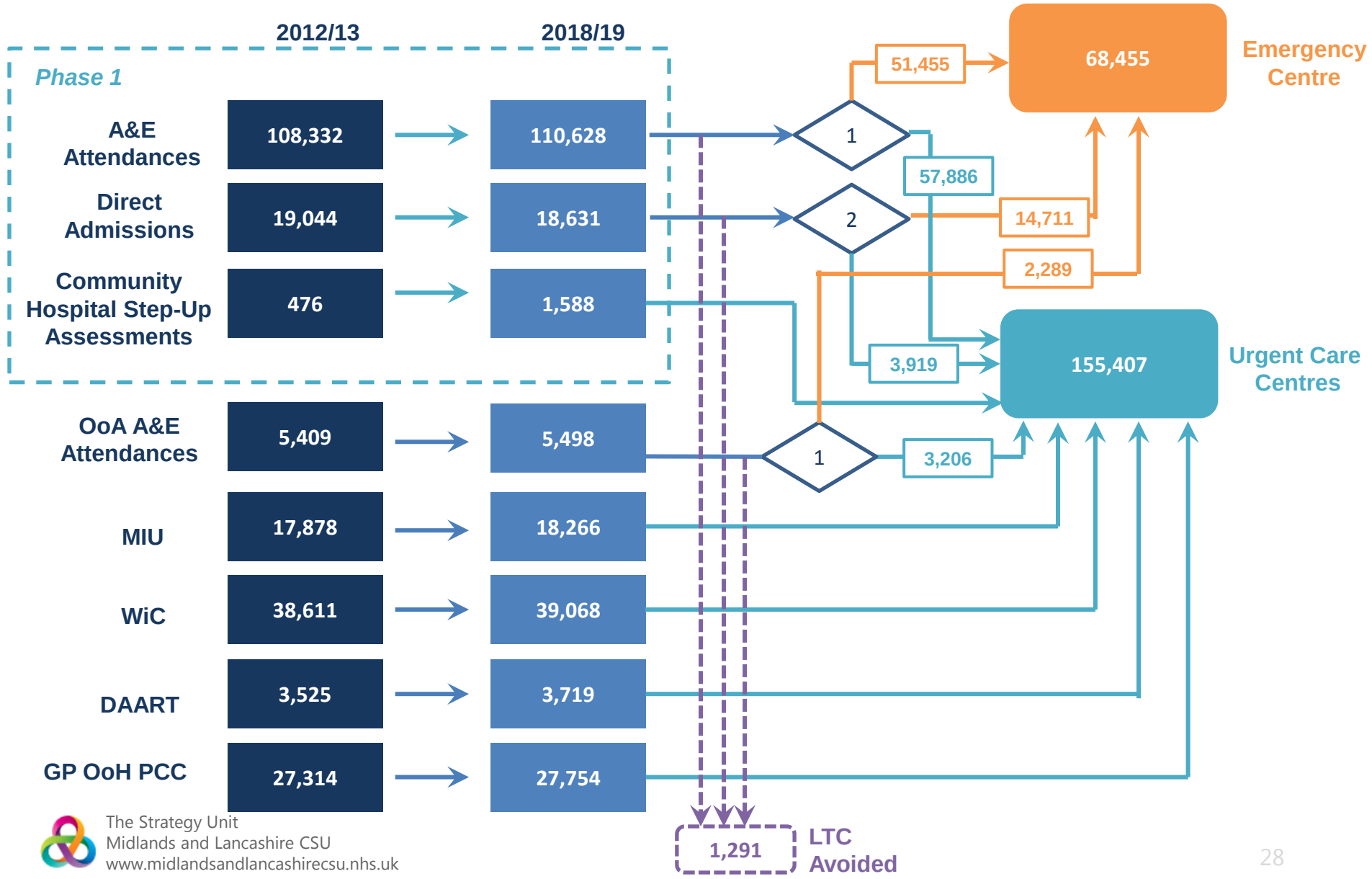
Acute & Episodic Care

- 69% of front door urgent care activity at UCC

  (incorporating activity current managed in ED, direct GP admissions community hospital step-up admissions, MIU and WIC attendances, DAART assessments and GP OoH PCC contacts)

- 31% (c 68,000 attendances) requiring the emergency centre.
- 75% of UCC activity is minor injuries or ailments, 12% as ambulatory emergency care, 8% as frailty management with 5% taking other forms.

Acute and Episodic Care – Allocation of Activity - Summary



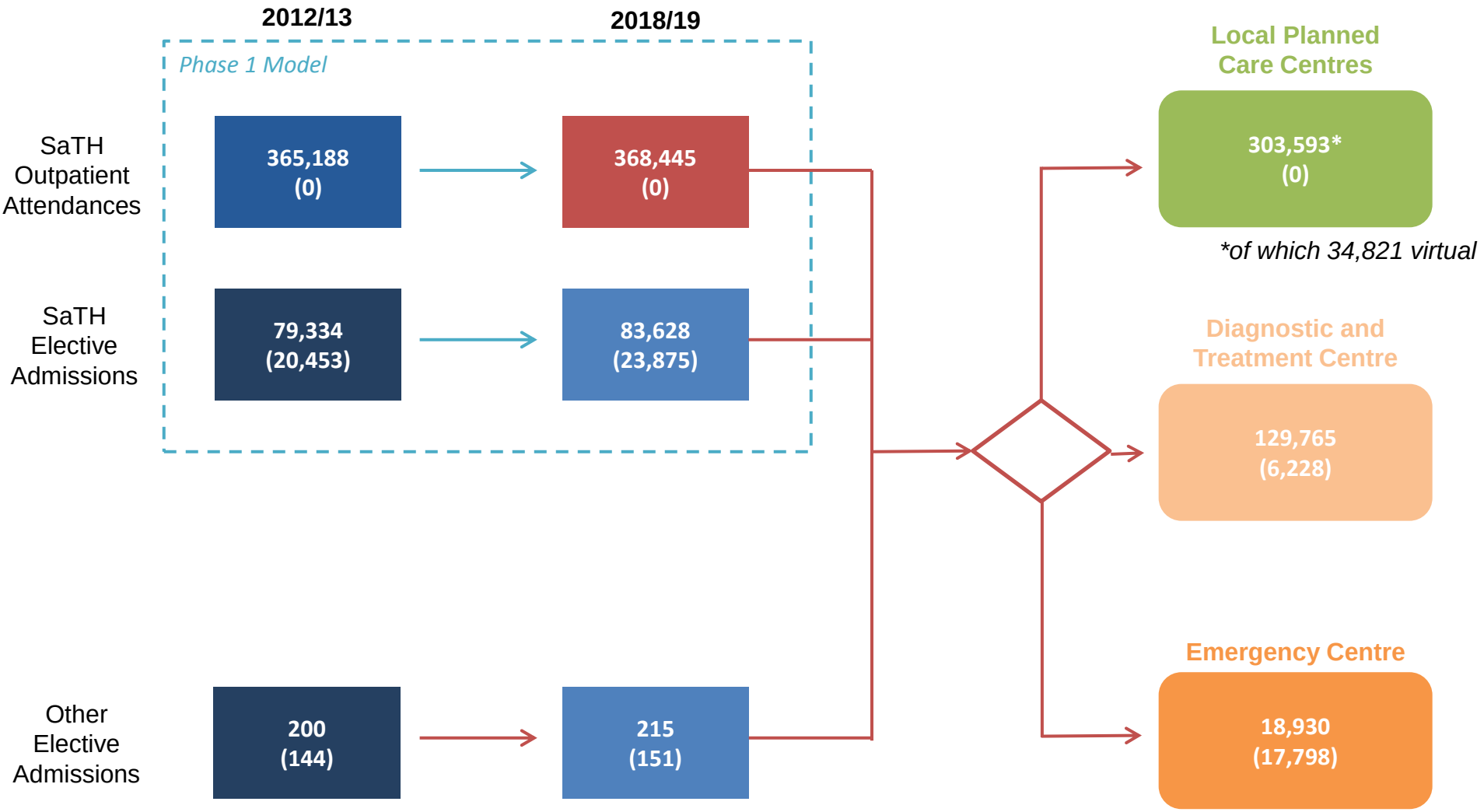
Activity & Capacity Modelling

Planned Care

- 67% of the planned care activity in 2018/19 would take place in Local Planned Care Centres, 29% at a Diagnostic and Treatment Centre and 4% in an Emergency Centre.

- Approximately 35,000 follow-up outpatient attendances managed by the local planned care centres could take place virtually.

Planned Care – Allocation of Activity (Bed Days) - Summary



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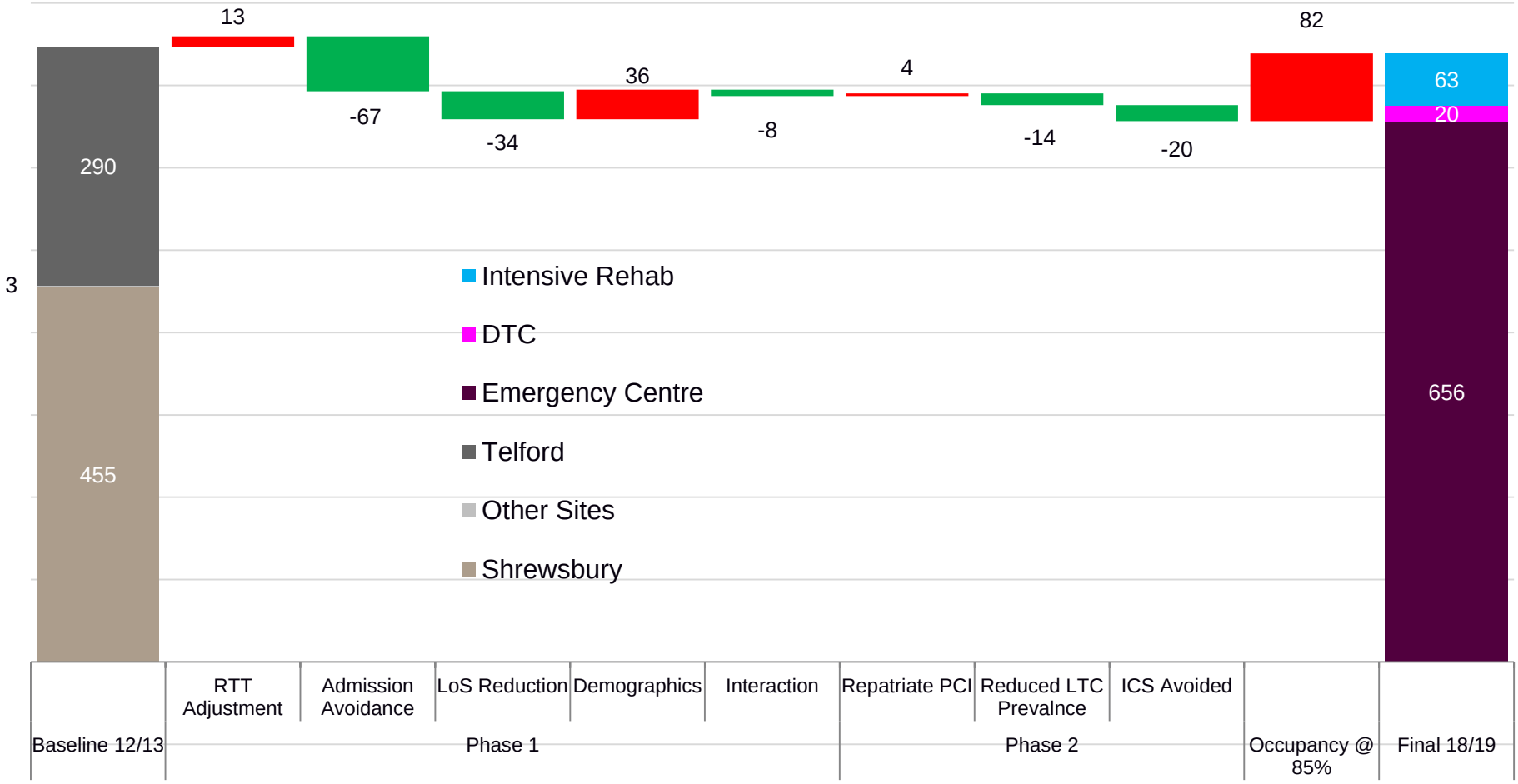
Activity & Capacity Modelling
Change in acute beds requirement



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Activity & Capacity Benchmarking

Phase 2 projections were compared against regional and national comparators, indicating that:

- Matching the performance of the most efficient West Midlands providers and SaTH's national peer group could save c.20% additional bed days and 120-145 beds;

- Additional annual savings to commissioners could range between £7.5m (matching regional Top Quartile performance) and £15m (regional Top Decile).

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Feasibility Study

Longer Term Capital Costs	Scenario 1 RSH Emergency Centre & Elective Centre	Scenario 2 PRH Emergency Centre & Elective Centre	Scenario 3 Greenfield site Emergency & Elective Centre	Scenario 4 Greenfield Emergency PRH Elective	Scenario 5 Greenfield Emergency RSH Elective	Scenario 6 RSH Emergency Centre PRH Elective Centre	Scenario 7 PRH Emergency Centre RSH Elective Centre
	£,000s	£,000s	£,000s	£,000s	£,000s	£,000s	£,000s
Years 1 - 5	164,539	229,259	443,574	420,565	431,335	223,059	187,915
Years 6 – 10	190,114	32,479	163,170	164,278	166,718	141,690	148,670
Years 11 – 15	37,423	13,059	27,375	25,997	26,668	38,740	25,943
Years 16 - 20	11,358	188,710	20,169	19,195	19,678	11,794	369,625
Years 21 - 25	211,142	35,931	84,220	79,650	81,812	218,301	73,975
Costs of Land and Buildings over 25 years	614,575	499,438	738,508	709,686	726,213	633,584	806,129

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Long List

	Royal Shrewsbury Hospital (RSH)	Princess Royal Hospital (PRH)	New site (to be confirmed)	Community sites
1	**Do minimum:** Provider and Commissioner efficiency strategies implemented but no major service change. **Existing dual site acute services (including A&E)**		-	**Remain as they are:** continue providing services as currently.
2 *	EC / UCC / LPC	DTC / UCC / LPC	-	**Between 2 and 5 further UCCs ideally co-located with LPCs / CUs**
3	DTC / UCC / LPC	EC / UCC / LPC	-	
4 *	UCC / LPC	DTC / UCC / LPC	EC / UCC	
5 *	DTC / UCC / LPC	UCC / LPC	EC / UCC	
6 *	EC / DTC / UCC / LPC	UCC / LPC	-	
7	UCC / LPC	EC / DTC / UCC / LPC	-	
8 *	UCC / LPC	UCC / LPC	EC / UCC / DTC	

* *the potential to locate consultant-led obstetrics (maternity services) either at the Emergency Centre or at PRH should be considered as a variant to these options.*

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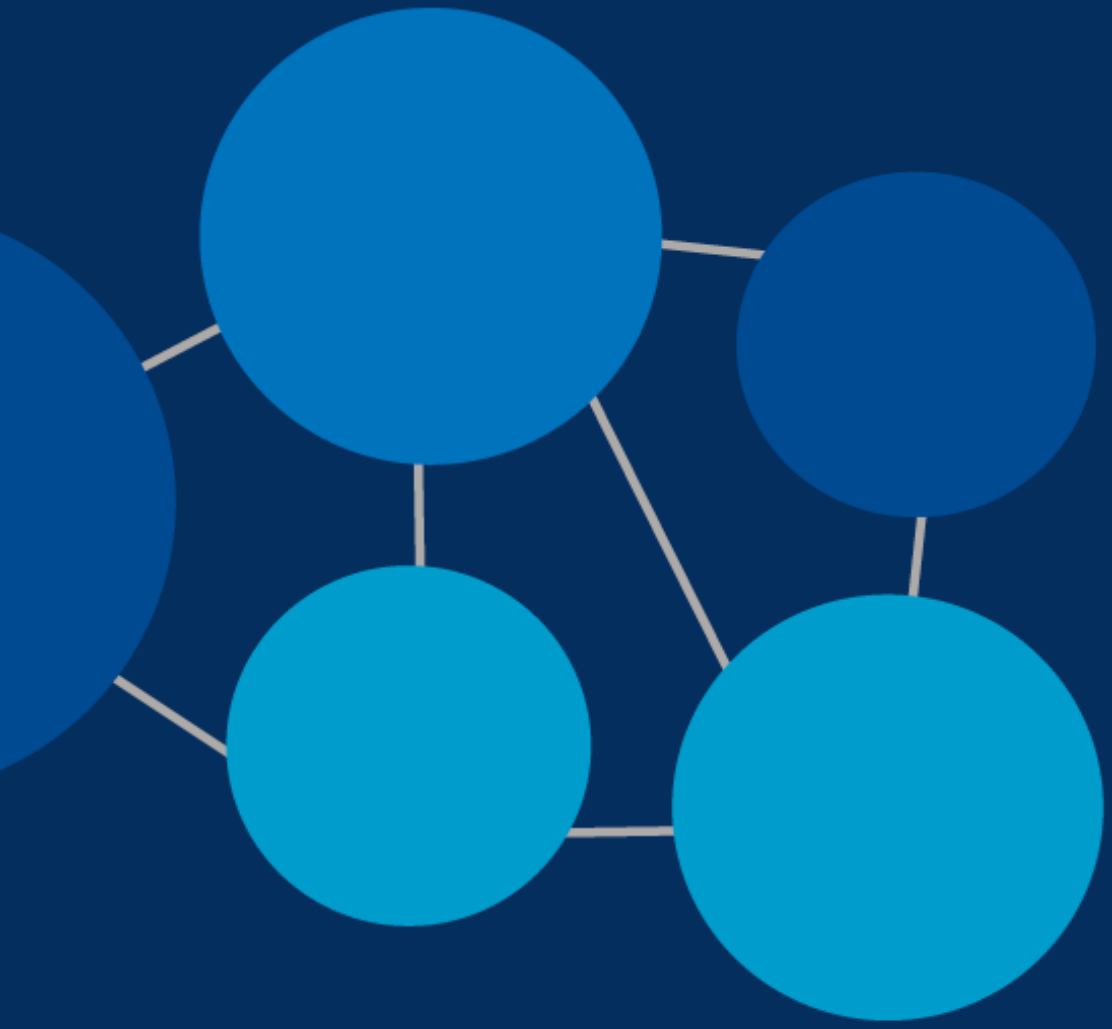

Phase 3

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Phase 3 (August 2014 - September 2015)

- **Identification of options and option appraisal**
  - Long list of scenarios appraised and shortlist recommended
  - Programme Board and Sponsor Board accept recommendations, add back Obstetric variants (pending further clinical work) and commission further (separated) work on rural urgent care solutions
  - Shortlist options more fully developed and appraised
  - Shortlisting decision reconsidered and confirmed on basis of more detailed financial information
- **Preparation of Strategic Outline Case(s)**
  - Options set out in SOC
  - New site options removed on affordability grounds (margin of £12-14m pa over remaining options)
  - Remaining options generate a surplus which would partially offset the underlying deficit
  - Commissioners develop letters of support for SaTH
  - SOC approved by SaTH Board and forwarded to NHS TDA.

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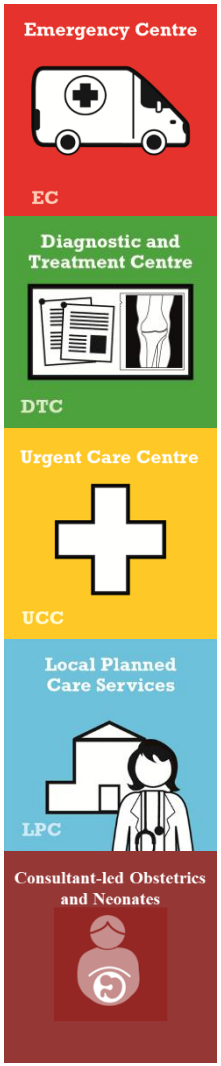
Clinical Model – networked components



Consolidates all non-elective activity on a single site, plus complex planned procedures (c.20%). 658 beds.

Consolidates all non-complex elective procedures on a single site. 20 beds.

Non life threatening urgent care continues on both existing sites.

Routine planned care appointments continue on both existing sites.

Consultant-led obstetrics/neonates to be sited either with EC or DTC. 71 beds.

N.B. Ambulatory cancer care unaffected – remains at RSH.

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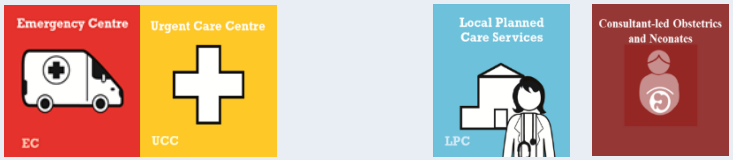
The Clinical Model - Site Configuration Options

	Princess Royal Telford	Royal Shrewsbury Hospital
A	No change	No change
B		
C_1		
C_2		

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Financial Appraisal

- Option B is preferred by a margin of 1% over Option C1
- Range of 1.3% between change options (B, C1, C2)
- The Do Nothing Option A is least preferred by a margin of 7.3%

Costs – 60 Years	Option A £000s	Option B £000s	Option C1 £000s	Option C2 £000s
Net Present Cost (NPC)	9,228,692	8,600,197	8,684,792	8,710,968
Equivalent Annual Cost (EAC)	344,477	321,017	324,175	325,152
Ranking	**4**	**1**	**2**	**3**
Marginal EAC over 1st Ranked	23,460	0	3,158	4,135
% over Option 1st Ranked	7.3%	0.0%	1.0%	1.3%
Switch Value	**(23,460)**	**3,158**	**(3,158)**	**(4,135)**

Scoring the Options

- Undertaken individually after clarification of evidence
- Each option scored against each criterion on scale of 1-7
- Initial scores fed back and used as focus for discussion
- Opportunity to revise scores in light of discussion
- Option C1 ranked 1st - remains 1st in sensitivity analysis

TOTALS	*Agreed Weighting*	Total Weighted Scores			
		Option A	Option B	Option C1	Option C2
ACCESSIBILITY	*25.1%*	56.0	47.2	62.0	46.4
QUALITY	*31.2%*	30.9	75.9	86.2	39.3
WORKFORCE	*27.3%*	21.6	69.2	72.2	36.6
DELIVERABILITY	*16.3%*	19.3	36.9	36.9	26.3
	100.0%	**127.8**	**229.1**	**257.2**	**148.7**
	RANK	**4**	**2**	**1**	**3**
	DIFFERENCE	*50.3%*	*10.9%*	*0.0%*	*42.2%*

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Overall Economic Appraisal

	Option A	Option B	Option C1	Option C2
Non-Financial Score	127.8	229.1	257.2	148.7
Benefits Margin below 1st	-50.3%	-10.9%	-	-42.2%
Non-financial Rank	**4**	**2**	**1**	**3**
Total EAC (£m)	344.5	321.0	324.2	325.2
Financial Margin above 1st	7.3%	-	1.0%	1.3%
Financial Rank	**4**	**1**	**2**	**3**
Cost £m per Benefits Point	2.7	1.4	1.3	2.2
Overall Margin below 1st	113.9%	11.2%	-	73.5%
Overall Rank	**4**	**2**	**1**	**3**
Combined Scores (50:50)	71.4	94.5	99.5	78.3
Overall Margin below 1st	28.2%	5%	-	-21.3%
Overall Rank	**4**	**2**	**1**	**3**

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Next Steps

In October 2015, the Programme Board was informed that the approval of any business case would depend on the development of wider plans to reduce the growing financial deficit in the local health economy. Board therefore agreed:

1. To note the outcomes of the process for appraising shortlisted options;
2. To defer reaching any conclusion about recommending a 'preferred option' to Sponsor Boards, until the Board is assured that there is an approvable case for investment;
3. To ask for an update at its November meeting on how commissioners and providers plan to take forward parallel discussions on dealing with the remaining financial deficit;
4. To ask SaTH to bring forward proposals for an interim solution to its workforce challenges that will ensure the ongoing safety of clinical services, and;
5. To ask its Core Group of Sponsor Chief Officers to urgently agree, and communicate to Board members, the implications of the current position for each of the Programme's workstreams and the overall Programme timetable.