futurefit
Shaping healthcare together

Clinical Reference Group Meeting

20th May 2015 | The Wroxeter Hotel, Shrewsbury

Attendees

Name	Organisation
Adrian Penney	Shropshire Clinical Commissioning Group
Alastair Neale	Shropshire Community Health NHS Trust
Alison Jones	Shrewsbury & Telford Hospitals NHS Trust
Amanda Taylor	Shrewsbury & Telford Hospitals NHS Trust
Andrew Cowley	Shrewsbury & Telford Hospitals NHS Trust
Andrew Roberts	Robert Jones & Agnes Hunt Orthopaedic Hospital
Andy Inglis	Telford & Wrekin Clinical Commissioning Group
Andy Raynsford	Powys Local Health Board
Anthea Gregory-Page	Shrewsbury & Telford Hospitals NHS Trust
Bill Gowans	Shropshire Clinical Commissioning Group
Carole Hall	Healthwatch, Shropshire
Cathy Smith	Shrewsbury & Telford Hospitals NHS Trust
Colin Stanford	Shropshire Clinical Commissioning Group
Conrad Newbold	Health Education West Midlands
Dave Evans	Telford & Wrekin Clinical Commissioning Group
David Beechey	Healthwatch
David Frith	Midlands & Lancashire Commissioning Support Unit
David Hinwood	Shrewsbury & Telford Hospitals NHS Trust
David Sandbach	Patient Representative
Debbie Jones	Shrewsbury & Telford Hospitals NHS Trust
Debbie Vogler	Shrewsbury & Telford Hospitals NHS Trust
Edwin Borman	Shrewsbury & Telford Hospitals NHS Trust
Ellen Nolan	Telford & Wrekin Clinical Commissioning Group
Emily Peer	Shropshire Community Health NHS Trust
Emma Sandbach	Public Health
George Rook	Patient Representative
Gill Stewart	Patient Representative
Gillian Sower	Patient Representative
Gren Jackson	Patient Representative
Harpreet Juttla	Midlands & Lancashire Commissioning Support Unit
James Briscoe	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
James Richardson	Robert Jones & Agnes Hunt Orthopaedic Hospital
Jill Dale	Shrewsbury & Telford Hospitals NHS Trust
Jo Leahy	Telford & Wrekin Clinical Commissioning Group

Karen Jackman	Shrewsbury & Telford Hospitals NHS Trust
Kate Shaw	Shrewsbury & Telford Hospitals NHS Trust
Kerrie Allward	Shropshire Council
Kevin Eardley	Shrewsbury & Telford Hospitals NHS Trust
Kevin Morris	Shropshire Clinical Commissioning Group
Lorraine Eades	Shrewsbury & Telford Hospitals NHS Trust
Louise Warburton	Telford & Wrekin Clinical Commissioning Group
Lynn Atkin	Shrewsbury & Telford Hospitals NHS Trust
Lynne Deavin	Shropshire LPC
Malcolm Locke	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Mark Cheetham	Shrewsbury & Telford Hospitals NHS Trust
Mark Garton	Robert Jones & Agnes Hunt Orthopaedic Hospital
Matt Ward	West Midlands Ambulance Service
Mike Innes	Telford & Wrekin Clinical Commissioning Group
Mike Sharon	Midlands & Lancashire Commissioning Support Unit
Mike Teague	Patient Representative
Narindar Kular	Shropshire Community Health NHS Trust
Neil Harper	Telford & Wrekin Clinical Commissioning Group
Paul Taylor	Telford & Wrekin Council
Paul Tulley	Shropshire Clinical Commissioning Group
Pete Gillard	Patient Representative
Peter Clowes	Shropshire Clinical Commissioning Group
Sally-Anne Osborne	Shropshire Community Health NHS Trust
Sanjeev Deshapande	Shrewsbury & Telford Hospitals NHS Trust
Sara Biffen	Shrewsbury & Telford Hospitals NHS Trust
Saskia Perrott-Jones	Shrewsbury & Telford Hospitals NHS Trust
Stefan Walendorf	Shropshire Clinical Commissioning Group
Stephen Chandler	Shropshire Council
Steve James	Shropshire Clinical Commissioning Group
Stuart Wright	Shropshire Clinical Commissioning Group
Subramanian Kumaran	Shrewsbury & Telford Hospitals NHS Trust
Tim Hughes	Telford & Wrekin Council
Yvonne Rimmer	Robert Jones & Agnes Hunt Orthopaedic Hospital

Welcome & Outline
All guests were welcomed by Dr Bill Gowans and Dr Mike Innes.

The Group were asked to think of any potential questions they had regarding the Programme and these were answered:

- *Are all the organisations associated with delivering? Can they deliver?* It was noted that there has been good engagement around this and it is widely acknowledged that it is everyone's responsibility.
- *What is the Community Trust offer?* Bill explained that there has been work done on Community beds and how they can be used in a more effective way.
- *Where is the cash coming from?*
- *Has there been enough attention to Primary and community care?*
- *How are the 2 independent CCGs going to come to a joint decision about DTC/EC?*
- *Nature of involvement with E+P*
- *Are we on track with the current timeline?*
- *How will you make sure that staff across all trusts will work together from a practical point of view?*
- *Has the operational delivery of UCCs been explored, particularly from a workforce perspective*
- *Are you considering sub-specialities included Mental Health and Rheumatology within in the acute setting?* Bill confirmed that these are being factored in the design of the acute and UCC settings and stressed the importance of accessible mental health services throughout the healthcare system
- *What can we do now in terms on Primary & Community Care*

Programme Update
Mike Sharon presented a full programme update. He described the current timeline and explained that we are in the process of clarifying the Urgent Care Centre (UCC) offer and trying to obtain a clearer picture of the overall health economy. He added that there are expectations about how well we can describe this offer when we reach Public Consultation.

A lot of work has been on affordability to date, but there is still more to do. He noted that we are looking at both the building and running costs for each of the shortlisted options based on assumptions. We are also looking at each of the options to determine if the costs will allow the CCGs to invest in non-hospital based care. Mike reported that we are expecting a clearer answer on affordability of the options very shortly. However the current timeline is dependent on all of the options being affordable, and if there was a situation where some of the options weren't affordable, this will delay the programme.

The Clinical Model as set out depends on staffing working together and this involves a broader network of health economy organisations. It was reported that there is a Workforce

workstream within the programme who are exploring and challenging clinical behaviour through leadership networks.

There has also been a separate programme set up called 'Community Fit' which will run in parallel to Future Fit. This piece of work has been commissioned to look at the Community aspect of the programme. They will be looking at the impact any acute service changes may have on different areas for Community & Primary Care and identifying opportunities to change and improve current services.

IT systems are also being explored to see if how much technology can assist in providing care closer to home. There is currently an Integrated Care Records project set up to try and link up care services, such as Acute care, Primary care and Community care.

The CCGs are due to present a paper to Programme Board regarding the decision making processes.

A Clinical Senate Review is also due to take place within the programme and the Senior Responsible Officers (SROs) have having regular meetings with the MPs to update them on the progress of the programme and go through the options and affordability if these options. A stage 1 senate review has already taken place and the feedback and recommendations has been acknowledged and acted upon.

The importance of patient and public involvement throughout the programme was stressed. There has been a strong effect to try and ensure that there is a patient representative from each area on all workstreams. Some of the work within the programme has been paused while we act upon public feedback and complete more work on the affordability information.

Urgent Care Centres

There is national guidance been released based on the urgent care centres and Future Fit plans follow this guidance.

It was noted that the national offer included making a networked UCC offer which includes UCC, Emergency Care Centre (ECC) and Specialist Emergency Care Centre (SECC). An 'Urgent and Emergency Care Centre Network' is likely to include Shropshire, Staffordshire and surrounding areas. This is a national programme but some local tailoring is allowed. We will also be exploring the possibility of training.

It was also noted that there are expected changes to Finance funding which are due in the near future. For the Financial models it is likely that tariffs will be unbundled which will allow for more flexibility around non-sore offers of care and services.

Rural UCC Offer

Andrew Ferguson, Shropshire Community NHS Trust, is leading on the Rural UCC work. He reported that the in the model, it is assumed that the EC will have support of UCCs in both Urban and Rural locations. It is important that the core UCC offer is consistent. There are meetings taking place with each locality to look at what services are required in the different areas.

Question: *Will Social Care and Mental Health be included within the UCCs?*
Answer: Bill Gowans reported that we are currently looking at the core clinical UCC offer. We are due to explore the wider services that may be included and see whether other services can be co-located.

Question: *How do local people have an input in the discussions??*
Answer: We are firstly planning to look at the initial areas were there is currently a community hospital. We are having meetings with members of each locality which include clinical staff, non clinical staff and patients. We will then be expanding the scope to look at an analysis of other population areas.

Question: *How is the current timeline pressure going to impact on the work?*
Answer: Andrew explained that we are consciously going to make a decision about the impact and feasibility of services in smaller areas.

It was acknowledged that different areas have different health needs, so we are currently working up 2 types of UCCs, one for Urban areas (Shrewsbury & Telford) and one for the Rural areas.

Question: *What is the staffing model for the UCCs? Have GPs been involved in the process? As the work is based on assumptions, can you ensure that the assumptions used are correct?*
Answer: The modelling completed has been based on the current staffing numbers. We are exploring ways of re-focusing current staff to support the model. Work is also being completed with Health Education organisations to look at increasing training programmes within Shropshire. We are also looking at the competencies required for the UCC offer and we are hoping to tweak the training programmes to teach new staff the skills required. It was acknowledged that this a long term piece of work.

Question: *There has been a lot of work done within the programme based on skill shift, how do we expect to achieve this?*

Answer: there has been a lot of focus within the programme in prevention, especially related to Long Term Conditions (LTC) and how this could fit into a UCC setting.

Question: *Calculations of 900 staff into community settings – some in county, some out. To make model work it is vital to increase access to training – especially in community settings.*

Answer: It was confirmed that this was what the model was working towards and one of the goals of the programme is to increase access of training within the community.

Question: *Will there be a UCC in front of the EC?*

Answer: Yes, the model supports a UCC in front of the EC.

Question: *Have existing experience through shropdoc (i.e underused Units) been taken into consideration?*

Answer: Yes, we are looking at how a footprint of the area with the UCC will work. For example, the UCC may not be 24 hour but will be supported with out of hours care.

UCC Discussion

It will be explored if a clinician consulting within a UCC could provide a duty of care in a virtual setting. It was acknowledged that there is a responsibility of care from the person who provides advice within a UCC.

The Governance issue was also highlighted. It was felt that changing advice and guidance arrangement currently to be two way.

Question: *If a decision made by multiple team, will this mean shared responsibility?*
Answer: This is not about just Dr's but involving all health workers, which needs to include new governance and management framework. In a case of MDT, we need to determine who is the overall member of staff overseeing governance, training and estates?

It was noted that there is a challenge of commissioning, but this leads to the opportunity to work together and in different ways. There may be a need for a new governance structure eg memorandum of understanding. It was highlighted that all new work ways need to go through clinical and operational governance procedures.

It was suggested that the acute settings will need to 'pick up' any failings, which would suggest that they be in charge of governance. It was stressed that a networked governance structure is the key to a good process.
If the care was doctor-led, would need generalists rather than specialists within the EC and UCC's.

We would need to review how to look at pathways in MDT without having to consult all other members of MDT? Eg WMAS governance structure would need to cover wider than *just* clinicians.

Telehealth: Remote Consultations

It was highlighted that a critical factor of the plan is technology. We are planning to use Skype/telephone/internet/apps for information sharing and

A change in advice and guidance tariffs allows for remote consultations. The implications on SaTHs financial situation were raised. It was felt that the current financial tariff is unhelpful in Future Fit model
It was acknowledged that we would need to obtain more information around how it will be deployed. This may include embedded training and learning, including remote access.

We will be reviewing how other areas have used remote access and review the lessons learnt by others.

It was explained that this will be a local solution development by local people. It will involve giving 'system requirements' to local people to customise for their locality. This will result in communities have own local variations.

Question: *How do you plan to stop 'hidden agendas' from each stakeholder?*
Answer: We are aware of this challenge and we are working closely with all organisations to try and minimise any impacts. It was noted that all organisations involved are co-dependant, and they work as a system rather than individual organisations

It was stressed that remote Consultations are NOT designed to be better than face to face, but to resolve some workforce issues. It was noted that this option as being explored for the following reasons:

- Rather than locations, we will be looking at workforce
- It will give an Initial view of how much imaging there is in the community. This would depend on usage and locations of UCC and UCC offer
- If there are concerns for looking at the bigger picture – eg looking for gallstones and missing cancer
- Alternative of having imaging moving within area – MRI every 2 weeks etc
- See follow up consultations being done via remote consultation

It was noted that remote consultation offers **A** solution, rather than **THE** solution. However, not all consultations require face to face meetings and these could be done by phone.

It is estimated that therecould be a saving of 1.35m by reducing transport costs if consultations are done remotely. There was some research done at SaTH in the 1990's which showed an high acceptance of remote consultations from patients. We are aware of the potential technology problems and additional costs that may occur.

It was felt that the the best group to manage with remote consultations are those with Long Term Conditions (LTCs). This will help with coordinating with regular contact professional and triggering management plan when necessary. Birmingham have already been using remote consultations to treat LTC patient and this has worked exceptionally well. It has also meant that there has been money saved bu reducing admissions.

West Midlands Ambulance Service (WMAS) are starting to use Electronic Patient Records (EPR) linked to diagnostics. By using similar technology, we could solve some of technology issues and technology may be able to help with variant of social vs clinical admissions. We will need to be aware of capabilities of technology (4G/3G/Mobile black spots).

Question: Where would these be prototyped?
Answer:

- Dermatology patients
- Pathway driven Renal patients
- Orthopaedics - Often in follow up needed for x-ray eg arthritis in different joints
- For observations during consultation for some specialities

Next Steps

The next steps for the Clinical Reference Group are:

- Taking into account comments made and looking into which specialities this new technology could be used for.
- To look at the possibility of holistic solutions to care in the Community
- Put together a Planned Care Working Group to review the delivery of planned care
- Ensure that the rich discussion regarding UCC's continues throughout the programme. Any updates will be presented back to CRG members.

All guests were thanked for their attendance and participation. It was noted that these discussions and events are crucial to the success of the programme and any input is greatly appreciated it.

It was agreed to set up another CRG meeting in 3 -4 months' time.