futurefit
Shaping healthcare together

NHS

PROGRAMME EXECUTION PLAN

VERSION CONTROL

Version	Date	File Name	Status
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Version 1.6	24th March 2015	150324 FutureFit PEP V1.6	Updated for Phase 4
Version 1.7	13th August 2015	150813 FutureFit PEP V1.7	Updated with revised Engagement and Communications remit and strategy, and minor changes to workstream memberships.

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1. Introduction

1.1 Background

There are significant challenges faced by the NHS both locally and nationally in planning for the future sustainability of its services. Shropshire, with its two CCGs, also faces unique challenges in securing sustainable hospital services. Shropshire CCG covers a large geography with issues of physical isolation and low population density and has a mixture of rural and urban aging populations. Telford & Wrekin CCG has an urban population ranked amongst the 30% of most deprived populations in England. Both are dependent on in-county acute and community care provision operating across multiple sites with the challenges that that can bring. Both commissioners are also aware of the needs of the Powys population who are dependent on utilising services from the same local hospital trusts.

Shropshire CCG, Telford and Wrekin CCG, Shrewsbury and Telford Hospitals Trust (SaTH), Shropshire Community Health Trust and Powys THB have committed to work collaboratively to undertake a clinical services review, engaging fully with their patient populations, to secure long-term high quality and sustainable patient care.

The review programme will focus on acute and community hospital services in Shropshire and Telford & Wrekin. It will involve all communities who use those services, particularly across Shropshire, Telford & Wrekin and mid Wales. The aim will be to develop a clear vision for excellent and sustainable acute and community hospitals - safe, accessible, offering the best clinical outcomes, attracting and developing skilled and experienced staff, providing rapid access to expert clinicians, working closely with community services, focused on those specialist services that can only be provided in hospital.

1.2 Document Status

This Programme Execution Plan (PEP) forms the basis for the development of an agreed model of care for excellent and sustainable acute and community hospitals that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin and Mid Wales. It sets out the systems and processes by which the Programme will be planned, monitored and managed, and is owned, maintained and used by the partner organisations to ensure the successful day-to-day operational management and control of the Programme and the quality of the outputs.

The purpose of the PEP is to:

- Define the Programme and the brief;
- Define the roles and responsibilities of those charged with delivering the Programme;
- Set out the resources available and the budgetary control processes;
- Identify the risks relating to the Programme and the risk management processes;
- Define the programme management and issue control arrangements;

- Set out the approvals processes;
- Define the administrative systems and procedures;
- Set out the controls assurance processes.

1.3 Document Scope

The scope of this PEP covers:

- **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 (October 2015 – June 2016)**
    - Preparation for Public Consultation including submission of Pre-Consultation Business Case and NHSE Formal Assurance
    - Public Consultation on preferred option(s)
    - Preparation of Outline Business Case(s) and Decision Making Business Case
- **Phase 5 (To be determined)**
    - Full Business Case(s)
- **Phase 6 (To be determined)**
    - Capital Infrastructure work
    - Full Implementation
- **Phase 7 (To be determined)**
    - Post Programme Evaluation

This is a live document and will be progressively developed by the Programme Board as the project progresses, and will be formally reviewed and updated at the conclusion of each Phase.

1.4 Document Audience

The PEP is a public document and may be viewed by anyone interested in the Programme or in how it is being managed and delivered. However, as the prime audience are those directly involved with the programme, it assumes a degree of technical knowledge and understanding of programme management and the relevant procurement processes used by the NHS.

2. The Case for Change

2.1 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.

2.2 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. More detailed information is set out in **Appendix 1**:

- **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.

2.3 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.

3. Programme Definition & Scope

3.1 Definition

The programme is Future Fit - Shaping healthcare together.

3.2 Scope

The CCGs and Powys tHB commission services from a number of providers locally. The Programme will focus on the services provided by Shrewsbury & Telford Hospital NHS Trust and Shropshire Community Health NHS Trust since those organisations are facing specific challenges which require potential wider reconfiguration. There are other providers of services to commissioners who will be involved as stakeholders in the redesign of services in terms of any impact on improving quality for patients. However these organisations' services in full will not be part of this programme and are outside the scope of this exercise. These organisations provide services to other commissioners both locally and more widely as specialist providers to populations outside of this health economy. All of the organisations represented on the Programme Board are committed as stakeholders to the redesign of services to improve quality, and have agreed to support this programme.

The following parameters have been identified to delineate the scope of the activities that fall within the scope of the Programme:

Table 1 Programme Scope

Within Programme Remit	Outside of Programme Remit
General	
Hospital services physically located within the geography covered by Shropshire and Telford & Wrekin CCGs.	Services currently provided by Robert Jones & Agnes Hunt Hospital NHS FT Acute and community hospital services which are not physically located in the geography covered by Shropshire and Telford & Wrekin CCGs
The impact on other providers, particularly in terms of changed patient flows, of the potential options for improving hospital services within the patch, including: • Primary Care Services • Robert Jones & Agnes Hunt Hospital NHS FT • Social Care • Mental Health • Community Health Services • Other providers outside of the county • Ambulance Services	Primary Care Services* Re-design of Community Health Services*

Within Programme Remit	Outside of Programme Remit
Development of key/main integrated care pathways, including both rural and urban models to reflect the differing needs of the populations served	Care pathways outside of those key/main pathways defined within the Programme
'Virtual' hospital services in the community (these 'virtual' services are community services that might substitute for 'traditional' hospital services	Local Authority Integrated Care services Services provided from community hospitals which are not related to the key/main integrated care pathways defined by this programme
Phase 1a - Programme Set-Up	
Finalisation of Case for Change and Programme Mandate	
Preparation and approval of Programme Execution Plan	
Preparation and approval of programme timetable and plan	
Securing key programme resources	
Establishment panel of external clinical experts	
Development of Benefits Realisation Plan	
Development of Engagement & Communications Plan	
Development of Assurance Plan	
Phase 1b - High Level Clinical Vision	
Securing clinical consensus on overall model of care	Preparation of plan for sustaining A&E services in short to medium-term *
Analysis of Community Hospital services and utilisation	Existing Powys community hospital services Existing Mental Health services
Acute Hospital services activity projections and categorisation	Robert Jones & Agnes Hunt Hospital services
Stakeholder engagement on high-level vision and model of care	Re-design of Ambulance Services
Assessment of recurring affordability envelope & capital investment capacity	
Gateway Review 0	
Phase 2 - Development of Models of Care	
Refinement of acute hospital activity projections	Development of CCG Commissioning Strategies *
Activity projections for other services	Re-design of Social Care services
Development of whole LHE financial models	
Agreement of non-financial appraisal criteria and	

Within Programme Remit	Outside of Programme Remit
process	
Feasibility Study for Single Emergency Centre	
Public Engagement on the Model of Care	
Phase 3 - Identification and Appraisal of Options	
Development and agreement of long-list of options	
Selection of short-list of options	
Gateway Review 0	
Financial and non-financial appraisal of short-listed options	
Selection and approval of preferred option	
Strategic Outline Case(s)	
Phase 4 - Public Consultation & OBC	
Gateway Review 1	
Clinical Senate Stage 2 Review	
Pre-Consultation Business Case	
Preparation for public consultation	
Formal public consultation	
Integrated Impact Assessment	
Preparation of Outline Business Case(s) and Decision Making Business Case	
Partner organisations' approval of OBC and consultation outcomes	
Securing all necessary NHS, DH & HM Treasury approvals for OBC(s) & DMBC	
Preparation and submission of any necessary planning applications	
Gateway Review 2	
Phase 5 - Full Business Case(s)	
Procurement processes	
Preparation and partner organisations' approval of FBC(s)	
Gateway Review 3	

Within Programme Remit	Outside of Programme Remit
Phase 6 - Implementation	
Capital infrastructure developments	
Implementation of service changes	
Phase 7 - Post Programme Evaluation	
Evaluation of Programme against key objectives and benefits	

* Key interdependencies requiring close coordination with the Programme. It is assumed that all other items listed as being outside of the scope of the Programme will be encompassed within the development of CCG and NHS England commissioning strategies and of the Better Care Fund.

In order to ensure the robust coordination of plans across the local health economy, the Programme Board will seek periodic formal reports from sponsor organisations as follows:

- Plans being developed outside of the Programme by sponsor/stakeholder organisations to develop, change and/or sustain existing services (including emergency care services). It is expected that these will be brought to Programme Board for discussion ahead of any decision so that the Board can be assured that plans take account of the Programme; and
- Plans to develop or change services in response to the Programme's identification of its expected impact on services outside its scope, to assure the Board that the required changes are being implemented.

The nature of the reports to be provided will be determined by sponsor/stakeholder organisations and will first be reviewed by the Assurance Workstream which will highlight any issues arising to the Programme Board.

As the formal responsibility for determining the configuration of services belongs to commissioners, the programmes of work for taking forward plans outside the scope of FutureFit are to be determined by commissioners in consultation with the relevant providers.

3.3 Our 'Moral Compass' - Principles for Joint Working

Given the 'Case for Change' set out in Section 2 above and the goals and objectives of the Programme set out in Section 4 below, 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 PEP.
- 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 cost 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 about 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 the 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 make 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 Programme represents a clear commitment, and we will take collective responsibility for making progress towards a shared vision for improved services and health.

3.4 Programme Member Code of Conduct

The public has a right to expect appropriate standards of behaviour of those who serve on the Future Fit working groups. Member of Future Fit working groups have a responsibility to make sure that they are familiar with, and that their actions comply with, the provisions of this Code of Conduct.

GENERAL PRINCIPLES

The general principles upon which this Model Code is based should be used for guidance and interpretation only. These general principles are:

- **Duty** - You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. If you are a member of a public body, you have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

- **Selflessness** - You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

- **Integrity** - You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

- **Accountability and Stewardship** - You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others.

- **Openness** - You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

- **Honesty** - You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

- **Respect** - You must respect fellow members of your working group, treating them with courtesy at all times.

CONFIDENTIALITY REQUIREMENTS

There may be times when members will be required to treat discussions, documents or other information relating to the work of the body in a confidential manner. Members may receive

information of a private nature which is not yet public. They must always respect the confidential nature of such information and comply with the requirement to keep such information private.

All Programme information will be made public (except where it would be in breach of patient or staff confidentiality or of commercial interests). The timing of publication, however, is a matter for the Programme Board to determine. Members of Programme groups are not at liberty to publish information provided to them by the Programme until such time as that information is formally published.

The limited sharing of Programme information by members of Programme groups within their nominating sponsor/stakeholder organisation (as set out in the Programme Execution Plan) is permitted, however, and does not constitute publication under this code. In such circumstances, members must ensure that those receiving the information understand and accept the responsibility not to make that information more widely known.

All Programme staff, advisors and other persons who may have privileged access to information that is considered to be commercially confidential will be required to sign a confidentiality agreement before gaining access to such information.

REGISTRATION OF INTERESTS

Members must at all times comply with the declaration of interests procedure that has been set out elsewhere in the Programme and is attached for information.

In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

NON COMPLIANCE WITH THIS CODE

If members do not comply with this Code, the Programme Board (or the Core Group acting on its behalf) has the right to remove any member of any Future Fit working group.

4. Goals and Objectives

4.1 Goals

The key benefits to be secured from the programme are:

- Highest quality of clinical services with acknowledged excellence in our patch;
- A service pattern that will attract the best staff and be sustainable clinically and economically for the foreseeable future;
- A coherent service pattern that delivers the right care in the right place at the right time, first time, coordinated across all care provision;
- A service which supports care closer to home and minimises the need to go to hospital;
- A service that meets the distinct needs of both our rural and urban populations across Shropshire, Telford & Wrekin and in Wales , and which anticipates changing needs over time;
- A service pattern which ensures a positive experience of care; and
- A service pattern which is developed in full dialogue with patients, public and staff and which feels owned locally.

The key benefits to be achieved will be set out in a Benefits Realisation Plan which will be initiated as part of Phase 1 of the programme. This plan will set out the measurable benefits and key performance indicators to be realised under the following headings:

- Improved clinical effectiveness (outcomes);
- Improved experience of care, including environment;
- Reduced harm;
- Better support for people with long term conditions, minimising their need to rely on hospital based care;
- Better support for people to live independently;
- Most effective use of resources across the whole care system;
- Equitable access to the full range of services; and
- Improved staff recruitment, retention and satisfaction.

4.2 Objectives

The key objectives of the programme are:

- To agree the best model of care for excellent and sustainable acute and community hospital services that meet the needs of the urban and rural communities in Shropshire, Telford and Wrekin, and Mid Wales;
- To prepare all business cases required to support any proposed service and capital infrastructure changes;
- To secure all necessary approvals for any proposed changes; and
- To implement all agreed changes.

5. Roles and Responsibilities

5.1 Introduction

This section details the programme management structure, the roles and responsibilities of the personnel responsible for delivering the Programme, and the terms of reference for the teams, committees and groups responsible for individual aspects of the Programme.

5.2 Programme Structure

The overall programme structure is set out in ***Appendix 2***.

5.3 Programme Sponsors

The Programme Sponsors are the Boards of:

- Shropshire Clinical Commissioning Group
- Telford and Wrekin Clinical Commissioning Group
- Shrewsbury and Telford Hospital NHS Trust
- Shropshire Community Health Trust
- Powys Teaching Health Board.

5.4 Programme Owners

The joint Programme Owners and Senior Responsible Officers (SROs) are:

- Dr Caron Morton, Accountable Officer, Shropshire CCG; and
- David Evans, Chief Officer, Telford and Wrekin CCG.

5.5 Programme Board

The Programme Board will oversee the programme on behalf of the Programme Sponsors and will have authority to take all decisions relating to the management of programme, with the exception of matters which are statutorily reserved to individual sponsor and/or stakeholder bodies and as set out in Table 3 below, including to:

- Agree, lead and coordinate the actions and deliverables in progressing the programme;
- Oversee and ensure the implementation of the programme, ensuring alignment with individual provider Trusts and local health system change plans;
- Have delegated authority for capital and revenue expenditure in line with the Programme Budget;
- Approve the Programme Execution Plan (PEP) for the Programme and have delegated authority to update the PEP (with the exception of the Case for Change, the Principles for

Joint Working and Programme Scope which is reserved to sponsor Boards) to reflect the specific requirements of each programme phase or otherwise in response to changing needs and circumstances;

- Approve the appointment of the Programme Advisory Team;
- Receive regular progress reports from, and consider any recommendations made by, the Programme Director;
- Approve and sign off the outputs from each stage of the Programme;
- Report progress on a monthly basis to all Programme Sponsor Boards and the Chief Officers' meeting, and seek relevant Programme Sponsor Board approvals of outputs where appropriate;
- Oversee the management of risk and issues within the programme and support the risk mitigation plans;
- Ensure the quality and safety impact of any service change is assessed and all necessary actions delivered;
- Ensure that a communications and engagement programme is developed that secures meaningful engagement and consultation with patients, public and other stakeholders at all stages of the programme;
- Ensure that effective and independent clinical and programme assurance processes are put in place, including
    - Strong links with the Joint HOSC & CHC;
    - Gateway Reviews;
    - Effective and timely Local Assurance Processes (LAP); and
    - Clinical Senate reviews.
- Ensure that the key areas of work which are outside of the remit of, but are interdependent with, the programme are progressed as required by the relevant members of the Programme Board.

A schedule of meetings of the Board will be arranged to meet key programme plan requirements and milestones. Meetings will be held in private but a report on the meeting and all final papers received will (subject to issues of confidentiality) be made public following each meeting.

The Board will be jointly chaired by the two Programme Owners/SROs and will comprise the following membership:

Table 2 Programme Board

Name	Role	Organisation
Programme Sponsors		
Dr Caron Morton (Jt Chair)	Accountable Officer	Shropshire CCG
Paul Tulley	Chief Operating Officer	Shropshire CCG
Dr Bill Gowans	Vice Chair	Shropshire CCG
David Evans (Jt Chair)	Accountable Officer	Telford and Wrekin CCG
Dr Mike Innes	Chair GP Board	Telford and Wrekin CCG
Andrew Nash	Chief Finance Officer	Telford & Wrekin CCG
Carol Shillabeer	Chief Executive Officer	Powys tHB
Dr Andy Raynsford	Chair, North Locality GP Cluster	Powys tHB
Neil Nisbet (from 1st August) Simon Wright (from 28th Sept)	Chief Executive	Shrewsbury and Telford Hospital NHS Trust
Dr Edwin Borman	Medical Director	Shrewsbury and Telford Hospital NHS Trust
Debbie Vogler	Director of Business & Enterprise	Shrewsbury and Telford Hospital NHS Trust
Adrian Osborne	Communication Director	Shrewsbury and Telford Hospital NHS Trust
Jan Ditheridge	Chief Executive	Shropshire Community Health NHS Trust
Dr Alastair Neale	Medical Director	Shropshire Community Health NHS Trust
Stakeholder Members		
Carole Hall	Chair	Healthwatch Shropshire
Jane Chaplin	Joint Chair	Healthwatch Telford & Wrekin
Jayne Thornhill	Deputy Chief Officer	Powys CHC
Stephen Chandler	Director of Adult Services	Shropshire Council
Paul Taylor	Director of Care, Health & Well Being	Telford and Wrekin Council
Amanda Lewis	Strategic Director - People	Powys County Council
Anthony Marsh	Chief Executive	West Midlands Ambulance Service NHS FT
Rachael Edwards	Head of Service Resourcing	Welsh Ambulance Services NHS Trust
Wendy Farrington-Chadd	Chief Executive	Robert Jones & Agnes Hunt Hospital NHS FT
Neil Carr	Chief Executive	South Staffs & Shropshire Healthcare NHS FT
Fiona Hay	Nominated Representative	G.P. Federation/Local Medical Committee
Ian Winstanley	Chief Executive	Shropshire Doctors Cooperative Ltd
Richard Chanter	Nominated Representative	Shropshire patients
Christine Choudhary	Nominated Representative	Telford & Wrekin patients
Vikki Taylor	Locality Director	NHS England

Name	Role	Organisation
In Attendance		
Mike Sharon	Programme Director	Midlands and Lancashire CSU
Peter Spilsbury	Engagement Director	Midlands and Lancashire CSU
David Frith	Senior Programme Manager	Midlands and Lancashire CSU
Harpreet Jutlla	Communications Lead	Midlands and Lancashire CSU
Lorna Cheesman	Programme Administrator	Midlands and Lancashire CSU

A quorum will consist of a minimum of one of the joint SROs, one representative from each of the Programme Sponsors and one Programme Team member.

5.6 Decision-Making

Decisions of the Programme Board are to be made by consensus.

The following schedule sets out the actions desired from sponsor Boards and other organisations in relation to key programme decisions:

Table 3 Key Programme Decisions

	Key Decision Documents	Programme Board	CCGs	Other Sponsors	Joint HOSC	Health & Wellbeing Boards	Assurance
1	Programme Execution Plan/Case for Change	Approve	Approve	Approve	Consider	Endorse Case for Change	Gateway 0
2	Evaluation Criteria & Process	Approve	Approve	Endorse	Consider	n/a	Gateway 0
3	Clinical Model of Care	Approve	Approve	Endorse	Consider	Endorse	Senate
4	Benefits Realisation Plan	Approve	Approve	Endorse	Consider	Endorse	Gateway 0
5	Selection of short list of Options	Approve	Approve	Endorse	Consider	Receive	Gateway 0
6	Selection of Preferred Option	Approve	Approve	Endorse	Consider	Receive	Senate, Gateway 1
7	Consultation Document	Approve	Approve	Respond	Consider	Respond	Gateway 1
8	Decision Making Business Case	Approve	Approve	Endorse	Consider	n/a	Gateway 2
9	Outline Business Case(s)	Approve	Approve	Relevant Board to Approve	n/a	n/a	Gateway 2

Commissioners will seek to agree a method of joint decision making in relation to the final outcome of the programme.

5.7 Core Group

In order to enhance the functioning of the Programme Board, a Core Group made up of a single representative of each sponsor organisation shall meet informally as determined by the SROs. The function of the group is to make recommendations to the Programme Board on matters within its remit and, in exceptional cases where the SROs judge that matters cannot wait for a full meeting of the Programme Board, to have authority to take decisions on its behalf. The Programme Board shall immediately be informed of such decisions along with the Core Group's rationale for the decision taken.

The Programme's assumption is that Core Group members have authority from their own Boards to act in this way, and that they will take responsibility for reporting back to their Boards the agreed actions of the Core Group in a timely manner.

5.8 Programme Director

The Programme Director provides the interface between programme ownership and delivery, and is responsible for defining the Programme objectives and ensuring they are met within the agreed time, cost and quality constraints. The Programme Director is also the link point for all major stakeholders at a strategic level.

The Programme Director will report to, and be accountable to, the Programme Owners, will attend meetings of the Programme Board and Core Group, will chair the Programme Team and will support designated workstreams.

5.9 Senior Programme Manager

The Senior Programme Manager will run the programme on a day-to-day basis on behalf of the Programme Board within the constraints it lays down.

The Senior Programme Manager will report to and be accountable to the Programme Director and will support the Programme Board, Core Group, Programme Team and designated workstream meetings.

5.10 Programme Team

The remit of the Programme Team is to:

- Manage the overall Programme;
- Ensure that structures, processes and resources are in place to enable delivery of the Programme's aims and objectives;
- Develop monitoring and reporting mechanisms;
- Ensure documentation and audit trails are maintained;
- Develop Programme Plans and report on progress of those plans;
- Establish and support the Programme workstreams;

- Develop and maintain the Risk Register;
- Develop, maintain and review the Benefits Realisation Plan;
- Develop and maintain the Programme Assurance Plan;
- Ensure the effective engagement of and communication with staff, service users and other stakeholders;
- Commission external support as necessary;
- Work with the appointed technical team, programme workstreams and ad hoc sub-groups to develop detailed descriptions of each of the options, including -
  - Service delivery models and clinical service and activity brief
  - Functional content
  - Design brief
  - Scale plans
  - Capital cost estimates
  - Revenue cost estimates and I&E projections;
- Undertake Post Programme Evaluation.

The Programme Team will be chaired by the Programme Director and will comprise the following membership:

Table 4 Programme Team

Name	Role	Organisation
Mike Sharon (Chair)	Programme Director	Midlands and Lancashire CSU
David Frith	Senior Programme Manager	Midlands and Lancashire CSU
Dr Bill Gowans	Vice Chair	Shropshire CCG
Adrian Osborne	Director of Communications	Shrewsbury & Telford Hospital NHS Trust
Andrew Nash	Director of Finance	Telford & Wrekin CCG
Paul Tulley	Chief Operating Officer	Shropshire CCG
Andrew Ferguson	Director of Strategy	Shropshire Community Health NHS Trust
Fran Beck	Executive Lead - Commissioning	Telford & Wrekin CCG
Julie Davies	Representative	Shropshire CCG
Debbie Vogler	Director of Business and Enterprise	Shrewsbury & Telford Hospital NHS Trust

The Programme Team will normally meet on a weekly basis and notes of its meetings will be produced and made available in the Programme Library.

The Programme Team will routinely be attended by members of the appointed support team as necessary.

5.11 Workstreams

The remit, leadership and membership of the programme's workstreams are detailed below.

5.11.1 Workstream 1: Clinical Design

The remit of the Clinical Design Group will be to:

- To develop the high level clinical model and clinical consensus for that model, including the development of key/main integrated care pathways, taking into account the scope for the use of assistive technologies;
- To support the translation of this model into clinical algorithms amenable to quantitative modelling;
- To support the detailed development of options;
- To ensure that there are defined evidenced standards against which to assess options for viability (and 'accreditation' where applicable);
- To develop the evidence base to assess the clinical effectiveness of options;
- To determine the impact of options on clinical workforce recruitment and retention; and
- To identify the benefits and risks in relation to clinical services and ensure effective strategies for benefits realisation and risk management, including:
    - contributing to the Benefits Realisation Plan
    - contributing to the Programme Risk Register

The Workstream will be led by Dr Bill Gowans, with support from the Programme Director, and will comprise the following membership:

Table 5 Workstream 1: Clinical Design

Name	Role	Organisation
Dr Bill Gowans (Chair)	Vice Chair	Shropshire CCG
Dr Mike Innes	Chair	Telford & Wrekin CCG
Steve Gregory	Director of Nursing	Shropshire Community Health NHS Trust
Dr Edwin Borman	Medical Director	Shrewsbury & Telford Hospital NHS Trust
Mr Steve White	Medical Director	Robert Jones & Agnes Hunt Hospital NHS FT
Dr James Briscoe	Deputy Clinical Director	South Staffs & Shropshire NHS FT
Matthew Ward	Head of Clinical Practice	West Midlands Ambulance Service NHS FT
Paul Taylor	Director of Care, Health & Well Being	Telford & Wrekin Council
Stephen Chandler	Director of Adult Services	Shropshire Council
Carole Hall	Nominated Representative	Healthwatch Shropshire

Name	Role	Organisation
Mike Sharon	Programme Director	Midlands and Lancashire CSU
David Frith	Senior Programme Manager	Midlands and Lancashire CSU

5.11.2 Workstream 2: Activity & Capacity

The translation of the overall vision and model of care requires that forecasts are made concerning the level of demand for services in the future, their location, and the capacity required to deliver them. These forecasts are based on assumptions concerning growth in demand and the potential impact on demand and capacity of a range of proposed service changes. This work provides a health economy-wide basis for all service and facilities change projects.

The remit of the Activity & Capacity workstream will be to:

- Develop the key planning assumptions for future service delivery models in conjunction with the Clinical Leaders Group;
- Assess the future capacity and patient activity level requirements in health and social care, based on the agreed service models and planning assumptions;
- Assess the impact of the Programme on patient flows within and outside of the county, taking into account other known developments.
- Develop a comprehensive model which will enable analysis of the future activity and capacity projections in ways which are meaningful for clinicians, commissioners and individual provider organisations, and which will facilitate the financial evaluation of identified options.
- To identify the benefits and risks in relation to activity and capacity and ensure effective strategies for benefits realisation and risk management, including:
    - contributing to the Benefits Realisation Plan
    - contributing to the Programme Risk Register

The Workstream will be led jointly by Dr James Hudson and Mr Mark Cheetham, with support from Steve Wyatt (Midlands and Lancashire CSU), and will comprise the following membership:

Table 6 Workstream 2: Activity & Capacity

Name	Role	Organisation
Dr James Hudson (Joint Chair)	GP Lead	Telford & Wrekin CCG
Mr Mark Cheetham (Joint Chair)	Scheduled Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Jon Cook	Head of Strategic Transformation	Midlands and Lancashire CSU

Name	Role	Organisation
Steve Wyatt	Head of Strategic Analytics	Midlands and Lancashire CSU
Jake Parsons	Strategic Analytics Senior Manager	Midlands and Lancashire CSU
Julie Davies	Director of Strategy & Redesign	Shropshire CCG
Dr Bill Gowans	Vice Chair	Shropshire CCG
Donna McGrath	Chief Finance Officer	Shropshire CCG
Andrew Nash	Chief Finance Officer	Telford & Wrekin CCG
Fran Beck	Executive Lead, Commissioning	Telford & Wrekin CCG
Steve Gregory	Director of Nursing	Shropshire Community Health NHS Trust
Lee Osborne	Programme Manager	Shropshire Community Health NHS Trust
Dr Emily Peer	Associate Medical Director	Shropshire Community Health NHS Trust
Dr Subramanian Kumaran	Clinical Director	Shrewsbury & Telford Hospital NHS Trust
Dr Kevin Eardley	Unscheduled Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Debbie Vogler	Director of Business & Enterprise	Shrewsbury & Telford Hospital NHS Trust
Mr Andrew Tapp	Women's & Children's Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
John Crowe/ Graham Shepherd	Nominated Representative	Shropshire Patient Group
Carole Hall	Nominated Representative	Healthwatch Shropshire

5.11.3 Workstream 3: Engagement & Communications

The engagement and communications workstream consists of two core elements;

1. An Executive Group, and
2. A Stakeholder Reference Group.

The overall goal of the workstream is to empower patient, community, staff and stakeholder leadership at the heart of the Programme, ensuring the creation and delivery of a compelling vision for Excellent and Sustainable Acute and Community Hospital Services.

1. Executive Group

The remit of the Executive Group is to:

- Engage with relevant and representative stakeholders to develop a robust engagement and communications plan

- Ensure delivery of the engagement and communications plan for each phase of the Programme
- Commission products and materials as required for the delivery of the plan
- Ensure compliance with key statutory and mandatory guidance (including statutory framework for England and for Wales, national reconfiguration tests, NHS Act 2006, Freedom of Information Act 2000 etc.)
- Undertake relevant engagement that has impact

  To provide leadership for patient, community and stakeholder engagement on behalf of the Programme, and support organisations within the programme to lead their workforce engagement
- Deliver engagement-led communication
- Work with members to develop and implement the overall visual identity and brand for the Programme
- Maximise engagement and communication opportunities, minimising risks

  To identify the benefits and risks in relation to engagement and communication and ensure effective strategies for benefits realisation and risk management
- To assure engagement, robust delivery

  To support the Assurance Workstream, particularly in relation to engagement with key statutory bodies such as Health Overview and Scrutiny Committees (HOSC), Healthwatch bodies and Community Health Council (CHC), including reporting to the HOSCs, Health and Wellbeing Boards and CHCs.

Membership of the Executive Group includes the appointed NHS Future Fit engagement and communications team, the Programme's Senior Responsible Officers, senior executives accountable for engagement and/or communications from sponsoring organisations, officers from Healthwatch Shropshire and Telford & Wrekin, and Powys CHC, supported by the core programme team.

Please note: CHC members will be accountable for the conduct of their role on the Engagement and Communications Workstream in accordance with their statutory responsibilities and any guidance that may be issued by Welsh Government.

The Executive Team will meet as and when required. The group will report directly to the Programme via Programme Team/Board. Meetings will be chaired as appropriate between SROs, Executives and the (CSU appointed) Communications and Engagement Lead.

2. Stakeholder Reference Group

To ensure all plans are sense checked by a wider stakeholder community a Stakeholder Reference Group will be formed.

The remit of the Stakeholder Reference Group includes four key areas:

- **Strategy – commenting on overall strategic goals and risks**

  Such as reviewing and providing feedback on the workstream deliverables and strategy including advising on the workstream risk register and highlighting risks not observed

- **Championing Engagement**

  Such as providing industry insights to enhance programme engagement plans, in addition all members of the Stakeholder Reference Group become information providers and act as a conduit to the public, as and when required

- **Synergy across core delivery partners**

  Such as providing additional assurance that the delivery of the plans is embedded within the sponsoring organisations' own activities, but also provide insights on how to best deliver across the wider community that the programme impacts.

- **Expert input**

  Such as providing expert input into the development of the Programme plans and activities and advising the best use of resources. The Stakeholder Reference Group members bring with them a wealth of experience and knowledge to be shared with the group and the wider workstream.

Membership of the Stakeholder Reference Group includes representatives from local patient and public groups, sponsoring organisations, members of the Executive Group, independent health committees and third sector organisations. In attendance are members of the Executive Group (as appropriate).

A full list of current members can be found at the end of this document.

The Stakeholder Reference Group will meet regularly between 4-6weeks. The meetings will be chaired by SaTH Communications Director and deputised by the (CSU appointed) Communications and Engagement Lead.

Table 7 Workstream 3: Engagement & Communications

Name	Role	Organisation
Adrian Osborne (Chair)	Communications Director	Shrewsbury & Telford Hospital NHS Trust
Harpreet Jutlla	Communications & Engagement Manager	Midlands and Lancashire CSU
Anne Wignall	Nominated Representative	Healthwatch Shropshire
Kate Ballinger	Chief Officer	Healthwatch Telford & Wrekin
Nick Hutchins	Nominated Representative	Shropshire Patient Groups
Ian Roberts	Nominated Representative	Telford & Wrekin CCG
TBC	Nominated Representative	Powys Patient Groups
David Parton	Young Health Champion	Health Champion Network
Abi Fraser	Young Health Champion	Health Champion Network
Hannah Davies	Young Health Champion	Health Champion Network
Cathy Briggs	Staff Engagement Representative	Shrewsbury & Telford Hospital NHS Trust
Lynne Weaver	Staff Engagement Representative	Shropshire Community Health NHS Trust
Julie Thornby	Director of Governance	Shropshire Community Health NHS Trust
Bharti Patel-Smith	Director of Governance & Involvement	Shropshire CCG
Christine Morris	Executive Lead Nursing, Quality & Safety	Telford & Wrekin CCG
Tin Wheeler	Communications Lead	Powys tHB
Samantha Turner	Communications Lead for CCGs	Staffordshire & Lancashire CSU
Rachel Wintle	VCS Assembly Board representative	Shropshire Voluntary & Community Sector Assembly
Debbie Gibbon	Head of Projects/Service Manager for Local Carers	Telford & Wrekin CVS
Trish Buchan	Health & Social Care Facilitator	Powys Association of Voluntary Organisations

5.11.4 Workstream 4: Finance

The model of care developed through the Programme is likely to lead to substantial shifts in costs and to have a significant impact on the total cost of the services delivered across the system as a whole. It is essential that robust systems are in place to forecast and monitor the impact of these changes, in order to ensure that they constantly remain affordable for all the partner organisations.

The remit of the Finance workstream will be to:

- Oversee the assessment of the financial impact on all partner organisations of the identified options for the Programme;
- Develop and maintain a financial model to support the identification of financial and affordability envelopes;
- Undertake an assessment of the financial and economic impact of the changes arising from all options identified by the Programme;
- Complete the financial and economic aspects of all Outline Business Cases and Full Business Cases in line with NHS and HM Treasury guidance;
- To identify the benefits and risks in relation to finance and affordability and ensure effective strategies for benefits realisation and risk management, including:
    - contributing to the Benefits Realisation Plan
    - contributing to the Programme Risk Register

The Workstream will be led by Andrew Nash, with support from the Programme Finance Director, and will comprise the following membership:

Table 8 Workstream 4: Finance

Name	Role	Organisation
Andrew Nash (Chair)	Chief Finance Officer	Telford & Wrekin CCG
Donna McGrath	Chief Finance Officer	Shropshire CCG
Colin Thomas	Programme Finance Director	Telford & Wrekin CCG
Neil Nisbet	Finance Director	Shrewsbury & Telford NHS Trust
tbc	Director of Finance & Performance	Shropshire Community Health NHS Trust
Greg Chambers	Locality Finance & Performance Manager	Powys tHB
Mike Sharon	Programme Director	Midlands and Lancashire CSU
Richard Chanter	Nominated Representative	Shropshire Patient Group
Mandy Thorn	Nominated Representative	Healthwatch Shropshire
David Frith	Senior Programme Manager	Midlands and Lancashire CSU

5.11.5 Workstream 5: Assurance

The purpose of Workstream 5 is to develop for Programme Board approval, and to ensure the effective implementation of, a comprehensive Programme Assurance Plan which will provide assurance to the Programme Board, sponsor Boards, the Joint Health Overview and Scrutiny committees and other external parties regarding the governance, management and decision making within the programme. This will include:

- Ensuring that there is proactive engagement with Health and Wellbeing Boards throughout the programme so that service change proposals can reflect joint strategic needs assessments and joint health and wellbeing strategies, and so that Health and Wellbeing

Boards are given an opportunity to comment on and be involved in the development of plans.

- Ensuring that decisions taken by the Programme Board are ratified by the appropriate governance structures within each of the partner organisations.
- Development and implementation of effective and independent clinical and programme assurance processes, including:
    - Development and maintenance of strong links with the Joint HOSC & CHC;
    - Planning and coordination of Gateway Reviews;
    - Effective and timely Local Assurance Processes (LAP);
    - National Clinical Assurance Team (NCAT) reviews.
- Receiving and reviewing reports from sponsor/stakeholder organisations about their plans in order to provide assurance to the Board that those plans will support and contribute to the FutureFit vision.
- Ensuring best practice and value for money in the management of the Programme.
- Ensuring the appropriateness and effectiveness of all evaluation processes and decision-making.
- Ensuring processes are in place to ensure collective decision making can be achieved, including the development of a dispute resolution process.
- In conjunction with the Engagement & Communications workstream ensuring that patients and the public are appropriately involved in the Programme, and that involvement and consultation has covered equitably the different geographies affected by the programme.
- Identifying the benefits and risks in relation to governance and assurance and ensuring effective strategies for benefits realisation and risk management, including:
    - contributing to the Benefits Realisation Plan
    - contributing to the Programme Risk Register

It will be the responsibility of each individual workstream to secure any external assurance which the Programme Board or Programme Team deems to be required for work which that workstream has undertaken or commissioned.

The Workstream will be led by Paul Tulley, with support from David Frith, and will comprise the following membership:

Table 9 Workstream 5: Assurance

Name	Role	Organisation
Paul Tulley (Chair)	Chief Operating Officer	Shropshire CCG
Bharti Patel-Smith	Director of Governance & Involvement	Shropshire CCG
Alison Smith	Executive Lead, Governance &	Telford & Wrekin CCG

Name	Role	Organisation
	Performance	
Julie Thornby	Director of Governance	Shropshire Community Health NHS Trust
Julia Clarke	Director of Corporate Governance	Shrewsbury & Telford Hospital NHS Trust
Rani Mallison	Corporate Governance Manager	Powys tHB
Cllr Gerald Dakin	Joint Chair	Shropshire HOSC
Fiona Bottrill	Scrutiny Group Specialist	Telford & Wrekin HOSC
Amanda Holyoak	Scrutiny Group Specialist	Shropshire HOSC
Terry Harte	Nominated Representative	Healthwatch Shropshire
Paul Wallace	Vice Chair	Healthwatch Telford & Wrekin
David Adams	Nominated Representative	Powys CHC
Daphne Lewis	Nominated Representative	Shropshire Patient Group
Phil Smith	Delivery Manager	NHS Trust Development Authority
David Frith	Senior Programme Manager	Midlands and Lancashire CSU

5.11.6 Workstream 6: Emergency Care Feasibility Study

This workstream was terminated in September 2014 following completion of the Study.

The Clinical Model of Care emerging within the Programme includes a vision for a Single Emergency Care Centre. The purpose of this Workstream is to prepare for Programme Board a report which assesses the feasibility of such a centre before detailed options are developed. This will include:

- Commissioning the technical work required to enable an assessment of the feasibility of a single emergency care centre, including
    - Examination of three options for the location of a single emergency centre only (Royal Shrewsbury Hospital, Princes Royal Hospital Telford and an as yet to be defined new site on the A5 corridor between Shrewsbury and Telford);
    - Setting out the high level physical requirements on each site for each Option;
    - Developing plans for the Physical Solutions on each site for each Option (1:1,000 Site Plans and 1:500 Block Plans);
    - Producing Capital Cost forecasts for each Option (plus direct revenue impact);
    - Assessing the sensitivity of the results of the appraisal to changes in the assumptions used;

- Producing a Report with appropriate detailed appendices for sign-off by the Programme Board.

- Overseeing the work of the commissioned technical team to ensure that the study is delivered on time and to the Board's specification.

The Workstream will be led by Mike Sharon, with support from the technical team, and will comprise the following membership:

Table 10 Workstream 6: Feasibility Study

Name	Role	Organisation
Mike Sharon (Chair)	Programme Director	Midlands and Lancashire CSU
David Frith	Senior Programme Manager	Midlands and Lancashire CSU
Paul Tulley	Chief Operating Officer	Shropshire CCG
Fran Beck	Executive Lead, Commissioning	Telford & Wrekin CCG
Debbie Vogler	Director of Business & Enterprise	Shrewsbury & Telford Hospital NHS Trust
Dr Kevin Eardley	Unscheduled Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Mark Cheetham	Scheduled Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Andrew Tapp	Women & Children Care Group Medical Director	Shrewsbury & Telford Hospital NHS Trust
Dr Edwin Borman	Medical Director	Shrewsbury & Telford Hospital NHS Trust
Neil Nisbet	Finance Director	Shrewsbury & Telford Hospital NHS Trust
Chris Needham	Director of Estates	Shrewsbury & Telford Hospital NHS Trust
John Cliffe	Chief Information Officer	Shrewsbury & Telford Hospital NHS Trust
Dr Peter Clowes	Urgent Care Lead	Shropshire CCG
Zena Young/ Ann-Marie Morris	Urgent Care Lead	Telford & Wrekin CCG
Dr Bill Gowans	Vice Chair	Shropshire CCG
Dr Mike Innes	Chair	Telford & Wrekin CCG
Dr Andy Raynsford	Chair, North Locality GP Cluster	Powys tHB
Richard Chanter	Nominated Representative	Shropshire Patient Group
Vanessa Barrett	Nominated Representative	Shropshire Healthwatch
Tbc	Nominated Representative(s)	Patient Groups/Healthwatch/CHC

5.11.7 Workstream 7: Impact Assessment

The role of this workstream is to ensure that the impact of programme proposals on local populations is fully assessed in line with statutory requirements and best practice guidance, including through:

- Defining the requirements for undertaking integrated assessments of the likely impact of Programme proposals in line with current guidance and best practice;
- Developing a plan which sets out the key points at which assessments should be undertaken;
- Commissioning the work required to undertake the required assessments;
- Overseeing the work of commissioned advisors to ensure that assessments are delivered on time and in line with Programme requirements;
- Preparing reports for the Programme Board in line with the workstream plan.

The workstream will be led by Ruth Lemiech and will comprise the following membership:

Table 11 Workstream 7: Impact Assessment

Name	Role	Organisation
Ruth Lemiech (Chair)	Transformation Associate	Midlands and Lancashire CSU
Mike Sharon	Programme Director	Midlands and Lancashire CSU
David Frith	Senior Programme Manager	Midlands and Lancashire CSU
Harpreet Jutlla	Communication and Engagement Lead	Midlands and Lancashire CSU
Terry Harte	Nominated Representative	Shropshire Healthwatch
Penny Haswell	Nominated Representative	Shropshire Patient Group
Janet O'Loughlin	Nominated Representative	Telford Healthwatch (and Listen not Label)
Susan Stavrides	Nominated Representative	Fairness Respect Equality Shropshire
Professor John Reid	Public Health	Powys tHB
Liz Noakes	Locum Consultant in Public Health	Shropshire Council
Tracey Jones	Director of Public Health	Telford & Wrekin Council
Linda Izquierdo	Quality Lead	Telford & Wrekin CCG
tbc	Director of Nursing, Quality and Patient Experience	Shropshire CCG
Andrew Coleman	Quality Lead	Powys tHB
Sarah Bloomfield	Deputy Director of Nursing	Shropshire Community Health NHS Trust
Ruth Lemiech (Chair)	Director of Nursing and Quality	Shrewsbury & Telford Hospital NHS Trust

5.11.8 Workstream 8: Workforce

Whatever the final option chosen, the Programme assumes significant changes to the way in which care is delivered in the future. In addition, the Case for change recognises current workforce pressures as a driver for change. Both of these drivers have workforce implications. These include

the need for staff to work differently, possibly in different locations, using different technology, and probably acquiring new skills.

The Programme, as it develops more detailed options for change also needs to be able to make some assumptions about how the workforce will look in the future, expressed both in terms of numbers and types of staff and in terms of workforce costs.

The purpose of this workstream is to provide a workforce model that identifies the workforce implications of the clinical model of care, financial, activity and capacity modelling and the development of options. It will do this by:

- Developing a workforce vision that complements the clinical vision;
- Developing a narrative on the workforce implications of the overall clinical model and on specific components of the model (such as Urgent Care Centres);
- Supporting the development of descriptions of new roles to support the delivery of the clinical model and ensuring links are made to local workforce planners and commissioners of education and training;
- Providing advice to the clinical design workstream on prototyping early implementation of components of the clinical model;
- Developing a workforce model that is linked to the financial and activity and capacity models and that allows differing assumptions about workforce numbers and types to be modelled in terms of WTEs and financially.

The workforce group will not provide OD/change management support to deliver FutureFit changes. It is assumed that this resource is available within local organisations' HR support arrangements.

The workstream will be led by Victoria Maher, and will comprise the following membership:

Name	Role	Organisation
Victoria Maher	Workforce Director	Shrewsbury & Telford Hospital NHS Trust
Chris Morris	Executive Nurse	Telford & Wrekin CCG
Linda Izquierdo	Director of Nursing, Quality and Patient Experience	Shropshire CCG
Andrew Coleman	Deputy Director of Nursing	Shropshire Community Health NHS Trust
Lynne Taylor	Deputy Director of HR	Shropshire Community Health NHS Trust
Colin Thomas	Programme Finance Director	Telford & Wrekin CCG
Bill Gowans	Clinical Design Lead	Shropshire CCG
Jo Leahy	GP	Telford & Wrekin CCG
Teresa Hewitt-Moran	Member of LETC	LETC

Name	Role	Organisation
Graham Shepherd	Patient representative	Shropshire Patient Group
Janet O'Loughlin	Patient representative	Telford Healthwatch
Mike Sharon	Programme Director	Midlands and Lancashire CSU
David Frith	Senior Programme Manager	Midlands and Lancashire CSU

5.12 Advisory Team

The Programme Director, Programme Team and Workstreams will be supported by an experienced team of advisors to be appointed as necessary to meet specific identified needs.

A Design Champion will be appointed at an appropriate point in the Programme, who will be responsible for ensuring that any capital investment proposals deliver high quality products that meet the needs of patients, staff and local people. The Design Champion will be directly involved in the production of briefing information on design quality, consulted at regular intervals during the design development process and be a part of the design evaluation teams.

6. Timetable

6.1 Milestones

An outline timetable for the programme has been determined as follows:

Table 12 Programme Plan – Target Milestones

Key Tasks	Target Completion Date
Phase 1a - Programme Set-Up	**End January 2014**
Finalisation of Case for Change and Programme Mandate	
Preparation and approval of Programme Execution Plan	
Preparation and approval of programme timetable and plan	
Securing key programme resources	
Establish panel of external clinical experts	
Development of Benefits Realisation Plan	
Development and approval of Engagement & Communications Plan	
Development of Assurance Plan	
Phase 1b - High Level Vision	**End January 2014**
Securing clinical consensus on overall model of care	
Analysis of Community Hospital services and utilisation	
Acute Hospital services activity projections and categorisation	
Stakeholder engagement on high-level vision	
Assessment of recurring affordability envelope & capital investment capacity	
Gateway Review 0	
Phase 2 - Development of Models of Care	**End August 2014**
Refinement of acute hospital activity projections	
Activity projections for other services	
Development of whole LHE financial models	
Agreement of non-financial appraisal criteria and process	
Assessing the feasibility of a single emergency centre	
Public engagement on Clinical Model and provisional long-list & benefit criteria	
Gateway Review 0	

Key Tasks	Target Completion Date
Phase 3 - Identification and Appraisal of Options	**End Sept 2015**
Development and agreement of long-list of options Selection and development of short-list of options Preparation of Strategic Outline Case(s) Gateway Review 0	
Financial and non-financial appraisal of short-listed options Selection and approval of preferred option	
Phase 4 - Public Consultation & OBC	**End June 2016**
Gateway Review 1	
Preparation for Public Consultation including Pre Consultation Business Case & NHSE Formal Assurance	
Formal Public Consultation	
Preparation of Outline Business Case(s) and Decision Making Business Case Partner organisations' approval of OBC/DMBC and consultation outcomes	
Gateway Review 2	
Phase 5 - Full Business Case(s)	**To be determined**
Procurement processes Preparation and partner organisations' approval of FBC(s)	
Gateway Review 3	
Phase 6 - Implementation	**To be determined**
Capital infrastructure developments	
Implementation of service changes	
Phase 7 - Evaluation	**To be determined**
Post Programme Evaluation	

A more detailed programme plan is attached as ***Appendix 3***.

7. Resources

7.1 Core Partners

The following resources will be made available from within the core partners' existing resources:

- Programme Board members
- Programme Team members
- Workstream Leads and members
- Design Champion
- Programme Auditor.

7.2 External Support

External consultancy support will be provided by NHS Central Midlands Commissioning Support Unit, and the following additional appointments will be made to support the Programme:

- Programme Director
- Senior Programme Manager
- Programme Administrator

Additional specialist consultancy support will be commissioned by the CSU as required.

7.3 Programme Budget

The budget for the Programme is summarised in Table 13 below:

Table 13 Programme Budget

Element	2015/16 Budget
Programme Management Office	£320,000
Strategic Analytics	£50,000
Communications & Engagement	£352,763
Technical Advisory Team (estimate)	£295,000
Integrated Impact Assessment	£109,000
Legal Advice (estimate)	£20,000
Rural Urgent Care support	£15,668
Meeting Room Costs	£12,000
TOTAL PROGRAMME BUDGET	**£1,174,431**

FUNDING	
NHS England, Area Team	-
Shropshire CCG	£634,193
Telford & Wrekin CCG	£422,795
Powys LHB	£117,443
TOTAL FUNDING	**£1,174,431**

The programme budget will be reviewed and updated as the programme progresses and changes will be submitted to the Programme Board for approval.

8. Programme Management

8.1 Approach

The Programme will be managed in accordance with the PRINCE2 ("Programmes in a Controlled Environment") and "Managing Successful Programmes" methodologies, suitably adapted for local circumstances in order to meet the needs of this Programme.

The programme management arrangements will therefore be driven by outputs - or in the PRINCE2 terminology, "Products". All Products will be formally signed off by the appropriate workstream before being approved by the Programme Team or Programme Owners as required.

The PEP includes all the management controls required to ensure the partner organisations meet their fiduciary obligations with respect to the development and implementation of the Programme, and the management of the Programme within a framework of acceptable risk. This governance framework will ensure that:

- Local health services are modernised through the controlled and measured management of a wide range of risks;
- Decisions on the strategic direction and future needs of local health care are only made after proper consideration;
- The views and interests of stakeholders are considered;
- Appropriate behaviour with respect to the codes of corporate governance, policy guidance and good management practice;
- Open reporting of Programme progress and performance.

To ensure the quality of the outputs is maintained and the objectives are met, the PEP and the implementation of the Programme will be managed and undertaken on the basis of:

- Proven methodologies and standards;
- Effective monitoring procedures;
- Effective change/issues/problem management;
- Review and acceptance procedures; and
- Appropriate documentation and record keeping.

8.2 Methodologies & Standards

The Programme will only use standard and prescribed methods for service and financial modelling.

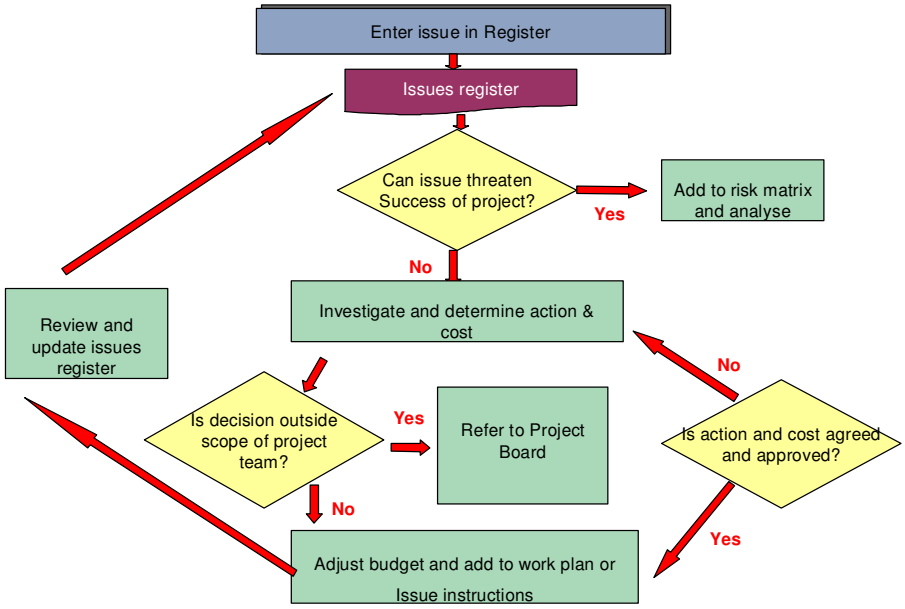
All documents and publications will be based on standard DH documents where available. Any deviation from the standards will be referred for approval to NHS England as required.

The Programme will use a standard set of protocols and templates.

8.3 Issues Management

The management process for dealing with issues and concerns identified during the execution of the Programme is illustrated in Figure 1 below. The Programme Team will undertake an initial assessment of the nature and impact of the issue, drawing on appropriate technical support as necessary.

Figure 1 Process for Managing Issues



Where the matter does not involve a change in Programme cost, is not at variance to the clinical service models and strategies and is supported by all core partners, the Programme Team will have authority to approve and implement any necessary changes.

Issues that are outside the scope or authority of the Programme Team will be referred to the Programme Board.

8.4 Monitoring & Audit

The Programme documents, processes, outputs and progress will be monitored by the Programme Board and through continuous audit by the Programme Auditor.

8.5 Administrative Systems & Procedures

8.5.1 Meetings

Notes will be produced of all meetings of the Programme Team and of its Workstreams and will be kept in the Programme Library.

8.5.2 Records

A copy of all Programme communications originating in the Programme Team and Workstreams or from the Programme advisors will be sent to the Programme Office for record keeping. All electronic data and computer files produced by the Programme Team are to be stored on a system that is the subject of daily back-ups. All Programme Team advisors are to have suitable data security and back-up arrangements in place.

8.5.3 Programme Library

In order to ensure key programme documents are made available as swiftly as possible, an electronic Programme Library will be. The library will be managed by the Programme Administrator.

8.6 Communications and Stakeholder Engagement

8.6.1 Communications

A Programme Directory will be established, detailing the contact details for all members of the Programme Board, Programme Team, Workstreams and Advisory Team. The Programme Directory will be maintained by the Programme Administrator.

The Programme Team will provide advice and support on all communications relating to the Programme, and will act as the Programme's interface with the media.

The specific inputs into the Programme include:

- Communications link to the partner organisations' communications systems;
- Internal partner organisations' communication links;
- Advice on external communications support;
- Link to other external communications, including NHS publications;
- Identification of communications opportunities that can be used to keep the local population informed and up-to-date.

8.6.2 Stakeholder Engagement

A detailed Stakeholder Engagement & Communication Plan will be prepared by the Engagement & Communications Workstream as part of Phase 1 of the Programme, and forms ***Appendix 4***.

8.6.3 Freedom of Information

All Programme information will be made public except where it would be in breach of patient or staff confidentiality or of commercial interests.

8.7 Conflicts of Interest

A Register of Interests of all Programme staff and advisors will established and will be formally updated and reported to the Programme Board on a regular basis, in line with the Programme's Code of Conduct.

Where a person is found to have a conflict of interest they will not be given access to such information and will be required to take no active part in the programme, or the relevant part of the programme.

8.8 Confidentiality

All Programme staff, advisors and other persons who may have privileged access to information that is considered to be commercially confidential will be required to sign a confidentiality agreement before gaining access to such information.

8.9 Gateway Reviews

Elements of the Programme may be subject to Health Gateway reviews as required by NHS England and in accordance with the prescribed process. Programme Team and Advisory Team members will co-operate fully with the review process.

9. Assumptions, Constraints, Risks

9.1 Assumptions

The programme is proceeding on the basis of the following assumptions:

- Sufficient human and financial resources continue to be made available by the partner organisations;
- The Programme Sponsors will continue to work jointly and will ensure that their governance systems and processes allow for collective decision-making;
- The continued engagement in the Programme of all stakeholder organisations; and
- Any changes required to maintain the safety and sustainability of services in the short-term will be consistent with the longer-term service model to be developed by the Programme.

9.2 Constraints

The key constraints within which the programme must proceed are considered to be as follows:

- The programme's goals must remain demonstrably affordable to the health economy as a whole and to individual partner organisations;
- The availability of capital funding. However, it has been agreed that a single-site new-build solution should be included in any long-list of potential options, and it would be for the option appraisal to determine if this could be a short listed option; and
- Timescales: the urgency to achieve the quality benefits including safety, effectiveness and clinical sustainability, require significant service change to be implemented and the longer-term service model will therefore need to be agreed by the end of 2014.

9.3 Risks

The key risks to the success of the programme are considered to be in the following areas:

- Affordability of the agreed service models;
- Availability of capital funding for any changes to facilities and physical infrastructure;
- Public / stakeholder resistance and objections to plans; and
- Failure to meet project timescales.

Following the establishment of an initial high-level Risk Register, the Programme's risk management process has been further developed in the light of recommendations from the Health Gateway Review Team. This uses qualitative and quantitative measures to calculate the overall level of risk according to their impact and probability.

Those risks which are considered to be both High Probability and High Impact will considered in depth by the Programme Team and risk containment plans prepared. The Risk Register will be formally reviewed and updated on a monthly basis by the Programme Team and risks rated 'red' (either before or after mitigation) will be reported to the Programme Board. Core Group will also review the full register at each of its meetings.

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10. Appendix 1 - Strategic Context

Clinical Services Strategy - Shropshire Hospitals
Strategic Context

This document has been prepared on behalf of Shropshire and Telford & Wrekin Clinical Commissioning Groups, Shrewsbury and Telford Hospitals NHS Trust (SaTH) and the Shropshire Community Health NHS Trust (SCHT). It sets out the strategic context for the local health community and in particular for acute and community hospital services. A recent NHS England publication – 'The NHS Belongs to the People – A Call to Action', – sets out the national picture and makes the case that the way in which health services are provided will need to change if the NHS is to meet the challenges which it will face in the next 5-10 years. In this document we set out how these challenges apply to our local health system and make the case that we need to change how our hospital services are provided so that the people of Shropshire, Telford and Wrekin, and residents in Powys who look to the SaTH as their main acute hospital provider, can continue to receive high quality services which are clinically and financially sustainable.

Current Local Context

Commissioning

On the 1 April 2013 Clinical Commissioning Groups replaced Primary Care Trusts as the local NHS bodies responsible for the commissioning of a range of health services for their local populations. The Shropshire area is served by Shropshire Clinical Commissioning Group, based in Shrewsbury and Telford & Wrekin Clinical Commissioning Group, based in Telford. Clinical Commissioning Groups responsible for commissioning services in the following areas of care:

- hospital care;
- rehabilitation care – such as visits from district nurses;
- urgent and emergency care – the out-of-hours GP service, ambulance call-outs, A&E;
- community health services; and
- mental health and learning disability services.

Clinical Commissioning Groups are membership organisations which represent local GP's. Shropshire has 44 GP practices and Telford and Wrekin has 22 GP practices

Telford and Wrekin Clinical Commissioning Group serves a population of approximately 172,000, which is mainly centred around the new town of Telford but covers the surrounding rural areas and towns including Newport. It has co-terminus boundaries with Telford Borough Council and there are strong partnership links between the two bodies in health and social care.

Shropshire Clinical Commissioning group serves a population of 302,000. Shropshire is a large rural county. The county town of Shrewsbury is central to the county with a number of market towns geographically spread across the area. Shropshire Clinical Commissioning Group has co-terminus boundaries with Shropshire Council and the two agencies work closely together.

Services and Provision

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is the main provider of district general hospital services for half a million people living in Shropshire, Telford & Wrekin and mid Wales, Services are delivered from two main acute sites: Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care. Total bed capacity across the two hospitals is 819. Within this, PRH has 327 beds (including 248 adult inpatient beds) and RSH has 492 beds (including 349 adult inpatient beds). The Shrewsbury and Telford Hospital NHS Trust provide outreach services to Shropshire's four Community Hospitals along with the Community Hospital in Welshpool as well as outreach services to Robert Jones & Agnes Hunt Orthopaedic Hospital in Oswestry.

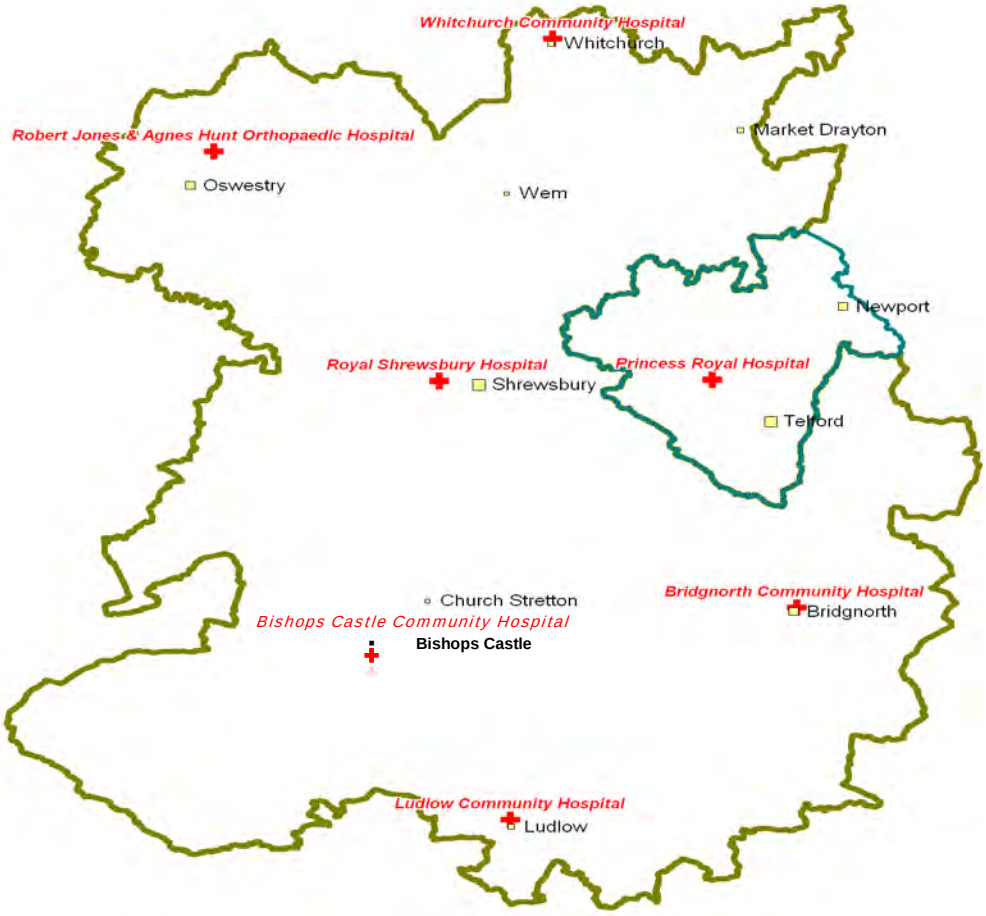
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a leading orthopaedic centre of excellence. The Trust provides a comprehensive range of musculoskeletal surgical, medical and rehabilitation services; locally, regionally and nationally.

The organisation is a single site hospital based in Oswestry, Shropshire, close to the border with Wales. As such, the Trust serves the people of both England and Wales, as well as acting as a national healthcare provider. It also hosts some local services which support the communities in and around Oswestry.

The hospital has eight inpatient wards including a private patient ward, ten operating theatres, as well as extensive outpatient and diagnostic facilities. Outreach clinics are held in neighbouring healthcare facilities to ensure that specialist services are provided as close to people's homes as possible.

Shropshire Community Health NHS Trusts provides community health services to people across Shropshire and Telford & Wrekin in their own homes, local clinics, health centres and GP surgeries. These services include Minor Injury Units, community nursing, health visiting, school nursing, podiatry, physiotherapy, occupational therapy, support to patients with diabetes, respiratory conditions and other long-term health problems. In addition, they provide a range of children's services, including specialist child and adolescent mental health services. Full details of services can be found in Appendix 1.

Shropshire's four Community Hospitals have a total of 113 beds. These hospitals, operated by Shropshire Community Health Trust, are situated in Bishops Castle, Bridgnorth, Ludlow and Whitchurch. They provide care for those who do not need acute hospital care or have been transferred from an acute hospital for rehabilitation or recovery following an operation or who need palliative care



The following table summarises the range of services offered at each of these hospitals:

	Ludlow	Bishops Castle	Bridgnorth	Whitchurch
Beds	40	16	25	32
Maternity	X		X	
Minor Injuries Unit	X		X	X
Physiotherapy	X	X	X	X
Audiology	X	X		X
Podiatry	X	X	X	
Renal Dialysis	X			
Speech and Language therapy	X	X	X	X
X-ray	X		X	X
Deep Vein Thrombosis prevention		X		
Falls service		X		
Day surgery			X	
Adult diagnosis, assessment and rehabilitation		X		
Community midwifery				X
Occupational therapy				X
Phlebotomy				X
Rehabilitation			X	

There are no community hospitals within Telford and Wrekin and therefore a model of care has developed that has a strong focus on community care and on care in the patients home and reablement.

There are 66 GP practices across Shropshire and Telford and Wrekin, 44 of these are in Shropshire and 22 in Telford and Wrekin, providing the first point of contact for health services in the area. These are complimented by Walk in Centres located in Shrewsbury, Telford town centre and the Princess Royal Hospital. Open from 8am to 8pm these cater for individuals requiring urgent medical attention who are unable to get an appointment with their own doctor, or are not registered with a GP practice.

Shropshire Doctors Co-operative Ltd (Shropdoc) provides services to 600,000 patients in Shropshire, Telford and Wrekin and Powys when their GP surgery is closed and whose needs cannot safely wait until the surgery is next open.

South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide adult and older people's mental health services in the county.

The Adult Mental Health Service consists of teams providing services through multidisciplinary and multi-agency working for people of working age. They work in partnership with local councils and work closely with the voluntary sector, and independent and private organisations to promote the independence, rehabilitation, social inclusion and recovery of people with a mental illness.

Services for Older People provide inpatient and community mental health services across Shropshire and Telford & Wrekin and a small inpatient service to Powys. The service is available for people over the age of 65 with any form of mental illness and for people of any age with dementia.

Facilities include the Redwoods Centre in Shrewsbury which opened in 2012 and provides 80 adult mental health beds for Shropshire, Telford and Wrekin and Powys and 23 low secure beds for the West Midlands.

To complete the picture of health commissioning and provision locally NHS England's role in the commissioning of specialised services, primary care services, offender healthcare and services for members of the Armed Forces should also be noted.

The wider Shropshire area is serviced by the two Unitary Councils of Shropshire and Telford & Wrekin

Our local councils are responsible for providing a range of services to their local populations but most relevant for this document is the delivery and oversight of social care and some health related provision

Adult social care is the range of services and support available for vulnerable people aged 18 and over, such as older people and people with a disability, to help them lead independent lives in their own communities.

Social care for children and families provides information relating to child protection, care services such as foster care, leaving care, young carers and adoption services. As well as providing information on services for disabled children and family support.

Shropshire Council is composed of 74 Councillors and Telford & Wrekin Council has 54 Councillors, elected every four years. Councillors are democratically accountable to residents of their electoral division. Local Councils are responsible for delivering a range of services to the local population including social care and some health related activities.

The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Each top tier and unitary authority will have its own health and wellbeing board, taking on statutory responsibility from April 2013. Board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.

Health and wellbeing boards are a key part of broader plans to modernise the NHS to:

- ensure stronger democratic legitimacy and involvement
- strengthen working relationships between health and social care, and,
- encourage the development of more integrated commissioning of services.

The boards will help give communities a greater say in understanding and addressing their local health and social care needs.

What will they do?

- Health and wellbeing boards will have strategic influence over commissioning decisions across health, public health and social care.
- Boards will strengthen democratic legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards will also provide a forum for challenge, discussion, and the involvement of local people.
- Boards will bring together clinical commissioning groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the Joint Strategic Needs Assessment (JSNA) and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.
- Through undertaking the JSNA, the board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care

system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

Under the Health and Social Care Act 2012, local authorities and local Clinical Commissioning Groups (CCGs) are required to produce a Joint Health and Wellbeing Strategy which aims to positively deliver improved health and wellbeing outcomes for local communities.

Both Shropshire and Telford & Wrekin's Health and Wellbeing Strategies are based upon evidence produced from a comprehensive Joint Strategic Needs Assessment (JSNA) of Shropshire and Telford and Wrekin's respective populations, coupled with feedback gained from engagement events held with a wide range of stakeholders including partner organisations, patient and service user groups and service providers.

Shropshire's Health and Wellbeing Strategy sets out the following 5 priority areas:
Outcome 1 –Health inequalities are reduced;
Outcome 2 - People are empowered to make better lifestyle and health choices for their own and their family's health and wellbeing;
Outcome 3 – Better emotional and mental health and wellbeing for all;
Outcome 4 - Older people and those with long term conditions will remain independent for longer; and
Outcome 5 - Health, social care and wellbeing services are accessible, good quality and 'seamless'.

Similarly Telford & Wrekin's Health & Wellbeing Strategy sets out a number of priority areas as follows:

- Reduce excess weight in children and adults
- Reduce teenage pregnancy
- Improve emotional health and wellbeing
- Support people with Autism
- Reduce the number of people who smoke
- Reduce the misuse of drugs and alcohol
- Improve adult and children carers' health and wellbeing
- Improve life expectancy and reduce health inequalities
- Support people to live independently
- Support people with Dementia

Both Strategies describe how resources will be targeted to where they will have greatest impact in meeting health and wellbeing needs and achieving positive outcomes for both population groups and outline how the strategies will be delivered in partnership by a whole range of organisations across the private, public and voluntary and community sectors.

Phase One Hospital Reconfiguration
In May 2012 a Full Business Case was agreed in relation to the future reconfiguration of acute hospital services in Shropshire. These changes addressed immediate clinical and service challenges to inpatient children's services, maternity services and acute surgery. This set out the case for change as:

- Safety and viability of clinical services;
- Workforce challenges; and
- Poor facilities for Women and Children.

At that time agreement was reached to progress reconfiguration along the following parameters:

At the Princess Royal Hospital (PRH):

- A consultant-led maternity and neonatology unit, co-located with gynaecology and paediatric inpatient services and a Paediatric Assessment Unit;
- Enhanced antenatal services;
- To establish a Women's service to include inpatient gynaecology and breast surgery, gynaecology assessment and treatment, Colposcopy and the Early Pregnancy Assessment Service (EPAS) on one ward;

- Adult inpatient head and neck services being located near theatres and critical care; and
- New accommodation for paediatric outpatients, paediatric cancer and haematology unit and parts of the children's ward alongside refurbishment of the existing children's ward.

At the Royal Shrewsbury Hospital (RSH):

- All inpatient general surgery, both planned and emergency, for vascular, colorectal, bariatric;
- urology and upper gastro-intestinal co-located near theatres and critical care;
- Developing a Surgical Assessment Unit (SAU) adjacent to A&E;
- Relocating and improving accommodation for the antenatal services, Pre Antenatal Day Assessment unit (PANDA) and the Midwifery-Led Unit (MLU); and
- Relocating and improving accommodation for paediatric outpatients and a PAU adjacent to A&E.

To date the following progress with the reconfiguration plans can be noted:

- July 2012 - a range of adult inpatient surgery was consolidated at the Royal Shrewsbury Hospital;
- September 2012 - Head and Neck inpatient services moved to the Princess Royal Hospital;
- December 2012 – Building works commenced on the new Women's and Children's Unit at Princess Royal Hospital which is scheduled to open in the summer of 2014; and
- The completion of the Lingen Davies Centre at RSH for cancer and haematology patients.

National & Political Landscape

The recently published "The NHS Belongs to the People - A Call to Action" reinforces the pace and level of change expected within the NHS to meet the challenges it faces. This document is a precursor to the launch of a sustained programme of engagement with NHS users, staff and the public to debate the future of the NHS.

Challenges and Drivers for Change

Demographics

Shropshire

Shropshire Clinical Commissioning Group serves a rural population of c.302,000. This population is of mainly white British ethnicity with a high proportion of people aged over 50 years old. Like many rural areas, Shropshire is expecting an increase in the future population of people aged 65 years and over. Overall the county is fairly affluent – however there are areas of deprivation and factors of rural sparsity which create issues with access to services.

2011 census data tells us that between 2001 and 2011 there has been an overall population growth of 8%. Within this there has been a 24% rise in the number of older people living in Shropshire compared to a 10% rise in England and Wales. The number of over 85's has increased by 31% in the same period compared to a 24% rise in England and Wales

Overall the health of the population in Shropshire is good[1], both male and female life expectancy is significantly higher than the national figures. Similarly, rates of all age all-cause mortality for males and females are significantly lower than the national figures. Life expectancy has increased in the total population in the last decade and all age all-cause mortality has decreased. However, inequalities in health persist in Shropshire and the increases in life expectancy and reductions in all age all-cause mortality have not had equal impact across all sections of the population.
In the most deprived fifth of areas in Shropshire there has been no significant increase in life expectancy in either males or females, although there has been a significant increase in life expectancy in the most affluent fifth of the population. There are also significantly lower rates of life expectancy in the most deprived fifth of areas compared to the most affluent fifth for both males and females, and this gap appears to be increasing.

[1] Shropshire JSNA

Telford & Wrekin
Telford & Wrekin Clinical Commissioning Group serve a more urban population of c.170,000. This population is younger than the national profile with 20.1% of the population aged 0-15 compared to 18.7% nationally. The over 65 years age group accounts for 14.5% of the population compared to 16.5% nationally. Between 2001 and 2011 the population of Telford & Wrekin increased by 7.6% and is predicted to reach 200,000 by 2025. However, within this growth there has been a decrease in the number of people aged 0-44 and an increase in those aged over 65, bringing the age profile much closer to the national average . In Telford and Wrekin 9% of the population are from BME groups, this is an increase of 37% from 2001.

Over the next 16 years (2010-2026) the most significant changes to the Borough's population structure are forecast to be;
- The population will increase by 26,100 – an increase of 15.3%
- The number of people aged 65+ will increase by 9,200. In 2010 this cohort accounts for
- 14.5% of the population, by 2026 this is projected to be 17.3%.
- The 0-15 cohort will grow by 10,000 people, increasing from 20.1% of the population in
- 2010 to 22.5% of the population in 2026.
- The ratio of older people to children in 2026 will be 1:1.30 compared to 1:1.38 in 2010.
- This compares with the change for England from 1:1.13 (2010) to 1:0.95 (2026)

Telford and Wrekin is in the top 30% most deprived districts in the West Midlands, and in the top 40% most deprived in England
- Just over a fifth (21%) of the population (approximately 36,000 people) live in communities classified within the 20% most deprived in the country
- Almost a quarter (24.5%) of children live in poverty (over 8,000 children under 16 years)
- Levels of deprivation across the Borough vary considerably, with some areas in the
- 10% most deprived nationally (areas of Woodside, Malinslee, College and Brookside) and others ranked in the 10% least deprived nationally (areas of Priorslee, Shawbirch, Newport North, Apley Castle and Edgmond)

Over the past 20 years the health of Telford and Wrekin's population has improved. However, there remain some health challenges and differences across the borough, where there are significant areas of deprivation. Too many people, particularly men, die early from cancer, heart disease and stroke and the rates of teenage pregnancy, maternal smoking, breastfeeding and childhood obesity are all worse than the England average. Long term conditions are also prevalent . A key challenge is that the health of residents is not consistent across the Borough with people living in more deprived areas more likely to die earlier and more likely to suffer from poorer physical and mental health.

Demand

National Picture
There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are a seeing significant increase in the number of people with long term conditions e.g. heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use will mean fundamental changes to how we deliver and use health care services[2].

[2] The NHS Belongs to the People – A Call to Action, NHS England, 2013

Ageing society

- Nearly two thirds of people admitted to hospital are over 65 years old;
- In the over 65 age group there are more than 2 million unplanned admissions each year (70% of emergency bed days); and
- Once admitted older people stay in hospital for longer and tend to be re-admitted.

Long Term Conditions

- LTC's are the most significant source of demand for NHS services;
- Using current estimates by 2035 there is likely to be 550,000 additional cases of diabetes, and 440,000 additional cases of stroke and heart disease[3]; and
- Hospital based delivery is not necessarily the optimum model of care for these conditions with self care, telecare and co-ordinated cross agency care in the community providing alternative options.

Rising expectations

- Demand for access to the latest therapies is rising and patients want more information and involvement in their care; and
- Patients want convenience through means such as care closer to home or work, seven day access and the use of technology.

Whilst more people are living longer, many people are spending more years in declining health. This places significant demand on health and social care services and highlights the importance of healthy lifestyles. Many of the causes of poor health and early death are largely preventable.

Rurality and Access

Shropshire's geography is an important factor - it covers a large area of 1235 square miles, of which only approximately 6% comprises suburban and rural development and continuous urban land. The geography of Shropshire is diverse. The southern and western parts of the county are generally more remote and self-contained and have been identified as a rural regeneration zone. With about only 0.9 persons per hectare, or 234 persons per square mile, the county is one of the most sparsely populated in England, with South Shropshire having the lowest population density.

Shropshire is one of the largest and most rural inland counties of England and incorporates two unitary councils: Shropshire Council and Telford and Wrekin Council. The county is characterised by a combination of large and small market towns, villages and small isolated hamlets, together with the new town of Telford and its associated housing developments.

[3] Y.C. Wang et al, 2011, cited in The NHS Belongs to the People – a Call to Action, NHS England 2013

Within the Shropshire council area, the economy is mainly based on agriculture, tourism, and food industries as well as healthcare and other public sector services. The transport infrastructure in the west of the county is poor, with no motorways, and limited dual carriageways and public transport across large rural areas. Telford and Wrekin accounts for a much smaller geographical area but has a significant rural area to the north and west. Telford developed as a new town in the 1960s and has manufacturing and tertiary service industries.

The geography of Shropshire County, with its long distances and travel times to acute hospitals, scattered and disproportionately elderly population and limited public transport, makes the provision of a comprehensive range and increased scale of community-based health services especially important. This becomes vital if the local health economy is to respond effectively to the challenge of the increasing elderly population combined with funding pressures. The geography of rural areas means particular challenges around providing services efficiently. Poor public transport increases the need for care close to home for the elderly and those from lower socio-economic groups without easy access to their own transport.

Quality

The Publication of the Francis Inquiry into failings at Mid Staffordshire Hospital has been one of the most significant events in the recent history of the NHS and has firmly placed quality at the top of the NHS agenda. Although the public inquiry was focused on one organisation, it highlights a whole system failure. The 1,782 page report has 290 recommendations which cut across and have major implications for all levels of the health service across England. There is no doubt that any plans for reconfiguration of provision must have quality as its central focus.

In his report (2010), Robert Francis QC calls for a whole service, patient centred focus. His detailed recommendations do not call for a reorganisation of the system, but for a re-emphasis on what is important, to ensure that this does not happen again. These themes, outlined below, will need to be embedded in any reconfiguration plans:

- Emphasis on and commitment to common values throughout the system by all within it;
- Readily accessible fundamental standards and means of compliance;
- No tolerance of non compliance and the rigorous policing of fundamental standards;
- Openness, transparency and candour in all the system's business;
- Strong leadership in nursing and other professional values;
- Strong support for leadership roles;
- A level playing field for accountability;
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation.

Further to this the NHS Outcomes Framework sets out the improvements against which the NHS Commissioning Board will be held to account from 2013/14. Each of the five domains, set out below, within the NHS Outcomes Framework will be supported by a suite of NICE quality standards which will provide authoritative definitions of what high-quality care looks like for a particular pathway of care:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

As well as embedding these principles in the development of future healthcare, local Clinical Commissioning Groups will need to continue to progress a significant programme of change alongside the Quality, Innovation, Productivity and Prevention (QIPP) agenda which will see changing models of local service delivery. One of the key lessons identified by the initial Francis Inquiry was the need to ensure continued delivery of safe and effective services through a period of intense change during financially challenging times.

Significant progress has already been made by the CCG's to ensure systems are in place to monitor quality of health services commissioned across providers. However there is still much to do and there

is a recognition that we need to work in partnership to provide assurance of quality, safety and positive patient experiences across the local health and social care economy.

All reconfiguration initiatives will need to be assessed against quality and safety standards at both a macro and micro level supported by an agreed Quality Impact Assessment (QIA) Tool with quality assurance and improvement as the key guiding principles.

Two Site Working

The Shrewsbury and Telford Hospitals NHS Trust has a large enough catchment population to support a full range of acute hospital services (excluding those more specialist services which require a much larger population and which are provided for the local population in Stoke on Trent, Birmingham and, for heart services, in Wolverhampton.) A number of services are provided either on the Royal Shrewsbury Hospital site or the Princess Royal Hospital site, but not both. However, there are a number of services which are currently provided on both sites requiring the duplication of specialist staff and equipment and the training needs of junior medical staff where two site working is increasingly difficult to maintain without compromising the quality and safety of the service.

Developing the future clinical services strategy for the acute Trust and any proposed change to the configuration of services across its two main sites, has to address any clinical quality, safety and sustainability issues and therefore ensure that we can maintain safe and appropriate staffing levels; it has to ensure we plan services to respond to future demands and demographic trends; and it has to ensure that we are able to improve efficiency and productivity and present a financially viable future for the Trust.

Evidence from the Medical Royal Colleges suggest, for instance, that the quality of clinical care can be improved by consolidating and increasing the scale of services and that patients should have greater and quicker access to consultant opinion. This all results in the need for increasing consultant delivered care which creates recruitment challenges and significant potential cost pressures for acute Trusts. For example, the College of Emergency Medicine advises that in order to provide safe care in A&E the standard should be:

- 10 WTE minimum coverage for all A&E's providing 16 hour/7 day consultant coverage;
- 24/7 emergency medicine consultant coverage of A&E

A report from the Royal College of Surgeons of England has also set out recommendations on the size of populations required to safely and efficiently run A&E services. Its recommendations include a minimum necessary population to provide a safe, efficient and effective fully-functioning 24/7 A&E service as ideally 450,000-500,000, with an underlying rationale around improving overall consultant presence, training opportunities and access to support from critical care, acute medicine, general surgery, trauma and orthopaedics and anaesthetics services.

The Trust currently runs two full A&E departments for a population of 500,000 and does not have a consultant delivered service, 16 hrs/day 7 days a week. Even without achieving these standards as set out by the Royal Colleges, the Trust currently has particular medical workforce recruitment issues and wider workforce sustainability challenges around A&E services, hyperacute and acute stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites.

Whilst the future provision of a single hyperacute and acute stroke care has been agreed through a strategic review of stroke services led by the network, the recent inability to fill vacant specialist stroke consultant posts resulted, on a temporary basis, in the provision of a single site hyperacute and acute stroke unit at PRH. The Trust now needs to set out its long term clinical services strategy for all its services with some urgency to prevent similar situations occurring where providers are having to react to short term quality and safety challenges for some specialist services without a longer term sustainable vision for the configuration of services across its two sites.

In setting out its strategy, the Trust believes it has a small number of fixed points or givens in terms of location of future services: a new Women's and Children's Unit at PRH; the Cancer centre to be based

at RSH; that services will be provided from two hospital sites and that the Trust will provide a 24/7 A&E service.

Workforce

In 2012/13 the FTE staffing level at SaTH was 4566. This included:

- 537 fte doctors and dentists (11.3%);
- 1,363 wte nursing and midwifery staff (29.9%);
- 595 wte scientific, technical and therapies;
- staff (13.0%);
- 1,175 wte other clinical staff (25.7%); and
- 896 wte non-clinical staff (19.6%).

In 2012/13 the FTE staffing level at SCHT was 1404. This included:

- Nursing and midwifery registered (39.7%);
- Administrative & Clerical (26%);
- Additional Clinical Service (12.9%);
- Allied Health Professionals (12%);
- Estates & Ancillary (3.9%);
- Medical & Dental (3%);
- Students (1.8%); and
- Additional professional scientific and technical (0.7%).

Workforce in the Acute Setting

In order to provide high quality and effective patient care, SaTH has to ensure that the right people with the right skills are always in the right place at the right time to meet the needs of patients. In a number of specialties the duplication of service provision across the two sites provides a real challenge.

Whilst some changes have already been made to the workforce in obstetrics, vascular and stroke, the workforce challenges facing SaTH in relation to future provision of services and reconfiguration as set out in the Women's and Children's Full Business Case and summarised below, remain largely unchanged:

- Changes to the training of medical staff resulting in the training programme for doctors now being significantly different to training in previous years. In the past, a general surgeon would have carried out large volumes of abdominal, breast and vascular surgery during their training. Now, consultants specialise in one of these surgical sub-specialties much sooner meaning they will not have the necessary skills to perform techniques that they have not been trained to deliver. This results in a situation where a surgeon is required to operate on the abdomen for example at night, when they do not perform this surgery in the day.
- Reduction in 'middle grade' doctors – due to the changes in training described above, traditional 'middle grades' are disappearing. The Trust will have to increasingly move towards a consultant led services to fill this gap.
- Changes to staff working hours – the European Working Time Directive continues to challenge the Trust in that more doctors have to be recruited that in the past to maintain a 24 hour rota across two sites.
- Challenges in recruiting medical staff means that on occasions there are not enough medical staff to cover all departments. This is because doctors can choose where to work and some are deciding not to come to the Trust and also because the Trust has experienced a reduction in the availability of some doctors from overseas.

Although phase one reconfiguration has moved some services to delivery on one site there continues for the most part to be two site working bringing with it duplication of provision. This in turn effectively doubles the impact of the workforce issues highlighted above

Workforce in the Community Setting

Current pressures in the system have caused an increase in the complexity and acuity of admissions and there is an increased demand on bed space. SCHT is exploring with other providers possible solutions to these pressures. In particular work is taking place with SaTH to explore the role of community physicians and geriatricians in providing medical overview but this remains reliant on successful recruitment.

It is anticipated that in future there may be difficulty recruiting to the medical workforce depending on:

- GP's performing specialist clinics within their practice, reducing the potential GPwSI pool
- Tendency of GPwSI to opt for roles within commissioning
- Hospital based consultants aptitude or enthusiasm for community roles

To improve and increase care in the high demand areas of business within the community (frail and elderly and pro-active management of long term conditions) SCHT have identified the following workforce requirements:

- skill mix review to ensure workforce profile is in line with evidenced 'norms' to match the needs of this extended cohort of patients;
- ensuring that clinical skills are maximised at the optimum level to ensure effectiveness and patient safety
- focus in a number of specific areas around proactive case management and risk stratification to support additional LTC management
- There will also be an emphasis on nursing support for long term conditions, early discharges and a children's hospital at home.
- It is also anticipated that there will be a shift from acute service provision to that provided within the community and closer to patient's homes. In return this will require an increase in numbers and change in the skills base of staff working at the Trust.

Currently, the services provided by the Trust and the on-call demands are such that no medical staff are impacted by the Working Time Regulations.

Additional requirements for new staff to support service developments over the period 2012-2018 will total 79.2 wte. The largest groups of staff required are:

- Qualified community nurses;
- Health Visitors
- Medical, nursing and therapy staff to support the Ludlow Health Facility

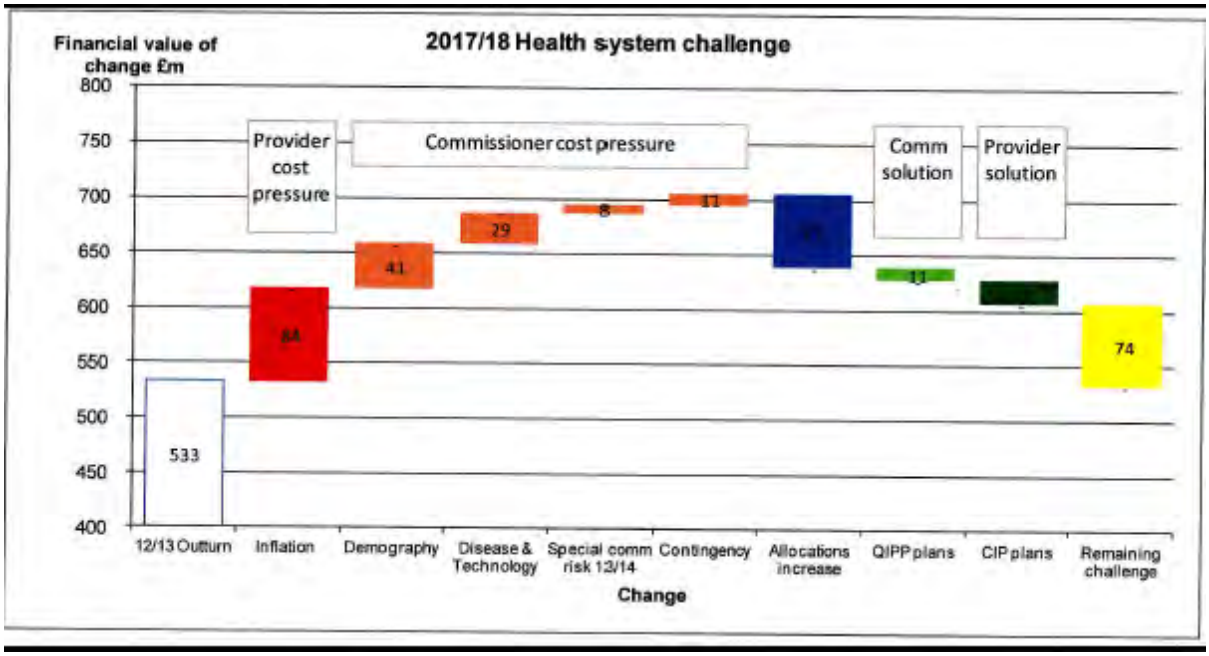
Finance

"In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending and requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21.) This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms" [4]

It is anticipated that over the next decade the NHS can expect its budget to remain flat in real terms, which represents a significant slow-down in spending growth. Further to this, recent spending settlements for local government have also slowed, placing greater demand on social care budgets with the potential consequence of increasing demand on health services and therefore increasing health costs.

The local health economy across Telford & Wrekin and Shropshire has recently refreshed its analysis of the financial challenge which it faces over the next five years and from this work it is evident that even if the delivery of the 2013/14 QIPP savings plans are realised the remaining financial gap will still be £74m. This is summarised in the figure below.

[4] The NHS Belongs to the People – A Call to Action, NHS England, 2013



The most significant area of challenge for the pan-Shropshire health economy was identified to be the ongoing growth in unscheduled care. In addition to this cost pressures were identified in relation to medical technology, obesity, demography and inflation.

Estates

The issue of estate forms a key part of any plans to reconfigure services. Within the scope of this work the consideration focuses on 6 key sites: two Acute Hospital sites and 4 Community Hospital sites. The progress of the transfers of services across sites and new build developments to date has been set out above. Notwithstanding these, a number of the opportunities and constraints set out in the SaTH Full Business Case remain relevant:

The PRH site presents the Trust with a number of opportunities and constraints.
The PRH site has the following constraints:

- The existing nucleus hospital template needs to be retained where possible;
- A helipad provision must be maintained;
- There are a number of mature trees and planting surround the existing car parks, many the subject of Tree Preservation Orders;
- The site is surrounded by the Telford Green Network;
- A dedicated emergency arrival point is required;
  The Trust are working with the Telford and Wrekin and Shropshire County on a transport plan that addresses the know cross site travel, site access and excess single car usage issues;
- The works will need to be constructed within a live hospital environment, maintaining services at all times; and
- Any site development is subject to planning permission and adequate travel planning

The PRH site has the following opportunities:

- Developable zones are available;
- The existing site infrastructure (building fabric, finishes, and services) are in good condition;
- There should be sufficient capacity within the existing M&E services; and
- There is an opportunity to improve the site's energy performance.

The RSH site presents the Trust with a number of opportunities and constraints.
The RSH site has the following constraints:

- The existing hospital layout and overall functionality needs to be retained where possible;
- There is a strong driver to utilise the existing Maternity building for non-clinical functions, as there would be significant enabling works required to divert and re-provide significant

portions of the M&E infrastructure if the building were to be disposed of
- The proposed works are all constrained by the existing hospital layout and need to use existing buildings (wherever possible);
- All of the proposed areas for development are currently occupied and the works will need to be constructed within a live hospital environment, maintaining services at all times.
- The works will need to be sequentially phased, and there is a need to manage a complex set of decanting within the buildings;
- There is a need to maintain a complex set of clinical adjacencies;
- Care needs to be taken with tapping in to the existing fragile site infrastructure, however many of the systems have had primary components upgraded over the last few years;
- A helipad provision must be maintained
- The site suffers from poor ground conditions, but this is not thought to be a specific issue for the PAU extension works; and
- Any site development is subject to planning permission and adequate travel planning

The RSH site has the following opportunities:
- There is an opportunity to move non-clinical functions away from prime clinical space in order to optimise clinical functionality in key areas;
- There is an opportunity to repatriate existing off-site management functions back on to the RSH site;
- All of the developable areas are in the Trust's ownership.

Information regarding estate appraisals in relation to the Community Hospitals would also need to inform the development of future reconfiguration plans, although there are likely common themes with the opportunities and constraints set out above for the acute hospitals. There would undoubtedly be opportunities to consider the various components of the wider estate collectively and therefore explore potential for improvements in asset utilisation where this is identified as an issue.

Technology
The use of technology in society has increased exponentially over the past decade – be this use of mobile phones, internet or more complex technology. The use of technology to support every day life is routine for many people:
- 92% of adults personally own/ use a mobile phone in the UK (Q1, 2012 – OFCOM) with 81.6 million mobile phone subscriptions in the UK (Q4 2011);
- At the end of 2011 the number of fixed residential broadband connections in the UK was 18.8 million with 76% (Q1 2012) of adults having a broadband connection;
- The proportion of people using their mobile handset to access the internet is 39% (Q1, 2012);
- The proportion of adults who use social networking sites at home is 50% (Q1, 2012).

This trend has not been replicated in the health and social care sector, where the use of technology to support care packages remains the exception rather than the rule.

The case that technology is changing the way that we live our lives is irrefutable. The need to promote this technology to support the health and social care sector in the future has been made, but to date there is less impact than would have been expected in the way people are cared for. The need to improve the understanding of what technology can do and its limitations, is something that needs collaborative working across commissioners and providers. It may also need significant changes in systems and working patterns for some areas.

Conclusion
Within the local health economies throughout the West Midlands, East Midlands and East of England, the set of circumstances faced by the populations of Shropshire, Telford & Wrekin and Powys in relation to service reconfiguration are exceptional.

The clinical and financial sustainability of acute hospital services in this patch, have been a concern for more than a decade and have involved several periods of public consultation and engagement, which unfortunately tend to split the local geography despite all efforts to avoid 'win/lose' debates over services.

It is in this context that the current need to realise major benefits from further integration of hospitals services takes place. It is really important that there is a major programme of public engagement because we want to achieve a very positive debate about the real benefits of change. This will include debating issues which may be highly controversial and will require a skilled and intensive engagement programme. In comparative terms nationally the sparsity factor is at its most extreme in parts of Shropshire and combined with the demographic effect of an ageing population (greater than that of the national picture) make the discussions around the potential new pathways for urgent care and long term conditions crucial.

The case for change is based on the patient benefits of new models of service which overcome some of the safety, quality and clinical sustainability concerns of current fragmented and duplicated services. A recent economic analysis of financial projections for the health economy, show that the severe financial constraints within which we have to operate compound the unique set of challenges we face and the controversial nature of some of the potential changes have a risk of significant challenge. Given that this needs to be a service strategy for the next 20 years, considerable expertise will need to be commissioned to run both the extensive stakeholder engagement process alongside the detailed planning required for the FBC, not least because of the timescales which are very pressing. Furthermore, the workforce challenges of sustaining two A&E departments with critical care back up, have become extreme and from a trust perspective this must be resolved as soon as possible

Moving forward with this work a Programme Board has been established to oversee the development and management of this Clinical Services Review.

Appendix 1 : Table of Shropshire Community Health NHS Trust services

Community Services	Community Hospitals and Treatment Centres	Children's and Specialist Services
Interdisciplinary teams including: ➢ community nurses and therapists. ➢ Diabetes specialist nursing. ➢ Falls prevention. ➢ End of life care. ➢ Community equipment/home delivery. ➢ Continence service. ➢ Physiotherapy. ➢ Podiatry. ➢ Wheelchair service. ➢ Adult learning disability service. ➢ Sexual health. ➢ Health improvement services.	Community hospital inpatient, outpatient and diagnostic services: ➢ Whitchurch -Ludlow -Bridgnorth -Bishops Castle ➢ Specialist GP-led ➢ outpatient services ➢ Urgent assessment centres at Shrewsbury ➢ Bridgnorth and Oswestry Minor Injury Units ➢ Day Surgery	Child and Adolescent Mental Health Services ➢ Health visiting ➢ School nursing ➢ Nurse- led home visiting for young mums (Telford and Wrekin) ➢ Looked after children's health ➢ Safeguarding ➢ Children's Medical and Therapy service ➢ Community dentistry ➢ Prison health ➢ Substance misuse service

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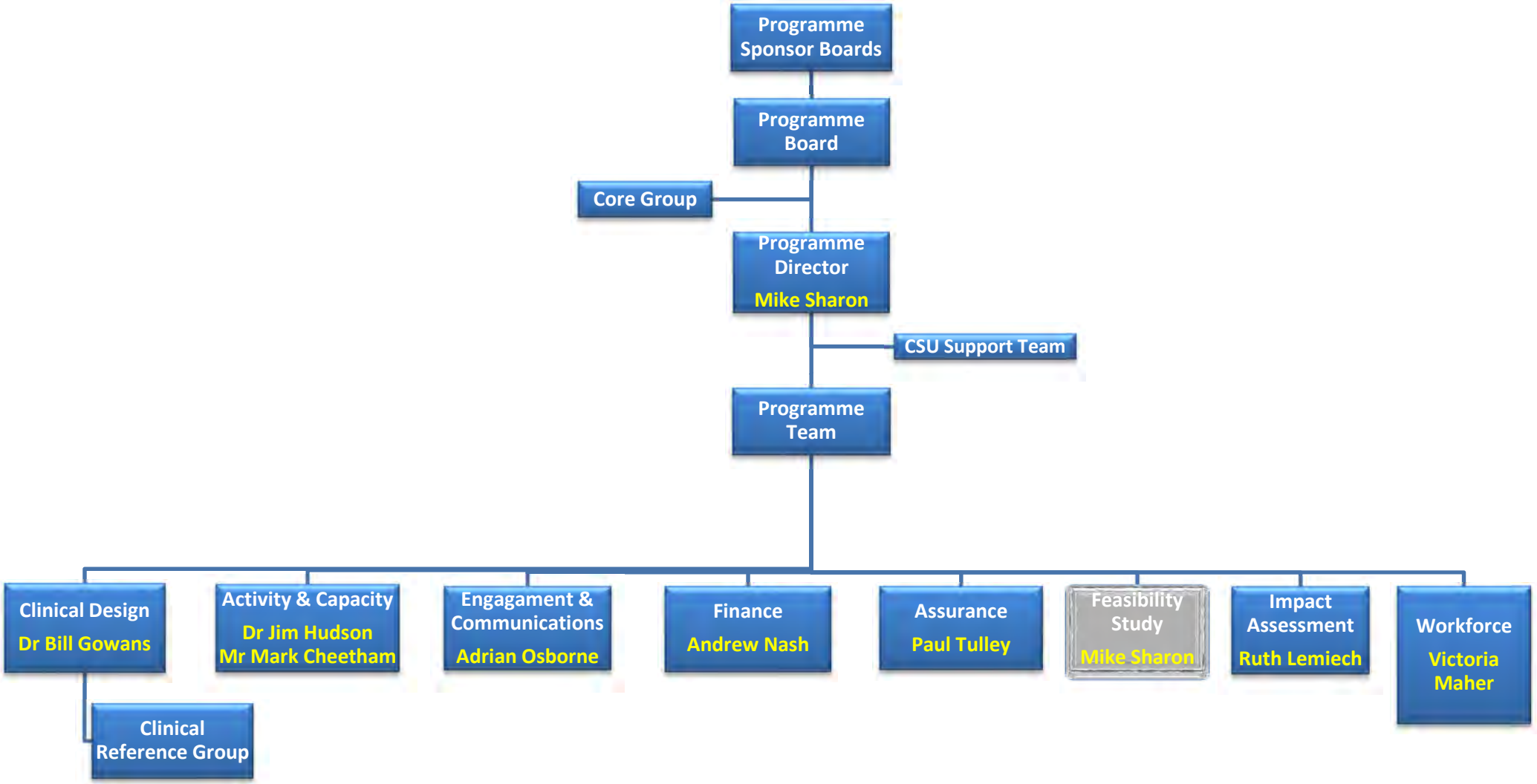
11. Appendix 2 - Programme Structure



12. Appendix 3 - Programme Plan

Shropshire Future Fit Programme

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
1	**PHASE 1a - Programme Set-up**	**689 days?**	**Fri 01/11/13**	**Thu 23/06/16**		
2	**Programme Appointments**	**40 days**	**Fri 01/11/13**	**Thu 26/12/13**		
8	**Programme Mandate**	**22 days**	**Thu 14/11/13**	**Fri 13/12/13**		
12	**Programme Execution Plan**	**57 days**	**Fri 01/11/13**	**Mon 20/01/14**		
23						
24	**Programme Board Meetings**	**689 days?**	**Fri 01/11/13**	**Thu 23/06/16**		
25	Meeting #1	1 day	Mon 02/12/13	Mon 02/12/13		Programme Board
26	Meeting #2	1 day	Mon 20/01/14	Mon 20/01/14		Programme Board
27	Meeting #3	1 day	Mon 10/03/14	Mon 10/03/14		Programme Board
28	Meeting #4	0 days	Wed 21/05/14	Wed 21/05/14		Programme Board
29	Meeting #5	0 days	Tue 10/06/14	Tue 10/06/14		Programme Board
30	Meeting #6	0 days	Wed 25/06/14	Wed 25/06/14		Programme Board
31	Meeting #7	0 days	Wed 17/09/14	Wed 17/09/14		Programme Board
32	Meeting #9	0 days	Wed 17/12/14	Wed 17/12/14		Programme Board
33	Meeting #10	0 days	Wed 04/02/15	Wed 04/02/15		Programme Board
34	Meeting #11	0 days	Wed 15/04/15	Wed 15/04/15		Programme Board
35	Meeting #12	0 days	Wed 27/05/15	Wed 27/05/15		Programme Board
36	Meeting #13	0 days	Wed 24/06/15	Wed 24/06/15		Programme Board
37	Meeting #14	0 days	Thu 13/08/15	Thu 13/08/15		Programme Board
38	Meeting #15	0 days	Thu 01/10/15	Thu 01/10/15		Programme Board
39	Meeting #16	0 days	Thu 19/11/15	Thu 19/11/15		Programme Board
40	Meeting #17	0 days	Thu 18/02/16	Thu 18/02/16		Programme Board
41	Meeting #18	0 days	Thu 12/05/16	Thu 12/05/16		Programme Board
42	Meeting #19	0 days	Thu 23/06/16	Thu 23/06/16		Programme Board
43	**Programme Team Meetings**	**515 days?**	**Fri 01/11/13**	**Thu 22/10/15**		
44	**2014**	**294 days**	**Fri 01/11/13**	**Thu 18/12/14**		
81	**2015**	1 day?	Fri 01/11/13	Fri 01/11/13		
82	Meeting #41	0 days	Thu 08/01/15	Thu 08/01/15		Programme Team
83	Meeting #42	1 day	Thu 15/01/15	Thu 15/01/15	82FS+5 days	Programme Team
84	~~Meeting #43~~	~~0 days~~	~~Thu 22/01/15~~	~~Thu 22/01/15~~	~~83FS+5 days~~	~~Programme Team~~
85	Meeting #44	0 days	Thu 29/01/15	Thu 29/01/15	84FS+5 days	Programme Team
86	Meeting #45	0 days	Thu 05/02/15	Thu 05/02/15	85FS+5 days	Programme Team
87	Meeting #46	0 days	Thu 12/02/15	Thu 12/02/15	86FS+5 days	Programme Team
88	Meeting #47	0 days	Thu 19/02/15	Thu 19/02/15	87FS+5 days	Programme Team
89	Meeting #48	0 days	Thu 26/02/15	Thu 26/02/15	88FS+5 days	Programme Team
90	Meeting #49	0 days	Thu 05/03/15	Thu 05/03/15	89FS+5 days	Programme Team
91	Meeting #50	0 days	Thu 12/03/15	Thu 12/03/15	90FS+5 days	Programme Team
92	Meeting #51	0 days	Thu 19/03/15	Thu 19/03/15	91FS+5 days	Programme Team
93	~~Meeting #52~~	~~0 days~~	~~Thu 26/03/15~~	~~Thu 26/03/15~~	~~92FS+5 days~~	~~Programme Team~~
94	Meeting #53	0 days	Thu 02/04/15	Thu 02/04/15	92FS+10 days	Programme Team
95	Meeting #54	0 days	Thu 09/04/15	Thu 09/04/15	94FS+5 days	Programme Team
96	Meeting #55	0 days	Thu 16/04/15	Thu 16/04/15	95FS+5 days	Programme Team
97	Meeting #56	0 days	Thu 23/04/15	Thu 23/04/15	96FS+5 days	Programme Team
98	Meeting #57	0 days	Thu 30/04/15	Thu 30/04/15	97FS+5 days	Programme Team
99	Meeting #58	0 days	Thu 07/05/15	Thu 07/05/15	98FS+5 days	Programme Team
100	Meeting #59	0 days	Thu 14/05/15	Thu 14/05/15	99FS+5 days	Programme Team
101	Meeting #59	0 days	Thu 21/05/15	Thu 21/05/15	100FS+5 days	Programme Team
102	Meeting #60	0 days	Thu 28/05/15	Thu 28/05/15	101FS+5 days	Programme Team
103	Meeting #61	0 days	Thu 04/06/15	Thu 04/06/15	102FS+5 days	Programme Team
104	Meeting #62	0 days	Thu 11/06/15	Thu 11/06/15	103FS+5 days	Programme Team
105	Meeting #63	0 days	Thu 18/06/15	Thu 18/06/15	104FS+5 days	Programme Team
106	Meeting #64	0 days	Thu 25/06/15	Thu 25/06/15	105FS+5 days	Programme Team
107	Meeting #65	0 days	Thu 02/07/15	Thu 02/07/15	106FS+5 days	Programme Team
108	Meeting #66	0 days	Thu 09/07/15	Thu 09/07/15	107FS+5 days	Programme Team

Shropshire Future Fit Programme

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
109	Meeting #67	0 days	Thu 16/07/15	Thu 16/07/15	108FS+5 days	Programme Team
110	Meeting #68	0 days	Thu 23/07/15	Thu 23/07/15	109FS+5 days	Programme Team
111	Meeting #69	0 days	Thu 30/07/15	Thu 30/07/15	110FS+5 days	Programme Team
112	Meeting #70	0 days	Thu 06/08/15	Thu 06/08/15	111FS+5 days	Programme Team
113	Meeting #71	0 days	Thu 13/08/15	Thu 13/08/15	112FS+5 days	Programme Team
114	Meeting #72	0 days	Thu 20/08/15	Thu 20/08/15	113FS+5 days	Programme Team
115	Meeting #73	0 days	Thu 27/08/15	Thu 27/08/15	114FS+5 days	Programme Team
116	Meeting #74	0 days	Thu 03/09/15	Thu 03/09/15	115FS+5 days	Programme Team
117	Meeting #75	0 days	Thu 10/09/15	Thu 10/09/15	116FS+5 days	Programme Team
118	Meeting #76	0 days	Thu 17/09/15	Thu 17/09/15	117FS+5 days	Programme Team
119	Meeting #77	0 days	Thu 24/09/15	Thu 24/09/15	118FS+5 days	Programme Team
120	Meeting #78	0 days	Thu 01/10/15	Thu 01/10/15	119FS+5 days	Programme Team
121	Meeting #79	0 days	Thu 08/10/15	Thu 08/10/15	120FS+5 days	Programme Team
122	Meeting #80	0 days	Thu 15/10/15	Thu 15/10/15	121FS+5 days	Programme Team
123	Meeting #81	0 days	Thu 22/10/15	Thu 22/10/15	122FS+5 days	Programme Team
124	**Workstreams**	**50 days**	**Thu 14/11/13**	**Wed 22/01/14**		
144						
145	**Risk Register**	**300 days**	**Thu 14/11/13**	**Thu 08/01/15**		
163						
164	**Benefits Realisation Plan**	**75 days**	**Tue 26/11/13**	**Mon 10/03/14**		
172						
173	**Engagement & Communications**	**83 days**	**Thu 14/11/13**	**Mon 10/03/14**		
181						
190	**Assurance Plan**	**46 days**	**Mon 06/01/14**	**Mon 10/03/14**		
198						
199	**Gateway Review 0**	**115 days**	**Thu 12/12/13**	**Wed 21/05/14**		
209						
210	**PHASE 1b - High Level Vision & Overall Service Model**	**106 days**	**Mon 14/10/13**	**Mon 10/03/14**		
266						
267	**PHASE 2 - Development of Models of Care**	**316 days**	**Fri 28/02/14**	**Fri 15/05/15**		
343						
344	**PHASE 3 - Option Development & Appraisal**	**497 days**	**Tue 17/06/14**	**Thu 12/05/16**		
345	**Identification of Options**	**217 days**	**Tue 17/06/14**	**Wed 15/04/15**		
357						
372	**Strategic Outline Case**	**263 days**	**Mon 24/11/14**	**Wed 25/11/15**		
373						
374	**Stage Plan**	**20 days**	**Mon 24/11/14**	**Fri 19/12/14**		
379						
380	**Project Team Meetings**	**115 days**	**Thu 18/12/14**	**Thu 28/05/15**		**Programme Team,Technical Team**
393						
394	**Design Engagement Workshops**	**52 days**	**Tue 13/01/15**	**Wed 25/03/15**		
398						
399	**Acute SOC**	**184 days**	**Mon 08/12/14**	**Fri 21/08/15**		
400	**Acute SOC Document**	**184 days**	**Mon 08/12/14**	**Fri 21/08/15**		
401	Prepare Shell Document	5 days	Mon 08/12/14	Fri 12/12/14	376	
402	Review and Sign-off Shell Document	10 days	Mon 15/12/14	Fri 26/12/14	401	
403	Agree responsibilities for completion	5 days	Mon 29/12/14	Fri 02/01/15	402	
404	Contributions to Draft 1	0 days	Fri 20/02/15	Fri 20/02/15	405SF-1 day	
405	Prepare Draft 1	5 days	Mon 23/02/15	Fri 27/02/15	403,430,448	
406	Review Draft 1	5 days	Mon 02/03/15	Fri 06/03/15	405	Programme Team
407	Contributions to Draft 2	0 days	Fri 24/04/15	Fri 24/04/15	406,408SF-1 day	
408	Prepare Draft 2	10 days	Mon 27/04/15	Fri 08/05/15	454,436	
409	Review Draft 2	5 days	Mon 11/05/15	Fri 15/05/15	408	Programme Team

Shropshire Future Fit Programme

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
410	SaTH sets out capital investment revenue expenditure limit that is affordable and provide redeisgn brief for technical team	0 days	Mon 01/06/15	Mon 01/06/15		
411	Technical team commence redesign of options	0 days	Tue 02/06/15	Tue 02/06/15		
412	Discussion on redesign of options	0 days	Tue 09/06/15	Tue 09/06/15		
413	Work commences on revising option costs including for excluded options	0 days	Tue 09/06/15	Tue 09/06/15	412	
414	SaTH to confirm design assumptions	0 days	Tue 16/06/15	Tue 16/06/15		
415	SaTH provide income assumptions from Specialised Commissioners	0 days	Fri 19/06/15	Fri 19/06/15		
416	Prepare revised option descriptions - 1st iteration	0 days	Wed 24/06/15	Wed 24/06/15		
417	Programme Board meeting	0 days	Wed 24/06/15	Wed 24/06/15	416	
418	Review and sign off redesign work progress	0 days	Fri 26/06/15	Fri 26/06/15		
419	Prepare revised option descriptions - 2nd iteration	0 days	Wed 01/07/15	Wed 01/07/15		
420	Review and sign off redesign work progress	0 days	Fri 03/07/15	Fri 03/07/15		
421	Complete costing of revised option designs	0 days	Fri 17/07/15	Fri 17/07/15		
422	Assess revenue impact of options	0 days	Fri 24/07/15	Fri 24/07/15		
423	Review affordability of options	0 days	Mon 27/07/15	Mon 27/07/15	422	
424	Review and sign off redesign work progress	0 days	Fri 31/07/15	Fri 31/07/15	423	
425	Confirm review timetable with Senate	0 days	Mon 03/08/15	Mon 03/08/15		
426	Programme Office/Technical Team test whether new capital costs and higher financial weighting would have altered shortlisting decision.	0 days	Thu 06/08/15	Thu 06/08/15		
427	Commissioners confirm affordability of Phase 2 implications under current planning assumptions	0 days	Wed 12/08/15	Wed 12/08/15		
428	Programme Board reconsiders the Shortlist in light of capital affordability (any change to be confirmed by Sponsor Boards by end August)	0 days	Thu 13/08/15	Thu 13/08/15		
429	Complete preparation of final SOC draft	0 days	Fri 21/08/15	Fri 21/08/15		
430	**Activity & Capacity**	**50 days**	**Mon 15/12/14**	**Fri 20/02/15**		
436	**Greenfield Site**	**60 days**	**Mon 05/01/15**	**Fri 27/03/15**		
444	**Options**	**120 days**	**Mon 08/12/14**	**Fri 22/05/15**		
445	Define Baseline Estates Information Requirements	5 days	Mon 08/12/14	Fri 12/12/14	376	
446	Receive Baseline Estates Information Requirements	10 days	Mon 15/12/14	Fri 26/12/14	445	
447	Site Reviews	20 days	Mon 29/12/14	Fri 23/01/15	446	
448	Receive Shortlist Report	0 days	Wed 21/01/15	Wed 21/01/15	353	
449	Review Option Shortlist Report	5 days	Wed 21/01/15	Tue 27/01/15	448	
450	Prepare draft Schedules of Accommodation for Options	10 days	Mon 23/02/15	Fri 06/03/15	395,435,447,449	
451	Review and Sign-off Schedules of Accommodation for Options	5 days	Mon 02/03/15	Fri 06/03/15		Programme Team
452	Develop 1:1000 Site Plans and 1:500 Block Plans for Options	20 days	Mon 09/03/15	Fri 03/04/15	396,439,451	
453	Review 1:1000 Site Plans and 1:500 Block Plans for Options	5 days	Mon 06/04/15	Fri 10/04/15	452	
454	Finalise 1:1000 Site Plans and 1:500 Block Plans for Options	10 days	Mon 13/04/15	Fri 24/04/15	397,453	
455	Design Quality Indicator (DQI) Assessment of Options	10 days	Mon 27/04/15	Fri 08/05/15	454	
456	Initial BREEAM Assessment of Options	10 days	Mon 27/04/15	Fri 08/05/15	454	
457	Prepare Estate Strategy Annex	20 days	Mon 27/04/15	Fri 22/05/15	454	
458	**Workforce & Finance**	**134 days**	**Mon 08/12/14**	**Thu 11/06/15**		
459	Define Baseline Activity, Income, Workforce and Expenditure Information	5 days	Mon 08/12/14	Fri 12/12/14	376	
460	Prepare Financial Model	10 days	Mon 12/01/15	Fri 23/01/15	461	
461	Collate Baseline Activity, Income, Workforce and Expenditure Information	20 days	Mon 15/12/14	Fri 09/01/15	459	
462	Prepare Workforce & Income & Expenditure Forecasts	20 days	Mon 13/04/15	Fri 08/05/15	452,454FF+10 days,	
463	Prepare Capital Costs	20 days	Mon 13/04/15	Fri 08/05/15	452,454FF+10 days	
464	CCG Affordability sign-off	24 days	Mon 11/05/15	Thu 11/06/15	463	
465	Finalise Income & Expenditure Forecasts	15 days	Mon 11/05/15	Fri 29/05/15	462	
466	Finalise Sensitivity Analysis	5 days	Mon 25/05/15	Fri 29/05/15	465FF	
467	Finalise Workforce Plans	10 days	Mon 11/05/15	Fri 22/05/15	462	
468	Review and Sign-off Workforce and Financial Plans	5 days	Mon 25/05/15	Fri 29/05/15	467	
469	**Project Planning**	**65 days**	**Mon 23/02/15**	**Fri 22/05/15**		
470	Refresh Draft Benefits Realisation Plan	30 days	Mon 23/02/15	Fri 03/04/15	430,448	Programme Team
471	Prepare Procurement Strategy	15 days	Mon 06/04/15	Fri 24/04/15	430,448,452	Technical Team,Finance
472	Prepare Post Project Evaluation Plan	15 days	Mon 23/02/15	Fri 13/03/15	430,448	Technical Team
473	Prepare Draft Project Timelines	15 days	Mon 23/02/15	Fri 13/03/15	430,448	Technical Team

Shropshire Future Fit Programme

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
474	Finalise Benefits Realisation Plan	15 days	Mon 27/04/15	Fri 15/05/15	454,470	Programme Team
475	Update Risk Register	5 days	Mon 27/04/15	Fri 01/05/15	454	Programme Team
476	Finalise Post Project Evaluation Plan	15 days	Mon 27/04/15	Fri 15/05/15	454,472	Technical Team
477	Finalise Engagement and Communications Plan	10 days	Mon 27/04/15	Fri 08/05/15	454	Engagement & Comms
478	Finalise Project Timelines	15 days	Mon 27/04/15	Fri 15/05/15	454,473	Technical Team
479	Review & Sign-off Project Plans	5 days	Mon 18/05/15	Fri 22/05/15	474,475,476,478	Programme Team
480						
481	**Exploration of Rural UCC Solutions**	**173 days**	**Mon 02/02/15**	**Thu 01/10/15**		
482	Development of Project Plan	20 days	Wed 18/02/15	Tue 17/03/15		Programme Team
483	Project Plan sign-off	0 days	Thu 19/03/15	Thu 19/03/15	482FS+2 days	Programme Team
484	Core Specification development	45 days	Wed 18/02/15	Tue 21/04/15		Rural Project Group
485	Core Specification sign off	5 days	Wed 22/04/15	Tue 28/04/15	484	Clinical Design
486	**Locality Analysis**	**59 days**	**Mon 09/02/15**	**Thu 30/04/15**		**Rural Project Group**
491	**Locality Assessment**	**173 days**	**Mon 02/02/15**	**Thu 01/10/15**		**Rural Project Group**
492	Initial review of potential	45 days	Mon 02/02/15	Fri 03/04/15		Rural Project Group
493	Locality meetings	95 days	Mon 06/04/15	Fri 14/08/15	492	Rural Project Group
494	Review and sign off	0 days	Thu 20/08/15	Thu 20/08/15	104,493	Programme Team
495	Locality Board/Forum clinical review	25 days	Thu 20/08/15	Wed 23/09/15	494	Rural Project Group
496	CCG Board review	5 days	Thu 24/09/15	Wed 30/09/15	495	Programme Team
497	Programme Team sign off	0 days	Thu 24/09/15	Thu 24/09/15	118	Programme Team
498	Programme Board sign off	0 days	Thu 01/10/15	Thu 01/10/15	497,38	Programme Board
499	**Initial Financial Analysis**	**50 days**	**Fri 01/05/15**	**Thu 09/07/15**		**Rural Project Group**
500	Costing of core requirements	15 days	Fri 01/05/15	Thu 21/05/15	490	Rural Project Group
501	Sign off costing paper	0 days	Thu 11/06/15	Thu 11/06/15	104	Programme Team
502	Locality costing for UCC	10 days	Fri 22/05/15	Thu 04/06/15	500	Rural Project Group
503	Locality costing for non UCC if appropriate	10 days	Fri 12/06/15	Thu 25/06/15	104	Rural Project Group
504	Review of financial implications	10 days	Fri 26/06/15	Thu 09/07/15	503	Rural Project Group
505	Programme Team sign off of financial implications	0 days	Thu 09/07/15	Thu 09/07/15	106,504	Programme Team
506						
507	**SOC Approvals**	**65 days**	**Thu 27/08/15**	**Wed 25/11/15**		
508	Trust Board Approval	25 days	Thu 27/08/15	Wed 30/09/15		SaTH Board
509	TDA Approval	40 days	Thu 27/08/15	Wed 21/10/15	508SS	TDA
510	DH / HMT Approval (ASSUMES PARALLEL TO TDA)	65 days	Thu 27/08/15	Wed 25/11/15	508SS	DH/HMT
511						
512	**Integrated Impact Assessment**	**366 days**	**Wed 17/12/14**	**Thu 12/05/16**		
513	Develop proposal	4 wks	Wed 17/12/14	Tue 13/01/15	32	Impact Assessment
514	Programme Board approval	1 day	Wed 04/02/15	Wed 04/02/15		Programme Board
515	Undertake Next Stage Impact Assessment (Initial Equalities Analysis)	24 wks	Wed 04/02/15	Tue 21/07/15	356	Impact Assessment
516	Initial Equality Report to Board	0 days	Thu 13/08/15	Thu 13/08/15		Programme Board
517	Develop IIA Plan	45 days	Mon 31/08/15	Fri 30/10/15		Impact Assessment
518	Review IIA Plan	0 days	Thu 05/11/15	Thu 05/11/15	517	Programme Team
519	Sign Off IIA Plan	0 days	Thu 19/11/15	Thu 19/11/15	518	Programme Board
520	Undertake IIA	12 wks	Mon 04/01/16	Fri 25/03/16	519	Impact Assessment
521	Develop Report and Mitigation Plan	4 wks	Mon 28/03/16	Fri 22/04/16	520	Impact Assessment
522	Review Report and Mitigation Plan	0 days	Thu 28/04/16	Thu 28/04/16	521	Programme Team
523	Sign Off Report and Mitigation Plan	0 days	Thu 12/05/16	Thu 12/05/16	522	Programme Board
524						
525	**Option Appraisal**	**53 days**	**Mon 06/07/15**	**Thu 17/09/15**		
526	Non-financial appraisal	50 days	Mon 06/07/15	Fri 11/09/15	457	Panel
527	Financial & Economic Appraisal	38 days	Mon 27/07/15	Wed 16/09/15	468	Technical Team,Programme Team
528	Identify Preferred Option	0 wks	Thu 17/09/15	Thu 17/09/15	527	Programme Team
529						
530	**Preferred Option Confirmation**	**20 days**	**Thu 01/10/15**	**Wed 28/10/15**		
531	**Programme Board sign-off**	**0 days**	**Thu 01/10/15**	**Thu 01/10/15**	**528**	**Programme Board**
532	Shropshire CCG approval	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director

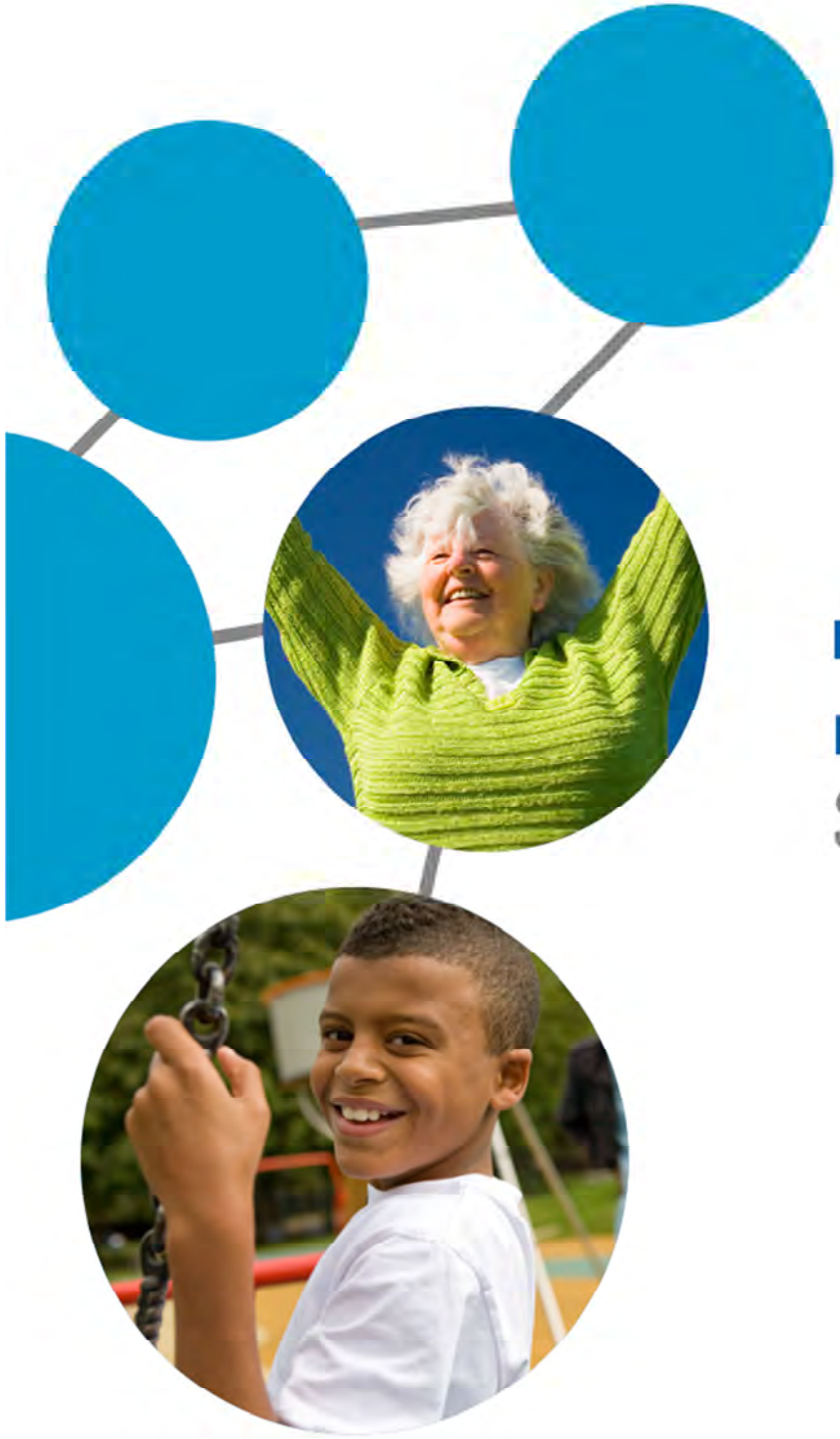
Shropshire Future Fit Programme

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
533	Telford & Wrekin CCG approval	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director
534	Shrewsbury & Telford Hospital NHS Trust endorsement	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director
535	Shropshire Community Health NHS Trust endorsement	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director
536	Powys LHB endorsement	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director
537	Shropshire Health & Well-Being Board receipt	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director
538	Telford & Wrekin Health & Well-Being Board receipt	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director
539	Joint HOSC scrutiny	20 days	Thu 01/10/15	Wed 28/10/15	531	Programme Director
540						
541	**External Clinical Review (Stage Two) - tbc**	**190 days**	**Thu 05/03/15**	**Wed 25/11/15**		
542	Agree process for responding to Stage One Report	0 days	Thu 05/03/15	Thu 05/03/15		Clinical Design
543	Prepare Response to Stage One Report	60 days	Thu 05/03/15	Wed 27/05/15	542	Clinical Design
544	Prepare Description of Preferred Option	10 days	Thu 17/09/15	Wed 30/09/15	543,528SS	Clinical Design
545	Stage 2 Review	5 days	Thu 15/10/15	Wed 21/10/15	544FS+10 days	External Clinical Panel
546	Receipt of Final Report	25 days	Thu 22/10/15	Wed 25/11/15	545	External Clinical Panel
547						
548	**Gateway Review 1**	**20 days**	**Thu 29/10/15**	**Wed 25/11/15**		
549	Gateway Review 1	3 wks	Thu 29/10/15	Wed 18/11/15	532	Programme Team
550	Prepare and sign-off action plan	1 wk	Thu 19/11/15	Wed 25/11/15	549	Programme Director,Programme Team
551	**Programme Board sign-off**	**0 days**	**Wed 25/11/15**	**Wed 25/11/15**	**550,38**	**Programme Board**
552						

Shropshire Future Fit Programme

ID	Task Name	Duration	Start	Finish	Predecessors	Resource Names
553	**PHASE 4 - OBC & Public Consultation**	**492 days**	**Wed 28/01/15**	**Thu 15/12/16**		
554	**NHSE Assurance**	**227 days**	**Wed 28/01/15**	**Thu 10/12/15**		
555	Prepare Pre-Consultation Business Case (incl. 4 Tests Evidence)	40 wks	Wed 28/01/15	Tue 03/11/15	354	Programme Team
556	Programme Team Sign-off	5 days	Wed 04/11/15	Tue 10/11/15	555	Programme Team
557	**Programme Board Sign-off**	**0 days**	**Thu 19/11/15**	**Thu 19/11/15**	**556**	**Programme Board**
558	NHSE Stage 2 Assurance	1 wk	Fri 04/12/15	Thu 10/12/15	557FS+10 days	NHSE
559						
560	**Public Consultation on Proposed Solution**	**293 days**	**Mon 04/05/15**	**Wed 15/06/16**		
561	Preparation for Consultation - plans and draft document	26 wks	Mon 04/05/15	Fri 30/10/15		Engagement & Comms
562	Engagement Workstream sign-off	5 days	Mon 02/11/15	Fri 06/11/15	561	Engagement & Comms
563	Programme Team sign-off	0 days	Thu 12/11/15	Thu 12/11/15	562	Programme Team
564	**Programme Board sign-off**	**0 days**	**Thu 01/10/15**	**Thu 01/10/15**	**38**	**Programme Board**
565	Final Preparations post assurance	6 wks	Mon 09/11/15	Fri 18/12/15	562	Engagement & Comms
566	PUBLIC CONSULTATION	70 days	Mon 21/12/15	Fri 25/03/16	565	Programme Director,Engagement & Co
567	Prepare Post Consultation Report	4 wks	Mon 28/03/16	Fri 22/04/16	566	Programme Director
568	Programme Team sign off	5 days	Mon 25/04/16	Fri 29/04/16	567	Programme Team
569	**Programme Board sign off**	**0 days**	**Thu 12/05/16**	**Thu 12/05/16**	**568**	**Programme Board**
570	Period for HOSC/CHC to respond to Post Consultation Report	15 days	Thu 12/05/16	Wed 01/06/16	569	HOSC
571	Agree Responses to any HOSC/CHC recommendations	10 days	Thu 02/06/16	Wed 15/06/16	570	Programme Team,SaTH Board,SCCG Bo
572						
573	**DECISION MAKING PROCESSES - OBC/DMBC - tbc**	**265 days**	**Fri 11/12/15**	**Thu 15/12/16**		
574	OBC/DMBC development (tbc in light of Post Consultation Report)	24 wks	Fri 11/12/15	Thu 26/05/16	510,558	Technical Team
575	**CCG & Trust Board approvals**	**3 wks**	**Fri 27/05/16**	**Thu 16/06/16**	**574**	**CCG Boards,SaTH Board**
576	NHS England & NHSTDA approvals (estimated)	10 wks	Fri 17/06/16	Thu 25/08/16	575	Programme Director
577	DH/HMT Approvals (estimated)	16 wks	Fri 26/08/16	Thu 15/12/16	576	
578						
579	**Gateway Review 2**	**10 days**	**Fri 17/06/16**	**Thu 30/06/16**		
580	Gateway Review 2	2 wks	Fri 17/06/16	Thu 30/06/16	575	Programme Team

13. Appendix 4 - Engagement & Communications Strategy



NHS

futurefit

Shaping healthcare together

Engagement & Communications Strategy

May 2014 – to formal consultation

futurefit
Shaping healthcare together

NHS

Contents

Version	Date	File Name	Status
Version 1	11th May 2014	Draft 1 Engagement &Communications Strategy	Initial draft prepared by Ruth Boyd & Nick Hutchins, commented upon by Stephanie Belgeonne and Adrian Osborne
Version 2	12th May 2014	Draft 2 Engagement & Communications Strategy	Circulated to the following groups and individuals for comments: • Joint Senior Responsible Officers • Clinical Design Workstream Leads • Assurance Workstream • Engagement & Communications Workstream • Engagement & Communications Officers • Programme Team • Consultation Institute • LAT Patient Experience Lead For comment by noon 15 May 2014
Version 3	15th May	Engagement & Communication Strategy	Prepared for Programme Board approval, updated to incorporate comments from all of the above
Version 4	31st July 2015	Engagement & Communication Strategy update	Initial draft update prepared by Harpreet Jutlla, commented upon by Engagement & Communications Workstream
Version 5	13th August 2015	Engagement & Communication Strategy update	Prepared for Programme Board approval, updated to incorporate comments from all attended

1 Introduction

1.1 Case for Change

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, we face a number of challenges:

- We have an increasingly aging population
- More people living with long-term conditions
- Increasing expectations from patients about levels of service
- Medicine becoming more sophisticated
- A difficult economic environment

Therefore 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 decades to come.

The Call to Action consultation activity in 2013 explored the challenges above with patients, the public, staff and medical staff. It was accepted 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**. There is an opportunity for:

- Better outcomes for patients by bringing specialists together, who then treat a higher volume of cases routinely maintaining and growing their skills
- Better planning of services so that right departments are close to one another to deliver a better service to patients
- A better match between need and levels of care through a shift towards greater care in the community and in the home
- A reduced dependence on hospitals
- 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

This then is the positive case for change - the opportunity to improve the quality of care we provide to our changing population.

1.2 Delivering Effective Engagement & Communications

To reflect the co-creative nature of the Future Fit programme, the approach to engagement and communications detailed in this strategy is in response to the feedback from patients and partners gathered from a number of key sources:

- Call to Action project that culminated in a summit in November 2013 (see appendix 1)
- Engagement and Communications Workstream January to March 2014 (see appendix 2). The Workstream includes; patient representatives, Healthwatch, voluntary sector representatives, NHS staff union representatives, NHS Engagement Leads and Young Health Champions
- Five 'Shaping Engagement' Workshops held across the three commissioning areas in April 2014 (see appendix 3). Attendees included patients, voluntary sector representatives, carer support services, social housing employees and local councillors
- A planning and review meeting with the Senior Responsible Officers, a number of Communications and Engagement Leads and the team, as well as the Chair of the Engagement and Communications Workstream in March 2015 (see appendix 6).

The initial phase of this report was co-authored by Nick Hutchins, Chair of Bishop's Castle Patient Group, member of the Engagement & Communications Workstream and former publisher and editor.

The 2015/16 phase has been contributed to by a number of patient representatives. In addition the report has been shaped by feedback from a wide range of stakeholders as listed in the version control sheet above. Full details are supplied in appendix 4.

1.3 You Said …

Pulling together the responses from Call to Action, the Engagement & Communications Workstream, Shaping Engagement Events and a recent review meeting themes have emerged in regard to how patients, staff and the public feel Engagement & Communications should be delivered:

a. The future plan for services, whilst clinician-led, needs to be the result of genuine consultation. All those affected need to be able to understand the process and the reasons for the outcomes and so have the **opportunity to feed into the debate**

b. There is a widely-held belief that decisions have already been taken. To combat this cynicism the public need to be given a **wide range of ways to be involved**.

c. **All groups and individuals** must be targeted e.g. all age groups, ethnic groups, those without internet access, isolated communities, NHS staff, politicians, clinicians, carers, vulnerable groups, the working well etc.

d. **Genuine consultation** must be undertaken, not a paper exercise in order to tick boxes

e. Need to **go to where people are** e.g. Shrewsbury Flower Show, schools, GP surgeries etc.

f. Keep **politics out of the debate**

g. Work with organisations that have **existing networks** e.g. Patient Groups, Healthwatch, Young Health Champions, voluntary groups, community and religious leaders, etc.

h. The impact on **populations in mid-Wales as well as Shropshire and Telford and Wrekin** should be taken into account at all stages

i. **All media** to be utilised, e.g. internet, social media, traditional media, newsletters, etc.

j. Prepare **information** for distribution at regular intervals to involved groups

k. Avoid jargon in all communications, ensure language is **clear and easy to understand**

l. Provide regular updates and feedback to let people know that their input is being taken into account – **close the loop**

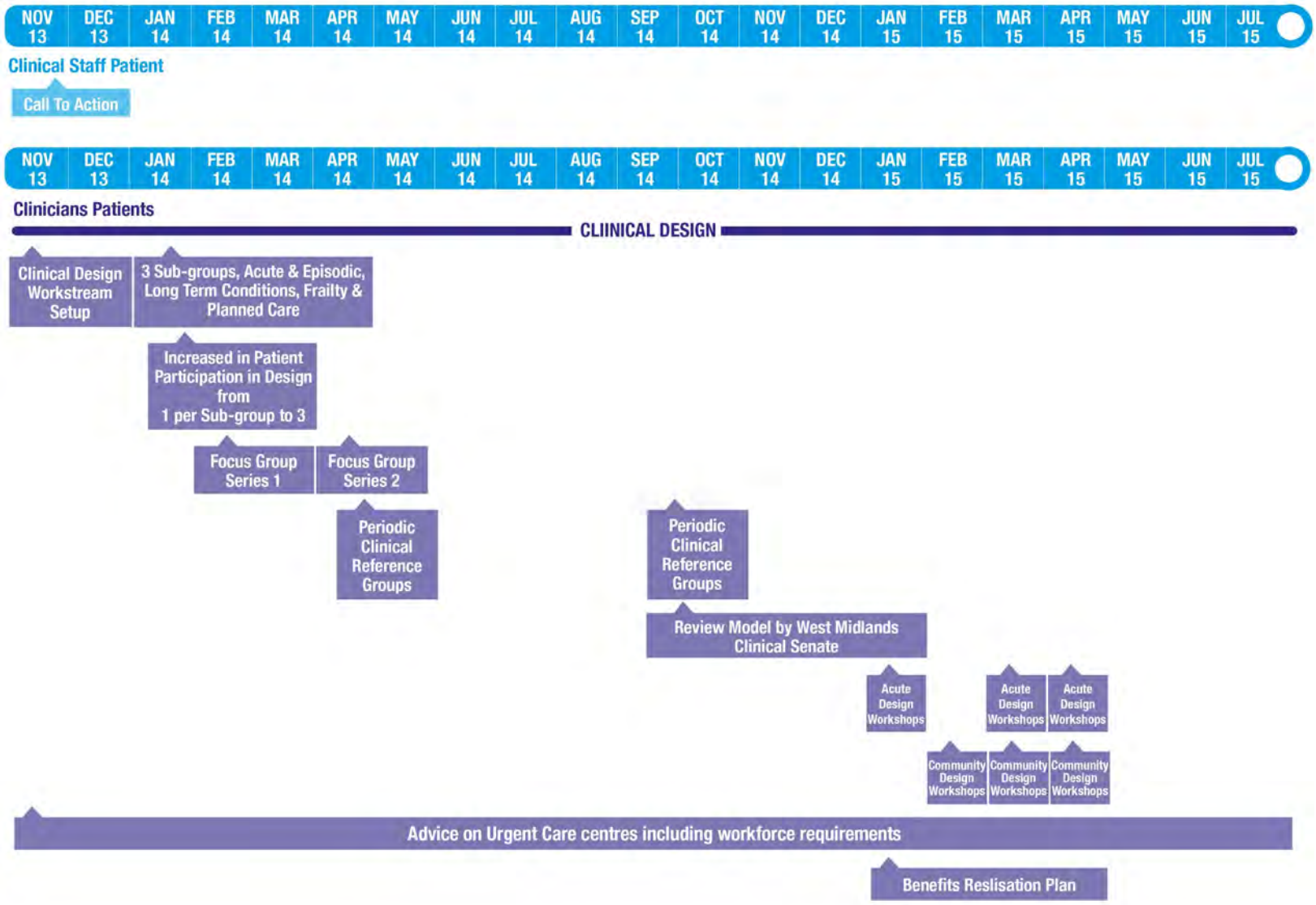
m. Communications should **be accurate and honest**; acknowledging shortcomings, providing the facts

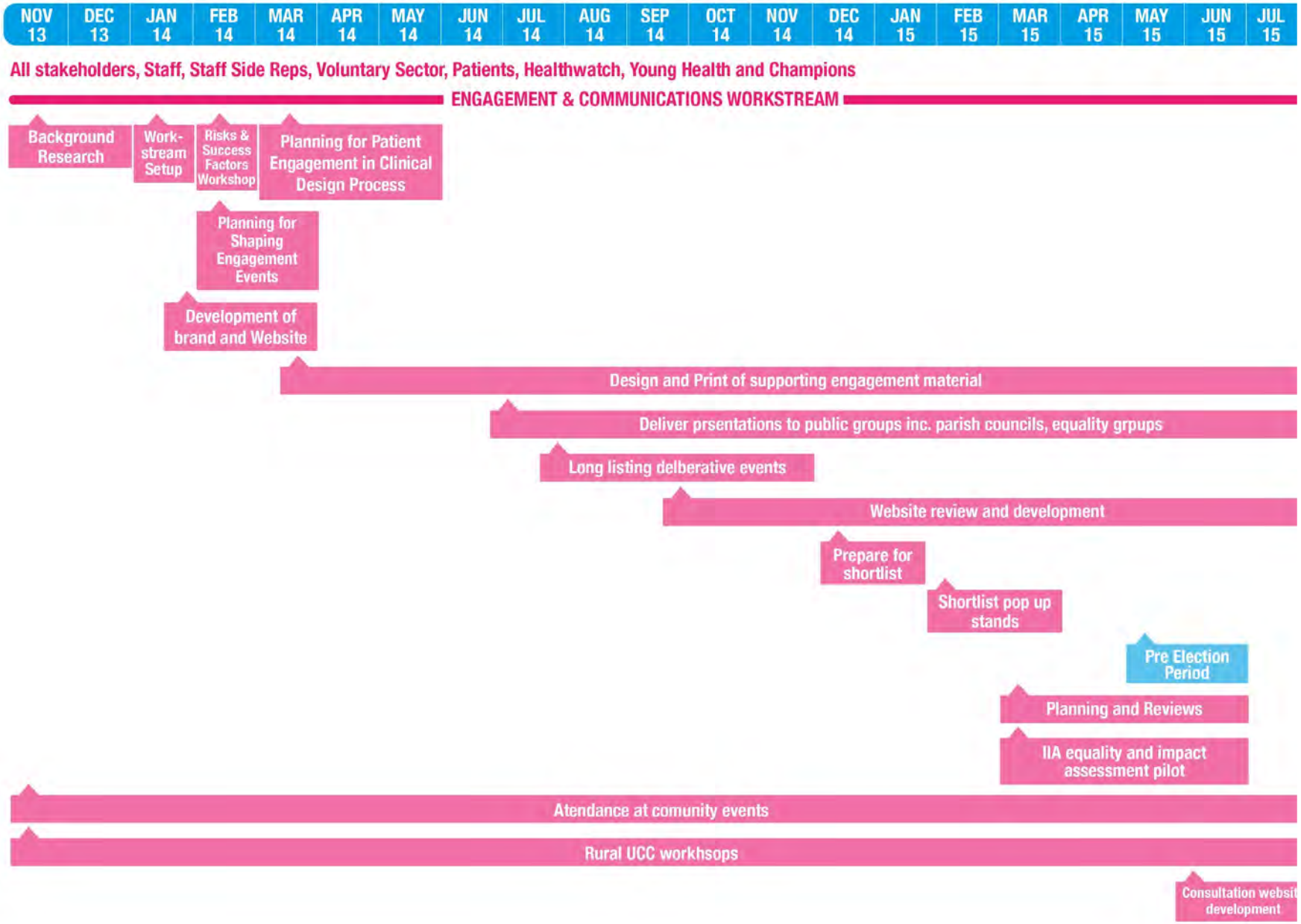
n. Varying, appropriate approaches to engagement and communication to be employed including **specific approaches** for those with learning difficulties, disabilities and English as a second language (please see appendix 7 for IIA equality pilot learnings)

The themes highlighted in blue will be responded to in the approaches described later in this plan.

1.4 Progress to date

The activities below have continued to date and been built upon using the approach described below.

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MAR 15
APR 15
MAY 15
JUN 15
JUL 15
All stakeholders, Staff, Staff Side Reps, Voluntary Sector, Patients, Healthwatch, Young Health and Champions
ENGAGEMENT & COMMUNICATIONS WORKSTREAM
Background Research
Work-stream Setup
Risks & Success Factors Workshop
Planning for Patient Engagement in Clinical Design Process
Planning for Shaping Engagement Events
Development of brand and Website
Design and Print of supporting engagement material
Deliver prsentations to public groups inc. parish councils, equality grpups
Long listing delberative events
Website review and development
Prepare for shortlist
Shortlist pop up stands
Pre Election Period
Planning and Reviews
IIA equality and impact assessment pilot
Atendance at comunity events
Rural UCC workhsops
Consultation websi development


NOV 13
DEC 13
JAN 14
FEB 14
MAR 14
APR 14
MAY 14
JUN 14
JUL 14
AUG 14
SEP 14
OCT 14
NOV 14
DEC 14
JAN 15
FEB 15
MAR 15
APR 15
MAY 15
JUN 15
JUL 15
Public
MEDIA
Ongoing proactive and reactive press media including BBC Shropshire Radio appearances, Local newspaper coverage and feature on BBC 1 Sunday Politics West Midlands, BBC Radio Shropshire "NHS Week" ehich featured NHS FF, Shropshire Star Special Report on Future Fit, BBC Radio Shropshire "NHS WEEK" which featured NHS FF
Social media set up of Twitter and Facebook accounts
Ongoing monitoring and messaging
Shortlist press briefing
Social sign-in campaign
Pre Election Period
Blogs
Newsletters
NOV 13
DEC 13
JAN 14
FEB 14
MAR 14
APR 14
MAY 14
JUN 14
JUL 14
AUG 14
SEP 14
OCT 14
NOV 14
DEC 14
JAN 15
FEB 15
MAR 15
APR 15
MAY 15
JUN 15
JUL 15
LEADERSHIP ENGAGEMENT
Programme Partners
Set up of Programme Board and regular meetings
Council Leaders, JHOSC, MPs
The Joint Senior Responsible Officers have regular formal and informal meetings with senior politicians in their respective areas

MIDLANDS AND LANCASHIRE
COMMISSIONING SUPPORT UNIT

midlandsandlancashirecsu.nhs.uk

futurefit

Shaping healthcare together

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

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

1.5 Measures of Success

There are a number of statutory requirements and guidance standards relating to engagement, communications and consultation as described in appendix 5. In addition, the Engagement & Communications Workstream held a workshop in 2014 to consider what success for engagement and communications would include and the key risks to success (risk details are in appendix 2). Subsequently, a workshop took place in March 2015 to review activities to date and noting lessons learnt (please see notes in appendix 7). In addition, the Engagement and Communications Workstream hold and govern a workstream risk register which is reviewed regularly for both risks and mitigating actions, and risks deemed to impact the Programme are escalated to the Programme risk register via Programme team.

The Engagement & Communications Workstream agreed critical success factors will include:

- **Awareness**: Seeking to ensure that the maximum number of people within Shropshire, Telford & Wrekin and mid Wales are aware that the debate is taking place – through a consistent and clear programme name and identity, coherent communication, awareness raising
- **Debate**: Encouraging a widespread debate by developing strong networks of intermediaries. These networks are to enable and empower organisations and individuals to take forward the debate at a local level
- **Staff** : Supporting NHS staff to advocate on behalf of the process – regular and early information enabling them to respond to questions from patients and the public, tools and skills for communication and engagement, empowering NHS staff as intermediaries in focused campaigns for awareness-raising and feedback
- **Choice**: Creating a programme of choice that enables public and patient engagement at different levels – being informed, being engaged, leading change as a patient representative in the Programme
- **Inclusion**: Focusing on inclusion by designing all parts of our communities into the process rather than excluding them
- **Confidence**: Nurturing confidence in NHS bodies as engaging organisations – maintaining a strong engaging ethos, reaching out to organisations and communities rather than expecting them to come to us, ensuring that the debate is not driven by the "usual" voices inside and outside the NHS
- **Partnership**: Maintaining confidence in our statutory partners (e.g. Local Healthwatch, Community Health Councils and Health Overview and Scrutiny Committees) in their vital role to provide critical challenge and/or support engagement
- **Focus**: Maintaining a clear focus on the programme remit and avoiding "mission creep"
- **Compliance**: Fulfilling key statutory and mandatory responsibilities in relation to engagement, communication and consultation

2 Engagement Approach

This approach is developed in response to the themes identified in the section 1.3 You Said.

You said … **All groups and individuals**

We will … Recognise that there is a wide range of stakeholders for this programme and we will have to make **best endeavours to engage with as many as possible** within the time and resources available. The table below shows whom we will engage with, who will lead the engagement plus where and when the engagement is needed.

Whom to engage with	Who leads the engagement	Where	When
Public/Patient Engagement • Patient groups • Councils; borough, parish and town • Community and patient leaders • Seldom heard and vulnerable groups • Media • Voluntary sector providers • Social care providers • Healthwatch • Patients, carers and the public • Montgomeryshire Community Health Council	Lead clinicians, Executive Teams and Engagement & Communications Team	Extensive programme of outreach to meet people where they are plus use of research and insight as described below	Already commenced and will continue until eight weeks prior to commencement of formal consultation. eight weeks needed for preparation of consultation material and series of approvals

Whom to engage with	Who leads the engagement	Where	When
Future Fit Champions • Patient Groups • Healthwatch • Engagement & Communications Workstream Members • Voluntary Sector Organisations • Social Housing Teams • Youth Health Champions These are groups who through the engagement to date have indicated that they would be willing to actively support Future Fit to spread the message and gather views/feedback	Engagement & Communications Team	Attend their meetings to agree the support they are willing and able to offer	Review in June 2015 but work to be ongoing until eight weeks prior to the election
Leadership Engagement • Professional bodies • MPs • Councillors • Health Overview & Scrutiny Committees • Other relevant local authority committees and senior officers • Regulators • NHS England Local Area Team & Trust Development Authority • Gateway Review Team • Health and Well Being Boards • Neighbouring Clinical Commissioning Groups & Trusts • Programme Board members	Senior Responsible Officers and Lead Clinicians with support from executive teams and the programme engagement and communications lead Engagement & Communications Lead to map individuals and committees who need to be engaged	Regular formal and informal meetings	Ongoing throughout the programme

Whom to engage with	Who leads the engagement	Where	When
Programme Engagement • Engagement and Communications Workstream members • Programme Team and other workstreams • Programme Board	Engagement & Communications Workstream Lead supported by Engagement & Communications Team Engagement & Communications Workstream Lead	Monthly meetings supplemented by email updates Update reports to fortnightly Programme Team for cascade to other Workstreams Formal reporting to each Programme Board	Ongoing throughout the programme
Internal Engagement • Clinicians • Local NHS staff • NHS staff union representatives	Lead clinicians supported by Engagement & Communications Team Executive Teams supported by Engagement & Communications Team Engagement & Communication Workstream Reps	Extensive programme of outreach to meet clinicians and staff where they are plus use of research and insight as described below Seek advice regarding how the local convenors should be engaged in the programme	From July 2014 to 8 weeks prior to commencement of formal consultation. 8 weeks needed for preparation of consultation material and series of approvals June/July 2014 onwards

How

You said … Work with organisations that have existing networks

We will … Develop Champions of Change

Through our recent 'shaping engagement' events we have heard a clear message that our patient groups, Healthwatch, voluntary sector organisations, Young Health Champions and others are keen to help spread the message. We welcome this rich resource and will support these groups, with the training, materials and other support to allow them to be able to reach out on our behalf and gather views and feedback from their networks, or simply to support our efforts by volunteering their time and skillsets.

We recognise the challenge of some prospective champions not necessarily wishing to advocate the clinical model but are instead keen to spread messages of change and help insure that the views of as many people as possible are gained and fed back into the programme. With this in mind, though we initially set out to form Future Fit Champions we have received a clear message this is not appropriate and instead we are looking to support 'Champions of Change'.

Being a Champion of Change will not be limited to external groups, we will encourage clinicians, young people and, importantly, our NHS staff to take messages out to their teams and feedback responses. There is a clear recognition that engaging NHS staff and young people are key groups to engage with so separate tactical plans has been developed to encourage more Champions of Change from these groups.

You said … Go to where people are

We will … Continue the good practice of Call to Action, reaching out and attending groups, events and meetings across the three commissioning areas; Shropshire, Telford & Wrekin and Powys. A cohort of Senior Responsible Officers, Executives and clinicians will be provided with the training and materials needed to get the Future Fit messages out on the ground. They will be attending groups such as:

- Parish and Town Councils

- Clinical Networks
- Special interest groups e.g. Women's Institute, Carer Networks, Cancer Support Groups, Mother/Father and toddler groups
- Groups representing people with protected characteristics, e.g. Age UK, ethnic minority groups, women's support groups etc
- Isolated communities that do not have access to convenient transport links
- Large crowd events such as Shrewsbury Flower Show and County Shows

You said … There is a need for **genuine consultation, opportunities to feed into the debate and providing** a **wide range of ways to be involved**.

We will … Identify what can be influenced at each stage of the programme and provide a variety of means for people to be involved in the ongoing debate which will include:

- Focus groups
- Medium and small-scale events where people can be informed of progress and where they can learn how they can contribute to the process; such as pop up shops and stands in the community
- Large-scale deliberative events where large numbers of people can engage in an interactive format rather than being talked at from a stage
- Smaller-scale public activities (such as Local Joint Committee meetings or Patient Group meetings) where people can be informed of progress and consulted on proposals and developments
- Surveys supplied electronically, hosted on the website, by text and provided in hard copy, additionally phone surveys will be used as a method of collating data in a stratified manner
- Twitter chats and other social media platforms will be explored
- Going to where people are – see above

You said … Ensuring we reach all possible groups and individuals and closing the loop

We will … Actively monitor participation to identify whom we have made contact with and more importantly, whom we haven't

In order to ensure we are meeting our statutory duties to engage and involve all sections of society we will gather equality and demographic information with every contact. The monitoring form will be provided online and in hard copy. We will encourage every person who engages with Future Fit through any type of activity to provide this information. Though we are unlikely to engage every single resident of Shropshire, Telford & Wrekin and mid-Wales, we can ensure that we monitor our coverage to ensure it is representative of the population as a whole and target any under-represented groups. Capturing information and storing it systematically will also allow us to be able to continue the dialogue with individuals who have taken part and to demonstrate how their efforts have influenced the programme therefore closing the loop.

You said … The impact on populations in **mid-Wales as well as Shropshire and Telford and Wrekin** should be taken into account at all stages

We will … Develop a specific plan for engagement in mid Wales

It is appreciated that many people living in Powys currently rely on hospital services provided in Shrewsbury and Telford for their care, particularly acute care. The Future Fit Engagement & Communications Team will work on a specific plan for the Powys area taking into account the needs of this rural community and the requirements of Welsh regulations and legislation. These discussions began at the 'shaping engagement' event hosted by Montgomeryshire Community Health Council (CHC) on 14 April 2014 (see Appendix 3). Meetings focused on engaging the communities of Powys happen regularly between key stakeholders across Powys, and include Powys teaching Health Board, CHC, Powys County Council and Powys Association of Voluntary Organisations (PAVO). This is helping to develop a specific appendix to this plan created in conjunction with all relevant stakeholders to fulfill statutory requirements.

You said … We need specific approaches for those with learning difficulties, disabilities and English as a second language
We will … Co-create solutions with our voluntary sector colleagues
The Future Fit Engagement and Communications Team, supported by Midlands and Lancashire CSU, have access to local and national expertise in engaging groups for which traditional approaches will not suffice. Working with our voluntary sector colleagues we intend to co-create events/methods for these groups that will include accessible engagement

You said … keep politics out of the debate

We will … focus on health and best outcomes for patients

We need to keep our local Councillors and MPs informed and updated about the progress of this important programme. However, we will ensure that the debate in our engagement activities is about health and best outcomes for patients. Political debates are best discussed in other more appropriate settings.

3 Communications Approach

With whom?	By whom?	How?	When?
Public/Patient Engagement • Patient groups • Councils; borough, parish and town • Community and patient leaders • Seldom heard, hard to reach and vulnerable groups • Media • Voluntary sector providers • Social care providers • Healthwatch • Patients, carers and the public • Montgomeryshire Community Health Council	Engagement & Communications Team	**You said…all media** **We will…**provide proactive media activity to keep up public awareness of the programme to include: • Press releases • Radio interviews • Social media • YouTube channel Regular syndicated news items to go into local newsletters and websites	Ongoing throughout the programme

With whom?	By whom?	How?	When?
• Champions of Change • Patient Groups • Healthwatch • Voluntary Sector Organisations • Social Housing Teams • Young Health Champions These are groups who through the engagement to date have indicated that they would be willing to actively support Future Fit to spread the message and gather views/feedback	Engagement & Communications Team	**You said…**prepare **information packs.** **We will…**provide a fortnightly update to key stakeholders and include (where appropriate): • News articles to include in local publications • Newsletters • Surveys / results • Updates on any slide deck and key messages • Messaging training to ensure champions are confident in delivering messages	June 2014 onwards
Leadership Engagement • Professional bodies • MPs • Councillors and HOSC Chairs • Regulators • NHS England Local Area Team • Gateway Review Team • Health and Well Being Boards	Engagement and Communications Team	Programme Bulletin after each Programme Board to update on progress and any decisions made	Week after Programme Board

With whom?	By whom?	How?	When?
• Neighbouring CCGs			
Programme Engagement • Engagement and Communications Workstream members • Programme Team and other workstreams • Programme Board	As above	As above and in addition a fortnightly update on activities and review of the plan during meetings	As per meetings
Internal Engagement • Clinicians	Engagement & Communications Team	Regular syndicated news items to go into local newsletters and websites	Ongoing throughout the programme
• Local NHS staff	Sponser organisations supported by Engagement & Communications Team and advised by Workforce workstream	Info and training to support colleagues, A specific workforce plan will be created	June 2014 onwards
• NHS staff unions representatives	Initially CCG & provider organisations supported with collateral by Engagement & Communications Team and advised by Workforce	Seek advice from local convenors on their preferred way to receive communication	June/July 2014 onwards

With whom?	By whom?	How?	When?
	workstream		

How

You said … Be clear and easy to understand and communications should be accurate and honest
We will … Identify a small group of patient readers
As well as the expertise provided by Midlands and Lancashire CSU and their copywriting team, we will encourage a small group of patient readers to check our content for accessibility before it is published. The patients and public who have taken part in the three key events listed in the introduction were very clear that the only way to build trust in the programme and to challenge cynicism is to communicate regularly, accurately and honestly. This test will apply when the patient readers check the communications content for the programme.

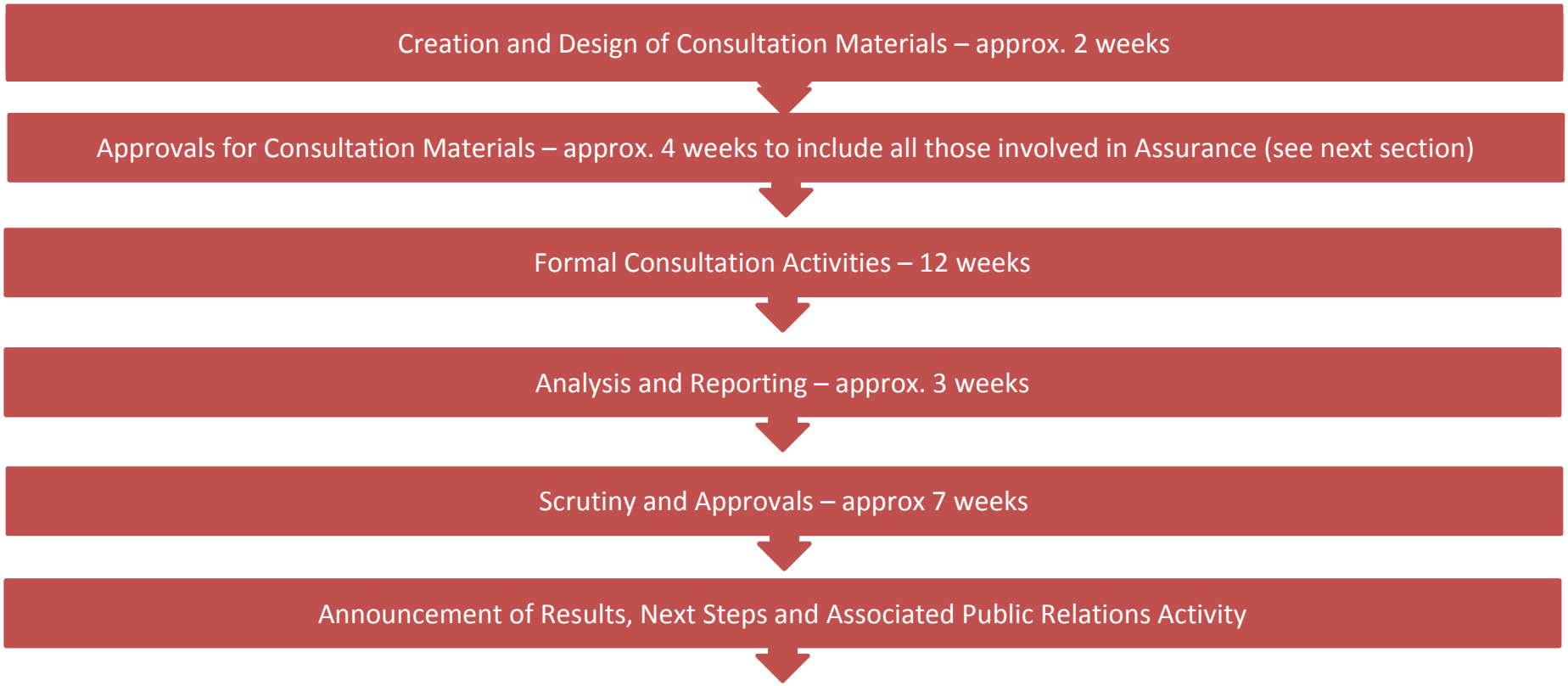
You said … Develop specific approaches for those with learning difficulties, disabilities and English as a second language
We will … Identify a small group of patient readers

Where words aren't the most helpful means to communicate we will provide picture-based communication tools and video content via our YouTube channel. We will develop specific approaches taking guidance from our voluntary sector colleagues such as Mind for mental health patients and Taking Part for reaching out to patients with learning difficulties.

We will also take learnings from the Engagement and Communications work delivered as part of the Integrated Impact Assessment (IIA), in particular preparation for the equality assessment (please see appendix 7 for more details of an equality assessment pilot and lessons learnt).

4 Consultation Approach

Future Fit is a major service reconfiguration and will therefore require a full 12 week formal consultation. Mirroring the previous phase of extensive engagement, the consultation will be delivered through multiple platforms to ensure it is accessible to all communities within Shropshire, Telford & Wrekin and Powys. The timing of this phase will be subject to Programme Board approval and exact timings will need to be agreed, however it will include the activities shown below. However, for further consultation specification please read Appendix 6 note 1 on the Institute of Consultation recommended checklist for formal consultation.



5 Monitoring, Evaluation & Assurance

8.1 Monitoring and evaluation

The Engagement and Communications Workstream has responsibility for agreeing detailed action plans for all the activities outlined in this plan and monitoring delivery against plans. Each activity will have a target outcome against which the workstream will evaluate success. The workstream will take responsibility for:

- Ensuring compliance with key statutory and mandatory guidance (as outlined in Appendix 5)
- Supporting all workstreams to ensure that their plans are shaped and influenced through clinical, patient/public and wider stakeholder engagement
- Identifying the benefits to the programme of effective engagement and communications, and risks associated with engagement and communications that should be managed (a Workstream risk register to be generated and maintained, with escalation to programme team as and when required)
- The workstream group will support organisations to deliver engagement to local networks and groups, but it is essential partners report back and this is recorded as part of an Engagement Schedule and Evidence Log (also known as the operational plan) that will be maintained by the Future Fit Engagement & Communications Team.
- Monitoring delivery of the Engagement and Communications Plan in the context of the overall programme aim and objectives.

The Engagement and Communications Workstream will report progress to the Programme Team and Programme Board.

8.2 Assurance

Assurance external to the Engagement and Communications Workstream will be provided by:

- Assurance Workstream – who will receive reports and evidence throughout both the engagement and consultation phases and will in turn report findings to the Programme Board.
- Consultation Institute – are commissioned to provide a 'critical friend' role to the Engagement & Communications Workstream during the engagement phase. They will provide a formal assurance function via their consultation compliance assessment process during the formal consultation phase (see Appendix 8)
- Reporting and evidence of activity will be routinely included in the Senior Responsible Officer updates to the Joint Health Overview & Scrutiny Committee and Health & Well Being Boards
- The NHS England Local Area Team have a formal assurance role in overseeing major reconfiguration programmes such as Future Fit including ensuring the engagement and communications activity is meeting the Four Tests (see appendix 5)
- The Gateway Review Team will also scrutinize engagement and communications activity at key points in the overall programme

Appendix 1 – Call to Action

NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

The NHS belongs to the people

A CALL TO ACTION

In July 2013, NHS England called on the public, NHS staff and politicians to engage in an 'open and honest debate on the future shape of the NHS in order to meet rising demand, introduce new technology and meet the expectations of its patients'. In response to this national initiative, Shropshire and Telford and Wrekin Clinical Commissioning Groups agreed to undertake a joint Call To Action engagement process with local populations.

But, What Next?

The Call To Action consultation run by Shropshire and Telford and Wrekin Clinical Commissioning Groups (SCCG and T&WCCG) closed on 25th November 2013 with a conference held at the Telford International Centre.

The conference was led by Accountable Officers Dr Caron Morton, from SCCG, and David Evans, from T&WCCG. The public, voluntary groups, NHS staff and stakeholders met to discuss the challenges the NHS is facing and to debate possible ways of addressing these vital issues.

Both CCGs were delighted with the level of survey responses from across the county, with related twitter debates and with attendance at the conference. The CCGs would like to thank everyone who participated. The Call To Action conference was also attended by Jim Hawkins, BBC Radio Journalist who compèred the event and by Sir David Nicholson, Chief Executive of NHS England who was the conference's keynote speaker.

In-depth survey responses have now been put together with summaries of the discussions at the conference, and the outcomes are summarised on the next page. This information will be used in two ways:

- First, to help inform plans for what services are commissioned in the next three to five years. The information will help to prioritise and design services that meet the needs of local populations in Shropshire and in Telford and Wrekin;
- Second, to help inform the NHS Future Fit work over the next six to nine months and agree the best model of care for acute and community hospital provision across Shropshire that best meets the needs of both urban and rural communities.

The Call To Action conference confirmed that there was agreement from those taking part in the consultation process on the need for radical change within the local NHS.

Our personal commitment to you:

On this basis the Accountable Officers of NHS Shropshire Clinical Commissioning Group, Dr Caron Morton and NHS Telford and Wrekin Clinical Commissioning Group, Mr David Evans committed to undertaking further work to look at how the need for change could be translated into local safe and sustainable NHS services for the next 50 years.

Call To Action Feedback

An online public and clinician survey ran from 4th October to 4th November 2013 and asked respondents which aspects of the NHS were important to them. A Call To Action conference took place on 25th November 2013 to provide an opportunity for those attending to hear the feedback from the survey and to have further discussion and debate. The results of the survey and the issues raised in the conference in response to the question 'What is important to you?' have been collated and a series of common themes have emerged which are set out over these two pages.

Our experience

Patients want a trustworthy NHS, centred around patient needs, taking account of physical, mental and environmental wellbeing and using a holistic approach. Different solutions for service delivery should be considered, but risks should be managed, particularly for marginalised groups. It is important that the overall experience of the NHS is consistent, not only for patients, but also for their relatives, visitors, friends and carers.

Real life feedback from patients' experiences should be encouraged and welcomed and, more importantly, acted upon. Sometimes patients may not feel confident or able to provide feedback and so it is important that there is an advocate who can speak for them in these situations.

Staff morale contributes to patients' experiences and it is important that poor or variable staff morale is addressed.

Working together

There must be trust between patients and doctors. This should be supported by improved co-ordination and integration between clinical staff, health professionals, health organisations, social care and informal care in our communities.

It is important that politics; national, local and that between public organisations, is not allowed to adversely influence healthcare design and decision-making.

Finance and resources

It is important that the NHS receives a sustainable level of resources, collaborates with social care and considers joint working with other 'over the border' services. Funding should follow the patient across organisational boundaries. The current economic climate means that reduced budgets will impact on services, staffing and retention – but this should not detract from a good patient experience.

The NHS needs to focus on value for money and improve the use of its resources by:

- Tackling waste/duplication
- Bringing together health and social care budgets
- Improving number/location and quality of hospitals
- Considering restricting access to some treatments
- Making better use of technology
- Prioritising some patient groups
- Improving population health
- Considering reducing or abolishing car parking charges.

Information

Patients need information on what health services exist so they can access them more readily. This information will help support self-care and decision-making for ongoing health issues.

It is important that information is in plain English.

Communication and engagement

Communication starts with the basics and, all too often, hospital layout and signage is confusing.

Communication with patients must be open and honest – with less 'hoodwinking', and clarity about what is or is not possible.

The NHS should promote itself more and highlight all the good work it does.

It is important that the NHS listens to and involves the wider community in decision-making by engaging, consulting and communicating with the local population. It should ensure more involvement of marginalised groups (with potential cultural differences) and the 'silent majority'.

The NHS must undertake meaningful clinical engagement and foster better communication between NHS organisations and within each NHS organisation.

Personal Responsibility

Everyone must take more responsibility for the management of their own health, rather than over relying on the NHS to undertake this.

The NHS should support patients by providing peer education (e.g. health champions), access to self-management education using a variety of different mechanisms and focusing resources on prevention and lifestyle choices.

Quality

Services in different parts of the NHS are variable and addressing quality in one area may have unintended consequences in other areas.

Services should be seamless between different parts of the NHS and social care. There should be continuity of care from the GP with a consistent level of competency from all health professionals.

It is important to receive care, compassion and respect and be treated with dignity when in contact with the NHS.

Poor staff morale needs to be addressed as this impacts on quality of care.

People

Patients must be at the heart of everything the NHS does. The NHS is about people – and so relationships and mutual respect between patients and staff matter.

Access to services

Access needs to be right for the patient, but necessarily limited to the range and scope of potentially available services. It is important to have 24 hour A&E, 7-day access to primary care and GPs who are able to spend more time with patients and less on administrative tasks. High quality social care and acceptable access to secondary care services are also needed. There is a desire for more minor injuries units, walk in centres, community and acute services available locally.

There is also awareness that more specialist services could be located on one hospital site, but this must be considered alongside geographical access to services.

Accountability

NHS decision-makers must take responsibility for the outcomes of their decisions about NHS services and be held to account. The public want to make sure that where decisions are being made, they are shaped by clinicians, stakeholders and patients. They also want politics to be kept out of the decision-making process. There is concern about what the decision-making process will be for the review of acute and community hospitals.

Design of Services

It is important that the design of services is radical and sustainable and that the NHS avoids more tweaking of services. In the past, previous NHS management and political interference have introduced unsustainable change. Questions were raised about whether A&E is being used by the public in the way it was designed to be used. Also, should A&E provide different services and should it be located on both hospital sites or in one central facility?

Redesign should be based on a joined-up 5 - 10 year, long-term plan which is clinically sensible, driven by clinicians and based on a clear understanding of demand and capacity. This redesign must provide:

- Clinical safety and the movement /transfer of services to a GP/ community setting
- A design where 'form follows function' and integration is not compromised by current building stock or current working arrangements
- The wider use of technological solutions
- A simpler system of assessment to allow easier navigation by clinicians, NHS staff and patients.

All decisions must be based on the reality of an ageing population and different socio-economic groups.

It is important that the NHS addresses the dilemma of the location of services. Clinical quality might be improved by centralising more specialist/acute services, but patients will need more primary - and community-based care closer to their homes.

The NHS must also focus on the care of older people, children, those with long-term conditions and mental health problems and address concerns about reducing services at one or other of the hospital sites.

What makes a decision sustainable?

We are committed to using a set of principles, developed at the conference, which will make our decision making more robust:

- Patients are at the heart of everything we do
- All factors have been taken into account
- All decisions must be based on accurate or best-available information
- There is shared confidence that problems and issues will be addressed
- Decisions will be objective and rational, but also compassionate
- Processes will be transparent
- Decisions will be based on shared principles
- There must be two-way, honest and accurate communication with affected people
- Easily understandable language must be used
- Everyone affected by a decision must have an equitable opportunity to be involved in helping shape the decision
- A decision must attempt to address the problem for as many people as it can
- Any risks arising from the decision must be identified and mitigated as far as possible
- There must be access to specialist advice to help make the decision
- Ongoing monitoring must be in place to ensure the outcome of a decision is as expected.

Shropshire CCG and Telford and Wrekin CCG would like to note the invaluable input from patient representatives who took time and care to assist with the Call To Action feedback and in producing this document.

Thank you.

The NHS belongs to the people

A CALL TO ACTION

Shropshire and Telford and Wrekin CCGs recognised the need to introduce Call To Action to local populations, and to explain the challenges the NHS is facing in order to stimulate interest and debate.

To do this quickly, the CCGs produced an engagement pack comprising website links (see http://www.shropshireccg.nhs.uk/call-to-action and http://www.telfordccg.nhs.uk/call-to-action) which included a presentation (in hard copy and on YouTube), and a leaflet and poster that set out the key challenges for the NHS. The pack aimed to identify how people could feed their views into the process. A survey was made available online and printed. The survey asked four main questions:

"I really hope that this is not a 'cosmetic' attempt to make the public feel that they have been consulted..."

- *In terms of healthcare, what is most important to you and your family and why?*
- *What might be some options for change?*
- *What do you think are the main difficulties and opportunities for the NHS over the next 5 years?*
- *Do you have any other comments you would like to make?*

The survey was conducted between 4th October and 4th November 2013 and 2906 responses were received. A report on the findings from the public survey can be viewed online at http://www.shropshireccg.nhs.uk/call-to-action and at http://www.telfordccg.nhs.uk/call-to-action.

Some key findings included:

- 59% of respondents addressed the issue of access to healthcare services
- Of the 1,034 comments received about improving local services, 61% referred to improving access to GPs or GP out-of-hours services
- 67% lived in urban areas and 31% in a rural setting or village

Clinicians across Shropshire were asked to complete a similar survey online and 250 clinical staff responded – see the high level feedback here: http://www.shropshireccg.nhs.uk/call-to-action and http://www.telfordccg.nhs.uk/call-to-action.

The CCGs arranged a whole day conference at Telford International Centre on 25th November 2013 to provide an opportunity for the survey results to be shared and for further debate and discussion to take place. This Call To Action conference was attended by over 300 individuals. Martin Fischer, an Associate of the Centre for Innovation in Health Management at Leeds University, facilitated some of the discussion.

A short video of the conference is also available on the CCG websites or, available here: https://www.youtube.com/watch?v=0utT80zqPOU. Online presentations and social media were used to assist with engagement activities including live twitter feeds and interaction with the hash tag #CallToAction during the conference.

Comments from the conference included:

"...public sector partners work closely together..."

"Sustainable in the long-term..."

"We're all taxpayers..."

futurefit

Shaping healthcare together

Get involved, Stay involved!

There is a lot we can celebrate in the local NHS - but also much that can, and should improve. Future Fit builds on the work we have done so far for Call To Action, by reviewing acute and community hospital provision. Help us shape the future of your NHS by visiting: **http://www.shropshireccg.nhs.uk/nhsfuturefit** or, **http://www.telfordccg.nhs.uk/nhsfuturefit**

Appendix 2 - Engagement & Communications Workstream Outputs

Critical success factors will include:

- Awareness: Seeking to ensure that the maximum number of people within Shropshire, Telford & Wrekin and mid Wales are aware that the debate is taking place – through a consistent and clear programme name and identity, coherent communication, awareness raising
- Debate: Encouraging a widespread debate by developing strong networks of trusted voices, intermediaries and networks that enables and empowers organisations and individuals to take forward the debate at a local level – syndication of engagement tools and information for use at a local level
- Staff : Supporting NHS staff to advocate on behalf of the process – regular and early information enabling them to respond to questions from patients and the public, tools and skills for communication and engagement, empowering NHS staff as intermediaries in focused campaigns for awareness-raising and feedback
- Choice: Creating a programme of choice that enables public and patient engagement at different levels – being informed, being engaged, leading change
- Inclusion: Focusing on inclusion by designing all parts of our communities into the process rather than excluding them
- Confidence: Nurturing confidence in NHS bodies as engaging organisations – maintaining a strong engaging ethos, reaching out to organisations and communities rather than expecting them to come to us, ensuring that the debate is not driven by the "usual" voices inside and outside the NHS
- Partnership: Maintaining confidence in our statutory partners (e.g. Local Healthwatch, Community Health Councils and Health Overview and Scrutiny Committees) in their vital role to provide critical challenge and/or support engagement
- Focus: Maintaining a clear focus on the programme remit and avoiding "mission creep" – for example, by seeking assurance that there are clear mechanisms for ongoing engagement in the other key themes raised through the Call To Action rather than raising expectations that all issues will be addressed through this programme
- Compliance: Fulfilling key statutory and mandatory responsibilities in relation to engagement, communication and consultation

Mechanisms will be established to make this happen effectively, including:

- Establishment of an Engagement and Communications Workstream group to bring together expert opinion and advice to shape the Engagement and Communications Plan, propose priorities for action and review delivery.
- A focus within the Engagement and Communications Plan on delivering outcomes and managing risks so that public resources are used most effectively for the benefit of the communities we are here to serve.
- A commitment from organisations to deliver engagement and communications activities to their respective organisations / groups, with defined roles and responsibilities for all partner organisations.
- Authority from the Programme Board for timely engagement and communications activities within agreed parameters.

- Ongoing review of the Engagement and Communications Plan via the Engagement and Communications workstream to ensure it is fit for purpose and meeting the agreed aim and objectives
- Transparency throughout the programme.
- A dedicated online resource to act as a portal for engagement, providing information and encouraging feedback.
- Embracing diversity and debate, recognising that any discussion of the configuration of health services will inspire a wide range of opinion and emotion both from those working within the NHS and those who use and rely on its services.

Risks

The following key risks associated with engagement and communications have been identified:

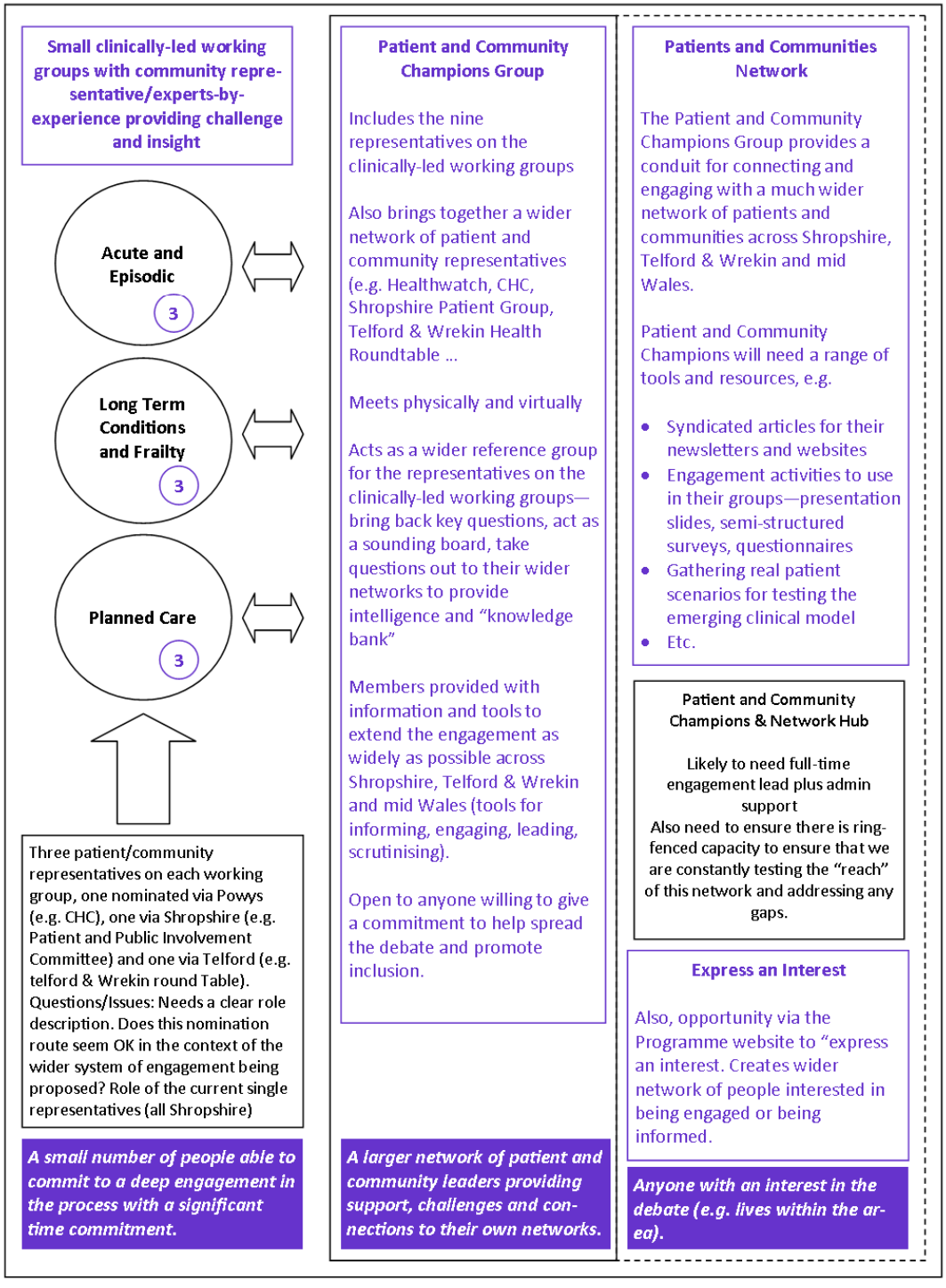
The plans developed through the Clinical Service Review do not satisfactorily improve outcomes, reduce inequalities and improve efficiency due to insufficient patient and public engagement as a result of …	• Fatigue and disengagement with a reconfiguration process due to previous attempts • Insufficient engagement activities to enable involvement across community groups • Reactive focus on the "usual voices" rather than proactive focus on inclusion • Insufficient adoption of guidance and best practice • Relative immaturity of organisations and/or organisational relationships following NHS restructuring in 2013 – including contribution to delays in approving engagement and communication mechanisms and messages • Insufficient investment in the development of trusted patient/public voices to advocate for change and for the process of debate • Excessive focus on a perception of "loss" rather than "benefit"
The plans developed through the Clinical Service Review do not satisfactorily improve outcomes, reduce inequalities and improve efficiency due to insufficient clinical engagement as a result of …	• Fatigue and disengagement with a reconfiguration process due to previous attempts • Lack of understanding and ownership of the case for change • Insufficient investment in the development of trusted clinical voices to advocate for change and for the process of debate
Effective plans are not developed because broad and open public debate is stifled due to …	• Lobbying on behalf of individuals or groups (e.g. clinicians, politicians) particularly in the lead up to a general election in 2015 • Insufficient engagement to support broad and impartial reporting by local media • Skepticism in the transparency of the process

	(stakeholders and public) • Relative immaturity of organisations and/or organisational relationships following NHS restructuring in 2013 • Insufficient early engagement and communication with wider NHS staff and partners about the case for change and the need for debate
The process of debate is subject to formal or legal challenge due to …	• Insufficient compliance with statutory and mandatory requirements, including cross-border engagement • Insufficient assessment of compliance with the four reconfiguration tests • Insufficient engagement with key statutory stakeholders including Healthwatch, Community Health Councils and Health Overview and Scrutiny Committees • Insufficient equality impact assessment • Inconsistency in message across partner organisations • Defensive approach that seeks to stifle rather than embrace debate and difference

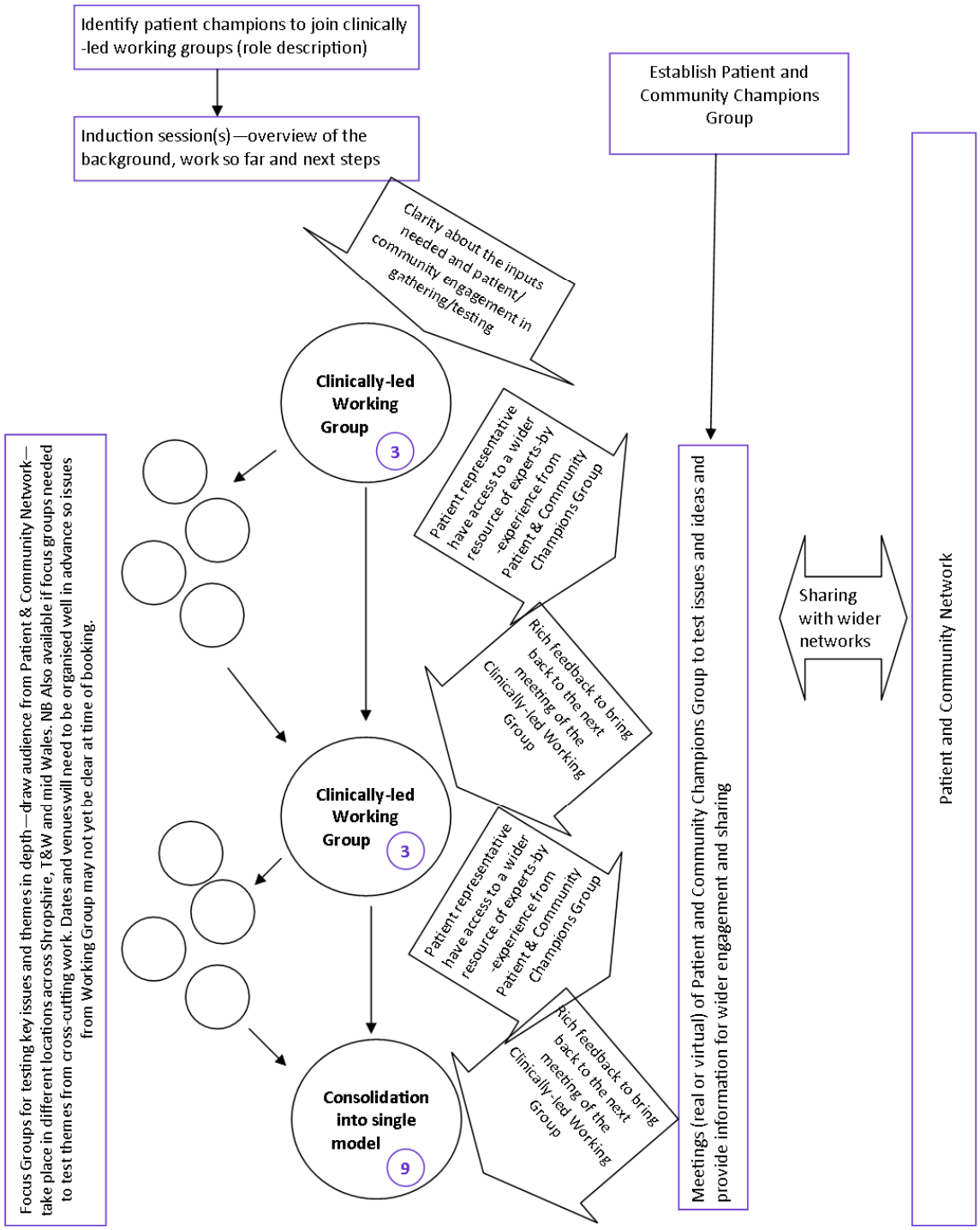
The activities outlined in this Engagement and Communications Plan will actively seek to mitigate the above risks. Ongoing monitoring and review of the risks will be undertaken through the workstream and contribute to the programme risk register.

Initial Ideas for Patient and Community Leadership and Engagement in the Phase 2 Clinical Design Work

What does the System look like?



Initial Ideas for Patient and Community Leadership and Engagement in the Phase 2 Clinical Design Work
What does the Process look like?

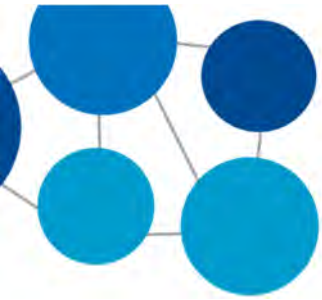


Appendix 3 - Shaping Engagement Events Outputs

1 UPDATE AND SHAPING ENGAGEMENT IN FUTURE FIT

These sessions will provide an update on the Future Fit programme; who is involved, the work done so far and the next steps. There will be an opportunity to discuss and design engagement plans to ensure the programme effectively involves patients, carers and the public throughout its work.

Date	Time	Venue
14 April	9:30 – 12:00	Meeting Point House, Southwater Square, **Telford**, TF3 4HS
14 April	1:30 – 4:00	Meeting Point House, Southwater Square, **Telford**, TF3 4HS
15 April	2:00 – 4:30	**Newtown**
25 April	9:30 – 12:00	Lantern Community Building, Meadow Farm Drive, Harlescott, **Shrewsbury**, SY1 4NG
25 April	1:30 – 4:00	Lantern Community Building, Meadow Farm Drive, Harlescott, **Shrewsbury**, SY1 4NG



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Shaping Engagement Workshop
Telford AM 14 April

Agenda

- Intro
- Announcements
- Aims of the session
- Future Fit overview
- Options for people to get involved
- Tools/support to get involved
- Who are our seldom heard groups?
- How do we engage them?
- Next steps
- Thanks

Options for people to get involved

- Clinically robust service / Patient
- Challenge network

- People need to know why we are doing Future Fit
- Must not be a political debate
- Best services for whole area
- Health Watch – big piece of work
- Safe and accessible
- Accessible language
- Some understanding across the whole area
- Meaningful engagement
- Closing the loop
- Wider context – living longer, etc.
- Every hospital can't provide every service

- People understanding range of services – pharmacy, walk-in, urgent care, A&E, GP
- Low income can't afford to select pharmacy first
- Whole system
- How do we engage the 'working well'
- Need to protect NHS
- Prevention
- Community hospital – role?
- Charities
- Use of technology, e.g. Telehealth
- How to engage older public/mental health/learning disability
- Outcome – real commitment if people are willing to give their time
- Prior provision of reading material
- Acronyms are ok but first explain
- Chair

Roles – how do we get people involved?

- Local media – and involving people such as Eric Smith – hosting events and cross-promotion
- GP surgeries – promotion and questionnaire
- People already in hospital – how does it currently work for them? And what improvements could be made?
- Are these identified with an outline of expectations, what exists
- Specialism's MH/LD how to engage with the most vulnerable
- Continuity within all services
- Social media
- Promote through Health Watch, etc.
- Show how it could/would impact people
- Patient participation and other such groups (local and national)
- Local joint committees
- Events at community hospitals and RSH/PRH
- GP's/Social services, etc. targeting recent users (after a stay in hospital) to ask – what worked for them, what could be improved

- Involve Shropshire Chambers of Commerce and large businesses for help in involving people who can't get to engagement events (networking events)
- SALC – Shropshire association of local councils
- Involve local district nurses as well as social services (those going into people's homes to provide support-domiciliary care)
- Involving local support groups (for learning disabilities, voluntary sector assembly, etc.)
- Community care coordination in GPs surgeries
- Community council(s)
- Simple messages – short – high impact
- Young health champions spreading the word
- Schools directly – big summer events
- Shropshire senior citizens forum
- Using each organisation's newsletter – T&W voice through door, school newsletter, etc.

What support does programme need to provide?

- Media
    - Need to give them starting point for debate and keep them briefed
    - Regular but simple release
    - Regular interview opportunities (e.g. radio/TV)
    - Milestones and showing feedback has been listened to
- GP surgeries
    - Provide printed material (questionnaires, posters, leaflet)
    - Feedback regularly. Positive feedback
    - Dedicated space in each GP surgery, updated monthly
- People in hospital
    - Ask what would make things easier for you? What would have made your stay better? Would it have been better closer to here?
    - Is this the right time to ask these questions? Depends on illness/condition
    - Tailored
- LJC's
    - Held at community hospitals centered on health need
    - Also at larger GP practices
    - What is the equivalent in Telford and Wrekin and Mid Wales (community health/town/parish council)
- Recent users
    - Choosing sample of people to phone
    - Questionnaire at own leisure
    - Ask district nurses, etc. – what will work and what is lacking?
- Businesses
    - Providing printed material and editorial from lead clinicians and asking them to share the messages
    - Leading business people talking about why it is important
    - Attend networking events and forums
    - Articles for newsletters/magazines

- SALC/TC/PC
    - Fully inform councils about what it is about
    - Attend regular monthly meetings
    - Not political – Health f Shropshire/TW/MW
- Young health champions/senior citizens
    - Go speak to these groups
- Newsletters
    - Regular slots, regular interviews, commenters, editorial

What will time and commitment be for each role?

- We have one chance to get this right for the next twenty years + - important message to promote with all
- Venues need to be DDA
- LOW – read a newsletter, listen to the media, read an article, email information
- MEDIUM (1.5hours max) – more people would engage, try not to duplicate (4 times a year meetings)
- HIGH – focus groups (3 hours too long), getting involved (should be limited to prevent saturation of the individuals), 6 weekly meetings
- Keep feedback simple – impactful but short questionnaire
- Regular feedback. Let people know how their feedback has been used
- Feedback events
- Clear remit
- Appropriate training
- Outcomes are achieved
- E-learning to back up knowledge
- Group learning for new people who join later into the process
- Regular updates but only need to get involved at certain points, e.g. quarterly
- Informed environment/no fear to question
- Bear in mind anyone who volunteers is mindful of the budget. Don't waste money. Keep it basic and to the point

Hard to reach groups

- Use existing networks (specialist agencies and charities)
- Events tailored to specific communities or groups of people
- How do they want to be contacted/involved
- Provide presentation in different languages – playing in GP surgeries/waiting rooms, on the website, etc.
- Be creative – particularly for younger people – amateur dramatics, etc. to help explore the issues
- Alzheimer's
- Dementia
- Mental health
- Learning disabilities
- Long term conditions

- Rural isolation
- Ethnic groups

How could we reach our seldom heard groups?

- Discharge teams
- Town center locations
- Use of village halls
- Use of Women's institute, young farmers, U3A
- Groups who use speakers
- Survey monkey
- Job centers
- Schools
- Youth centers
- Email in advance
- 3rd sector
- Media – Shropshire Start through articles
- Visiting staff, community nurses, social workers, Age UK staff and other staff
- Think outside the box
- Churches/places of worship
- Apps
- Schools newsletters
- If there is a multi-agency approach there needs to be an agreed way of working that is consistently good
- Maternity services/GPs
- Need to work with the professionals who are already working with and have relationships with these people – too also avoid duplication and too much information
- One of the hardest groups is the working well – they may not feel it's relevant to them
- Go out to the work place/ unions
- Elected members
- School governors
- Utilize the internet/social media properly
- Voluntary sector (Age UK, RVS, Mind, etc.
- Disability networks
- Advocacy organisations
- Special schools

For each role, what support and tools would we need to provide?

- Expectations for all roles
- Time commitment
- Level of understanding
- Information – people need to clearly understand what it is and what it is trying to do before they can join in the conversation
- All champions
- Training

- Toolkit – to include printed literature
- Clear purpose
- Consistency
- Clear channels to feed back – key support mentor
- Finite number of people at the moment
- Volunteers need some support – continual travel
- Full cost recovery model
- Email – Skype
- DDA venue – access critical

How can people actually get involved? What roles and activities could we offer?

- The voluntary sector needs to be used a lot more than they are
- Newsletter sign up on working partners website
- Questionnaires at pharmacies
- In T&W there are over 200 health support groups – normally it is always the same people that come to meetings
- Everyone expects a level of understanding
- Get rid of jargon
- Commission them to put things in easy read – if you do this everyone will be able to understand
- Communication – the NHS is a minefield to work through there are too many mixed messages
- Engagement champions rolling programme at hospitals, roadshows, having clinicians involvement at roadshows
- Media champions – press, paper, TV, radio
- App
- 'if you always do what you've always done you will always get what you've always got'
- People feel over-engaged

Shaping Engagement Workshop
Telford PM, 14 April

Agenda

- ✓ Intro
- ✓ Announcements
- ✓ Aims of the session
- ✓ Future Fit overview
- ✓ Options for people to get involved
- ✓ Tools/support to get involved

- ✓ Who are our seldom heard groups?
- ✓ How do we engage them?
- ✓ Next steps
- ✓ Thanks

Aims of the session

- Work out how we can best co-create the engagement plan
- Feedback to PG's
- Where housing might fit in? – Advice on reaching homeless etc.
- Ensure input from PG's
- Need to engage vulnerable groups – 4 structure programme to receive feedback
- Is there a fit – friends and family, etc.?
- Ensure whole population engagement / consultation
- Get up to speed, re: health
- Where Red Cross fits in? – How patient and carers panel can help?
- Use output from today to produce a plan for Future Fit
- Ensure restricted resources do not stop us getting out to all and coordinate – local authorities and voluntary and community sector

Future Fit Overview comments

- Patients on other Workstreams
- GP engagement
- Funding assumptions
    - Can we make assumptions when this is a political decision
    - We have little choice
    - No party talking about £+
    - Talking of integration, e.g. better care funding
    - No certainty, best guesses
- 'Common good'?
    - How can programme make decisions
    - What are the criteria?
    - What are good outcomes? Clinical?
        - Care close to home?
        - Good experience of healthcare
- Benefits?

How can we involve people? What roles? What activities and commitment?

- Have different levels…
    - Into giving – in alternative format
    - Basic engagement/specific engagement

    - Fully involved
- We need to be more flexible to people's needs – they can tell us when!
    - 'working well'
    - NHS staff (i.e. also include cleaners, admin)
    - Tenants/clients/customers (i.e. housing hubs)
- Activities
    - Go to where people go (work with them)… e.g. supermarkets, libraries, WI, Rotary groups (for people who don't go online or read published media)
    - Some businesses already 'market segment' make use of it for Future Fit
    - Make use of patients, i.e. spokespeople
    - Use community pharmacist for those with long-term conditions
- Commitment levels
    - Will understand better through feedback
    - Understand 'why' – our responsibility to provide that – in easy-to-understand format

What support do we need to provide?

- Develop a 'support hub' which includes both NHS and both non-NHS people (including councillors) – i.e. getting access to different groups
- Identify community groups that aren't necessarily patients (we don't know what we don't know…who else)
- Work with local authority/mental health
- Sharing experience across colleagues
- Not a feedback process occasionally but rather an on-going dialogue...which means we can develop continual interests… (i.e. twitter and non-twitter)
- Community leaders to help, 'translate' information in their people/communications (i.e. easy read)

Seldom-heard groups

- Understanding cultural differences and working towards that
- Show that everyone's included by using their language
- Homelessness… 'The Ark' in Shrewsbury/Advice/Drop in
- Different cultures
- Traveler community
- Substance misuse – often big users of NHS
- Mental health/learning disabilities – represented on various boards/groups… go to those that already have a relationship
- Younger people through schools/LA
- Parents and carers – quality of care is very important
- House-bound or isolated people (rural isolation)

- Old and younger people – via library services, community nurses, district nurses, Age UK staff, British Red Cross, RVS…meals on wheels, Advocacy (A4U)
- Language and cultural difference – via translation, community leader, recognizing and understanding
- Home from hospital - Through intermediaries and trusted voices
- Cognitive and communication education levels, e.g. LD, dementia
    - using appropriate communication and channels
    - work through advocate groups
    - asking people questions that make sense to who they are
- Regular and ongoing contact - not one off
- Feedback 'you said, we did'
- Value people – what's in it for me?
- Isolated people – who is reaching them – what's the one call I need to make? – community leaders, community venues, e.g. church, pub, parish (parish newsletter)
- Understand the barriers to being engaged and address them
- No access/interest in technology, e.g. Twitter, website – through people who are talking with the community
- Transient lives, e.g. homeless, travelers, students – no organisation has a relationship?
- Step in to their shoes – What are they doing? Shopping, working, running/exercising, school run, pub, online, church, sleeping - Find way in to crowded market place
- Trusted voices, networks - people we trust
- As much as possible – people have been able to access information in a way that makes sense to them
- Go where people are (e.g. fairs, town centre, supermarkets) – multipurpose and high footfall
- Make it interesting/fun/useful – link to public health, self-care, home from hospital
- Endorsements – celebrities and known figures

How can we involve people?

- Engage wider with PPGs – broader engagement
- TORs
    - Representation from VGs – templates for VGS
    - Structured topics to discuss. i.e. Future Fit
    - Coordination - networking
- VCS – FOI's – represent vulnerable people
- Patient participation – Data, Ideas, Plan, Info
- VCS – deal with more complex issues
- Vulnerable people do not engage with PPGs

- Commitment has to vary according to what is needed.

Support

- Information packs – appropriate format! Tailored to individual groups
- Digital access – not all people can engage with digital
- Coordination – What questions do Future Fit need answering? Support PPGs and VCS to deliver and obtain resources

- BME
- LGBT
- Youth
- Families
- Older/Younger people
- Disability
- PD and SI, MH, ALD, AQBI, Autistic Spectrum
- Hidden disabilities/Rare conditions (i.e. heart problems, diabetes, eds, copd, parkinsons, Gyno, MH
- Working age people
- Travellers
- Homeless
- Domestic violence

Powys Workshop Notes – 15 April 2014

Who do we need to involve including hard to reach groups?

- As many as possible
- 'protected groups' Equality Act 2010
- i.e. women and children
- carers
- elderly
- transgender
- mental health
- faith
- chronically ill
- Socially excluded and marginalised people
- Schools
- Third sector organisations i.e. PAVO, Health and Social Care network
- Youth services
- Young farmers

- Teenagers
- Young parents, and other young people
- Ethnic minorities
- Armed forces personnel
- Patients
- Hard to reach – those not registered, rurally isolated, elderly, older elderly, farming community
- Carers and young carers – 'voice for cared for'
- Voluntary services e.g. Parkinson's etc.
- Domiciliary care / Social workers

How to engage them?

- Emails
- Councillor out door knocking
- Facebook and all social media
- Press – radio – local media
- Voluntary groups
- Carers
- Hospitals and Doctors surgeries
- LJC
- Councillors and County and Community (Town too)
- Schools and colleges – face-to-face
- Survey monkey
- Plain English/Welsh – to every door
- Public meetings
- Key influencers of public opinion – education
- Principles of public engagements (Wales) – apply these in engagement
- Social media
- Local radio
- My Welshpool, my Newtown
- Local papers
- Patient forums, health interest groups
- Questionnaires handed out by healthcare professionals, health visitors, etc.
- Relatives and carers of patients
- Newsletter – widely distributed
- Word of mouth
- Focus groups/events
- Police and neighbourhood management processes
- Community champions
- Hijack existing group's events
- Work with existing volunteers – Powys volunteer centre
- Being honest
- Community champions
- Social media – Twitter / Facebook / Tumblr

- Create a campaign – Big and Bold
- Press and Radio
- Trusted face – utilise services already familiar with people – red cross etc.
- Pharmacies – info in prescription bags
- Leisure centres
- Community and ambulance transport
- Town and community council
- Community events
- Schools – worker at the gates
- Health champions – dementia etc.
- Public health – Community researchers
- Cattle market
- Large factories
- PCC engagement forum

Opportunities and challenges

- Existing networks and groups
- Cross border work development
- Review previous consultations
- Undertake a family impact assessment on our engagement process
- implement an action research learning model

Challenges

- finance and geography
- increase in aging population
- mistrust – (already a decision made)
- transport
- Montgomery locality manager vacancy (PtHB)
- Buy in by GPs

Barriers

- if a way forward has been agreed already don't engage, just inform.
- Transport
- Levels of literacy
- Polish community and other languages
- Clarity – simple language (cartrefi cmryu assistance)
- Why should we bother – confidence that action will be taken – what feedback?
- Consistency

Shrewsbury Workshop Notes
25 April (AM)

Agenda

- ✓ Intro
- ✓ Announcements
- ✓ Aims of the session
- ✓ Future Fit overview
- ✓ Options for people to get involved
- ✓ Tools/support to get involved
- ✓ Who are our seldom heard groups?
- ✓ How do we engage them?
- ✓ Next steps
- ✓ Thanks

Comments/reflections

- How can clinicians come up with a solution without evidence/indication of what the finances are?
- Pre-determined outcome?
- Perception of Future Fit
- Patient representation on finance work stream

Options for people to get involved

- include those who have asked to be involved – in finance work streams
- keep them up to date
- honesty about finance and impact of cuts
- publicise meeting in local papers (i.e. church magazines, community newsletters) – open and accessible
- more involvement with the voluntary sector, e.g. carers week – go to them. They have not got time to study website also patient organisations – MS disability, Parkinson's, seniors etc.
- no predetermined outcomes e.g. loss of A&E
- patients and community involvement – from Mid-Wales
- cultural change within the NHS - yes links to council help but not enough community 'SILO's'
- health champions
- join in on community events
- social media – i.e. twitter

- go to schools (including special schools), youth groups, retirement homes, places of worship
- Step Council - preventative care
- cascade information down - too top heavy
- young people have a lot to say - go to their place
- older people - Shropshire farmers market
- patient groups active - no involvement from 'well'
- CCG? - replacement 2 days (KH)
- go to meet groups in community centres - e.g. Shropshire housing group - with Ruth, trusted staff attending, plus CSU staff
- visit all patient practice groups - with invitation for any person to visit / contribute
- mental health issues / care?
- geographically isolated groups - how to access?
- Parish magazines / dates
- church groups
- pubs / hairdressers
- mobile library
- youth clubs
- mum and toddler groups
- Women's Institute
- regular attendance
- food and drink
- transport

Tools/support to get involved

- Future Fit document
- education
- must be appropriate for reading age of 9 – youth parliament will proof read
- aspirational / reality (funding community)
- going out to SHG (HTR) groups
- changing services - no communication between Telford / Shrewsbury
- P.I.P. - how's that working? unknown quantity
- Birmingham - home visit for assessments
- government policy
- incentives
- support from Future Fit
- contacts

Hard to reach groups

- travellers
- parents
- socially deprived
- foodbank users

- migrants
- low income
- children in care
- political groups
- young offenders
- diabetics
- LGBT
- serious illnesses
- housebound
- less traditional community groups - i.e. at the bingo
- domestic violence/sexual abuse victims
- isolated/rural – access
- people who work during the day
- people with carers
- ‘go to them’ principle
- accessible venues and accessible materials (and seek specialist input, e.g. SLT)
- approach employers for release/events. GP surgery events. Take views on board
- dementia/mental health patients
- school nurses
- sensory impaired
- veterans
- carers
- employers
- illiterate
- self-harm
- substance misuse
- ethnic minority communities
- people in residential care homes
- young parents
- housebound
- youth workers
- NHS employees
- homeless
- young people
- learning disabilities
- autistic
- young people
- working well
- unemployed
- Shropshire disability network
- EVERYONE!

How to engage hard to reach

- NHS choices website
- community care coordinators
- befriending services
- trade unions
- compassionate communities
- funders - national lottery
- chambers of commerce / business links
- Jim Hawkins
- stop using acronyms - 'Your NHS' - alienates
- map your links - how many contacts do you have
- voluntary community sector assembly - (Jacqui Jeffries)
- preventative care - mental health / low self-esteem / isolation
- stop thinking they are groups - individuals
- transport - getting people to venues
- go to them - markets, community centres, etc
- GP's could do more - signposting - volunteers, healthcare visitors / midwives
- community mental team - health clinics
- social media
- councillors / libraries / schools / colleges / universities
- consistency
- Health Watch
- Plain English / no acronyms / no jargon
- Target via Shropshire News - specific page numbers

Shrewsbury Focus Group Notes – 25 April (PM)

Agenda

- ✓ Intro
- ✓ Announcements
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- ✓ Tools/support to get involved
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- ✓ Thanks

Comments/reflections

- MP's – holding petitions can cloud the real issues
- Better care fund
- Discharge plan
- Worst place to recover when you're not well is hospital
- Increase in state retirement age

Options for people to get involved

- Publicising via the press/media
- Known groups
- Go to where people are already
- Direct mail to known groups
- Social media – i.e. twitter
- Faith groups
- Public meetings
- Integrated care
- Email
- Written materials
- Assistive technology
- Patient passport /carers passport
- Education – schools
- Gyms
- Public places
- Life after caring – who listens to carers after their role has ended
- Clinical outpatient appointments
- PEIP, PPG, LD health programme board, Voluntary sector groups, Health Watch, PALS – where does all this information go? – black hole
- Voice of carers and advocates to be recognized
- Read patient notes
- Workforce development /skills / permission to challenge

Tools/support to get involved

- GP practices – GP's and Nurses are key – need to be more pro-active
- Community leaders/influencers
- Patient participation groups
- Closing the loop with information that's already there from various groups and communities - need to listen – where's all this information going? – is it just getting lost

- ‘ask the question’
- Patient passport
- Discharge planning – but needs improving
- Joined up / shared records as appropriate
- PPG
- Better understanding of cost of care – personal health budgets
- Assistive technology
- Press
- Direct mail – ‘known groups’
- Community – Shropshire/Parish/Town Councillors and faith groups
- Public meetings
- Existing health facilities: GP Practices
- Data sharing with assurance of confidentiality

Group work output - hard to reach groups

- Carers
- Housebound
- Isolated people at home
- Addicts
- Homeless
- Profoundly disabled – polio, etc
- Geographical isolation
- Residential care
- Looked after
- Non-digital people
- Young single men
- Men in general
- Ethnic minorities
- Addicts
- Homeless
- Travelers
- Mental health
- Sheltered accommodation
- Communications difficulties
- Self-denial – in certain conditions, e.g. pituitary, alcoholism, substance misuse, smokers
- People with rare conditions
- Older people
- LD without advocacy
- Children

- Busy people who are well
- Working mums

Group work output – how to engage hard to reach groups

- Ask the right questions – in the correct format – with a meaningful purpose / relevant
- Build trust and ensure that the information will be used and not just sit on a shelf and ignored
- Face-to-face
- Post
- Hubs
- Drop-in's
- Press
- Faith groups
- Church groups
- Good neighbor schemes
- Social media
- Apps
- NHS apps
- Trust
- Honesty
- Meaningful

Appendix 4 – Circulation and Response List

Name	Job title	Date of response
Stephanie Belgeonne	Senior Partner: Communications & Engagement, Central, Staffordshire & Lancashire CSU	12/05/14
Adrian Osborne	Communications Director, SaTH/Engagement & Communications Workstream Lead	12/05/14 (verbal)
Nick Duffin	Associate, Consultation Institute	12/05/14
Tracy Shewen	Patient Experience Lead, Shropshire & Staffordshire NHS England Local Area Team	13/05/14 (verbal)

Programme Team, all emailed

Engagement & Communications Workstream, all emailed, responses listed as below

Name	Job title	Date of response
Adrian Osborne (Chair)	Communications Director Shrewsbury & Telford Hospital NHS Trust	12/05/14 (verbal)
Ruth Boyd	Communications & Engagement Manager Central Midlands CSU	n/a co-author
Anne Wignall	Healthwatch Shropshire	13/05/14
Nick Hutchins	Patient Representative - Shropshire	n/a co-author
Bharti Patel-Smith	Director of Governance & Involvement Shropshire CCG	15/05/14
Judith Rice	Shropshire Patients Group	14/05/14 (verbal)

Assurance Workstream, all emailed, responses listed as below

Name	Job title	Date of response
Bharti Patel-Smith	Director of Governance and Involvement Shropshire CCG	15/05/14
Fiona Bottrill	Scrutiny Group Specialist, Democratic Services Telford & Wrekin HOSC	12/05/14 (verbal at Assurance Workstream)

Officer Group, all emailed, responses listed as below

Name	Job title	Date of response
Adrian Osborne (Chair)	Communications Director Shrewsbury & Telford Hospital NHS Trust	12/05/14 (verbal)
Ruth Boyd Harpreet Jutlla	Communications & Engagement Lead	n/a co-author n/a author
Mathew James	Head of Governance and Involvement, Shropshire CCG	15/05/14
Jane Randall-Smith	Chief Officer Healthwatch Shropshire	15/05/14
Sharon Smith	Engagement Lead, Telford & Wrekin CCG	12/05/14

UPDATE VERSION

Engagement & Communications Workstream, all emailed, responses listed as below

Name	Job title	Date of response
Mathew James	Head of Governance and Involvement, Shropshire CCG	16/07/15
Alison Smith	Director of Governance, Telford & Wrekin CCG	17/07/15
Sharon Smith	Engagement Lead, Telford & Wrekin CCG	21/07/15

Appendix 5 - Key statutory and mandatory guidance from both England & Wales

Equality Act 2010
The Equality Act 2010 places duties on public sector organisations to review the impact of their services on the communities they served based on protected equality characteristics. Specifically, by understanding the effect of a proposed reconfiguration on different groups of people, and how the NHS can be inclusive in supporting and open up people's opportunities (including mitigating action to minimise any adverse impact), this will lead to services that are both more efficient and effective.

The Engagement and Communications Plan will support the delivery of these duties by commissioning appropriate equality impact assessment to support the programme. This will also ensure that engagement and communications activities actively reduce and challenge discrimination based on characteristics such as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

Parity of Esteem
Definition: Valuing mental health equally with physical health

More fully, it means that when comparing with physical health, mental health is characterised by:

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- The allocation of time, effort and resources on a basis commensurate with need
- Equal status within healthcare education and practice
- Equally high aspirations for service users
- Equal status in the measurement of health outcomes

Freedom of Information
The NHS belongs to the people. A vital aspect of any programme of service review and change is therefore the accountability to the communities we serve and transparency in action and decision. The Engagement and Communications Plan will support accountability, openness and transparency through the development and delivery of effective engagement activities and by establishing a web portal to share programme information and encourage debate.

NHS Constitution
The NHS Constitution provides the principles and values that guide the NHS and the rights that

individuals have including those relating to the Human Rights Act. In particular, the following rights within the constitution will be regarded through all engagement and communications activities:

- You have the right to be treated with dignity and respect, in accordance with your human rights.
- You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age.

Legal requirements: Engagement and Consultation

Legislation and guidance relating to communities and NHS services in Wales

The Welsh Government sets policy and legislation for engagement and consultation in relation to NHS services provided for people living in Wales.

This includes the Community Health Councils (Constitution, Membership and Procedures) Regulations 2010 which place a duty on specified English NHS bodies which provide services to persons resident within the district of a Community Health Council to consult the Council when developing and considering proposals for changes in the way services are provided, and in decisions that will affect the operation of services.

Legislation is supplemented by guidance from NHS Wales, including NHS Wales Guidance on Engagement and Consultation (2011). This expects:

- Strong continuous engagement and formal consultation
- NHS bodies and Community Health Councils must work together to develop methods of continuous engagement which promote and deliver service transformation for their population
- In cases where substantial change or an issue requiring consultation is identified, the NHS should use a two-stage process where extensive discussions with citizens, staff, staff representative and professional bodies, stakeholders, third sector and partner organisations is followed by a focused formal consultation on any fully evaluated proposals emerging from the extensive discussion phase.

Legislation and guidance relating to communities and NHS services in England

The UK Government sets policy and legislation for engagement and consultation in relation to NHS services provided for people living in England.

This includes the Health and Social Care Act 2012 which places legal duties on CCGs to involve and consult, and the NHS Act 2006 which places legal duties to consult and involve patients and public and for consultation with Health Overview and Scrutiny Committees.

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, especially with regard to how NHS commissioners function. These amendments include two complementary duties for clinical commissioning groups with respect to patient and public participation. The second duty places a requirement on CCGs and NHS England to ensure public involvement and consultation in commissioning processes and decisions. It includes involvement of the public, patients and carers in proposed changes to services which may impact on patients.

CCG Constitutional Commitments

Both Shropshire CCG and Telford and Wrekin CCG have set out in their constitutions how they intend to deliver these statutory requirements at a local level. These constitutional commitments

will need to be reflected through the programme:

Shropshire CCG – extract from Constitution	**Telford and Wrekin CCG** – extract from Constitution
5.2. General duties - in discharging its functions the group will: 5.2.1. Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by: a) Ensuring that patients and the public are fully consulted and involved in every aspect of the commissioning cycle in line with the Duty to Involve. Promoting among its members and service providers the requirements of the Duty of Candour. b) Developing and publishing an engagement strategy and consultation policy. c) Ensuring compliance with the 'Code of Conduct' which was jointly developed by the Shropshire Patients' Group and the group. d) Publishing an annual consultation report at the AGM describing all the consultations it has undertaken and the findings and actions resulting. e) Embedding lay representation on all clinical pathway or service reform project teams. f) Creating and establishing a public reference group that will monitor and report the group's compliance against this statement of principles. **3.3. Petitions** 3.3.1. Where a petition has been received by the group, the Chair of the Governing Body shall include the petition as an item for the agenda of the next meeting of the Governing Body.	**5.2. General Duties -** in discharging its functions the group will: 5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by: a) delegating the responsibility to discharge this duty to the Clinical Commissioning Group Governance Board, to prepare and approve a communications and engagement plan. b) the Clinical Commissioning Group Governance Board will have regard to the following statement of principles in the discharge of the duty outlined in paragraph (a) above: i) working in partnership with patients and the local community to secure the best care for them; ii) adapting engagement activities to meet the specific needs of the different patient groups and communities where possible and affordable; iii) publishing information about health services on the group's website and through other media; iv) encouraging and acting on feedback. **3.4 Petitions** 3.4.1 Where a petition has been received by the group the Chair of the Clinical Commissioning Group Governance Board shall include the petition as an item for the agenda of the next meeting of the Clinical Commissioning Group Governance Board.

NHS England Guidance

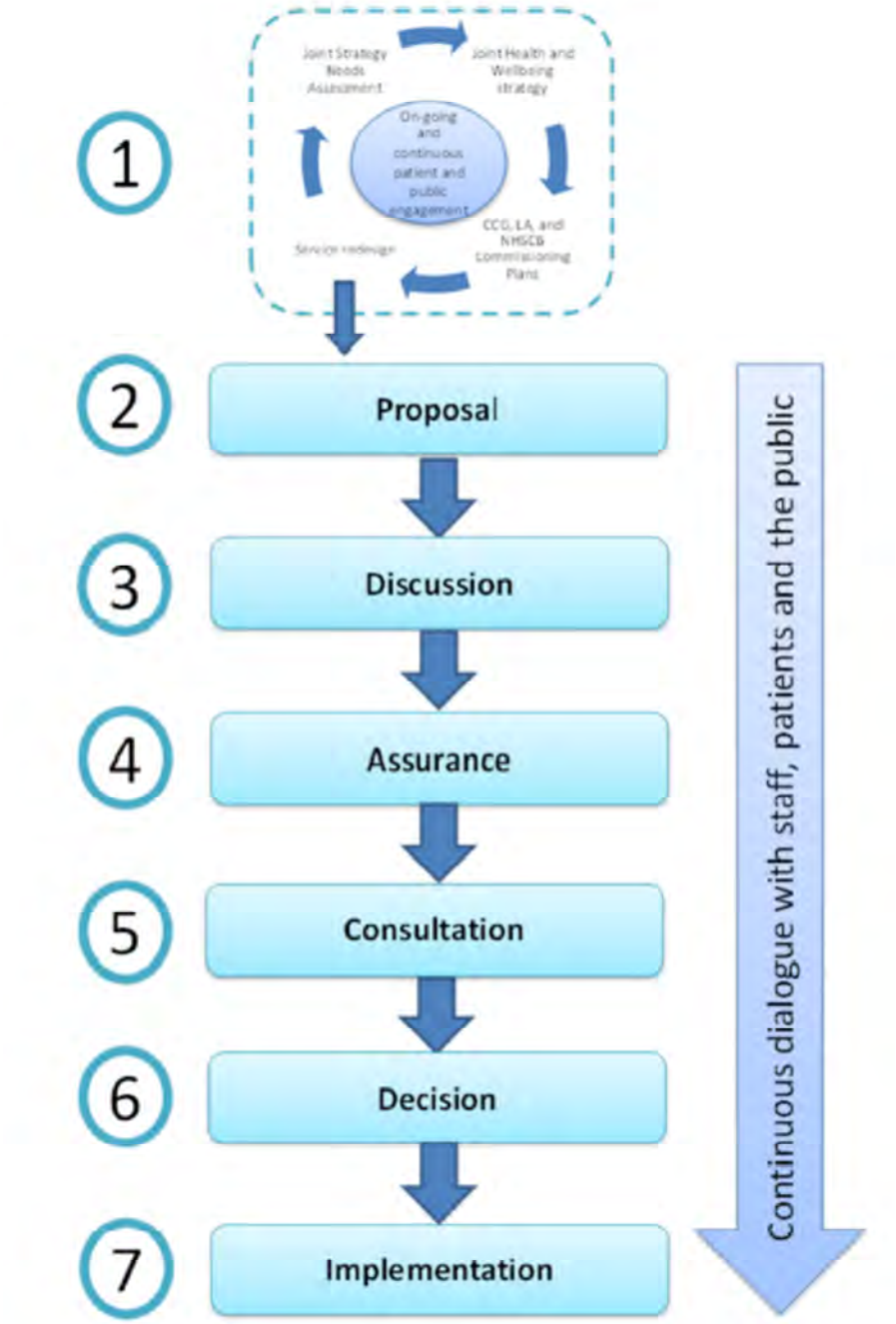
NHS England has recently supplemented national policy with new guidance on "Planning and delivering service changes for patients" (December 2013).

Legislation and guidance relating to cross-border health services

National legislation is supplemented by a Protocol for Cross-Border Healthcare Services (April 2013) between NHS England and NHS Wales. This places a requirement on these bodies to "ensure arrangements are in place so that bodies engage populations across the border in discussions on quality and changes to services provided."

Implications for the Engagement and Communications Plan

Delivering these requirements at a local level involves ongoing and deliberative engagement of patients and the public throughout the programme, encompassing the development of a shared understanding of health services challenges and the case for change from a clinical and patient perspective, co-production of options to address those challenges and respond to the case for change, shortlisting and refinement based on co-developed criteria, widespread consultation on final options for change, and ongoing engagement in implementation and delivering benefits for patients and communities. These stages are summarised (right) in a process diagram developed by NHS England in their guidance on "Planning and delivering service changes for patients". Whilst the terminology at Stage 1 refers to English planning mechanisms, the programme will ensure that this is expanded to include strategic planning processes in Wales.



Legislation and Guidance for Formal Consultation

Whilst ongoing engagement is crucial, the Engagement and Communications Plan will also feature a period of formal consultation based on English and Welsh legislation and best practice. A more detailed plan for this phase will be developed over the coming months, but will draw on key guidance and best practice including:

- The Consultation Principles set out by the Cabinet Office (Cabinet Office, 2012)

- NHS Wales Guidance on Engagement and Consultation (2011)
- The Four Reconfiguration Tests set out for the NHS in England which must be at the core of approach to engagement, communications, and consultation

It is also anticipated that the consultation process will draw on specialist external expertise to provide quality assurance for the consultation process.

The Four Tests

Extracted from 'Planning and delivering service changes for patients', NHS England 20 Dec 2013
http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

In 2010, the Government introduced four tests that are intended to apply in all cases of major NHS service change during normal stable operations (different circumstances may need to apply during the instigation of an unsustainable provider regime). It is the responsibility of organisations involved in developing service change proposals to work together to assure themselves and their communities of the strength of evidence for each of the tests. The relevant commissioner(s) should lead this assessment.

The four tests – as set out in the 2014/15 Mandate from the Government to NHS England - are that proposed service changes should be able to demonstrate evidence of:

- **strong public and patient engagement;**
- **consistency with current and prospective need for patient choice;**
- **a clear clinical evidence base; and**
- **support for proposals from clinical commissioners.**

NHS England has a statutory duty to seek to achieve the objectives in the Mandate. CCGs in turn have a statutory duty to exercise their commissioning functions consistently with the objectives in the Mandate (under s.3(1F) of the NHS Act 2006 as amended by the Health and Social Care Act 2012).

In building evidence in support of these tests, commissioners should assess how proposals will improve the quality, effectiveness and safety of care for patients, and whether proposals will deliver services that are clinically sustainable within available resources.

It is good practice that an initial assessment against the tests should take place at the early planning stage and then be repeated at intervals during the life cycle of a scheme, to ensure that any findings from stakeholder and public engagement, and any new evidence that is developed, continues to support the case for change. This helps to demonstrate compliance with the Public Sector Equality Duty and Duty as to reducing inequalities. It also ensures that the application and assessment of the 'four tests' is an on-going and iterative part of the wider reconfiguration process.

Developing the case for change to meet the four tests

To inform assessment of proposals against the four tests, the proposing body should develop a business case setting out the clinical and patient benefits for all options under consideration, and including a robust assessment of all options against an agreed set of criteria, including an economic and financial appraisal. In many cases, the lead commissioner(s) will prepare the business case, though this is for local determination and the detailed technical development could

be undertaken by a relevant provider or commissioning support service – with the commissioner(s) undertaking an oversight and approval role.

The nature of the application of the four tests will be for the Secretary of State to determine in the case of the Unsustainable Provider Regime for NHS Trusts and Monitor for other NHS providers including Foundation Trusts. These regimes are not within the scope of this guidance.

The exact form of the business case will also vary according to the changes being considered, but good practice is that it should:
• be clear about the impact in terms of outcomes;
• be explicit about the number of people – patients and staff – affected and the resultant benefits for each group, having due regard for the need to advance equality of opportunity; • outline how patients, the public and other community stakeholders have been involved to date and how their views have informed and influenced the development of the options that will be consulted on;
• show that options are affordable and clinically viable by demonstrating an evaluation of options against a clear set of criteria which demonstrate both affordability and value for money (including projections on income and expenditure and capital costs/receipts for affected bodies) demonstrate that proposals are affordable in terms of any necessary enabling capital investment, its deliverability on site, and its transitional and recurrent revenue impact;
• show that any planned savings that may arise are realistic and achievable within the specified timetable;
• include an analysis of travelling times and distances, identifying the impact on pedestrians and public and private transport users, as well as the ambulance service where relevant;
• outline how the proposed service changes will promote equality and tackle health inequalities;
• demonstrate links to relevant JSNAs and JHWSs, and CCG and NHS England commissioning plans;
• explain how the proposed changes impact on local government services (where applicable) and the response of local government where appropriate;
• have identified and considered choice and competition issues (where applicable) which may impact on the different options; and
• demonstrate how the proposals meets the four tests.

Preparing for an assessment against the four tests – key questions

In preparing proposals for assessment against the four tests, commissioners and other bodies involved in the process may find it helpful to consider the following questions.
It may not be necessary to have definitive answers to all questions during the early planning stages, if it is expected will be clarified as proposals are developed further. The application of the four tests should provide a helpful mechanism for assuring the robustness of plans throughout the process.

1. Can I demonstrate these proposals will deliver real benefits to patients?
2. Do I have strong and clear evidence that the proposals improve outcomes, will deliver higher quality care and are clinically sustainable within available resources?
3. Can I quantify with statistically robust evidence the nature and scale of any shortcomings with the current configuration, and can I quantify the extent of the improvement and efficiencies that would be expected from reconfiguration?

4. Are there viable solutions other than reconfiguration? Could I achieve the same outcomes through revising pathways or rotas within the current configuration?
5. How will performance of current services be sustained throughout the lifecycle of the reconfiguration programme?
6. What alternative options are there in the market? Could the services be provided by the other NHS providers, the independent or third sectors, and through new and more innovative methods of delivery?
7. Do the proposals reflect national and international best clinical practice? Have I sought the advice of my local clinical networks and clinical senate?
8. What plans have I put in place to engage relevant health and wellbeing board(s), and to consult relevant local authorities in their health scrutiny capacity? Do proposals align with local joint strategic needs assessments and joint health and wellbeing strategies? Have I considered the impact on neighbouring or related services and organisations?
9. Is there a clear business case that demonstrates clinical viability, affordability and financial sustainability, and how options would be staffed? Have I fully considered the likely activity and capacity implications of the proposed reconfiguration, and can I demonstrate that assumptions relating to future capacity (and capital) requirements are reasonable? Does the modelling including sensitivity analysis (e.g. does it account for uncertainty in any of the variables)?
10. Have I undertaken a thorough risk analysis of the proposals, and have developed an appropriate to mitigate identified risks, which could cover clinical, engagement, operational, financial and legal risks?
11. Do the proposals demonstrate good alignment with the development of other health and care services, and I have considered whether the proposals support better integration of services?
12. Have I considered issues of patient access and transport, particularly if the location where services are provided may change? Is a potential increase in travel times for any groups of patients outweighed by the clinical benefits?
13. Have I considered the potential equalities impact of the proposals on different groups of users, including those with protected characteristics, and whether the proposals will help to reduce health inequalities?
14. Have I considered how the development of proposals complies with my organisations legal duties and how I have considered and mitigated material legal risks
15. Can I communicate the proposals to staff, patients and the public in a way that is compelling and persuasive? What communication and media handling plans are in place and/or have I identified where I will secure any external communications support?
16. Have I identified local champions who are trusted and respected by the community and can be strong advocates for the proposals?
17. Have I engaged any Members of Parliament who may be interested in the proposals?

In addressing the questions above, commissioners may find it helpful to discuss with providers and local authorities. CCGs may also wish to seek the advice of NHS England. Depending on the nature of the issue and the specific changes under consideration, commissioners may also want to refer to advice and guidance from other national bodies including Monitor, NHS Trust Development Authority, the Care Quality Commission, Health Education England, Public Health England, the National Institute for Health and Care Excellence, and the Royal Colleges.

It is also important that organisations have regard to the Public Sector Equality Duty, which came

into force in 2011. By understanding the effect of a proposed reconfiguration on different groups of people, and how the NHS can be inclusive in supporting and open up people's opportunities (including mitigating action to minimise any adverse impact), this will lead to services that are both more efficient and effective. The Equality Delivery System (EDS) provides a toolkit that can help NHS organisations improve the services they provide for their local communities and provide better working environments, while meeting the requirements of the Equality Act 2010. Further information on the EDS is contained in the resources section on page 43. Commissioners and their partners may also find it useful to apply the NHS Change Model in developing their proposal and more detailed programme plans. The Model builds on the evidence and best practice from across the health system and elsewhere, and from existing improvement models and theories, on how organisations can successfully deliver large scale change. Further information is available at: www.changemodel.nhs.uk

Robust patient and public engagement test

Under NHS Act 2006 (as amended by the Health and Social Care Act 20129), clinical commissioning groups and NHS England must make arrangements that secure the involvement of people who use, or may use, services in:

- planning the provision of services;
- the development and consideration of proposals for change in the way those services are provided – where the implementation of the proposals would have an impact on the manner in which the services are delivered or the range of services that are delivered;
- decisions to be made by the NHS organisation affecting the operation of services.

Providers of NHS-funded services continue have a separate but similar legal duty regarding the involvement of service users under Section 242 of the NHS Act 2006. Clinical commissioning groups are required in their constitutions to include a description of the arrangements they will make to involve people and a statement of principles the CCG will follow in implementing those arrangements.

It is important that involvement is an integral part of the service change process. The best proposals are characterised by early and on-going engagement through all stages of the process, where communities are involved as partners in actively developing proposals rather than as passive recipients. Effective engagement both helps to build public support for proposals but also ensures that proposals are genuinely shaped around patients' needs. Commissioners (where appropriate in partnership with providers and local authorities) should ensure they spend time and effort in explaining and building the case for change from the outset, and in a language that can be understood by service users. Further guidance on public participation is available in NHS England's guidance 'Transforming Participation in Health and Care'.

When planning to involve patients and the public, commissioners should think about proportionality and appropriateness, understand and use a spectrum of involvement activity. There are a number of different activities which range from giving information through to active participation in planning the provision of services. Activity should be proactive and reach out to local populations, are engaged in ways that are accessible and convenient for them, and takes account of the different information and communication needs, and preferences of audiences. As plans should be clinically-evidence based, engagement plans should consider how clinicians can be

involved in reaching out to communities.

Assessment of proposals against this test should be iterative, given that there should be on-going engagement during the planning and development of proposals. Commissioners should assure themselves that they have taken an appropriate and proportionate level of engagement for each stage of the process. The business case should include clear engagement plans setting out subsequent phases of engagement (whether or not there is a formal consultation phase), so that the patients, the public and wider stakeholders are clear how they will be able to feed into the process and decision-making.

Commissioners should also seek the input of local Healthwatch (LHW) organisations when developing plans, as LHW can perform a valuable role in ensuring plans are shaped around the needs and views of users. Direct engagement of patients, carers, communities and local voluntary and community groups – in addition to LHW – remains a key part of the process, but LHW organisations can play an important coordinating role.

Appendix 6 – Notes from Pre-consultation engagement mid-term review and planning meeting.

Engagement & Communications
Review & Planning meeting 23 April 2015

Attendees: Caron Morton, David Evans, Bharti Patel-Smith, Alison Smith, Adrian Osborne, Harpreet Jutlla, Stephen Williams, Mikayla Williams, Richard Caddy, Sian Sansum, Samantha Turner, Sharon Smith, Stephanie Belgeonne.

1.0 AIM

The aim of this meeting was to provide:

1. A brief review of the 2014/15 engagement and communications plan and activities
2. A summary of recommended key activities proposed to be undertaken in 2015/16
3. A recommended resources model to implement proposals

The conclusion will make recommendations of the next steps to progress the work. Note that a next step is to prepare an **overarching communications and engagement plan.**

2.0 INTRODUCTION

This paper is a brief summary of a review and planning meeting, this has been prepared to allow the Engagement and Communications Workstream to have sight of planning that took part prior to resource proposals being submitted for 2015/16 and accepted. This paper also provides insight into proposed activities planning for 2015/16 including consultation

ASSUMPTIONS:

- That the formal consultation will commence from December 2015 into early 2016.
- That the final strategy for non-pay budget will be published post collaboration with the Engagement and Communications workstream.

3.0 MID-TERM REVIEW OF ENGAGEMENT AND COMMUNICATIONS

On Thursday 23 April 2015 the SROs and senior leads for engagement and communications (e&c) met with the NHS Future Fit e&c delivery team for a **mid-term review on the pre-consultation phase of the programme**. They discussed:

Values:

- Reinstate the core objectives of pre-consultation e&c and sense check we are on track
- How we 're-set' for the next phase: considered approaches

Process:

- Assure the process is sufficient to meet Gunning Principles and legislation
- Understand the internal processes due to pace of programme, so flexible support can be assigned
- Collectively 'own' the process
- Review activities against the (current) programme timetable and review risks of delay
- Ensure different communities feel they are gaining (benefits outcomes realisation)
- Identify what requires budget and how to resource activities

Review messaging:

- Reiterate 'no decisions have been made' and demonstrate public participation and influence avenues
- Community fit – how does it fit?
- Messaging: not about an Emergency Centre or buildings – its about services and outcomes

Leadership:

- Be proactive not reactive – step change
- Supporting SRO's and Clinical Leadership

With this context in mind the group undertook a mid-term review of pre-consultation e&c activities.

4.0 REVIEW OF 2014/15 ENGAGEMENT AND COMMUNICATIONS

PROCESS	PHYSICAL EVIDENCE
ACCOMPLISHED - Clear visibility of senior decision makers - Focus on patients and a realisation that they recognise need for change - Ensuring political engagement - Building media relationship - Establishing local contacts - Call to Action- materials, outputs, decision points - Strong evidence from Gateway Review - Strong core delivery team – process and products - Good strategic overview with creation of Risk Register/ messages/ evidence sharing/Powys engagement and assurance processes - Good pop ups/deliberative events/telephone survey/ presentations to LJC's, HWBBs, Parish Councils, HOSCs and focus groups with Protected Characteristics and Councilor sessions - Good e&c plan developed in conjunction with members of the public **GAPS, IMPROVEMENT REQUIRED** - Significant investment from too few	**ACCOMPLISHED** - A range of public events and layered outreach - Public engagement fed directly into evaluation panel so influenced decision-making - Evidence Trail based on internal audit - Scientific based research to support public input into decision making - Maintained links with Shropshire stakeholders; Healthwatch, Council, VCSA and promoted opportunities for networking into their communications route, to a wider public - Established positive relationships with key stakeholders in Powys - Pause – we have evidence of listening - Good e&c strategy and operational plan – including evidence of co-authorship by patient reps - A range of appropriate collateral created eg Website, Leaflets, Press coverage and adverts - Log of activity: e.g. attending external meetings - Deliberative events – enabling open

people - Clarification on a process for decision making - Supporting board governance and development - Complex stakeholder and political landscape - Could do more work with protected characteristic groups and vulnerable groups that sit outside these categories - Publication of information could be better planned - Adequacy of patient and public leadership and co-design - Board development, review possible – public board meetings - Positivity – need to promote rather than defend - Broader risks have not covered surrounding areas: such as Worcester and Hereford	discussion with community - Community meetings and events – getting into the heart of the community - EIA – allowing deep dialogue with protected characteristics - Recognition that need to talk to vulnerable groups that are not in protected characteristics groups **GAPS, IMPROVEMENT REQUIRED** - Clarity of defining how engagement is informing debate and decision - Delayed programme timeline - Equalities process – currently enhancing - No clear message re UCC's - Limited workforce engagement - Not as proactive in PR as desired - Publication of key reports on website could be more orderly - Updated stakeholder mapping to establish engagement with new MP's and key stakeholders - Recording of individual feedback - Website enhanced to show both evidence and be more interactive - Lack of clarity on core decision-makers and presenters - Message management – more overt regarding SaTH recruitment issues - More patient stories – LTC / Frail /Nursing homes
LEADERSHIP **ACCOMPLISHED** - Visible leaders both clinical and managerial - Workstream success - Resilience of team and workstream - Good relationships with statutory bodies - Visible outreach and events - Due diligence followed **GAPS, IMPROVEMENT REQUIRED** - Giving people choices – could do more - Managing consistency in messaging	**OTHER** **GAPS, IMPROVEMENT REQUIRED** - Public position of Telford stakeholders could be a problem - More engagement needed with hard to reach particularly in deep Rural and Urban locations - Continue to enhance PR on no decisions made, how we adapt to public opinion or where opinion has formed part of decision making - Unions need to be approached as part of

- Early proactive media stories - Using the Chairs of all Boards - Clinical training on media messaging - Board governance is currently of individual boards not cohesive of Programme Board - Clear story and principles – plan hasn't been clarified	workforce engagement - Risks at A&E need to be more overtly discussed - Building champions - Ensure team resilience, work together to support all in core delivery team - Pressure from campaigning individuals/groups a method of engagement needs to be identified

Where there are gaps and improvement is required will form part of the plan for the remainder of the pre-consultation plan for 2015/16.

Delivery team summary of key campaigns since September 2014:

- **Announcement of Long List**

Deliberative events:

- Pro: Quality in-depth data, open dialogue and discussion with public
- Con: Lack of awareness, general communications

Telephone survey:

- Pro: Scientific research, providing quantitative data, stratified for locality
- Con: Closed questions provided challenge on interpretation

- **Announcement of Short List**

Press/Media Briefing:

- Pro: Coverage of shortlist, 1-1 interaction with key players

Pop Up Campaign:

- Pro: Brand awareness/Quality data /Community settings
- Con: Seasonal timing

5.0 A SUMMARY OF RECOMMENDED KEY ACTIVITIES TO BE UNDERTAKEN IN 2015/16

To align with best practise and legislation activities planned will benchmark against the Gunning Principles (Four Tests).

Compliance with Gunning

In 1985 a proposed a set of principles changed the way consultations are run. These principles, known as Gunning are now applicable to all public consultations that take place in the UK.

1. When proposals are still at a formative stage

Public bodies need to have an open mind during a consultation and not already made the decision, but have some ideas about the proposals.

2. Sufficient reasons for proposals to permit 'intelligent consideration'

People involved in the consultation need to have enough information to make an intelligent choice and input in the process. Equality Assessments should take place at the beginning of the consultation and published alongside the document.

3. Adequate time for consideration and response

Timing is crucial – is it an appropriate time and environment, was enough time given for people to make an informed decision and then provide that feedback, and is there enough time to analyse those results and make the final decision?

4. Must be conscientiously taken into account

Think about how to prove decision-makers have taken consultation responses into account.

A number of public bodies across the UK have been taken to Judicial Review and deemed to have acted unlawfully in their Public Sector Equality Duty – usually linked to the four Gunning Principles.

	Process	Physical Evidence/ to do
Pre-consultation engagement phase	– Clarify what we are consulting on – Clarify decision making – Evidence that engagement has driven option development – Mapping out key areas of delivery and outlining requirements in detail – Meeting Gateway review action plan – Continuing with community presentations – Targeting vulnerable groups outside IIA, equality assessment report – Clarify expectations of partners: HOSC/HW/CHC Powys – Synchronise the events – proactive rather than reactive – More community based	- More online snap polls and surveys to reach general public - Draw advocates and messengers from workforce (including MH and Community) / patients/formal partners - Increased media briefings (more regular and consistent to prevent misinformation) - Tell the story so it can be appreciated at locality level - Patient stories - UCC offer clarification - Output from engagement in options pack - Finish off parish

	activities – The local towns understand FF is not a deficit model – Expectation of stakeholders understood and met – Clear timeline with mid-term review of each stage	councils/town council meetings - Training of clinicians - workforce engagement - Make post-election a new beginning - High profile media campaign
The formal consultation phase	– Issues based papers highlighting SaTH recruitment challenge – Wider plan implemented – Social media and PR mobilised – Agreed decision making process is in place to support reactive work as part of a fluid programme – Evidence that we have responded to public concerns – Meaningful choices – Let's have a target of 25 presenters, 150 ambassadors and 10,000 supporters to help disseminate info – Evidence of closing the loop – show how public have influenced decisions – Polish the key messaging so its benefit not deficit model – what's beneficial for each community – Patient stories – pathways, to help demonstrate the benefits model – Regular review points for engagement prior to decision making – Supportive environment when decisions are made – Informed and confident leadership – Realistic expectations on what can be achieved	- Organising visits to nursing and residential homes (Frail & LTC) - A broad range of engagement methods carefully and thoughtfully synthesised - Wider mapping of impact assessments of the surrounding areas (Hereford, Worcester etc) - Bespoke solution – locality level story/be clear/link principle of asset base not isolated - A high (numbers), extensive (all parts of community) and in-depth (quantitative and qualitative) response to consultation document - Regular presence in the media – no chance of 'What's Future Fit? - Core bank of clinical staff (doctors/nurses/AHP) who can front engagement both internally and externally - Best practice website - Prospective/New Health users ie Housing/ Regeneration/ Businesses - Schools, further and Higher Education
	– Refreshed E&C plan – diverse and innovative engagement informed by key stakeholders –	– Political buy-in from Westminster – Significant support

Post-consultation engagement phase	HOSC – Equality featuring more explicitly – 'Closing the loop' how can we demonstrate that the output from engagement/consultation has informed final decision – Enough time for review and analysis of feedback – Independent analysis? – Decision making workstreams with wide participation from boards – Evidence that engagement influences implementation – Clear narrative and evidence of delivery	required for analysis, governance and transparency – Clear messaging on outcome
Pre-consultation engagement phase	**Leadership** - Existing and new politicians reengagement post-election - Leadership development and resilience support - Board development – increase confidence - Every time we're questioned or challenged we can demonstrate we have already addressed that challenge	**Other** - Having champions from all the protected characteristic groups - Protesting individuals or groups are engaged - We are more overt with the SaTH recruitment and A&E risks
The formal consultation phase	- Retained clinical buy-in - Team and programme resilience - Retained broad political support	- Consistent messaging delivered by one team – the clinicians and the E & C delivery team - Reach as many people as possible - Brand recognition of Future Fit - Clever, themed messaging - Responses to surveys/snap polls - Focus group experiences captured amongst the vulnerable
	- Workforce are our	- We are still standing!

Post-consultation engagement phase	advocates	- Successful model passed - Workforce fully engaged - Asset model developed - Each locality understands what they gain not just lose - Increase positive media coverage on Urgent Care/A&E themes - Offered a number of opportunities for the wider population to get involved

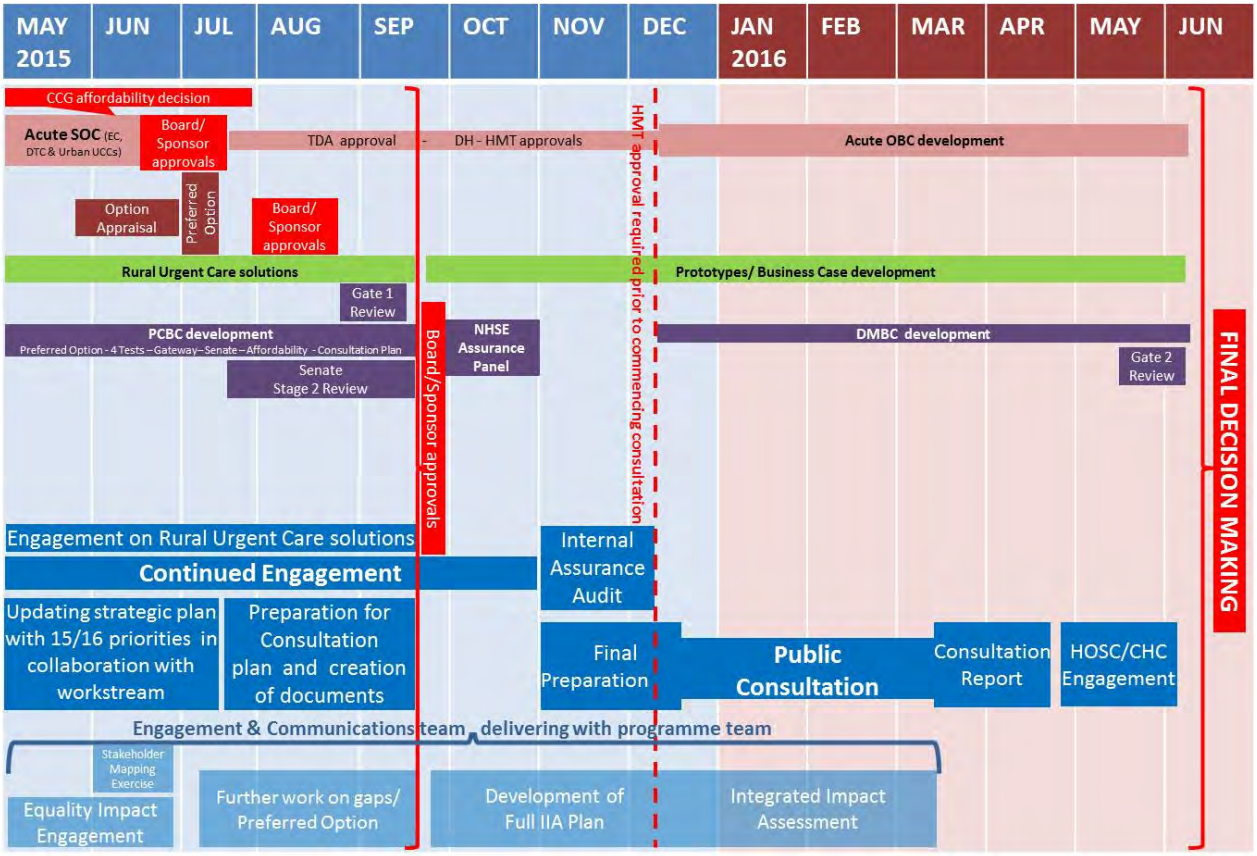
The formal consultation

The Constitution Institute recommends the following key themes for activities during the consultation. The exact methodology will be planned once the business case is submitted as the decision on what we are taking to consultation, and when, will influence the detail of the final plan.

To align with best practice, the formal consultation will include a number of activities from each of the three themes below; Quantitative, Qualitative and Participatory.

(Any planning done in advance of business case submission is subject to scrutiny as it shows pre-determination of consultation outcome. The final activities decided will be dependent on a multitude of factors including seasonal variance, resource and the number and the nature of the final options taken to consultation.)

The proposed project timeline



Information Governance

A key challenge is designing processes and procedures to disseminate information, decisions, and developments in line with a fast paced programme.

A structured solution shows the use of both client and CSU teams to govern information release.

6.0 RESOURCES

Widening the clinical cadre

Key to success is clinical leadership, presently this has been a small number involving a small and select group – this is unsustainable. During the formal consultation it will be vital to have a large cache of clinicians to call upon to engage with the public, we recommending using the pre-consultation period to identify, train, up skill and build confidence with a wider cache of clinical leaders. Including:

- Senior buy in is key. An agreement from provider/commissioner organisation to release key individuals for trainings and development. A minimum of five from each organisation is required for the formal consultation phase.

- PR & messaging workshops: A separate proposal is currently being drafted for consideration of:
    1. Media and messaging workshop for primary group of deliverers. This includes rigorous training techniques to build confidence and provide training for consultation ahead

    2. Managing the message workshop x 2: confidence building and mentoring session with a larger group of clinicians and key individuals (please note this will also allow the team to assess potentials for escalation to the primary group and opportunities to increase the cache).

- E&C team will work with current clinical leaders to handpick and train key prospective clinicians, this includes shadowing, mentoring opportunities with senior leads and the delivery team accompanying the clinicians to provide support and

training.

- E&C propose to procure an appropriate package from The Institute of Consultation, as part of the pack will include a number of training and information sessions on consultations (handy tips) which can be used for both clinical development and Board development.

- Hub costs (incorporate into the non-pay budget) include the use of PR associates for key PR strategy planning, handling of negative media and advice and guidance to core individuals.

Leading the formal consultation – ramping it up!

During the 12 week formal consultation there will be a greater need for not only clinical leadership but also for specialist expertise. It is vital during this time that existing engagement and communications leads and deliverers are able to provide local and specialist expertise and experience (please see 3.2).

More detail including roles and responsibilities will be clarified during the planning stage and a review of stakeholder map (including internal) has been booked as part of IIA commitments for 9 June 2015.

During the 12 week consultation phase it is likely that the embedded role will be required to do a **minimum of 3 days** per week on Future Fit. However, ahead of pulling together this proposal the lead e&C for the delivery team has sought feedback from the CCGs who have claimed that providing a robust plan is in place in advance of the formal consultation, resource and priorities can be managed effectively.

The below table shows an indicative rise in Future Fit commitment from existing non Future Fit resources, it also provides examples of e&c role played.

Commissioner / Provider Resources	**Pre-consultation phase commitment to FF**	**Formal Consultation* 12 week phase commitment to FF**
	Average estimate	
SROs Strategy engagement with political and statutory bodies and individuals as well as attendance and representation at activities and events. Mentoring new clinical leads to increase cache, Key decision making	1 day per week	2 days per week
Executive Directors (ie Alison Smith, Bharti Patel-Smith, Adrian Osborne, Andrew Ferguson to lead projects	0.5 day per fortnight	1 day per week

and provide support, expertise and experience)		
Clinical leads (increased in number for attendance and representation at activities and events)	2 days per month	*Dependent on numbers but certainly increased to weekly during this phase*
CCG & Provider Board / Chairs (attendance representation at activities and events)	0.25 day per month	0.5 days fortnight
Comms & Engagement leads (ie Mat James, David Burrows/John Kirk/Patient involvement team to assist with delivery of plan, provide local insight and contacts, alignment with organisation's strategy, seizing opportunities to assist with health economy discussions.)	0.5 day per week	1 day per week
Admin staff (PAs ie Claire Turner, Sarbjit Kaur, Lisa Rowley, Sandra Stackhouse – primarily used for admin/governance to assist in evidence collation of executives/SROs e&c activities)	0.25 day fortnight	0.25 per week
Workforce (ie champions and ambassadors as well as general consumption)	0.25 per month	0.5 per month

**This estimate is based on a full structure of support*

Optimum utilisation of client expertise

To best utilise CCG/Provider expertise and local insight, this paper proposes that during this crucial stage a number of Communications and Engagement Executives lead on key projects with the support of both core and local delivery teams.

As a result of the review and the need for embedded and integrated support during the consultation we are looking to explore more distributed leadership which requires further discussion and agreement with leads.

Non pay costs

2014/15 budget was £100,000 (original CSU proposal was £150,000). This financial year non pay budget is influenced by two key factors:

1. Acquisition of NHSE funds for 2014/15 budget, the vast majority has allowed assets and services to be procured which will be utilised in 2015/16 financial year
2. A proposed formal 12 week consultation, during the winter month

Non-pay costs will be closely monitored and opportunities to source low/no-cost venues will be pursued as well as opportunities for support from partners. Non pay budget will be used, as appropriate, for:

Coordination Centre 'Hub' support:

Access to resources that include:

- Media management (external and internal)
- Access to expert media consultants/specialists & training
- Social media strategy and implementation
- Marketing planning and media buying
- Procurement
- Graphics, web, design hub, licenses, hosting and print buying
- Patient and Public engagement support services
- Admin support including call handling in peak times
- Events management & implementation additional resources for consultation

This support will be tailored to the needs of the programme during each phase. It is averaged at three days per week and actual use will be logged and reported

To ensure that awareness about the programme and engagement in it is effective, well publicised and accessible there are a number of other costs that will be undertaken:

- **Venues** for events and focus groups
- Event **support/facilitation** to encourages participation
- **Hospitality**, where appropriate, to support attendance and comfort
- Displays, promotional items, advertising, print and production and distribution to raise **general awareness** about the programme amongst the public
- Design, print and production of **consultation documents** in a number of mediums (£10k has been sourced and set aside for the printing of this from 2014/15 budget)
- **Call handling** during the consultation is crucial to ensure a coordinated and integrated approach. Some is handled by the programme team and engagement team but systems are now in place to enhance call handling during peak periods of activity where teams are mainly off site.
- **Research advice** to test public perception and opinion at key stages during the programme
- **Service package with The Consultation Institute: Training for the programme** including legal requirements for public involvement, best practice and media training/refresher for key programme personnel and Board development and **assurance support** and **compliance assessment**
- **Website development and hosting** and efficient maintenance to ensure public can access up to date information in an appealing format
- **Video and photography** to support web development and provide quality visuals for marketing collateral
- **Accessible information and translation services**; there needs to be a budget to respond to requests for information in alternative formats such as braille, large

print, audio or translated into another language. *Note responsibility for compliance with the Welsh Language Scheme is assumed to be with the Powys Local Health Board*
Non pay to be itemised and recharged quarterly

It is essential to have a robust and detailed plan, owned and agreed by all. As per timeline (Item 2.3), the detail of the option development phase and the formal consultation will be planned with sponsoring organisations and partners as part of the next steps.
The CSU proposes that for non-pay 2015/16 a budget envelope of £150k is allocated. However with the intention that £50k of this envelope is only allocated post a review which will take place **two months prior to the commencement of formal consultation**.

The review will include assessing the status of:

- Remainder NHSE funds from previous year (procurement of assets for consultation in this year)
- Clarity on what is being consulted on and when
- Status and remainder of non-pay budget

CSU will make a commitment to

1. Endeavour to source appropriate funds as and when available
2. Demonstrate via quarterly reporting, economically efficient and SMART utilisation of budget.

7 CONCLUSION

Resource for Communications and Engagement completed in 31/03/15, the recommendation for next steps is:

1) **Re-secure the team**
2) Prepare a **Communications and Engagement Programme plan** to show how the resourcing model works and **refresh the governance arrangements** to take on board to “step change” required.
3) Agreeing a **budget review** ahead of formal consultation to assess status and progress in line with programme delivery
4) Agreeing the **wider resources** in detail ie non pay budget proposed above for 2015/16 with partners and programme board

NOTE 1: Consultation Institute recommended checklist for formal consultation

Agree the project timeline
Confirm what can and cannot be influenced
- Options?

Undertake a 'scoping' exercise (document)
Agree consultation processes
Do a risks analysis
Agree a risks strategy
- Tackle process issues
- Tackle the challenges

Undertake stakeholder mapping
Agree the right questions
Develop a comms plan
Run 'equalities analysis'
Develop the consultation engagement plan
- Quantitive
- Qualititive
- Participatory
- Online > Social Media
- Agree appropriate venues

Agree post consultation processes
Complete a project plan
Develop online resources
Develop the consultation documents
- The story so far
- Explain why change is necessary and provide clear evidence
- Explain any external drivers for change
- This is what you have told us
- What has been considered at the different stages (scenarios > options) [avoid accusations of fait accompli]
- Provide a clear vision of the future services
- Explain the consequences of change VS maintaining the status quo on quality, safety, accessibility, and proximity of services
- In the case of hospitals, demonstrate how services will in future be provided within an integrated service model
- Set out clearly evidence for any proposal to concentrate on a single site
- Include the evidence of support from clinicians/GPs for any proposed change
- Set out how sustainable staffing levels are to be achieved
- In the case of changes prompted by clinical governance issues show how these have been tested (through independent revue)
- Explain any risks and how they will be managed
- Give a clear picture of the financial implications of the different proposals
- Spell out who will be affected by the proposals and how their interests will be protected
- Explain how any change and benefit will be evaluated after implementation
- Be available in appropriate formats – easy read, Braille, BSL, audio, etc
- Get it signed off by the board
- Invitation to propose alternative solutions

Populate the website
- Put all relevant information in the public domain

Publish the opening equalities analysis
Launch the consultation
Engage
Hold a mid-Consultation review
Update equalities analysis
Make changes to the plan
Hold a closing date review
Analyse the feedback (independently?)
- Put into useful formats that support decision making
- Make all info available to decision makers

Confirm how the consultation will be analysed
Confirm how decision makers will be influenced
Update media, web and stakeholders of processes
Update equalities analysis and publish
Conduct decision making meetings
Publish the outcomes/decisions
Tackle process issues
Tackle any challenges
Develop/complete an implementation plan
Agree on-going engagement plan
Timescales

Appendix 7 – Integrated Impact Assessment & Equality pilot learnings

1. Background

In December 2014 the IIA steering group presented a baseline report to the programme board. The board requested a range of next steps including that during its next phase of work the IIA steering group ensured enhanced representation from specific geographies and ensured groups with protected characteristics were engaged in the equalities impact work.

In response to this the IIA steering group with support from the Engagement and communications team:

(i) engaged the services of a consultancy (Participate Ltd) with expertise in equality impact assessment and proven methodologies for engaging with groups with protected characteristics

(ii) strengthened its membership with representation from groups who worked with people with protected characteristics

(iii) designed a pilot equality engagement process to test approaches.

The pilot process was designed to facilitate initial contact with groups with protected characteristics, such that they would be better engaged during the planned Equality Impact Assessment, which will run in parallel to formal consultation. In recognition that there would be learning that would inform the future EQIA, the work culminated in a lessons learned workshop.

2. Introduction

The section below highlights the key lessons learned from the equality engagement process with groups with protected characteristics. A range of materials were designed to assist with the engagement activity which sought to obtain feedback regarding the current experience of acute and community hospital services amongst individuals and groups of people with protected characteristics. The approach was designed to work with 'gatekeeper' organisations who would facilitate access to groups with protected characteristics and who would themselves carry out some of the engagement activity. This would be supplemented by engagement to be carried out by our internal communications and engagement team. Due to capacity constraints and challenges with engaging people with protected characteristics in Powys, we commissioned Participate to conduct the equalities engagement work in Powys. The pilot equality engagement process was conducted during purdah and hence contact was restricted to specific groups.

A summary of the lessons learned during the equality engagement pilot process are reported below at note one, details the findings from the engagement activities.

3. Results

The intention of the equality engagement process was to obtain in depth feedback and

assess current and possible future links with groups with protected characteristics. Although a relatively small number of individuals participated, the depth of feedback was immense, as demonstrated in the accompanying report. Furthermore, experience in Powys has demonstrated that tenacity will deliver and as a result we have a significantly expanded stakeholder list of people and groups with protected characteristics.

4. Next steps

The equality impact assessment will run in parallel to the Consultation process. The equality impact assessment will form just part of the overall Integrated Impact Assessment, which will report after the Consultation has closed and help to inform the final decision. The lessons learned during this phase will be shared widely and relevant action points will be taken by the Engagement and Communications workstream. It is proposed that the IIA workstream forms and equality impact assessment sub-group to ensure that appropriate focus is maintained on this important aspect of engagement and feedback.

Note: Lessons learned through piloting the equality impact assessment work

Need to tailor our approach to different groups

- Coproduction of materials with groups with protected characteristics will ensure that materials are accessible and useable.
- Younger people who took part suggested that they might benefit from stories and scenarios to better understand the implications for them. Younger people were also keen to undertake EQIA work with their peers.

Use a variety of flexible engagement mechanisms

- Ensure facilitators have appropriate expertise to engage with the groups they are working with
- Consider training a cohort of volunteer 'experts' to conduct some of the work.
- Direct action – going through third parties to get contacts and then approaching those contracts directly was seen to be more successful than waiting for a third party to make introduction and linkages.
- It was felt that the digital questionnaire was not appropriate for face to face engagement as it was too rigid, therefore use the focus group 1-2-1 interview tools to enable a more informal style of structured conversation.
- Permanent displays regarding Future Fit in hospitals and other units may enhance understanding and awareness.

Wider general engagement and 'warming up'

- Illustrated that many of the people who were approached to participate in the equality impact assessment pilot had not previously heard of Future Fit. This will fall under the remit of the Engagement and Communications workstream and be of benefit to the planned equality impact assessment.

- Potential for a greater role to be played by Future Fit 'Champions'.
- A lack of understanding of Future Fit and the need for accessible messaging would help with engagement of some groups with protected characteristics.
- Our pilot survey enabled people to register their interest in being kept informed of progress – these will be added to the FF newsletter distribution list.
- Also where people have left their contact details, we will respond to them directly to thank them for their views. Groups who participated will be offered the opportunity to request a presentation from the Communications and Engagement team to further their understanding of Future Fit.
- For some groups, there was widespread cynicism regarding the process of engaging with groups with protected characteristics who felt this was a box ticking exercise and no confidence that their views would make an impact

Regular checkpoints

- Where multiple groups / people are involved in conducting EQIA process need for regular checkpoints and sharing of what works.
- Create some milestones and KPIs so that we can constantly assess progress.
- Assess progress and implement any mitigation action if e.g. it appears likely some groups of people with protected characteristics are not being reached.
- Checkpoints will also offer regular opportunities to share materials, e.g. in Powys an email briefing note resulted in strong engagement response.
- Logging contacts and feedback was seen to be helpful in keeping track of approaches made, even if this didn't initially result in full engagement with the process.

Tools, materials and methodology

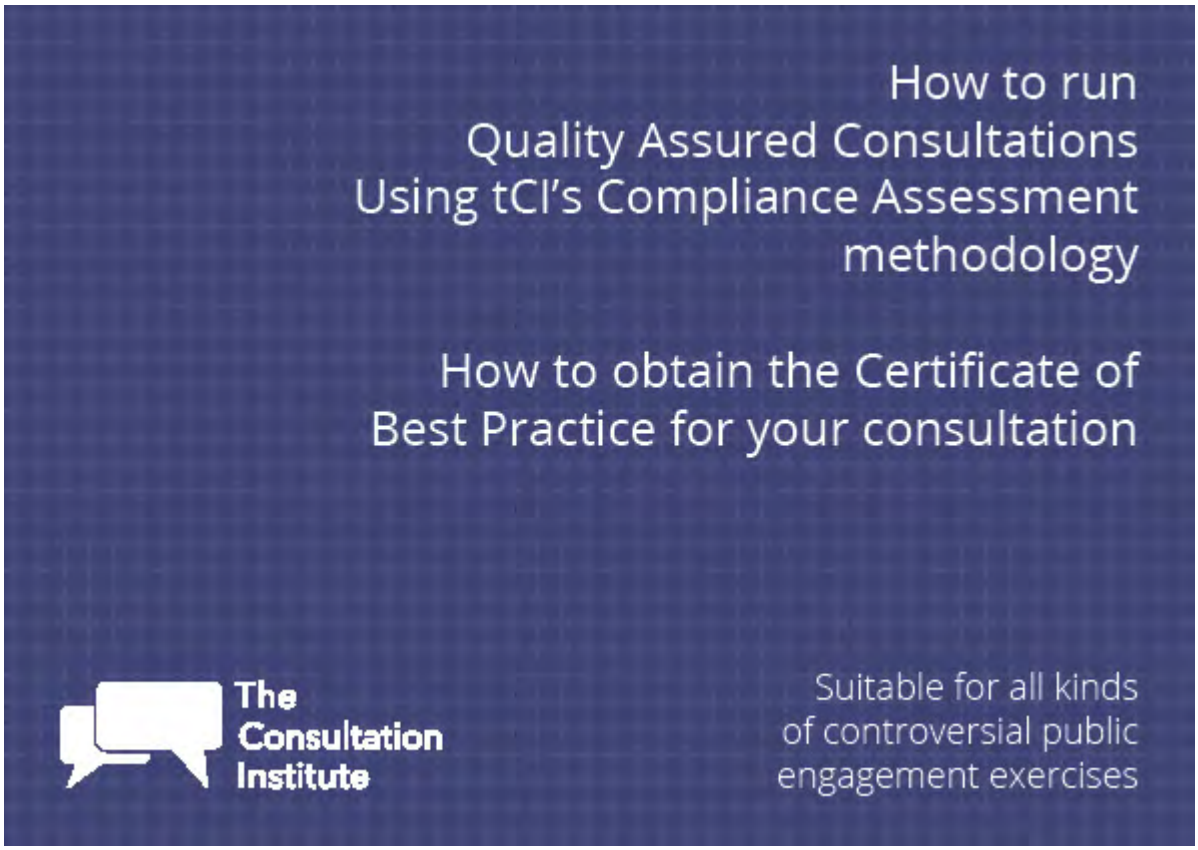
- Will continue to use a mixed methods (qualitative and quantitative) approach, the latter will be more robust when we reach a larger number of people.
- Ensure mechanisms for capturing feedback are appropriate and user friendly.
- Have identified some helpful individuals with disabilities who are helping us to work through accessibility issues (e.g. deaf and partially sighted).
- Some concerns that categorization of protected characteristics was too broad and as we reach greater numbers of people there may be a requirement to enhance the differentiation between groups with protected characteristics and reflect this in both data capture and reporting.
- Where questions will require specific external data in order to be able to analyse the questions, need to check with experts when phrasing the question to ensure that analysis will be possible.

Incentives and payment

Hospitality was broadly seen as a good way to get individuals to engage with the process. We have not yet seen the need to pay people for their views but this will be kept under review through checkpoints during the formal EQIA. There may be occasions where small numbers and seldom heard groups need to be encouraged to take part

Appendix 8 – Consultation Institute Compliance Assessment

For more information see
http://www.consultationinstitute.org/#/compliance-assessment/4562374189



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