Future Fit/Community Fit Reference Group

Meeting Agenda

Tuesday 19th April 2016 | 6pm – 9pm | Wroxeter Hotel, Shrewsbury, SY5 6PH

Time	Item	Lead
1800	**Arrival & Welcomes** *(Attendee list attached – Enclosure 1)*	**Mike Innes**
1815	**Introduction & Purpose of the meeting** • Future Fit History; Where have we come from and how we got here • Business Case Process • Design Principles	**Dave Evans** *Slides attached (Enclosure 2)*
1830	**Revised Strategic Outline Case** (Delivering a Balanced Site Model) 14 – 'At the end of the day we do not think a hot warm model is sustainable over a longer period of time, its important that obstetrics and ITU and EC is on one site. We had a long discussion on where it should be. There were some varied views on where it should be' 13 – 'We explored the hot/warm concept, the main topic was how do you ensure that services on offer in 10 year's time are still able to respond to the changing ways we will be delivering them. We feel there is more flexibility on the warm site to change things. IT question – need solutions that would work to support the system 12 – 'Feeling that from a public, patient and GP perspective that having two balanced sites was a good thing and would be well received. Negative media needs to be repaired, make people aware of the new options' 11 – 'Needs to be a decision made sooner rather than later, money wasted' 10 – 'Concerned about modelling assumptions on SOC. Problem with assumptions not being revisited means that activity could lead to smaller hospitals created than would be necessary. Needs to be redone' 9 – 'What was not mentioned, didn't talk about overall vision of moving work out into the community what resources needed to make this happen, with community fit, it seems to have been forgotten' 8 – 'Content with two hospital sites but general feeling has to be	**Andrew Tapp** *Slides attached (Enclosure 3)*

Time	Item	Lead
	a health system solution with primary and community need to be developed in parallel and not behind. Better comms between the different strands as well as the public.' 7 – 'Centred around balance across hot and warm site. Warm site must allow safe acute care. How do we make sure its both financially sustainable and for the workforce' 6 – ' Give us more detail about UCC's then it would be easier to know what's happening' 5 – 'Public don't know how to use the health service, public need to be better unformed. Primary care to cope with shift, critical care and paeds all on one site. Essential that Voluntary sector involved with preventative model. Its about designing the best compromise' 4 – 'Accepting of the SOC, transport is biggest issues and access. Urgent care, need to design it appropriately so patients know what to expect. Ensure we use the entire bed base within the economy, look at areas like Oswestry and other community beds base' 3 – 'All agree its really important we had clarity on the model, we need to carry the public with us, need to be clear what the model is and that it is the right model' 2 – 'What isn't in the SOC, community fit needs to catch up very quickly, interface between these two will make it sink or swim.' 1 – 'Process, people feel out of sorts as recent events are surprising. We need to accept the SOC, visibly do the work together, make a decision and stick to it'	
	REFRESHMENT BREAK	
1945	**Community Fit** • Rural Urgent Care Update • Results of Phase 1: Community Fit Modeling Output and Taxonomies • Proposal for Community Fit Phase 2: Themes going forward Key actions: 1 – 'same things as other three, acute, planned, long term conditions but to add prevention and access' 2 – 'LTC, Ambulatory and emergency care and end of life, cross cutting team work and prevention, resources, IT community pharmacies 3 – Prevention and well-being, end of life care, social care, personal care, urgent care centres rather than buildings, who would staff them, 111 shropdoc interface, how will it work in the	**Mike Innes/Steven Wyatt** *Slides to follow*

Time	Item	Lead
	community, need to be simple 4 – Prevention, work with schools, community based clinics, look at deprivation clinics as well as point of care testing. IT, a wealth of data but social care have different number system, how will it integrate, IT, data sharing, appalling broadband and long term conditions 5 – Capacity, primary care and transfer of work, prevention, joining with it enablement, affordability, pump prime funding needs to be there before this could happen 6 – Centralising specialized services into the community, identifying pharmacies in rural communities, merging health and social care systems, IT underpinning everything 7 – Delivery of prevention programmes, consider how services are coordinated in the community, one size does not fit all, access to local diagnostics is key to success of RUC 8 – IT very important, complete e record and way that access to records is linked up, how to design this sort of work, need to design outer community first then direct into central part. Bottom up type approach. How do we integrate all different parts of health and social care system, how do we get people to work together better? 9 – Workforce, how we retain staff better, rotate around organization, provide opportunities in other areas, IT, connecting services and people 10 – RUC - can it be designed and delivered, need to include community children services. 11 – Funding and managing transition, workforce in place before do change, more preventative services, ring-fencing public health services, targeted responses, working solutions, self-management, patients to help manage themselves, face time appointments, make a real impact, more nurses and AHP's managed by GP practices. Data should include 18 years too 12 – Need a care record that follows patients, workforce challenges facing communities, nurses and AHPs associated with practices adds value to patients, concentrate middle layer of pyramid how do we prevent them developing more and moving up the pyramid 13 – Home is best, how do we make that a reality, putting people at the heart of that, go back to the beginning, we are starting at the end. Big challenge for all of us, how do we best use the resources we have. Stop silo working, think of whole person and whole system and how best to respond to that. We all have a	

Time	Item	Lead
	contribution to make, one change would make a real difference. Community is the biggest answer not waiting til 2020 14 –Include data from Wales, using voluntary sector more often, they are bringing money into the economy and are cheaper and provide wonderful services such as walking for health, we don't use them enough. More awareness of what vol sector can offer. More comms about what is going on, work going on in pockets we don't know about. Oblivious to other work going on. Treating patients near to home is very important. Hospital at home or virtual ward, giving patients IV antibiotics in the community should be achievable, transport is a major problem. Workers should put pressure on services to be made available to those that need them better handover from primary care to secondary care.	
2045	**Next Steps** • Summarising next steps Key actions: Progress has been made with the SOC, we have all agreed there is a need for change. This work done today will go to the board to progress the SOC at the CCG boards. Community Fit will decide work streams going forward to build it. CRG early summer to review this work.	**Mike Innes**
2100	**Close**	

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Enclosure 1

Future Fit/Community Fit Reference Group

Attendee List

Tuesday 19th April 2016 | 6pm – 9pm | Wroxeter Hotel, Shrewsbury, SY5 6PH

Attendee	Organisation
Adam Huxley	Shrewsbury & Telford Hospitals NHS Trust
Adelle Wilkinson	Healthwatch Shropshire
Adrian Marsh	Shrewsbury & Telford Hospitals NHS Trust
Adrian Vreede	Shrewsbury & Telford Hospitals NHS Trust
Aidan Egleston	Telford & Wrekin Clinical Commissioning Group
Alan Olver	Maninplace
Alan Otter	Shropshire Clinical Commissioning Group
Alex Chamberlain	Shropshire Clinical Commissioning Group
Alison Grey	Telford & Wrekin Clinical Commissioning Group
Alison Jones	Shrewsbury & Telford Hospitals NHS Trust
Alison Parkinson	Shropshire Community Health NHS Trust
Amanda Walshaw	Shrewsbury & Telford Hospitals NHS Trust
Andrew James	Shrewsbury & Telford Hospitals NHS Trust

Attendee	Organisation
Andrew Roberts	Robert Jones & Agnes Hunt Orthopaedic Hospital
Andrew Tapp	Shrewsbury & Telford Hospitals NHS Trust
Andrew Thomas	Shropshire Community Health NHS Trust
Andy Begley	Shropshire Council
Andy Matthews	Shropshire Community Health NHS Trust
Anne Wignall	Patient Representative
Anthea Gregory-Page	Shrewsbury & Telford Hospitals NHS Trust
Arnold England	Telford & Wrekin Council
Bernie Bentick	Shrewsbury & Telford Hospitals NHS Trust
Bruce McElroy	Shrewsbury & Telford Hospitals NHS Trust
Carol McInnes	Shropshire Clinical Commissioning Group
Carole Hall	Healthwatch Shropshire
Chris Morris	Telford & Wrekin Clinical Commissioning Group
Clive Wright	Shropshire Council
Conrad Newbold	Health Education West Midlands
Damien Thompson	Telford & Wrekin Clinical Commissioning Group

Attendee	Organisation
Dave Evans	Telford & Wrekin Clinical Commissioning Group
David Bell	Healthwatch Telford & Wrekin
David Northern	Telford & Wrekin Clinical Commissioning Group
David Sandbach	Patient Representative
Debbie Jones	Shrewsbury & Telford Hospitals NHS Trust
Debbie Vogler	Shropshire Clinical Commissioning Group
Dianne Lloyd	Shrewsbury & Telford Hospitals NHS Trust
Edwin Borman	Shrewsbury & Telford Hospitals NHS Trust
Elin Roddy	Shrewsbury & Telford Hospitals NHS Trust
Ellen Nolen	Telford & Wrekin Clinical Commissioning Group
Emily Peer	Shropshire Community Health NHS Trust
Emma Pyrah	Shropshire Community Health NHS Trust
Emma Sandbach	Shropshire Clinical Commissioning Group
Emmanuel Le Goff	ShropDoc
Fran Beck	Telford & Wrekin Clinical Commissioning Group
George Candler	Shropshire Council

Attendee	Organisation
George Rook	Healthwatch Shropshire
Graham Shepherd	Patient Representative
Gwyneth Passant	Shrewsbury & Telford Hospitals NHS Trust
Harpreet Jutlla	Midlands & Lancashire CSU
Hazel Davies	Shrewsbury & Telford Hospitals NHS Trust
Heather Pitchford	Health Education West Midlands
Helen Herrity	Shropshire Clinical Commissioning Group
Ian Rummens	Shropshire Clinical Commissioning Group
Jacqui Seaton	Telford & Wrekin Clinical Commissioning Group
Janet Gittins	Shropshire Clinical Commissioning Group
Janet O'Loughlin	Patient Representative
Jenny English	SPiC
Jill Price	Shrewsbury & Telford Hospitals NHS Trust
Jo France	Shropshire Community Health NHS Trust
Jo Leahy	Telford & Wrekin Clinical Commissioning Group
Joanne Harding	ShropDoc

Attendee	Organisation
Joy Jones	Councillor - Powys
Julian Povey	Shropshire Clinical Commissioning Group
Julie Davies	Shropshire Clinical Commissioning Group
Julie Mellor	Taking Part, Charity Manager
Karen Calder	Shropshire Council
Karen Taylor	Shropshire Community Health NHS Trust
Kate Ballinger	Healthwatch Telford & Wrekin
Kate Garner	Shropshire Council
Kate Shaw	Shrewsbury & Telford Hospitals NHS Trust
Kath Goodchild	Voluntary Sector
Katy Driver	Midlands & Lancashire CSU
Katy Lewis	Shropshire Clinical Commissioning Group
Kevin Eardley	Shrewsbury & Telford Hospitals NHS Trust
Kevin Morris	Shropshire Clinical Commissioning Group
Kumaran Subramanian	Shrewsbury & Telford Hospitals NHS Trust

Attendee	Organisation
Leah Farrell	Shrewsbury & Telford Hospitals NHS Trust
Lee Chapman	Shropshire Council
Lesley Crawford	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Liz Noakes	Telford & Wrekin Council
Lorna Crofts	Midlands & Lancashire CSU
Lorraine Eades	Shrewsbury & Telford Hospitals NHS Trust
Louise Jones	Shrewsbury & Telford Hospitals NHS Trust
Louise Sykes	Shrewsbury & Telford Hospitals NHS Trust
Louise Warburton	Telford & Wrekin Clinical Commissioning Group
Madge Shinton	Shropshire Council
Mandy Thorn	SpiC/Healthwatch
Mark Cheetham	Shrewsbury & Telford Hospitals NHS Trust
Mark Garton	Robert Jones & Agnes Hunt Orthopaedic Hospital
Martin Whittle	STP
Martyn Rees	Shrewsbury & Telford Hospitals NHS Trust
Martyn Underwood	Shrewsbury & Telford Hospitals NHS Trust

Attendee	Organisation
Mel Abbey	Telford & Wrekin Clinical Commissioning Group
Mel Duffy	Shropshire Community Health NHS Trust
Michelle Brocklesby	Shropshire Clinical Commissioning Group
Mike Innes	Telford & Wrekin Clinical Commissioning Group
Mike Woodall	Midlands & Lancashire CSU
Narindar Kular	Shropshire Community Health NHS Trust
Natalie Dulson	Shrewsbury & Telford Hospitals NHS Trust
Nathan Harry	Healthwatch Telford & Wrekin
Neil Carr	South Staffordshire & Shropshire Healthcare NHS Foundation Trust
Neil Harper	Telford & Wrekin Clinical Commissioning Group
Nicky Jacques	SPiC
Pam Lyons	Powys Local Healthboard
Paul Kelly	Shropshire Council
Penny Bason	Shropshire Council
Peter Clowes	Shropshire Clinical Commissioning Group
Peter Gillard	Patient Representative

Attendee	Organisation
Richard Chanter	Shropshire Patients Group
Richard Parkes	Shropshire Young Association
Rita O'Brien	Shropshire Community Health NHS Trust
Roger Evans	Shropshire Council
Russell Muirhead	ShropDoc
Sally-Anne Osborne	Shropshire Community Health NHS Trust
Samantha Tilley	Shropshire Clinical Commissioning Group
Sanjeev Deshapande	Shrewsbury & Telford Hospitals NHS Trust
Sara Biffen	Shrewsbury & Telford Hospitals NHS Trust
Simon Edmonds	Shropshire Clinical Commissioning Group
Simon Hodson	Shropshire LMC
Simon Wright	Shrewsbury & Telford Hospitals NHS Trust
Steve Gregory	Shropshire Community Health NHS Trust
Steve James	Shropshire Clinical Commissioning Group
Steven Wyatt	Midlands & Lancashire CSU
Stuart Wright	Shropshire Clinical Commissioning Group

Attendee	Organisation
Tina Kirby	Shrewsbury & Telford Hospitals NHS Trust
Tom Jones	Shrewsbury & Telford Hospitals NHS Trust
Tony Fox	Shrewsbury & Telford Hospitals NHS Trust
Vanessa Barrett	Healthwatch Shropshire
Vanessa Roberts	Shrewsbury & Telford Hospitals NHS Trust
Victoria Maher	Shrewsbury & Telford Hospitals NHS Trust
Wendy Tyler	Shrewsbury & Telford Hospitals NHS Trust
Total	131

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Enclosure 2

NHS

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Clinical Reference Group
April 2016

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NHS

Welcome

Dr Mike Innes,
GP Telford & Wrekin Clinical Commissioning Group

Dr Julian Povey,
Clinical Chair, Shropshire Clinical Commissioning Group

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Timetable

NHS

18:00	Arrival & Welcome • Light buffet available from 1745	Mike Innes
18:15	Introduction & Purpose of the meeting • Future Fit History; Where have we come from and how we got here • Business Case Process • Design Principles	Dave Evans
	Revised Strategic Outline Case (Delivering a Balanced Site Model)	Kevin Eardley / Kate Shaw
	REFRESHMENT BREAK	
19:45	Community Fit • Rural Urgent Care Update • Results of Phase 1: Community Fit Modelling • Proposal for Community Fit Phase 2: Themes going forward	Mike Innes Steven Wyatt
20:45	Next Steps • Summarising next steps	Mike Innes
21:00	Close	

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By the end of the meeting you will have:

- Seen the SOC of Future Fit in a broader context together with Community Fit
- Had a chance to reflect and comment on the SOC
- Seen some of the data analysis from Community Fit
- Had a chance to steer the next steps of Community Fit
- Had a chance to connect with Colleagues across the whole health and social care economy
- The opportunity to get involved in the ongoing design of both Future Fit and Community Fit

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Programme Outputs

- Comments on the SOC that can inform further progress
- A steer on themes for the clinical design of Community Fit
- Volunteers to get involved in Community Fit design

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Programme Purpose

- 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.

- Focus is on configuration of acute services between Shrewsbury and Telford, and developing a model of rural urgent care.

- The success of Future Fit will depend on whole system transformational change.

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The story so far

Date	Deliverable
Nov 2013	• *Call to Action* process identified public and clinical support for significant change
Jan 2014	• Full Case for Change developed and programme initiated
May 2014	• NHSE Stage 1 Strategic Sense Check
Jun 2014	• Clinical Model developed with c.300 clinicians and patients • Long list of 13 options developed by stakeholder group
Aug 2014	• Conversion of Model into activity and capacity projections

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The story so far continued

Date	Deliverable
Jan 2015	• WM Clinical Senate confirms…*there is an unsustainable health model ……which warrants a need for fundamental change and improvement*
Feb 2015	• Short list of 6 delivery options plus 2 obstetric variants agreed
Aug 2015	• Option development completed • Proposed reduction of shortlist to 3 options/1 obstetric variant
Sep 2015	• Option appraisal completed
Oct 2015	• Separate work on developing a deficit reduction plan started • Options being revised to prioritise pressing clinical issues
Nov 2015	• New Programme Timeline agreed
Dec 2015	• New Programme Director appointed – Debbie Vogler
Mar 2016	• Revised SOC and deficit reduction plan completed.

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The Focus since we last met

- **For Future Fit**
  - Revised Strategic Outline Case (SOC)
  - Rural Urgent Care solutions
- **For Community Fit**
  - A descriptive analysis of community activity currently taking place for primary, community services, mental health and social care
  - A description of the future shift in activity that has been modelled from the acute setting
- **Sustainability and Transformation Plan STP**
  - Ongoing development of our system wide plan for health and social care

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The Clinical Model – System wide Principles

- Targeted prevention and Wellbeing – biggest single success factors
- Home is normal – less bed based focus
- Needs led-matching correct level of care
- Empowered patients, clinicians and communities
- Sustainability: clinical, workforce, service and financial
- Integrated Care - smooth transitions
- Partnership Care – shared decision making redefine specialist and generalist roles
- IT enabled
- The success of Future Fit will depend on whole system transformational change.(CRG November 2013)
- Focus is on configuration of acute services between Shrewsbury and Telford, and developing a model of rural urgent care.

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A Strategic Outline Case is High Level

- Provides a summary of the key strategic drivers and service requirements that support the case for investment.

- Demonstrates there are deliverable options and extent to which the schemes deliver on high priority requirements, e.g. clinical and financial sustainability improving patient safety and the patient environment, reducing backlog maintenance; enabling QIPP delivery, etc.

- Is clinically led and outlines the way in which the scheme supports delivery of local commissioning priorities.

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The Acute solution has a significant lead time

- Revise SOC approved by SaTH Trust Board March 2016
- OBC work Begins April 2016
- Department Health/Treasury support October 2016
- Full Public Consultation Dec 2016-March 2017
- Planning Application March-June 2017
- OBC approval June-December 2017
- Procurement process Sept-March 2017
- FBC approval August 2018
- Physical solutions 2-5 years from FBC approval

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Principles Going Forward

- Doing nothing is not an option
- Strong and resilient leadership
- Working together – co-design
- Best interests of patients – benefits are clear
- Balancing access and outcomes in our decisions
- Where there is a shift in activity there is a shift in resources
- Transformation/transition funding requirements

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Enclosure 3

Sustainable Services Programme
Strategic Outline Case
Clinical Reference Group
19 April 2016

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We Value Respect
Together We Achieve

Aims of this presentation

To share:

1. The clinical model and the agreed assumptions
2. Our proposal and how this improves services for our patients
3. The potential solutions described within the Strategic Outline Case
4. The work to do
5. Proposed timescales

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1. The agreed clinical model and assumptions

- One single fully staffed and equipped Emergency Centre
- 'Some' Urgent Care Centres
  - Urban Urgent Care on both acute sites
  - Rural Urgent Care throughout the county
- One Diagnostic & Treatment Centre
- Local Planned Care on both sites

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The agreed activity assumptions

- In remaining aligned to the Future Fit Programme, we have used the same principles to determine future activity
- However, we have amended the baseline from a 2012/13 out-turn to 2014/15 out-turn
- Future Fit activity modelling had two phases:
  - Phase 1: Estimated the impact of demographic change, traditional commissioner activity avoidance and provider efficiency strategies on acute and community hospital activity
  - Phase 2: Built on the initial models and estimated the consequence of more radical redesign proposals generated by three clinical redesign work streams:
    - acute and episodic care
    - planned care and
    - long term conditions and frailty

2. Our proposal and how this improves services for our patients

A single Emergency Centre:

- Better clinical outcomes with reduced morbidity and mortality
- Bringing specialists together treating a higher volume of critical cases to maintain and grow skills
- Ensure greater degree of consultant delivered decision making and care
- Improved clinical adjacencies through focused redesign
- Improved access to multi-disciplinary teams
- Delivery of care in environment for specialist care
- Improved recruitment and retention of specialists

Within our balanced site proposal, patients would:

- Be cared for in their nearest hospital as much as possible for their acute service needs – Urgent Care, Ambulatory Emergency Care, Outpatients, Diagnostics and some inpatient specialties
- Benefit from planned Care with defined separation form emergency care pathways
- Benefit from an ambition of improved pathways between primary and secondary care providers

The potential solution and the clinical model

- One single fully staffed and equipped Emergency Centre ✓

- 'Some' Urgent Care Centres
  - Urban Urgent Care on both acute sites ✓
  - Rural Urgent Care throughout the county –

- One Diagnostic & Treatment Centre ✓

- Local Planned Care on both sites ✓

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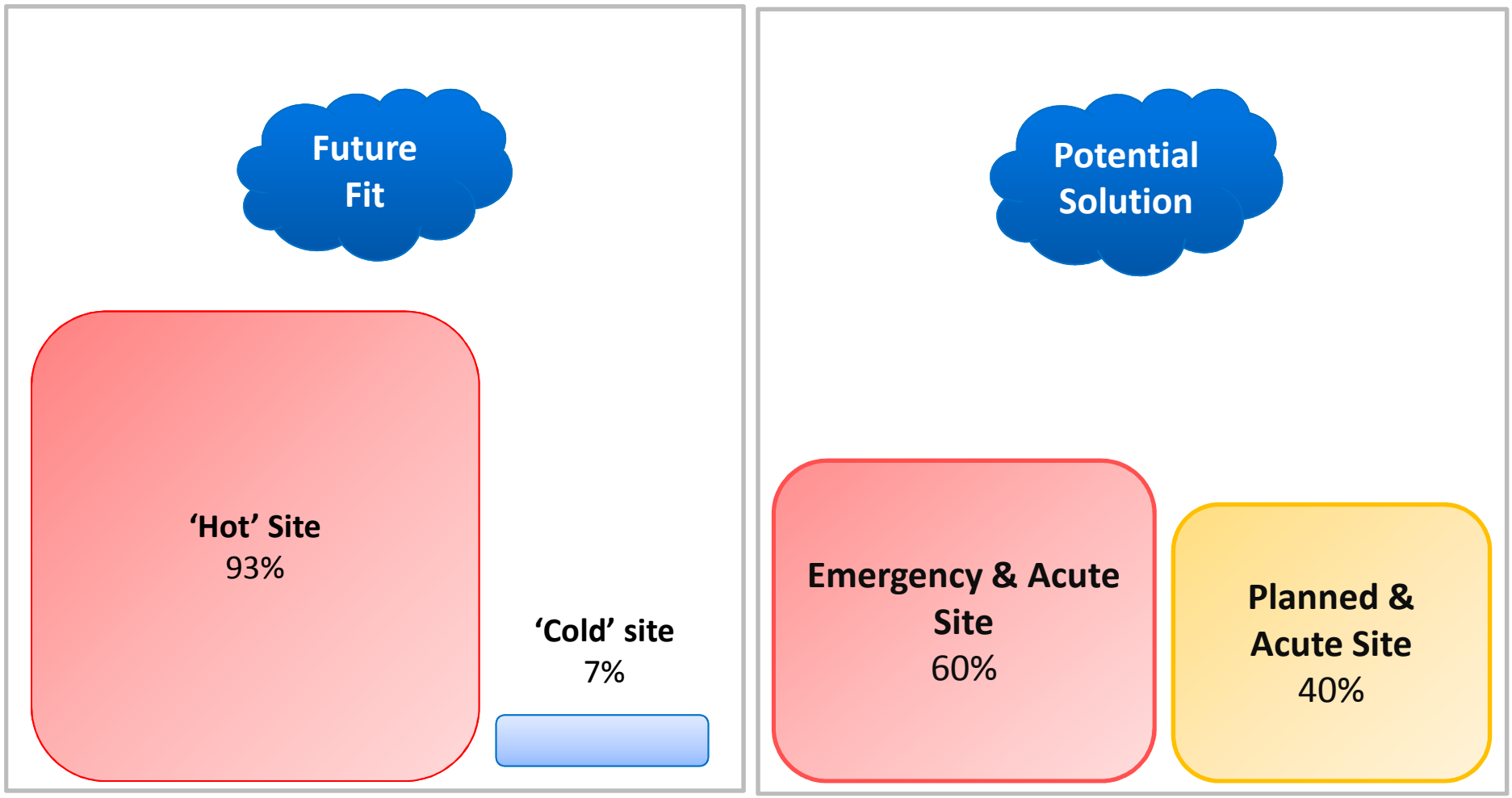
The difference - inpatient Beds



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3. The potential solutions

Option B (Acute and Emergency Care at PRH)

- ED and Critical Care at PRH
- Majority of planned care at RSH
- Urgent Care Centre, Outpatients, Diagnostics at both PRH and RSH

Option C1 (Acute and Emergency Care at RSH)

- ED and Critical Care at RSH
- Majority of planned care at PRH
- Urgent Care Centre, Outpatients, Diagnostics at both RSH and PRH

Option C2 (Acute and Emergency Care at RSH/W&C at PRH)

- ED and Critical Care at RSH
- Women and Children's at PRH
- Majority of planned care at PRH
- Urgent Care Centre, Outpatients, Diagnostics at both RSH and PRH

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The difference between September 2015 and now

A new way of delivering the options:

From:

One large, very ‘hot’ site with all bar 20 of the Trust’s inpatient beds and one very ‘cold’ site delivering planned and urgent care services only

To:

Two balanced, vibrant hospital sites – both delivering acute care with one delivering the Emergency Centre and one delivering the Diagnostic and Treatment Centre

With:

Much more work to be done with individual specialties to develop their own optimal balance

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4. The work to do

- Validate the activity assumptions and what this means for patients and services in partnership with GPs and Primary Care, Stakeholders and Patients

- Progress with the development of integrated shared care pathways

- Further develop the plans for delivery on both hospital sites for each solution (B, C1 and C2)

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5. Proposed timescales

Following today:

- Further CCG discussion on the SOC
- Cross sector staff, stakeholder and patient involvement and engagement
- Appraisal:
  - Clinical Senate
  - GP/GP Commissioners
  - Equality Impact Assessment
- Approval processes (April to June/July)
- Development of the OBC
- Public consultation (Winter)

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