The purpose of this report is to provide the Trust Board with a summary of the outcomes from the Programme Board meeting held on 19 November. The papers for consideration are:

1. The Summary Report describing progress of a number of workstreams and for particular attention of the Board is a revised Programme Timeline and Critical Path.

2. A report describing the approach to managing two new key interdependencies to the success of the Future Fit Programme: the revised OBC work that the Trust are taking forward; and the deficit reduction plan work currently sitting with the SROs, CEOs and FDs.

3. A Urgent Care Centre report update outlining the timelines and approach to defining urban and rural requirements.

These papers are all included within the main body of this report.

It is now two years on from the Call to Action engagement that originally set out the case for change. Whilst there is a shared frustration on the decision to defer reaching any conclusion about recommending a ‘preferred option’ to Sponsor Boards, a significant amount has been achieved through the Programme and it feels important at this stage to recognise that work.

A presentation has therefore been included for information within the Trust Board Supplementary Information Pack that sets out a summary of key programme products and identifies all the initial achievements over the past 2 years of local clinicians, of patients and of partner organisations in their work together on the NHS Future Fit programme.

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

Strategic Priorities

1. Quality and Safety
   - Reduce harm, deliver best clinical outcomes and improve patient experience.
   - Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards
   - Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme
   - To undertake a review of all current services at specialty level to inform future service and business decisions
   - Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme

2. People
   - Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work

3. Innovation
   - Support service transformation and increased productivity through technology
<table>
<thead>
<tr>
<th>Community and Partnership</th>
<th>Develop the principle of ‘agency’ in our community to support a prevention agenda and improve the health and well-being of the population</th>
<th>Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies</th>
<th>Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Strength:</td>
<td>Board Assurance Framework (BAF) Risks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sustainable Future</td>
<td>1. If we do not deliver <strong>safe care</strong> then patients may suffer avoidable harm and poor clinical outcomes and experience</td>
<td>2. If the local health and social care economy does not reduce the <strong>Fit To Transfer</strong> (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm</td>
<td>3. Risk to <strong>sustainability</strong> of clinical services due to potential shortages of key clinical staff</td>
</tr>
<tr>
<td></td>
<td>4. If we do not achieve safe and efficient <strong>patient flow</strong> and improve our processes and capacity and demand planning then we will fail the national quality and performance standards</td>
<td></td>
<td>5. If we do not get good levels of <strong>staff engagement</strong> to get a culture of continuous improvement then staff morale and patient outcomes may not improve</td>
</tr>
<tr>
<td></td>
<td>6. If we do not have a clear <strong>clinical service vision</strong> then we may not deliver the best services to patients</td>
<td></td>
<td>7. If we are unable to resolve our structural imbalance in the Trust's <strong>Income &amp; Expenditure</strong> position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment</td>
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<thead>
<tr>
<th>Care Quality Commission (CQC) Domains</th>
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<td>Safe</td>
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<tr>
<th>Receive</th>
<th>Review</th>
<th>Note</th>
<th>Approve</th>
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**Recommendation**

The Trust Board is asked to receive and discuss:

1. The Summary report form the Future Fit Programme Board meeting in November and in particular the proposed revised programme timeline and critical path.
2. The approach to managing the two key interdependencies of the OBC work and the deficit reduction plan
3. The timeline for the urgent care centre (UCC) work
4. The achievements within the Future Fit Programme to date
Programme Board Report

19th November 2015

The purpose of this report is to provide stakeholders with a summary of the last Programme Board meeting. All final papers considered by the Board are published on the Programme website - nhsfuturefit.org.

1 PROGRAMME TIMELINE

At the October Board meeting it had been agreed that the Core Group should set out a new programme timetable which reflected the implications of the decision to defer any conclusion on reaching a preferred option until there is an approvable case for investment.

Since that meeting the Core Group has held a number of discussions, including with representatives of NHS England and NHS Trust Development Authority. Advice has also been received from NHS England’s Project Appraisal Unit which supports the national Oversight Group for Service Change and Reconfiguration. These conversations highlight the difficulty in setting a comprehensive timetable to consultation in advance of the Department of Health and HM Treasury confirming the acceptability of the deficit reduction plan. They also note the limited availability of capital funds for which a number of schemes may find themselves competing.

In the light of the advice received, the proposed revised critical path sets out the key pieces of work for the next phase and notes the risks around external approvals which are not within the Programme’s control. Subject to those approvals the timeline indicates that:

- Public Engagement activities would continue, focusing initially on the Clinical Model and, especially, Urgent Care services;
- A preferred option would be identified in June 2016;
- Formal Public Consultation would take place from December 2016, and;
- The two CCGs would reach a final decision in June 2017.

The high-level timetable can be found at Appendix One.
2 MANAGING KEY INTERDEPENDENCIES

Key to the development of a plan for the next phase are two critical interdependencies:

a) Developing a deficit reduction plan for the Local Health Economy, and;

b) Completing a revised Strategic Outline Case for acute services which prioritises the most pressing clinical challenges.

An overview of how the programme proposes to manage these independencies was discussed and agreed, and of the scope and timing of these two pieces of work was noted. It was also agreed that a similar approach should be taken in relation to the development of Information Technology dependencies.

3 RURAL URGENT CARE

Following receipt in October of the sub-group’s report on rural urgent care, plans have been developed to:

a) Get further clarity on how urban Urgent Care Centres could work and on what support they will require from the wider Health Economy, and;

b) Further explore how best to provide enhanced urgent care services in rural localities.

A separate report provides more detail about these two pieces of work.

In addition, the Workforce workstream is considering the requirements for an urgent care workforce, and the Communication and Engagement workstream has developed a plan for enabling a greater public understanding of urgent care provision.

4 COMMUNITY FIT

The NHS Community Fit programme (formally outside the scope of the Future Fit Programme) is progressing well and remains on track to complete its first phase by end March 2016. This will provide a uniquely valuable and integrated view of out of hospital activity (Third Sector, Mental Health, Primary Care, Social Care and Community Healthcare).

The terms of reference of the NHS Community Fit steering group and a paper setting out the potential broader scope of the overarching programme of work have been submitted to CCG boards for approval and to agree any future phases. It was agreed that CCG Governing Bodies should consider their requirements from future phases of Community Fit.

A separate report set out current progress in more detail.
5 CLINICAL DESIGN

The workstream of key Clinical Leaders is collaborating with the Communications Team to shape plans for communicating with the public about the case for change, the clinical model and the urgent care offer. This includes a document summarising where patients would attend with a variety of conditions – both currently and as a result of Programme proposals. Plans for the ongoing engagement of clinical staff will also be considered.

In addition, the workstream will begin preparations for presenting Programme proposals to the West Midlands Clinical Senate for assurance around the clinical evidence base prior to Public Consultation.

6 IMPACT ASSESSMENT

The next phase of Integrated Impact Assessment (IIA) work will run in parallel with public consultation. Nearer that time, the workstream’s plans for the required activity will be finalised (in the light of the exact scope of the proposals to be consulted on). Until that time is reached the activity of this workstream has been paused.

7 WORKFORCE

The October Board meeting reviewed the draft Workforce Case for Change and asked for the scope of the document to be extended beyond hospital staff.

The Workstream has since expanded its membership to reflect the wider health and social care economy, and this larger group has started to take an overview of local challenges faced by all providers. A summary of those challenges is set out in a separate report.

The workstream’s other main focus has been the workforce requirements for urgent care centres. Information has been sought both from the pilot UCCs at PRH and RSH and from a range of other UCCs in the region and beyond.

8 ASSURANCE

The Assurance workstream had met in the days before the Board meeting to seek assurance about:

- The proposed new timeline;
- The process for managing interdependencies, and;
- The communications plan for the next phase.
The workstream also review the updated reconfiguration guidance from NHS England - Planning, Assuring and Delivering Service Change for Patients. This does not replace the 2013 guidance but seeks to add clarity around assurance processes and decision making levels. It also sets out the requirements for Pre Consultation and Decision Making Business Cases for the first time. Key points include in the guidance include:

a) The planning and development of reconfiguration proposals are rarely linear. The most successful proposals ensure continuous discussion and involvement of the local population and key stakeholders throughout the process.

b) There must be clear and early confidence that a proposal satisfies the four tests and is affordable in capital and revenue terms.

c) Proposals affecting services valued under £350m may be determined by the NHSE Regional Director rather than the Chief Financial Officer or Investment Committee.

d) CCGs should assure themselves that those proposals have the support of their member practices.

e) Schemes have struggled to build public support where they have not adequately addressed public concerns that:
   - The proposals are perceived to be purely financially driven.
   - Patients and their carers will need to make journeys that may reduce access.
   - Emergency services will be too far away, putting people at risk.

f) Until approval for the SOC is in place organisations should not incur material costs progressing to the next formal stages of the scheme (OBCs and FBCs).

g) Commissioner decision making involving two or more CCGs can be based on two models – committee in common or joint committees.

9 ENGAGEMENT AND COMMUNICATIONS

Following the Board meeting at the beginning of October, an announcement and a more detailed statement was shared with the public and stakeholders about the necessity of delay whilst a plan is developed to reduce the deficit.

Regular statements and media briefings have continued, a newsletter is being used to provide updates to key stakeholders and a range of engagement events has taken place with Local Joint Committees, Parish Councils, Community Groups, Patient Groups and GP surgeries. A comprehensive engagement programme is also speaking to specific groups, including the homeless, older people and Eastern European workers.
Politicians continue to be updated on a regular basis through MP briefings by the SROs and there are plans to hold further pop-up shops out in the community.

The website has been updated to improve document access. Presentations to workforce groups have been taking place and more are planned in the months ahead.

A summary document containing the Programme’s key outputs to date has been published on the website.

The workstream will shortly be finalising plans for the critical next phases of activity before and after the identification of a preferred option. This will involve a significant amount of work both by the Communications team and by key people in sponsor organisations.

10 FINANCE

The Finance workstream met on 5th November. Although the work to develop a deficit reduction plan is outside of the scope of the Programme, the meeting provided an opportunity for discussion of the scope and approach of the work to be undertaken. The need for external support was highlighted.

The Programme is facilitating a meeting of Finance Directors and Chief Officers which will take place in early December to take this work forward. It will involve all local NHS organisations as well as NHS England as the commissioner of specialised services.

It was recognised that the priority is to move towards a sustainable health economy for the long term. Although individual organisations may continue to carry deficits over the intervening period, the focus should be on making progress against the plan as whole health economy.

Any potential impact on social care services, and vice versa, would also be considered.

11 PROGRAMME RISKS

The Risk Register continues to be comprehensively reviewed by the Programme Team each month, and by the Core Group, after which it is published on the Programme website. All workstreams may raise new risks or recommend revision of existing risks at any point.

The Board has previously agreed that all red-rated risks (both pre- and post-mitigation) should be reported to it. These are appended to this summary (see Appendix Two).

There are currently a significant number of risks for which the post-mitigation rating remains above the indicated risk appetite of the Programme. The view of Programme Team is that, whilst the appetite to reduce certain risks further is appropriate, it is also to be expected that a Programme of this scale and complexity will carry a significant degree of risk.
Board agreed that there was a particular risk currently around change in leadership in sponsor organisations, and the register will be reviewed to ensure that this risk is adequately captured and mitigated.

12 PROGRAMME EXECUTION PLAN

An update of the PEP will be produced following agreement by the Board on the scope and timing of the next phase of Programme work.

The schedule of Board meetings will be reviewed as part of this.

13 PROGRAMME MANAGEMENT

At the inception of the Programme, Commissioners sought the support of The Strategy Unit from NHS Midlands and Lancashire Commissioning Support Unit to provide the Programme Management Office. It was expected that this support would run until 2016 after which the later phases of the Programme could be managed locally (though still with access to support from The Strategy Unit).

To avoid undue disruption, a managed transition is proposed which would take place during 2016. First, the responsibilities of Programme Director would be brought in-house by local Commissioners but with other Programme Office functions remaining in place. Then, at a later date, these other functions can also be adjusted to reflect the changing needs of the Programme.
APPENDIX ONE – PROGRAMME TIMELINE

HIGH LEVEL CRITICAL PATH

The following diagram sets out the expected timeline for the next phase of the Programme. This is critically dependent on external approval processes which are beyond the Programme’s control and could materially affect the timeline. The critical path also reflects the key assumptions below:

1. Work to produce an adequate deficit reduction plan will be completed by end January 2016 and signed off by all parties by end Feb 2016;
2. A revised Strategic Outline Case for acute facilities will be approved by SaTH by end February 2016;
3. The value of the SOC will remain over £50m. TDA guidance indicates 2 month approval process but no guidance is given for DH/HMT approvals;
4. SOC and PCBC approval are required before consultation;
5. Plans for Urban UCCs will be completed alongside SOC work and space requirements, at least, will be included in SOC;
6. Work on the wider community offer continues in parallel (including rural urgent care solutions and the potential to extend Local Planned Care/develop Health Hubs) and the PCBC will include (at least) any rural urgent care offer;
7. The appraisal of options has to be repeated in the light of new information and the changed scope of proposals;
8. Options B, C1 & C2 each remain under consideration;
9. Phase 2 modelling assumptions/financial implications continue to form the basis of the revised SOC work;
10. Commissioners and SaTH are willing, in principle, to support all of the remaining options, and Commissioners set out, before the option appraisal is revisited, how they will confirm a preferred option and reach a final decision (and what factors will influence those decisions);
11. Work to reach agreement with the Joint HOSC and CHC around any recommendations they may make post-consultation is completed by mid-June 2017.
APPENDIX TWO – RED RATED RISKS
The NHS Future Fit programme has developed this register which, in line with best practice, sets out the areas which could adversely impact the development and/or implementation of programme proposals. This uses qualitative and quantitative measures to calculate the overall level of risk according to likelihood of occurrence and potential impact.

Each risk is given an initial Red/Amber/Green rating, and a summary of how the risk is being mitigated by the programme is also provided. Where further action is needed, this is also set out. The Risk Register is formally reviewed and updated on a monthly basis by the Programme Team. Risks rated ‘red’ (either before or after mitigation) will be reported to the Programme Board.
### SCORING

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Narrative</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rare</td>
<td>&lt;20%</td>
</tr>
<tr>
<td>2</td>
<td>Unlikely</td>
<td>20-40%</td>
</tr>
<tr>
<td>3</td>
<td>Possible</td>
<td>40-60%</td>
</tr>
<tr>
<td>4</td>
<td>Likely</td>
<td>60-80%</td>
</tr>
<tr>
<td>5</td>
<td>Very likely to occur</td>
<td>&gt;80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consequence</th>
<th>Narrative</th>
<th>Possible Quantification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insignificant</td>
<td>Revenue impact &lt;£20,000; Capital impact &lt;£0.5m; Delay &lt;1 month</td>
</tr>
<tr>
<td>2</td>
<td>Minor</td>
<td>Revenue impact &gt;£20k &lt;£100k; Capital impact &gt;£0.5m &lt;£1.0m; Delay &gt;1 month &lt;3 months</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>Revenue impact &gt;£100k &lt;£500k; Capital impact &gt;£1.0m &lt;£3.0m; Delay &gt;3 months &lt;9 months</td>
</tr>
<tr>
<td>4</td>
<td>Severe/Major</td>
<td>Revenue impact &gt;£500k &lt;£2.0m; Capital impact &gt;£3.0m &lt;£6.0m; Delay &gt;9 months &lt;24 months</td>
</tr>
<tr>
<td>5</td>
<td>Catastrophic</td>
<td>Revenue impact &gt;£2.0m; Capital impact &gt;£6.0m; Delay &gt;24 months</td>
</tr>
</tbody>
</table>

### NOTES

- Risks are generally causes rather than consequences of an adverse event.
- Mitigation actions must be accurate, timely and owned. They may be significant enough to warrant a task within a programme plan.
- All risks and actions should be updated regularly and the owners of mitigation actions called to account for progress or lack thereof.
- All programme members have a duty to identify and report risks to the programme office.
- The programme appetite for risk (i.e. what risk overall can the programme tolerate) must be clearly articulated by the programme team.
- In general, only those risks that require defined Programme Board action should be formally raised to, and discussed with, the Programme Board.
- Risks should be managed as low down the programme structure as possible.
- Issues are essentially Risks with a probability of 100% (i.e. they have materialised and are thus in need of urgent action).
- If a defined risk or issue does not threaten the success of the programme, it need not be entered in the risk...
<table>
<thead>
<tr>
<th>No.</th>
<th>Date Added</th>
<th>Date Last Revised</th>
<th>Main Register</th>
<th>Workstream</th>
<th>Risk Name</th>
<th>Description</th>
<th>Risk Owner</th>
<th>Initial Rating</th>
<th>To reduce risk to acceptable level</th>
<th>Post Mitigation Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>27/03/2014</td>
<td>20/03/2015</td>
<td>Y FI CD</td>
<td>Key Staff Time</td>
<td>FI CD</td>
<td>Inability of stakeholder organisations to release key staff for the Programme leading to adverse impact on programme deliverability</td>
<td>SROs</td>
<td>4 4 16</td>
<td>Use of multi-site meetings increased. Evening meetings scheduled to support clinical involvement in design phase. Portable video-conferencing capability implemented. Critical path communicated to highlight consequences of any delay. Finance meetings moved to support attendance.</td>
<td>4 3 12</td>
</tr>
<tr>
<td>2</td>
<td>27/03/2014</td>
<td>24/08/2015</td>
<td>Y CD</td>
<td>Clinical Engagement</td>
<td>CD</td>
<td>Inadequate clinical engagement leads to lack of support for clinical model</td>
<td>BG</td>
<td>5 3 15</td>
<td>Extensive clinical engagement in developing model. Model approved by CRG and Board. GPs engaged on development of rural urgent care and ‘Community Fit’ plans. Staff engagement through sponsor organisations (including Trade Unions)</td>
<td>5 2 10</td>
</tr>
<tr>
<td>4</td>
<td>27/03/2014</td>
<td>04/08/2015</td>
<td>Y AS EC</td>
<td>Engagement Assurance</td>
<td>AS EC</td>
<td>Inadequate patient and public engagement may lead to failure to meet assurance tests re: due process, contributing to Independent Reconfiguration Panel referral or Judicial Review</td>
<td>AO</td>
<td>5 3 15</td>
<td>Comprehensive engagement &amp; communications strategy and plans developed and being implemented. Ongoing support from Consultation Institute. Activity log to be shared every quarter with workstream and Programme Office updates shared bi-monthly.</td>
<td>5 2 10</td>
</tr>
<tr>
<td>5</td>
<td>27/03/2014</td>
<td>05/11/2015</td>
<td>Y EC</td>
<td>Public Support for Plans</td>
<td>EC</td>
<td>Public resistance and objections to plans leading to lack of support for preferred clinical model</td>
<td>AO</td>
<td>4 4 16</td>
<td>Communication and engagement plans to be implemented including extensive pre-consultation public engagement around the case for change/clinical model (supported by NHSE funding).</td>
<td>4 3 12</td>
</tr>
<tr>
<td>6</td>
<td>24/11/2014</td>
<td>04/08/2015</td>
<td>Y EC</td>
<td>Negative Presence in Media</td>
<td>EC</td>
<td>Risk includes distraction to the process including utilisation of resources; it may undermine confidence in the programme which may lead to a financial impact</td>
<td>AO</td>
<td>4 4 16</td>
<td>To implement the Engagement and Communication Strategy and subsequent plans. To undertake more proactive communications including media training with Core Group. Increased SRO engagement with press.</td>
<td>4 2 8</td>
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<tr>
<td>10</td>
<td>24/11/2014</td>
<td>04/08/2015</td>
<td>Y EC IIA</td>
<td>Powys engagement</td>
<td>EC IIA</td>
<td>Confusion due to a number of programmes impacting Powys healthcare leads to reduced Powys engagement in Future Fit activities and potential challenge</td>
<td>AO</td>
<td>4 4 16</td>
<td>E&amp;C workstream and PHIB E&amp;C leads have met and agreed plan of action including tactics to clarify FF Powys engagement plans. E&amp;C workstream will monitor progress on plan over next few months and report to Programme Team . Regular meetings to continue.</td>
<td>4 3 12</td>
</tr>
<tr>
<td>No.</td>
<td>Date Added</td>
<td>Date Last Revised</td>
<td>Main Register</td>
<td>Work-stream</td>
<td>Risk Name</td>
<td>Description</td>
<td>Initial Rating</td>
<td>C L Score</td>
<td>Post Mitigation Rating</td>
<td>Further Actions (if required) to reduce risk to acceptable level</td>
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<tr>
<td>12</td>
<td>24/11/2014</td>
<td>04/08/2015</td>
<td>Y EC</td>
<td>Clinical leadership</td>
<td>Failure to gain and sustain support from clinicians to be visibly leading the programme. Consequences may include dwindling public support and undue burden on small number of leaders.</td>
<td>AO</td>
<td>5 4 20</td>
<td>5 3 15</td>
<td>Escalate to Core Group to ensure clinical leaders are able to be support programme activities.</td>
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<tr>
<td>14</td>
<td>24/11/2014</td>
<td>04/08/2015</td>
<td>Y EC</td>
<td>Divergence off proactive plan</td>
<td>Failure to implement a process to agree a plan and all programme to comply appropriately. Risk includes inability to implement a timely plan to meet best practice standards with no subsequent ownership</td>
<td>AO</td>
<td>5 4 20</td>
<td>5 3 15</td>
<td>Review and update the plan and risk register</td>
<td></td>
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<tr>
<td>17</td>
<td>04/08/2015</td>
<td>04/08/2015</td>
<td>Y EC</td>
<td>Failure to comply with Gunning Principles</td>
<td>Inadequate time allowed for consultation fails to comply with Gunning Principles leading to legal challenge</td>
<td>AO</td>
<td>5 4 20</td>
<td>5 2 10</td>
<td>No further action proposed.</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>24/11/2014</td>
<td>04/08/2015</td>
<td>Y EC</td>
<td>Inadequate workforce engagement</td>
<td>Failure to effectively engage with health and care staff thus raising risk for negative PR, workforce disengagement and ‘on ground’ lack of support / champions. This applies across commissioners, providers, and Welsh Healthboard</td>
<td>Key partners</td>
<td>4 4 16</td>
<td>4 3 12</td>
<td>No further action proposed.</td>
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<td>21</td>
<td>30/10/2014</td>
<td>09/06/2015</td>
<td>Y</td>
<td>Approval Requirements</td>
<td>Lack of clarity about the nature and alignment of external approval processes prevents agreement of a robust timetable.</td>
<td>MS</td>
<td>4 5 20</td>
<td>4 4 16</td>
<td>TDA &amp; NHSE to confirm common view on pre-consultation approval requirements.</td>
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<td>27/03/2014</td>
<td>30/10/2014</td>
<td>Y AS</td>
<td>Stakeholder Strategies</td>
<td>Development of stakeholder strategies and plans constrains or conflicts with the Programme</td>
<td>SROs</td>
<td>4 4 16</td>
<td>4 2 8</td>
<td>No further action proposed.</td>
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<td>24</td>
<td>29/05/2014</td>
<td>24/08/2015</td>
<td>Y Fi</td>
<td>Sponsor Financial Risk</td>
<td>The need to address short term financial risks in individual sponsor organisations compromises programme progress and/or outcome.</td>
<td>SROs</td>
<td>4 4 16</td>
<td>4 3 12</td>
<td>Alignment to be kept under review in case of any change to long term plans.</td>
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<td>27/03/2014</td>
<td>24/08/2015</td>
<td>Y</td>
<td>Political Support for Plans</td>
<td>Lack of political support for large-scale service changes resulting in challenge to preferred option</td>
<td>SROs</td>
<td>4 4 16</td>
<td>4 3 12</td>
<td>Local Assurance Panel to be considered.</td>
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<tr>
<td>No.</td>
<td>Date Added</td>
<td>Date Last Revised</td>
<td>Main Register</td>
<td>Work-stream</td>
<td>Risk Name</td>
<td>Description</td>
<td>Risk Owner</td>
<td>Initial Rating</td>
<td>Mitigating Actions</td>
<td>Post Mitigation Rating</td>
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</tr>
<tr>
<td>26</td>
<td>04/08/2014</td>
<td>04/08/2015</td>
<td>Y</td>
<td>WF</td>
<td>Interim A&amp;E Plans (SaTH Risk Register)</td>
<td>Inability to safely staff the Emergency Department with medical workforce. Potential adverse impact on quality and safety of care for patients. Poorer patient flow into and within hospital. Inability to meet national guidance in relation to levels of senior cover. An increase in costs if there is a reliance on internal locum shifts. Possible mismanagement of patient care. Difficulty meeting Trauma Network standards for Consultant cover.</td>
<td>SaTH Board</td>
<td>5 5 25</td>
<td>Attempts to recruit Locum/Substantive Consultants ongoing. Recruitment and training of Advanced Practitioners. Additional SHO shift allocated to PRH on late shift to support flow and safety to avoid the night shift being left with a backlog leaving the department vulnerable. Negotiation ongoing to cover Trauma Rota and Job Planning to make best use of Consultant resource. We have recruited a fixed-term Locum to cover our ED Consultant who is away on a sabbatical; and a Locum Consultant to work with us until February 2016. Ad hoc consultant on site cover over the weekends to support the department when in extreme difficulties.</td>
<td>5 4 20</td>
</tr>
<tr>
<td>27</td>
<td>04/08/2015</td>
<td>04/08/2015</td>
<td>Y</td>
<td>WF</td>
<td>Non compliance with Critical Care Standards for Intensivist Cover within ITU (SaTH Risk Register)</td>
<td>Critical care standards set out that ITU should have Intensivist cover 24/7 and that intensivists should undertake twice daily ward rounds. Guidelines from the Faculty of Intensive Care Medicine (FICM) state that there is clear evidence that units with dedicated intensivists are the safest and most clinically effective way to deliver Intensive Care with reduced ICU and hospital mortalities and reduced ICU and hospital lengths-of-stay. In general, the consultant/patient ratio must not exceed a range between 1:8 to 1:15 and the ICU resident/patient ratio should not exceed 1:8. At both sites, these ratios are significantly exceeded. The risk has been exacerbated at PRH due to a high level of medical staff sickness and an imminent retirement.</td>
<td>SaTH Board</td>
<td>5 5 25</td>
<td>In order to safely staff ITU, the Trust may need to stop elective work and shift sessions to Critical Care. This will affect our ability to staff all elective lists, which will have an impact on waiting lists and patient care unless a timely solution is found as the service and the team are highly vulnerable to further vacancies or unexpected absences. Splitting the Rota at RSH means we can ensure 24/7 cover of both intensive care, by intensivists and also take care of emergency activity. Critical Care is being provided with a mix of general anaesthetists and the small number of intensivists available but consultant presence is still well below recommended levels.</td>
<td>5 4 20</td>
</tr>
<tr>
<td>No.</td>
<td>Date Added</td>
<td>Date Last Revised</td>
<td>Main Register</td>
<td>Work-stream</td>
<td>Risk Name</td>
<td>Description</td>
<td>Risk Name</td>
<td>Description</td>
<td>Initial Rating</td>
<td>Post Mitigation Rating</td>
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<td>------------------------</td>
</tr>
<tr>
<td>28</td>
<td>27/03/2014</td>
<td>26/02/2015</td>
<td>Y</td>
<td>R</td>
<td>Interim A&amp;E Plans</td>
<td>The need to implement interim plan for sustaining A&amp;E services over the interim period adversely affects Programme</td>
<td>DV</td>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>29</td>
<td>01/07/2014</td>
<td>05/11/2015</td>
<td>Y</td>
<td>S</td>
<td>Interdependencies</td>
<td>Failure to effectively manage programme interdependencies adversely impacts the implementation of the preferred option</td>
<td>SROs</td>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>30</td>
<td>26/02/2015</td>
<td>05/11/2015</td>
<td>Y</td>
<td>E</td>
<td>Urgent Care Centre Offer</td>
<td>Inability to adequately define UCC offer leads to lack of support for single Emergency Centre.</td>
<td>MS</td>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>31</td>
<td>24/08/2015</td>
<td>05/11/2015</td>
<td>Y</td>
<td>E</td>
<td>Urgent Care Proposals</td>
<td>Failure to articulate rural urgent care offer before consultation adversely affects consultation</td>
<td>MS</td>
<td>4</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>32</td>
<td>23/02/2015</td>
<td>20/03/2015</td>
<td>Y</td>
<td>R</td>
<td>Out of Hospital Services</td>
<td>Lack of clarity on plans for out of hospital services impacts public support for acute and community hospital proposals</td>
<td>SROs</td>
<td>4</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>No.</td>
<td>Date Added</td>
<td>Date Last Revised</td>
<td>Main Register</td>
<td>Work-stream</td>
<td>Risk Name</td>
<td>Description</td>
<td>Risk Owner</td>
<td>Initial Rating</td>
<td>Post Mitigation Rating</td>
<td>Further Actions (if required)</td>
</tr>
<tr>
<td>-----</td>
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<td>--------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>33</td>
<td>23/03/2015</td>
<td>09/06/2015</td>
<td>Y</td>
<td>WF</td>
<td>Workforce Deliverability</td>
<td>Difficulties in recruiting in line with workforce plan (including new roles) adversely impacts implementation of programme proposals</td>
<td>tbc</td>
<td>4</td>
<td>16</td>
<td>Workforce workstream to identify new roles and to liaise with HEE and education providers to ensure supply of required roles. Develop a more comprehensive “work in Shropshire” offer.</td>
</tr>
<tr>
<td>34</td>
<td>23/03/2015</td>
<td>09/06/2015</td>
<td>Y</td>
<td>WF</td>
<td>Resistance to Workforce Change</td>
<td>Lack of appetite for change/new roles locally and from Royal Colleges and others adversely impacts definition of a deliverable workforce plan.</td>
<td>tbc</td>
<td>4</td>
<td>16</td>
<td>Workforce workstream to liaise with Royal Colleges and others to engender support.</td>
</tr>
<tr>
<td>35</td>
<td>27/03/2014</td>
<td>24/08/2015</td>
<td>Y</td>
<td>WF</td>
<td>Option Appraisal</td>
<td>The number and/or complexity of shortlisted options identified for appraisal delays the Programme</td>
<td>MS</td>
<td>4</td>
<td>16</td>
<td>Shortlist of 6 agreed in line with national guidance. Number of options reduced on affordability grounds.</td>
</tr>
<tr>
<td>36</td>
<td>26/02/2015</td>
<td>05/11/2015</td>
<td>Y</td>
<td>Fi</td>
<td>SaTH Affordability</td>
<td>Financial analysis demonstrates that one or more shortlisted options are not affordable, potentially leading to reconsidering shortlisting decision and significant delay.</td>
<td>NN</td>
<td>4</td>
<td>20</td>
<td>Phase 2 assumptions agreed by SaTH. Financial costs and benefits of options to be set out by Technical Team. A number of options excluded on affordability grounds. Remaining options potentially affordable to SaTH.</td>
</tr>
<tr>
<td>38</td>
<td>27/03/2014</td>
<td>27/07/2015</td>
<td>Y</td>
<td>Fi</td>
<td>Capital Availability</td>
<td>Lack of availability of capital to fund preferred option delays implementation</td>
<td>AN</td>
<td>4</td>
<td>20</td>
<td>Discussion with TDA/DH re: availability of funding. PF2 to be explored if necessary</td>
</tr>
<tr>
<td>39</td>
<td>29/05/2014</td>
<td>05/11/2015</td>
<td>Y</td>
<td>Fi</td>
<td>Commissioner Affordability</td>
<td>Lack of revenue affordability to Local Health Economy of capital requirement and of whole system change adversely impacts identification of the preferred option</td>
<td>AN</td>
<td>5</td>
<td>25</td>
<td>Affordability assessments to form part of appraisal processes. Extensive work undertaken to reconcile 5 year plans with Phase 2 assumptions and to allow for community investment.</td>
</tr>
<tr>
<td>40</td>
<td>05/11/2015</td>
<td>05/11/2015</td>
<td>Y</td>
<td>Fi</td>
<td>Local Health Economy Deficit</td>
<td>LHE deficit undermines viability of business cases</td>
<td>SROs</td>
<td>4</td>
<td>5</td>
<td>Commissioners and providers to set out nature and scale of deficit and to develop a deficit reduction plan acceptable to regulators.</td>
</tr>
<tr>
<td>No.</td>
<td>Date Added</td>
<td>Date Last Revised</td>
<td>Main Register</td>
<td>Work-stream</td>
<td>Risk Name</td>
<td>Description</td>
<td>Risk Owner</td>
<td>Initial Rating</td>
<td>C</td>
<td>L</td>
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</tr>
<tr>
<td>42</td>
<td>23/03/2015</td>
<td>09/06/2015</td>
<td>Y</td>
<td>WF</td>
<td>Dual Workforce Costs</td>
<td>Sufficient resources are not available to support double-running costs associated with introducing new roles, leading to delayed implementation</td>
<td>VM</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>45</td>
<td>27/03/2014</td>
<td>29/01/2015</td>
<td>Y</td>
<td>Fi</td>
<td>Programme Resources</td>
<td>Programme resources / staffing inadequate leading to difficulties in running Programme to agreed timelines</td>
<td>SROs</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>49</td>
<td>27/03/2014</td>
<td>09/06/2015</td>
<td>Y</td>
<td>AS</td>
<td>NHS Approvals</td>
<td>Failure to secure necessary NHS approvals at key milestones delays the programme</td>
<td>MS</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>50</td>
<td>09/03/2015</td>
<td>05/11/2015</td>
<td>Y</td>
<td>AS</td>
<td>Government Approvals</td>
<td>Uncertainty about timescales for DH/HMT approvals leads to flawed assumptions being made in the Programme Plan and to delay (including to the start of consultation).</td>
<td>MS</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>51</td>
<td>09/03/2015</td>
<td>05/11/2015</td>
<td>Y</td>
<td>AS</td>
<td>Decision making</td>
<td>Lack of an agreed process for reaching a final commissioner decision (including clarifying the role of Powys THB) prevents a final decision being agreed</td>
<td>SROs</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
Managing Key Programme Dependencies

Introduction

The purpose of this paper is to highlight two new key Programme Dependencies that have arisen and to propose how we manage them.

Background

At the last Programme Board it was agreed that:

- SaTH would take forward the work on developing the SOC and OBC for new acute hospital facilities. The Programme will no longer be resourcing or managing this work and the technical team have been stood down.
- The SROs would ask the Finance Directors to scope and define a whole system deficit reduction plan, starting with an assessment of the current underlying deficit position for the health economy.

It was decided that this work sits outside of the Future Fit Programme.

Issues

Before the Programme can set out a revised timeline, the scope, milestones and end point of these two pieces of work needs to be agreed.

It is also likely that the SOC cannot be completed without reference to the external context created by the deficit reduction plan.

Therefore, not only is the Programme dependent on these two pieces of work, but the SOC work is likely to be dependent on the outcome of the deficit reduction work. Some parallel running of these two pieces of work is inevitable, but presents a further risk.

The programme can develop a draft timeline but without a clear understanding of the scope and length of time needed for these two pieces of work, the Programme should not publicly commit to a timetable.

Conclusion

The following actions are proposed:

- The Programme Board establishes both pieces of work as key Programme dependencies
- The next Programme Board receives a report at its next meeting setting out the scope, milestones and deadline for each of the above pieces of work to reach a conclusion.
- The Programme Board receives a formal update report for each piece of work at each of its meetings
In handing over the SOC development to SaTH, the Programme makes the following assumptions:

That further development of the current shortlisted options that prioritise the most urgent clinical workforce challengers including A&E and ITU and will allow for the physical creation of the key components of the Clinical Model on the SaTH sites, namely:

- A single Emergency Centre
- A single Diagnostic and treatment Centre
- An Urban Urgent Care centre on the RSH and PRH sites
- Local Planned Care on the RSH and PRH sites
- That the income envelope that is used for the SOC remains the Phase 2 modelling

No assumptions have so far been made about the scope and process for the deficit reduction work as this is an entirely new piece of work that has not been within the scope of the Programme.

Mike Sharon
Report on Programme Interdependency

Acute Hospital Business Cases (Sustainable Services Programme)

What is the objective of the project?

- To develop a Strategic Outline Case (and subsequent Outline/Full Business Cases) that address the Trust’s workforce challenges in the short to medium term; focussing on the immediate challenges of emergency/urgent care whilst also understanding the impact and opportunities for planned care.

What is the scope of the project – what is included, and what is excluded?

- Completion of all business case requirements (in line with national guidance) for workforce and facilities on the PRH and RSH sites (see Key Assumptions).

- This includes workforce and facilities options to deliver the whole of the Clinical model including one Emergency Department and associated Urgent Care Centre provision, one Critical Care Unit plus associated interdependent services and beds. A Diagnostic and Treatment Centre and Local Planned Care on both sites

- The Future Fit Programme will have responsibility for:
  
  - Overall Programme management
  - Rural Urgent Care offer
  - Community Fit Managed as a dependency and overseen by its own steering group
  - Whole system workforce solutions
  - Production of Pre Consultation Business Case

What are the project deliverables and timescales?

- SOC – February 2016
- The OBC can be completed by Autumn 2016 and a Full Business Case by early 2017 but this is dependent on external approvals which is likely to extend the required by date for these deliverables.
Key assumptions that the project is making

- The deficit reduction plan is completed by the end of January 2016
- That a whole system IT solution is being developed through the health economy IT steering group
- The activity and income assumptions will not be materially different from the Phase 2 modelling outputs without agreement from commissioners, although these will be refreshed to reflect the current position against the 2018/19 trajectory
- Introduction of new information may result in the need for a reappraisal of the Future Fit options
- The SOC and subsequent business cases will be developed in line with TDA guidance
- Patient and public engagement and involvement in relation to the Sustainable Services Programme

Key risks to the project.

- The wider health economy deficit reduction plan materially affects the activity and capacity assumptions within business cases
- Clarity of responsibilities and work plans for Future Fit and the identification of interdependencies
Report on Programme Interdependency

Deficit Reduction Plan

What is the objective of the project?
To develop a plan which will return the local NHS health economy to a sustainable financial position.

What is the scope of the project – what is included, and what is excluded?
1. All NHS organisations within Shropshire.
2. Specialised services which are currently commissioned by NHS England.
3. Organisational five year financial plans commencing 1st April 2016.

What are the project deliverables and timescales?
1. The size and composition of the current financial deficit, broken down by organisation and recurrent and non-recurrent.
2. To establish the phased, five year extrapolated position based on organisational financial strategies and previous submissions to the Future Fit Finance Workstream.
3. To extrapolate forward, on a phased five year basis, the impact of historic commissioner QIPP (Quality, Innovation, Productivity and Prevention) performance on health system stakeholder organisations and to compare the analysis to current plans.
4. To extrapolate forward, on a phased five year basis, the impact of historic provider CIP (Cost Improvement Programme) performance on health system stakeholder organisations and to compare the analysis to current plans.
5. To review the analysis of the cost base of health system organisations in deficit. The analysis will be split into fixed, semi fixed, standard variable and premium variable.
6. Based on the cost analysis, derive the level of activity that requires “deflection” or to be “lost” to address the deficit. The activity reduction will also need to offset the cost additional investments to fund the “deflected activity”.

Main project milestones for delivery with dates.
1. Chief Executives and Finance Directors to meet to ratify the scope of the programme and discuss options and opportunities on 7th December 2015.
2. Organisational revised financial plans to be submitted by 11th December 2015.

Key assumptions within the project.
1. Future Fit Phase 2 activity projections will be used where applicable.
2. Organisational restructuring within the local NHS has not been considered.
Key risks to the project.

1. Outcome of the Comprehensive Spending Review (CSR).
2. Internal resource availability.
3. Deterioration of the financial position of the local health economy.
Urgent Care Centres

An update for the Future Fit Programme Board

19 November 2015

1. Introduction

There are two potential types of urgent care centre considered in the Future Fit clinical model: urban and rural. This paper sets out the approach and timelines to finalising and agreeing with all stakeholders the detail of these centres.

2. Urban urgent care centres

It is essential that there is clarity regarding the operation of the two urban centres as the relationship between these Centres and the Emergency Centre needs to be clear before the Acute Trust SOC can be completed. Prototype urgent care Centres are already in operation on both sites and there is a need to understand the learning from these prototypes. A workshop has been scheduled for Monday 3rd December and a small working group has been tasked to plan this workshop to ensure that the following issues can be addressed and signed off in early 2016:

- Lessons to be learned from current models in Shrewsbury and Telford and more widely in the West Midlands and Cheshire

- The activity assumptions and condition types

- The staffing model

- The services on which the UCCs are dependent that will be provided by SaTH or other secondary care providers (e.g. X-ray or specialist opinion)

- The relationship and mutual requirements between the UCCs and the GP out of hours service

- The relationship and mutual requirements between the UCCs and the 111 service

- The relationship and mutual requirements between the UCCs and the West Midlands and Welsh Ambulance services

The Future Fit team are preparing a report describing the operating models and workforce arrangements for a number of urgent care sites currently in place across the West Midlands, and Cheshire and this will be available to inform the workshop discussions alongside the previously shared rapid literature review.
2.1 Governance of urban urgent care centre work

The rural urgent care work is governed by a steering group which report into CCG governing bodies and the Future Fit programme board. The Future Fit programme is responsible for ensuring a specification for the two urban urgent care centres is developed for Future Fit board sign off in early 2016.

3. Rural urgent care centres

The rural urgent care work is governed by a steering group which reports into the Future Fit Programme Board. Considerable GP, patient and public engagement has taken place over the past 18 months on the issue of Rural Urgent Care centres. It has become apparent that a solution needs to be found for each of the localities in rural Shropshire. It is also apparent that an urgent care service in a rural setting cannot be considered in isolation from current and future primary care services and other local health and care services.

This work now needs to be brought to a conclusion by March 2016 in order to inform an engagement process with local communities prior to any formal proposals being developed for formal public consultation.

The Programme team will work with the CCGs to develop a detailed plan to ensure a proposal is delivered by March 2016.

Recommendations

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

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

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

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

• There is a case for making significant change;

• The process should be clinically-led and with extensive public involvement;

• There are real opportunities to better support people in managing their own health and to provide more excellent care in the community and at home;

• Hospitals are currently misused as a result of poor design of the overall system and the lack of well understood and properly resourced alternatives;

• It is possible to design a new pattern of services that can offer excellence in meeting the distinctive and particular needs of both rural and urban populations, and;

• Proposals should not be constrained by history, habit and politics.
## Summary of Programme Progress to Date

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

- **Phase 1** *(October 2013 - January 2014)*
  - Programme Set-up
  - Determining the High-Level Clinical Model

- **Phase 2** *(February 2014 - August 2014)*
  - Determining the Overall Model of Clinical Services
  - Identification and quantification of the levels of activity in each part of the Model
  - Determining the Feasibility of a Single Emergency Centre
  - Public Engagement on the Model of Care and Provisional Long-list & Benefit Criteria

- **Phase 3** *(August 2014 - September 2015)*
  - Identification of options and option appraisal
  - Preparation of Strategic Outline Case(s)

- **Phase 4** *(tbc)*
  - Preparation for Public Consultation, submission of Pre-Consultation Business Case and NHSE Formal Assurance
  - Public Consultation on preferred option(s)
  - Preparation of Outline Business Case(s) and Decision Making Business Case
Case for Change

Challenges

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

Opportunities

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

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

<table>
<thead>
<tr>
<th>All West Midlands Emergency Departments</th>
<th>ED Consultant Hours per week (max 24x7 = 168)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Site</td>
<td>Number</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital, Birmingham</td>
<td>119.0</td>
</tr>
<tr>
<td>University Hospital, Coventry</td>
<td>119.0</td>
</tr>
<tr>
<td>City General Hospital, Stoke</td>
<td>117.3</td>
</tr>
<tr>
<td>County Hospital, Stafford</td>
<td>112.0</td>
</tr>
<tr>
<td>New Cross Hospital, Wolverhampton</td>
<td>97.0</td>
</tr>
<tr>
<td>Birmingham Children’s Hospital</td>
<td>92.9</td>
</tr>
<tr>
<td>Manor Hospital, Walsall</td>
<td>88.0</td>
</tr>
<tr>
<td>Good Hope Hospital</td>
<td>86.0</td>
</tr>
<tr>
<td>Heartlands Hospital, Birmingham</td>
<td>86.0</td>
</tr>
<tr>
<td>City Hospital, Birmingham</td>
<td>82.0</td>
</tr>
<tr>
<td>Sandwell General Hospital</td>
<td>82.0</td>
</tr>
<tr>
<td>Queen’s Hospital, Burton</td>
<td>81.0</td>
</tr>
<tr>
<td>Worcestershire Royal Hospital</td>
<td>79.0</td>
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<tr>
<td>Russells Hall Hospital, Dudley</td>
<td>77.0</td>
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<tr>
<td>George Eliot Hospital, Nuneaton</td>
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<td>Warwick Hospital</td>
<td>68.0</td>
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<td>The County Hospital, Hereford</td>
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<tr>
<td>Alexandra Hospital, Redditch</td>
<td>60.0</td>
</tr>
<tr>
<td>Royal Shrewsbury Hospital</td>
<td>58.0</td>
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<tr>
<td>Princess Royal Hospital, Telford</td>
<td>49.0</td>
</tr>
<tr>
<td>Solihull Hospital</td>
<td>40.0</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>82.3</td>
</tr>
</tbody>
</table>

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

**Engagement**
- Deliberative events
  - Ten
  - 180 locations
  - 1006 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
  - 69 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 direct feedback
  - 178 x sign up
  - Increased brand awareness
  - Positive workforce engagement

**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 queries handled
  - 75 of which from Shropshire Star and BBC Radio Shropshire
  - Seven rebuffs 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

**Future Fit**
- Shaping healthcare together

**Digital**
- Website
  - Established in December 2013
  - 7.11k 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
  - 234.25 total potential reach
  - 488 retweets/shares
  - 83 likes
- Blogs
  - Nine blogs on key themes

**Administration**
- Governance and Workstream
  - Planning
  - Evidence 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 138, 146
  - Telford Journal readership - 61,541
- Contact lists
  - 1860 stakeholders on contact list
  - 403 public on mailing list
- Telephone survey
  - Scientific data collection
  - Telephone interviews with residents living in Shropshire (40%), Telford & Wrek (31%) and East Powys (9%)
  - Exploring the use of hospitals and perceptions of plans to improve future healthcare delivery in Shropshire, Telford & Wrek and East Powys
- The survey results include responses from 1015 people

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

**Equality and diversity monitoring**
- Supporting integrated impact assessment
- Investigating gatekeepers to ‘hard to reach’ groups
- Running equality focus groups
Phase 2
Phase 2 (February 2014 - August 2014)

- **Determining the Overall Model of Clinical Services**

  - c. 300 clinicians worked together in sub-groups, cross-cutting theme groups and Clinical Reference Group to develop and endorse a new Clinical Model.
  - Model reviewed by WM Clinical Senate which confirmed unsustainability of current configuration

- **Identification and quantification of the levels of activity and capacity in each part of the Model**

  - Clinicians (with patients and managers) undertook 2 phases of modelling
  - Phase 1 modelled the impact on acute & community hospitals of implementing commissioner and provider efficiency strategies but with no major service change
  - Phase 2 involved clinicians agreeing key activity assumptions based on the implementation of the Clinical Model.
  - The resulting activity and capacity impact was then modelled & assumptions revisited to test potential for further efficiencies.
Phase 2 (February 2014 - August 2014)

- Determining the Feasibility of a Single Emergency Centre
  - A study was commissioned to test the feasibility of delivering a single emergency centre and a planned care centre at PRH, RSH and a potential new site

- Public Engagement on the Model of Care and Provisional Long-list & Benefit Criteria
  - Extensive pre-consultation engagement activities were undertaken with patients to inform the development of the Clinical Model, a long list of site scenarios and the criteria against which scenarios should be assessed.
  - An evaluation panel was formed of nominated representative of Programme Board Sponsors & Stakeholders which:
    - Generated 40 ideas for the configuration of services
    - Proposed a long list of 13 scenarios for acute/community sites
    - Identified five evaluation criteria
Clinical Model – design principles

- **Home is normal**
- **Empowerment for patients and clinicians**
- **Sustainability**
- **New ways of working**
Clinical Design Process
Reconciling
Sense checking
Modelling
Planning
Future proofing
Sustainability

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

Clinical Vision

Consensus

Evidence

Modelling
Options
Consultations
Reviews
Service description

Clinical Design Process
Emergency and Urgent Care Model

- Direct access and self care needs
- 111, 999 or walk in needs, LTC needs with planned access to urgent care
- 999 and needs transfer by emergency ambulance

Primary Care

- Advice Self Help Signposting

Urgent Care Centres

- Prompt specialist opinion
- Single High Acuity Centre

Emergency Centre

- Professional Navigation

Intermediate Care
- Home
- GP

Community Beds
- Out of Area
- Other
Emergency and Urgent Care Model

'SOME UCCS'
- Urgent Care Centre
- Therapies
- Mental Health
- Social Care
- Voluntary Sector?
- Diagnostics
- GP OOH
- Beds

Primary Care & Community Services

'ONE EC'
- Emergency Centre
- Specialties
- GP OOH
- Assessment Units
- Critical Care
- Diagnostics
- Urgent Care Centre
- Primary Care
Planned Care Model

**Planned Care**

- **Patients**
  - Education
  - Information
  - Prevention

- **Facilitated Self Management**
  - IT/Map of Medicine
  - Expert Patients
  - Voluntary groups

**System Navigators**

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

**Informed Direct Access**

- **Diagnosis known (simple)**

**Primary Care**

- **Diagnosis unknown (complex)**

**Self Help**

- Guided self care

**Low Intensity Input**

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

**Medium and High Intensity Input**

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

**Communication**

**Information/Education**
Activity and capacity modelling
Activity & Capacity Modelling Process

Establish Reference Group and confirm baseline

Reference Group Meetings

Report Results

<table>
<thead>
<tr>
<th>Workshop</th>
<th>Content</th>
</tr>
</thead>
</table>
| 1        | Review and confirm objectives and scope
|          | Agree conceptual model & model components |
|          | Set inpatient parameters (admission avoidance) |
| 2        | Set inpatient parameters (LoS Reduction) |
| 3        | Set demographics parameters |
|          | Set A&E parameters |
| 4        | Set outpatient parameters |
| 5        | Review initial results |
|          | Adjust parameters |
Overview of Modelling Approach

Baseline

Changes

- Activity Avoidance Strategies
- Provider Efficiency Strategies
- Reconfiguration
- Demographic Change
- Patient Flows

Results 2018/19

Acute Activity

Non-acute alternatives
Long Term Conditions & Frailty

• c10,000 NEL admits associated with frailty or LTCs in 2012/13.

• Phase 1 - admits fall by 8% by 2018/19 (after demographic change which ADDS 5%), largely through improvements in primary care management and through better use of community hospitals.

• Phase 2 - a further 24% avoided by reducing the prevalence of the key risk factors that give rise to LTCs (e.g. smoking, cholesterol, blood pressure) and through greater integration of community and primary care.
## Long Term Conditions
### Emergency Admissions and Bed Days

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

• 69% of front door urgent care activity at UCC
  (incorporating activity current managed in ED, direct GP admissions community hospital step-up admissions, MIU and WIC attendances, DAART assessments and GP OoH PCC contacts)

• 31% (c 68,000 attendances) requiring the emergency centre.

• 75% of UCC activity is minor injuries or ailments, 12% as ambulatory emergency care, 8% as frailty management with 5% taking other forms.
### Acute and Episodic Care – Allocation of Activity - Summary

<table>
<thead>
<tr>
<th>Activity</th>
<th>2012/13</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E Attendances</td>
<td>108,332</td>
<td>110,628</td>
</tr>
<tr>
<td>Direct Admissions</td>
<td>19,044</td>
<td>18,631</td>
</tr>
<tr>
<td>Community Hospital Step-Up</td>
<td>476</td>
<td>1,588</td>
</tr>
<tr>
<td>Hospital Assessments</td>
<td>108,332</td>
<td>110,628</td>
</tr>
<tr>
<td>OoA A&amp;E Attendances</td>
<td>5,409</td>
<td>5,498</td>
</tr>
<tr>
<td>MIU</td>
<td>17,878</td>
<td>18,266</td>
</tr>
<tr>
<td>WiC</td>
<td>38,611</td>
<td>39,068</td>
</tr>
<tr>
<td>DAART</td>
<td>3,525</td>
<td>3,719</td>
</tr>
<tr>
<td>GP OoH PCC</td>
<td>27,314</td>
<td>27,754</td>
</tr>
</tbody>
</table>

**Phase 1**

- **A&E Attendances**: 108,332 → 110,628
- **Direct Admissions**: 19,044 → 18,631
- **Community Hospital Step-Up Assessments**: 476 → 1,588

**Emergency Centre**

- **51,455**
- **57,886**
- **14,711**
- **2,289**

**Urgent Care Centres**

- **155,407**
- **3,919**
- **3,206**

**LTC Avoided**

- **1,291**
Planned Care

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

- Approximately 35,000 follow-up outpatient attendances managed by the local planned care centres could take place virtually.
Planned Care – Allocation of Activity (Bed Days) - Summary

**Phase 1 Model**

**SaTH Outpatient Attendances**
- **2012/13**: 365,188 (0)
- **2018/19**: 368,445 (0)

**SaTH Elective Admissions**
- **2012/13**: 79,334 (20,453)
- **2018/19**: 83,628 (23,875)

**Other Elective Admissions**
- **2012/13**: 200 (144)
- **2018/19**: 215 (151)

**Local Planned Care Centres**
- **2018/19**: 303,593* (0)
  - *of which 34,821 virtual

**Diagnostic and Treatment Centre**
- **2018/19**: 129,765 (6,228)

**Emergency Centre**
- **2018/19**: 18,930 (17,798)
Activity & Capacity Modelling
Change in acute beds requirement

<table>
<thead>
<tr>
<th>Component</th>
<th>Baseline 12/13</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Final 18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Adjustments</td>
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<tr>
<td>Admission Avoidance</td>
<td></td>
<td></td>
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<tr>
<td>LoS Reduction</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Interaction</td>
<td></td>
<td></td>
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<tr>
<td>Repatriate PCI</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Reduced LTC Prevalence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICS Avoided</td>
<td></td>
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<tr>
<td>Occupancy @ 85%</td>
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<tr>
<td>Intensive Rehab</td>
<td>290</td>
<td>-67</td>
<td>-34</td>
<td>82</td>
</tr>
<tr>
<td>DTC</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Emergency Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telford</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Sites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shrewsbury</td>
<td>455</td>
<td>13</td>
<td>36</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>745</td>
<td>13</td>
<td>36</td>
<td>102</td>
</tr>
</tbody>
</table>

Note: The diagram illustrates the changes in acute beds requirement across different components and phases.
Phase 2 projections were compared against regional and national comparators, indicating that:

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

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

<table>
<thead>
<tr>
<th>Longer Term Capital Costs</th>
<th>Scenario 1 RSH Emergency Centre &amp; Elective Centre</th>
<th>Scenario 2 PRH Emergency Centre &amp; Elective Centre</th>
<th>Scenario 3 Greenfield site Emergency &amp; Elective Centre</th>
<th>Scenario 4 Greenfield Emergency PRH Elective</th>
<th>Scenario 5 Greenfield Emergency RSH Elective</th>
<th>Scenario 6 RSH Emergency Centre PRH Elective Centre</th>
<th>Scenario 7 PRH Emergency Centre RSH Elective Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
<td>£,000s</td>
</tr>
<tr>
<td>Years 1 - 5</td>
<td>164,539</td>
<td>229,259</td>
<td>443,574</td>
<td>420,565</td>
<td>431,335</td>
<td>223,059</td>
<td>187,915</td>
</tr>
<tr>
<td>Years 6 - 10</td>
<td>190,114</td>
<td>32,479</td>
<td>163,170</td>
<td>164,278</td>
<td>166,718</td>
<td>141,690</td>
<td>148,670</td>
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<tr>
<td>Years 11 - 15</td>
<td>37,423</td>
<td>13,059</td>
<td>27,375</td>
<td>25,997</td>
<td>26,668</td>
<td>38,740</td>
<td>25,943</td>
</tr>
<tr>
<td>Years 16 - 20</td>
<td>11,358</td>
<td>188,710</td>
<td>20,169</td>
<td>19,195</td>
<td>19,678</td>
<td>11,794</td>
<td>369,625</td>
</tr>
<tr>
<td>Years 21 - 25</td>
<td>211,142</td>
<td>35,931</td>
<td>84,220</td>
<td>79,650</td>
<td>81,812</td>
<td>218,301</td>
<td>73,975</td>
</tr>
<tr>
<td>Costs of Land and Buildings over 25 years</td>
<td>614,575</td>
<td>499,438</td>
<td>738,508</td>
<td>709,686</td>
<td>726,213</td>
<td>633,584</td>
<td>806,129</td>
</tr>
<tr>
<td></td>
<td>Royal Shrewsbury Hospital (RSH)</td>
<td>Princess Royal Hospital (PRH)</td>
<td>New site (to be confirmed)</td>
<td>Community sites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>-----------------------------</td>
<td>-----------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Do minimum: Provider and Commissioner efficiency strategies implemented but no major service change. Existing dual site acute services (including A&amp;E)</td>
<td></td>
<td>-</td>
<td>Remain as they are: continue providing services as currently.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><strong>EC / UCC / LPC</strong></td>
<td><strong>DTC / UCC / LPC</strong></td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><strong>DTC / UCC / LPC</strong></td>
<td><strong>EC / UCC / LPC</strong></td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><strong>UCC / LPC</strong></td>
<td><strong>DTC / UCC / LPC</strong></td>
<td><strong>EC / UCC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><strong>DTC / UCC / LPC</strong></td>
<td><strong>UCC / LPC</strong></td>
<td><strong>EC / UCC</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td><strong>EC / DTC / UCC / LPC</strong></td>
<td><strong>UCC / LPC</strong></td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td><strong>UCC / LPC</strong></td>
<td><strong>EC / DTC / UCC / LPC</strong></td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><strong>UCC / LPC</strong></td>
<td><strong>UCC / LPC</strong></td>
<td><strong>EC / UCC / DTC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* the potential to locate consultant-led obstetrics (maternity services) either at the Emergency Centre or at PRH should be considered as a variant to these options.
Phase 3
Phase 3 (August 2014 - September 2015)

• **Identification of options and option appraisal**
  • Long list of scenarios appraised and shortlist recommended
  • Programme Board and Sponsor Board accept recommendations, add back Obstetric variants (pending further clinical work) and commission further (separated) work on rural urgent care solutions
  • Shortlist options more fully developed and appraised
  • Shortlisting decision reconsidered and confirmed on basis of more detailed financial information

• **Preparation of Strategic Outline Case(s)**
  • Options set out in SOC
  • New site options removed on affordability grounds (margin of £12-14m pa over remaining options)
  • Remaining options generate a surplus which would partially offset the underlying deficit
  • Commissioners develop letters of support for SaTH
  • SOC approved by SaTH Board and forwarded to NHS TDA.
Consolidates all non-elective activity on a single site, plus complex planned procedures (c.20%). 658 beds.

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

Non life threatening urgent care continues on both existing sites.

Routine planned care appointments continue on both existing sites.

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

N.B. Ambulatory cancer care unaffected – remains at RSH.
### The Clinical Model - Site Configuration Options

<table>
<thead>
<tr>
<th>A</th>
<th>Princess Royal Telford</th>
<th>Royal Shrewsbury Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>No change</td>
<td></td>
</tr>
</tbody>
</table>

| B | ![Emergency Centre](#) | ![Urgent Care Centre](#) | ![Local Planned Care Services](#) | ![Contraceptive and Obstetric Services](#) | ![Emergency Centre](#) | ![Urgent Care Centre](#) | ![Diagnostic and Treatment Centre](#) | ![Local Planned Care Services](#) |
|   | EC | UC | LPC | CSCO | EC | UC | DTC | LPC |

| C₁ | ![Emergency Centre](#) | ![Urgent Care Centre](#) | ![Diagnostic and Treatment Centre](#) | ![Local Planned Care Services](#) | ![Emergency Centre](#) | ![Urgent Care Centre](#) | ![Local Planned Care Services](#) | ![Contraceptive and Obstetric Services](#) |
|    | EC | UC | DTC | LPC | EC | UC | LPC | CSCO |

| C₂ | ![Emergency Centre](#) | ![Urgent Care Centre](#) | ![Diagnostic and Treatment Centre](#) | ![Local Planned Care Services](#) | ![Emergency Centre](#) | ![Urgent Care Centre](#) | ![Local Planned Care Services](#) | ![Contraceptive and Obstetric Services](#) |
|    | EC | UC | DTC | LPC | EC | UC | LPC | CSCO |
• Option B is preferred by a margin of 1% over Option C1

• Range of 1.3% between change options (B, C1, C2)

• The Do Nothing Option A is least preferred by a margin of 7.3%

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

Scoring the Options

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

<table>
<thead>
<tr>
<th>TOTALS</th>
<th>Agreed Weighting</th>
<th>Total Weighted Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Option A</td>
</tr>
<tr>
<td>ACCESSIBILITY</td>
<td>25.1%</td>
<td>56.0</td>
</tr>
<tr>
<td>QUALITY</td>
<td>31.2%</td>
<td>30.9</td>
</tr>
<tr>
<td>WORKFORCE</td>
<td>27.3%</td>
<td>21.6</td>
</tr>
<tr>
<td>DELIVERABILITY</td>
<td>16.3%</td>
<td>19.3</td>
</tr>
<tr>
<td><strong>100.0%</strong></td>
<td><strong>127.8</strong></td>
<td><strong>229.1</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RANK</th>
<th>DIFFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>50.3%</td>
</tr>
<tr>
<td>2</td>
<td>10.9%</td>
</tr>
<tr>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td>3</td>
<td>42.2%</td>
</tr>
</tbody>
</table>
# Overall Economic Appraisal

<table>
<thead>
<tr>
<th></th>
<th>Option A</th>
<th>Option B</th>
<th>Option C1</th>
<th>Option C2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-Financial Score</strong></td>
<td>127.8</td>
<td>229.1</td>
<td>257.2</td>
<td>148.7</td>
</tr>
<tr>
<td>Benefits Margin below 1st</td>
<td>-50.3%</td>
<td>-10.9%</td>
<td>-</td>
<td>-42.2%</td>
</tr>
<tr>
<td><strong>Non-financial Rank</strong></td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total EAC (£m)</strong></td>
<td>344.5</td>
<td>321.0</td>
<td>324.2</td>
<td>325.2</td>
</tr>
<tr>
<td>Financial Margin above 1st</td>
<td>7.3%</td>
<td>-</td>
<td>1.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Financial Rank</strong></td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Cost £m per Benefits Point</strong></td>
<td>2.7</td>
<td>1.4</td>
<td>1.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Overall Margin below 1st</td>
<td>113.9%</td>
<td>11.2%</td>
<td>-</td>
<td>73.5%</td>
</tr>
<tr>
<td><strong>Overall Rank</strong></td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Combined Scores (50:50)</strong></td>
<td>71.4</td>
<td>94.5</td>
<td>99.5</td>
<td>78.3</td>
</tr>
<tr>
<td>Overall Margin below 1st</td>
<td>28.2%</td>
<td>5%</td>
<td>-</td>
<td>-21.3%</td>
</tr>
<tr>
<td><strong>Overall Rank</strong></td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
In October 2015, the Programme Board was informed that the approval of any business case would depend on the development of wider plans to reduce the growing financial deficit in the local health economy. Board therefore agreed:

1. To note the outcomes of the process for appraising shortlisted options;

2. To defer reaching any conclusion about recommending a ‘preferred option’ to Sponsor Boards, until the Board is assured that there is an approvable case for investment;

3. To ask for an update at its November meeting on how commissioners and providers plan to take forward parallel discussions on dealing with the remaining financial deficit;

4. To ask SaTH to bring forward proposals for an interim solution to its workforce challenges that will ensure the ongoing safety of clinical services, and;

5. To ask its Core Group of Sponsor Chief Officers to urgently agree, and communicate to Board members, the implications of the current position for each of the Programme’s workstreams and the overall Programme timetable.