This paper provides the Board with an update on progress with developing the key products of Phase 1 of the Future Fit Programme. The full Programme Directors Report can be found in the Board Supplementary Information Pack.

Key items to bring to the attention of the Board are the outputs from:
- the Clinical Design Workstream
- the Community Hospitals Utilisation Work stream
- the Activity and Capacity Modelling Workstream

The full report from the clinical design and activity and capacity modelling workstreams can also be found in the supplementary information pack.
<table>
<thead>
<tr>
<th>Care Quality Commission (CQC) Domains</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Receive</th>
<th>Note</th>
<th>Review</th>
<th>Approve</th>
</tr>
</thead>
</table>

**Recommendation**

The Trust Board is asked to:

NOTE the Future Fit Programme Update and in specifically:

- the outputs from the clinical design work stream
- the outputs from the community hospital utilisation work stream
- the outputs from the acute hospitals activity work stream
Future Fit programme Update

1. Introduction

This paper provides the Board with an update on progress with developing key products for Phase 1 of the Future Fit Programme. Following the approval of the Programme Execution Plan (PEP) at the last meeting of the Programme Board, the PEP has since been received by sponsor Boards as follows:

- Shrewsbury & Telford Hospital NHS Trust – approved 30th January 2014;
- Shropshire Community Health NHS Trust – Case for Change approved 23rd January 2014, PEP to be considered 20th March 2014;
- Shropshire CCG – approved 12th February 2014;
- Telford and Wrekin CCG – on agenda for 11th March 2014, and;
- Powys LHB – to be considered on 16th April 2014.

The report provides an update on the key milestones for phase 1 of the programme as defined within the PEP:

- Securing clinical consensus on overall model of care
- Analysis of Community Hospital services and utilisation
- Acute Hospital services activity projections and categorisation
- Stakeholder engagement on high-level vision and model of care

The full Programme Directors Report can be found in the Board Supplementary Information Pack for information together with, a report of output from the Clinical Design Work stream and a report of Output from the Activity and Capacity Modelling Work stream. The key items from these papers to bring to the attention of the Board are summarised below.

2. Overall Model of Care

The Clinical Design work stream was established in November 2013 and used the results from the patients’ and clinicians’ Call to Action survey and meetings as a starting point for its work. The clinical design work stream considered the health and social economy as a whole and establish models of care which fully integrate all services within it with a view that the success of Future Fit is likely to depend on achieving whole system transformational change.

A Clinical Reference Group have met on a number of occasions and agreed on the three main areas of health care delivery that need to be defined

- Acute and Episodic Care;
- Long Term Conditions (LTCs)/ Frailty, and;
- Planned Care

Three subgroups were formed to consider these areas further; each subgroup comprising approximately 30 clinicians from health and social care along with patient representatives. The full report on outputs to date of each subgroup is available within the Boards Supplementary Information Pack. The Board are aware of early outputs of this work and the 3 graphics attached to this report as Appendix 1 summarise these clinical models.

2.1 Acute and Episodic care

A number of design principles were agreed by this sub group: care closer to home, a needs led service, integrated care, care by experts, consistent and consolidated services and sustainable systems. It was unanimous that the outcome was a single high acuity emergency centre, providing expert specialist and generalist led services, will provide multiple clinical benefits. It will consolidate resources, improve
teamwork and integration, improve quality and safety, allow more effective generalist support in lower acuity settings and provide an economy of scale and high volumes of care to maximise expertise and improve outcomes. ‘Some’ community based urgent care centres, staffed by expert generalists with easy access to specialist support, will provide services closer to home but at a sufficient scale to ensure consistent, effective and sustainable ‘modular’ services.

The preferred model is therefore for a single, fully equipped and staffed high acuity emergency centre with consolidated technical and professional resources delivering high quality emergency medical care 24hrs 7 days a week. A combination of expert generalists (Acute physicians, Care of the Elderly consultants and new roles etc) and specialists (Emergency department consultants and specialists) will provide early expert opinions at all times. It will serve as a trauma centre with a co-located critical care unit. Other adjacencies include facilities for ambulatory care and assessment units with multi-disciplinary teams (including mental health) specifically dealing with patients suitable for 0 day length of stay (LOS) pathways (ambulatory care) and <3 day length of stay (LTC and frailty syndromes). There will be also be full and immediately accessible diagnostic facilities, blood bank and pharmacy.

Access will be via 999 ambulance or co-located urgent care centre.

A single emergency centre will improve safety and quality of care and focus resources to improve teamwork. Integration and consolidation of the workforce will promote better working practices both within the unit and in providing support to generalists in lower acuity settings. Improved trust and relationships across different care settings will be embedded through partnership care and rotating / posts, some in new roles designed to promote integrated care and whole system pathways.

In terms of next steps, the report details the output of the Clinical Design work stream over the first 3 months of its activity and acknowledges that the models of care are emerging but are still at a high level. A process of refinement will continue through a number of cycles where they will be:

- Repeatedly tested using patient scenarios, patient characteristics and flow volumes and financial impact.
- A further detailed review of the evidence base around each component of the model will be undertaken.
- External clinical assurance will be sought from an expert clinical team overseen by the West Midlands Clinical Senate.
- Clinical engagement will be deepened, both by continuing involvement of the clinicians in the clinical reference group and subgroups, and through events, such as webinars and meetings, designed to reach 2/3 of the clinical workforce of Shropshire and Telford & Wrekin.
- Patient representatives and patient groups will continue to be involved and co creating at every stage of the process.

3. Community Hospitals Utilisation

Two community hospital workshops have been held. The group agreed that the results reflected the radical shift in the utilization of community hospital beds in terms of (a) reducing length of stay (b) increasing the proportion of admissions/occupied bed days for ‘step up’ rather than ‘step down’. The modelling showed that in 2018/19 the proportion of ‘step up’ admissions increases to 50% of all admissions compared to only 25% currently. Assumptions were agreed on the reduction of the current average length of stay of over 20 days (based on 12/13 data) to 12.5 days by 2018/19. This significant change was thought achievable through changes in the model of provision of community hospital services including the nature and scale of the skills and competences required of a multidisciplinary team. The impact this has on the admissions, bed days and beds is summarised in the table overleaf.
Overall the modelling showed only a marginal change in the total community hospital bed numbers required by 2018/19. Over the 2012/13 bed base of 124, an increase of 8 beds was needed if no improvement in age-specific utilisation rates (AS rates) was assumed, and a decrease of 6 beds was predicted taking this factor into account. There was however a significant increase in the proportion of ‘step up’ beds from the current level.

It is worth noting that both the community hospital utilisation study and to a degree, the acute hospital activity modelling referred to in Section 4 below have taken the outcome from a bed utilisation study that was carried out in SaTH and the four community hospitals in Shropshire last year in setting a number of assumptions. A maximum of 300 patients from the two acute hospitals and 113 patients from the community hospitals were identified.

The review determined if patients were at the correct level of care; if not, what level of care was needed, and also, what were the reasons the patient was not at the correct level of care. The two assumptions agreed by the Community Hospitals modelling group concerning the transfer of activity from SaTH to community hospitals were:

- Of the non-qualified admissions to SaTH where the required service level was defined as, ‘sub acute’, ‘rehabilitation intermediate’ or ‘intermediate’, 70% should be treated as ‘step up’ cases in community hospitals.
- Of the non-qualified bed days in SaTH where the required service level was ‘sub acute’, ‘rehabilitation intermediate’ or ‘intermediate’ care, 70% should be treated as ‘step down’ bed days in community hospitals.
4. Acute Hospital Services Activity Projections

Seven acute hospital workshops have been held to agree the clinical parameters on which activity and capacity modelling should be based. In this phase of work, the activity and capacity modelling has focused on the period 2012/13 (as the baseline year) to 2018/19. This modelling started from an evidence base and with acute, community and primary care clinicians represented, applied local clinical judgement to that evidence together with an assessment of benchmark performance using West Midlands Trust as the peer group. A number of parameters were considered around admission avoidance (30 parameters) length of stay reduction (20 parameters) A&E (7 parameters) outpatients (11 parameter) and demographics. In this phase of work, these judgements were made in the context of the current models of care with the objective of achieving improvements in the period to 2018/19 in both quality of services and efficiency.

The format of the workshops broadly followed these stages:
• understanding the current baseline activity and capacity
• demographic change projections
• comparing current performance in this health economy with performance across the West Midlands
• discussing the potential for the redesign of services and improve performance in the period 2018/19
• setting parameters eg LOS, admission avoidance schemes, ambulatory care, enhanced recovery
• producing a quantification of the activity and capacity required in the future state
• checking the assumptions and outputs by the groups to produce finalised outputs

4.1 Disability Free Life expectancy (DFLE)
In terms of the scale of impact of the different parameters, demographic change projections was by far the most significant factor in projecting activity and capacity requirements. In assessing the impact of demographic change, the utilisation rates of services for each year of age are ‘multiplied’ by the predicted change in the number of people (by year of age). In the workshops there was a debate concerning the evidence base that as people are ageing they are reporting less disability/ill-health, compared with the reporting of people of the same age in the past (time series data on Disability Free Life Expectancy from the early 1980s to the present was considered). There was also the challenge that although there may be a body of opinion/evidence to support this, it was uncertain whether this has had an impact on utilisation as there could be other influencing factors eg patient/public expectations.

In the analysis in section 4.2 below, two scenarios are shown one which assumes that age specific utilisation rates are static and the other which assumes that there will be continued improvements in DFLE, but at a slower rates than in recent years (referred to as moderated trend in disability free life expectancy {DFLE}). This means that:

• for people aged over 50 years, it was assumed that age specific utilisation rates decreased by one year (e.g. 75-year-olds in 2018/19 have a utilisation rates of 74 year olds in 2013/14)
• for people aged between 40 and 50 years, it was assumed there was a graduated reduction in utilisation (from no change at age 40 years to a one-year reduction in those aged 50 years).
• for people aged 40 years and under, it was assumed utilisation rates did not change

4.2 Number of Overnight Beds Required
The table overleaf shows the number of overnight beds required in 2018/19 based on the agreed parameters and shows four scenarios. The group agreed that in line with national guidance, an occupancy level 85% should be achieved (the scenarios below show both the baseline 96% occupancy and an 85% occupancy). The impact of keeping the age-specific utilisation rates static or including a reduction in age specific utilisation based on a moderated trend in DFLE are shown.
If there is no change in bed occupancy from the baseline 96%, the numbers of overnight beds required in 2018/19 are minus 49 compared with the current 747 beds if no DFLE adjustment is made and minus 84 beds if an adjustment is made for moderated trend in DFLE. If a bed occupancy of 85% is to be achieved, the number of overnight beds required in 2018/19 is plus 37 compared with the current 747 beds, with no DFLE adjustment and minus 1 bed if an adjustment is made for moderated trend in DFLE.

### 4.3 Activity beds and costs

The table below summarises how this maps out in activity projections, beds and costs:

<table>
<thead>
<tr>
<th>Model</th>
<th>Activity</th>
<th>Cost</th>
<th>Bed Days</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static DFLE</td>
<td>-7.9%</td>
<td>-6.4%</td>
<td>-7.0%</td>
<td>-6.6%</td>
</tr>
<tr>
<td>Mod Trend DFLE</td>
<td>-9.7%</td>
<td>-9.4%</td>
<td>-10.8%</td>
<td>-11.2%</td>
</tr>
<tr>
<td>Outpatients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static DFLE</td>
<td>-9.2%</td>
<td>-8.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mod Trend DFLE</td>
<td>-10.6%</td>
<td>-10.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static DFLE</td>
<td>+3.1%</td>
<td>+3.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mod Trend DFLE</td>
<td>+2.1%</td>
<td>+2.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Based on the same agreed parameters, this shows that if the service changes could be implemented by 2018/19, there would be a potential reduction in the inpatient and outpatient activity with a corresponding reduction in commissioners spending in acute and a potential decrease in provider capacity. The full summary report is available within the Board Supplementary Information pack.

5. Stakeholder Engagement

An Engagement and Communications plan has been worked on but is now going to be developed through a co-production event with key stakeholders in order to respond to some of the concerns raised about this aspect of the Programmes activities. Resources available have been limited. Activities to date include:

- Issuing of final branding templates;
- Work to develop a programme website;
- Publication of the first Programme Bulletin, and;
- Planning and delivery of 3 patient focus group events.

Once the Programme timeline is agreed for Phase 2, urgent consideration will need to be given to the resources required to support the proposed extended engagement activities.

6. Proposed Change to the Current Timetable

At the Programme Board on 10th March, there was a view from the programme team that more detailed work was required on the clinical models prior to further iterations of the activity projections could be completed. In particular, the Clinical Design work stream wishes to undertake further work with the subgroups and others on testing the emerging models against a wide range of clinical and patient scenarios. It also wishes to ensure that there is full opportunity for iterative ‘sense checking’ as numbers start to be applied to the models and for obtaining external clinical assurance. The work completed in Phase 1 appears to be far more ambitious and wide ranging than had been anticipated and there are concerns that a clinical design that focuses simply on hospitals will not be radical enough to deliver a sustainable solution. The approach of painting the full canvas emerged, out of which the Future Fit Programme then takes forward the elements within its scope and will define the critical dependencies to be taken forward by commissioners outside of its scope.

There was also a view that to do justice to the emerging models, and to maintain and extend the engagement we have had to date, will require more time. It was reported that whilst it would be possible to keep to the current timetable, this could impact on engagement and quality assurance of programme outputs. As a result, the Programme Team proposed a change to the current Programme timetable as previously defined within the PEP approved by the Board.

Whilst the Trust recognises the absolute need for a thorough engagement process and quality assurance of programme outputs, it has expressed real concerns about the proposed extended timescales due to the potential level of risk associated with key workforce shortages. The proposed changes to the Programme timetable suggest that the clinical design and activity modelling phase is extended to August 2014 rather than April; that there is a further 8 week period of extended engagement on the clinical model of care (October/November); and that work to develop the short list of options commences in October and brought to Boards in December. These timescales would then allow a consultation to proceed in June 2015 rather than the original timescales of October 2014.

It was agreed that the necessary planning for Phase 2 clinical design activities went ahead as proposed in the revised timescales. However it was agreed that further discussions outside of the full programme Board between the SROs and the provider CEOs continue, including consideration of whether certain elements of the scope and the timescales could be rephased due to the potential level of risk associated with key workforce shortages.
A verbal update on these discussions will be included at the Trust Board.

7. **Recommendations**

The Trust Board is asked to:

**NOTE** the Future Fit Programme Update and particularly:
- the outputs from the clinical design work stream
- the community hospital utilisation work stream
- the acute hospitals activity work stream

and **DISCUSS** the proposed change to the current timetable
Future Fit: Shaping Health together

Report to the programme board 10th March 2014

Outputs from the Activity and Capacity Modelling work stream
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2.1 Disability Free Life Expectancy ............................. Page 4
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3 Key findings from the Acute sector modelling .......... Page 5
3.1 Parameters set .................................................. Page 5
3.2 Number of overnight beds required ....................... Page 6
3.3 Activity, Beds and Costs ..................................... Page 6
4 Key findings from the Community Hospitals modelling ... Page 7
4.1 Parameters set .................................................. Page 7
4.2 Significant impact of reducing age-specific utilisation rates Page 8
4.3 Increased use of community hospitals for ‘step up’ admissions Page 8
4.4 Reducing length of stay ........................................ Page 8
4.5 Overall Community Hospitals bed numbers required .... Page 9
4.6 Predicted access to community hospitals by electoral ward Page 9
5 Next steps ............................................................ Page 9
6 Recommendations .................................................. Page 9
**Introduction/context**

In this phase of work, the activity and capacity modelling of the acute and community hospitals sectors has focused on the period 2012/13 (as the baseline year) to 2018/19. The outputs from the two workshops held on community hospitals, are completed and attached to this document. In relation to the acute sector modelling, seven workshops have been held and the outputs are nearly completed however a final piece of work is being undertaken on the volume of planned care needed to achieve waiting time standards (RTT), which will affect the activity and bed numbers, therefore a final set of outputs will be available by 14th March 2014.

Although a final set of calculations will be made on the acute sector modelling, the initial findings from this phase of modelling are summarised in this paper. These figures will change when finalised.

Please note that this is the first phase of modelling outputs and is not yet the definitive modelling output for the Future Fit programme. This modelling starts from an evidence base (limited by what evidence has actually been published) and through the workshops, applied local clinical judgement to that evidence. In this phase of work, these judgements were made in the context of the current models of care with the objective of achieving improvements in the period to 2018/19 in both quality of services and efficiency. The Clinical Design work stream is considering a radical alternative model of care and the second phase of modelling will be to assess the quantified outputs of that model. Following this there will then be a ‘sense checking’ stage with the objective of reconciling these two approaches and identifying the areas of greatest difference; these areas will be subjected to detailed clinical evaluation. All of these outputs will then form the basis for developing options to deliver the agreed models of care.

1. **Approach to/methodology for this phase of work**

The modelling period to 2018/19 aligns with the five year strategic plans being produced by the two CCGs (to be finalised in June 2014). The two groups considering the acute and community hospitals modelling assessed the potential changes which could be implemented during this period to deliver improved services. In addition to this phase of modelling further work will be undertaken based on the outputs from the Clinical Design work stream.

The format of the workshops broadly followed these stages:

- understanding the current baseline activity and capacity
- demographic change projections (shown in slides 8-10 in the Community Hospitals outputs attached).
- comparing current performance in this health economy with performance across the West Midlands
- discussing the potential for the redesign of services and improve performance in the period 2018/19
- setting parameters,
- producing a quantification of the activity and capacity required in the future state
- checking the assumptions and outputs by the groups to produce finalised outputs

More detail on the methodology is included in the output packs. Two significant factors which affect both the acute and community modelling are described below.
1.1 Disability Free Life Expectancy

In assessing the impact of demographic change, the utilisation rates of services for each year of age are ‘multiplied’ by the predicted change in the number of people (by year of age). In the workshops there was a debate concerning the evidence that as people are ageing they are reporting less disability/ill-health, compared with the reporting of people of the same age in the past [time series data on Disability Free Life Expectancy from the early 1980s to the present was considered]. Some members of the group were somewhat skeptical about the evidence base however others were more convinced; everyone understood that in terms of the scale of impact, this was a very significant factor in projecting activity and capacity requirements.

Agreement on this could not be reached therefore in the analysis two scenarios are shown one which assumes that age specific utilisation rates are static and the other which assumes that there will be continued improvements in DFLE, but at a slower rates than in recent years (referred to as moderated trend in disability free life expectancy {DFLE}). This means that:

- for people aged over 50 years, it was assumed that age specific utilisation rates decreased by one year (e.g. 75-year-olds in 2018/19 have a utilisation rates of 74 year olds in 2013/14)
- for people aged between 40 and 50 years, it was assumed there was a graduated reduction in utilisation (from no change at age 40 years to a one-year reduction in those aged 50 years).
- for people aged 40 years and under, it was assumed utilisation rates did not change

1.2 ‘Frail Elderly’ transfer of activity from SaTH to the community

In the early workshops held on the acute activity/capacity modelling, the group deferred agreeing assumptions on strategies to reduce activity in the acute sector of patients often referred to as the ‘frail elderly’. In the two workshops on community hospitals activity/capacity modelling, there was discussion and agreement on the assumptions which should be used. In the sixth (the penultimate) workshop of the acute modelling group it was agreed that the assumptions agreed by the community hospitals group should be modelled and in the final acute workshop, the outputs were considered and it was agreed that they should be included in the final set of outputs from the acute modelling group.

The Oak group utilisation study was carried out in SaTH and the four community hospitals in Shropshire. The audit was targeted at patients who had already been admitted to hospital. A maximum of 300 patients from the two acute care hospitals and 113 patients from the community hospitals were identified.

A review was done using the MCAP System to determine if patients were at the correct level of care; if not, what level of care was needed; and also if not, what were the reasons the patient was not at the correct level of care.

A second similar review was done on the admission day of each patient identified, and a third day was retrospectively reviewed to determine if possible, the change from qualified to non-qualified stay.

Information was collected from the patient notes in most instances; nursing and other staff were consulted when additional information was needed. More detail on the methodology is included on slide 46 of the attached pack.
The two assumptions agreed by the Community Hospitals modelling group concerning the transfer of activity from SaTH to community hospitals were:

Of the non-qualified admissions to SaTH where the required service level was defined as, ‘sub acute’, ‘rehabilitation intermediate’ or ‘intermediate’ (definitions on slides 50 and 51), 70% should be treated as ‘step up’ cases in community hospitals.

Of the non-qualified bed days in SaTH where the required service level was ‘sub acute’, ‘rehabilitation intermediate’ or ‘intermediate’, 70% should be treated as ‘step down’ bed days in community hospitals. Note that this calculation excluded bed days related to non-qualified admissions to SaTH.

2. Key findings from the Acute sector modelling

This work focused on admitted activity (inpatient and day case), outpatient activity, and emergency department (ED) attendances, in the baseline year of 2012/13 and projected future requirements in 2018/19.

The main change factors considered were: demographic change; commissioner strategies to reduce reliance on the acute sector; and activities to improve provider efficiency.

2.1 Parameters set

In order to set the parameters the group took into account the recent past trends in performance, comparisons with all other trusts in the West Midlands, the rate of change within Princess Royal Hospital and Royal Shrewsbury Hospital, and known local schemes/initiatives. For some factors the group did not believe there would be any change from the current performance by 2018/19. A full set of parameters used will be included in the finalised outputs.

Admitted care

Approximately 30 subgroups of admissions were considered which are commonly the focus of admission avoidance strategies. In some cases, the group reached a view that some level of reduction in admissions of this type was achievable, in other cases the group agreed that no change was likely by 2018/19. The assumptions concerning ‘Frail Elderly’ and the transfer of admitted cases from SaTH to the community are described above in section 2.2 above. Decisions about the potential to reduce the number of patients who are admitted and discharged on the same day without a coded intervention was deferred to the clinical reference group.

On length of stay reductions the following assumptions were made to different categories of activity as follows: specialty specific assumptions were made to improve day case rates and for some procedures a transfer from day case provision to outpatient procedures; for ‘enhanced recovery’ against specific cases/conditions there were length of stay reductions predicted (or no change predicted); on ambulatory emergency care categories of patients, improvements in zero day length of stay were predicted to achieve current best practice in the West Midlands.

Outpatients

GP referred first attendances; for most specialties it was assumed the regional average would be achieved.

New to follow up ratios; in general medicine a ratio of 1:2.5 was assumed; no change in general surgery or ophthalmology; T&O at Telford was to achieve the regional average.
Consultant to consultant referrals; to achieve the regional average.

**A&E parameters**
No change was predicted in either the volume of attendances from people living close to A&E or the volume of patients leaving A&E before being seen. Reductions in the number of investigations (by type) were predicted. Importantly it was predicted that on average 97% of attendees would be dealt with in four hours. Decisions about the potential to reduce the number of patients who attended A&E with a condition that could have been managed in a primary care setting was deferred to the clinical reference group.

**2.2 Number of overnight beds required**

The table below shows the number of overnight beds required in 2018/19 based on the agreed parameters and shows four scenarios. The group agreed that in line with national guidance, an occupancy level 85% should be achieved (the scenarios below show both the baseline 96% occupancy and an 85% occupancy). The impact of keeping the age-specific utilisation rates static or including a reduction in age specific utilisation based on a moderated trend in DFLE are shown. This summary will be adjusted when the bed requirement is for RTT are finalised.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Overnight Beds Available</th>
<th>Overnight Beds Occupied</th>
<th>% Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (2012/13)</td>
<td>747</td>
<td>714</td>
<td>96%</td>
</tr>
<tr>
<td>2018/19 (No change in occupancy – static age specific rates)</td>
<td>698</td>
<td>667</td>
<td>96%</td>
</tr>
<tr>
<td>2018/19 (Occupancy @ 85% – static age specific rates)</td>
<td>784</td>
<td>667</td>
<td>85%</td>
</tr>
<tr>
<td>2018/19 (No change in occupancy – reducing age specific rates)</td>
<td>663</td>
<td>634</td>
<td>96%</td>
</tr>
<tr>
<td>2018/19 (Occupancy @ 85% – reducing age specific rates)</td>
<td>746</td>
<td>634</td>
<td>85%</td>
</tr>
</tbody>
</table>

If there is no change in bed occupancy from the baseline 96%, the numbers of overnight beds required in 2018/19 are minus 49 compared with the current 747 beds if no adjustment is made to age specific utilisation rates, and minus 84 beds if an adjustment is made for moderated trend in DFLE.

If a bed occupancy of 85% is to be achieved, the number of overnight beds required in 2018/19 are plus 37 compared with the current 747 beds, if no adjustment is made to age specific utilisation rates, and minus 1 bed if an adjustment is made for moderated trend in DFLE.

**3.3 Activity, Beds and Costs**
The table below shows the percentage change in 2018/90 over the 2012/13 baseline in terms of
activity levels, the financial value of the activity based on tariff, and for admitted care the change in bed days and beds required. The transfer of care from SaTH to the community hospitals for non-qualified admissions and bed days, described in section 2.2, is included in these calculations. Both scenarios concerning disability free life expectancy of either a static position or moderated adjustment are shown. No adjustment has been made in the ‘beds’ column to achieve the 85% occupancy level.

<table>
<thead>
<tr>
<th>Model</th>
<th>Activity</th>
<th>Cost</th>
<th>Bed Days</th>
<th>Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static DFLE</td>
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<td>-7.0%</td>
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</tr>
<tr>
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<tr>
<td><strong>Outpatients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static DFLE</td>
<td>-9.2%</td>
<td>-8.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mod Trend DFLE</td>
<td>-10.6%</td>
<td>-10.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Static DFLE</td>
<td>+3.1%</td>
<td>+3.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mod Trend DFLE</td>
<td>+2.1%</td>
<td>+2.3%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table above, based on the agreed parameters, shows that if the service changes could be implemented by 2018/19, there would be a reduction in the inpatient and outpatient activity with a corresponding reduction in commissioners spend and a decrease in provider capacity. The financial calculation which is based on tariff does not therefore assess the level of cost reduction which SaTH could make. Furthermore, as was shown in section X, the number of staffed beds would remain static, even with reduced age-specific utilisation rates, if an 85% occupancy level was to be achieved; the costs of staffing beds to achieve an 85% occupancy level have not been calculated. These figures are likely to change when finalised.

3. **Key findings from the Community Hospitals modelling**

3.1 **Parameters set**

- Remove all but 7.5% of non-qualified admissions from Community Hospitals
- Assume same level of NQ admissions in step-up and step-down care
- Assume RJAH has same level of NQ admissions

- Remove proportion of non-qualified bed days – such that average length of stay is reduced to 12.5 days
- Do not remove bed days related to non-qualified admissions
Reduce length of stay in step-up and step-down care by the same rate

- Transfer 70% of non-qualified admissions from SaTH where the required service level was sub-acute, rehab intermediate or intermediate
  Treat these cases as step-up cases

- Transfer 70% of non-qualified bed days from SaTH where the required service level was sub-acute, rehab intermediate or intermediate
  Do not remove bed days related to non-qualified admissions
  Treat these as step-down cases

- Reduce overnight occupancy to 85%
  Current position in 2012/13 c.95%

- Redistribute activity geographically relative to need
  At ward level using population aged 75+ as marker of relative need

- Assume Community Hospitals service Shropshire population only

4.2 Significant impact of reducing age-specific utilisation rates

If no account is taken of reducing age-specific utilisation rates then demographic growth and the changing age profile would increase ‘step up’ admissions to community hospitals by nearly 19% and ‘step down’ admissions by nearly 17% by 2018/19; however this growth is reduced to only 6% for both types of admissions if a reduction in age to utilisation rates is assumed (i.e. moderated trend in DFLE).

4.3 Increased use of community hospitals for ‘step up’ admissions

When patients cannot be treated in their usual place of residence, the modelling group wanted to see better access to community hospitals for ‘step up’ admissions. As previously noted, a proportion of the non-qualified admissions identified in the Oak group study at SATH would transfer to community hospitals. The modelling therefore shows that in 2018/19 the proportion of ‘step up’ admissions increases to 50% of all admissions compared to only 25% currently; a somewhat similar pattern of change is reflected in the bed days and beds calculations (the detailed figures are shown in slide 23)

4.4 Reducing length of stay

Within the community hospital modelling group there was considerable discussion about the assumption agreed on the reduction of the current average length of stay of over 20 days to 12.5 days by 2018/19. Changes in the model of provision of community hospital services including the nature and scale of the skills and competences required of a multidisciplinary team providing these services were debated. Overall there was considerable confidence that the reduction in the average length of stay could be achieved and this work would be taken forward through the community hospitals group which had been established and should link into the Future Fit, Clinical Design work stream.

4.5 Overall Community Hospitals bed numbers required

Overall the modelling showed only a marginal change in the total community hospital bed numbers required by 2018/19. Over the 2012/13 bed base of 124, an increase of 8 beds was needed if no improvement in age-specific utilisation rates was assumed, and a decrease of 6 beds was predicted
taking this factor into account. There was however a significant increase in the proportion of ‘step up’ beds from the current level of 20% to over 40%.

4.6 Predicted access to community hospitals by electoral ward

In line with most service provision, proximity to services drives an inequitable level of access and this is the case for community hospitals. As the role of community hospitals develops in the way envisaged by the modelling group, the principle of achieving greater equity of access must be addressed practically. The maps (slides 24 to 27) show the projected increases and decreases of ‘step up’ and ‘step down’ admissions by electoral ward in 2018/19 compared with current usage (slide 28 shows this in a table).

5 Next steps

5.1 The final set of outputs from the acute modelling workshops will be made available by 14th of March 2014

5.2 The next phase of modelling work, to be overseen by the activity and capacity work stream will be determined in conjunction with the Clinical Design work stream.

5.3 The activity and capacity work stream must be aligned to the Finance work stream.

6 Recommendations

The programme board is asked to:

6.1 Note the outputs from the community hospitals modelling workshops and that the outputs from the acute modelling workshops will be available by 14 March 2014

6.2 Consider the key messages in this summary paper and, if appropriate, give direction to the next phases of the activity and capacity work stream.
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      7.1.1 Patient empowerment & navigation
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8. Cross cutting themes
9. Whole system synergies
10. Next steps
1. Introduction

The Clinical Design workstream was established in November 2013 and used the results from the patients’ and clinicians’ Call to Action survey and meetings as a starting point for its work. From this, it has established an approach to ensure that the future of hospital and community services is considered within the context of the whole system. It has embedded a process which maximises patient and clinician engagement and co-creation, and agreed that there is a compelling case for change. It has also considered the clinical and design principles applicable to the whole system and key components within it, examined the national and international evidence base and formulated high level models of care across the whole system which have undergone some initial testing.

The output up to this point, together with a summary of next steps, is described fully in the following report.

2. Scope of the Clinical Design workstream

The design of high quality, safe, efficient and sustainable hospital services must be done within the context of a coherent and deliverable whole system plan. So, although the scope of the FutureFit programme is confined to the future of acute and community hospital services, the clinical design work stream is required to consider the health and social economy as a whole and establish models of care which fully integrate all services within it. The success of FutureFit is likely to depend on achieving whole system transformational change. This has significant implications for commissioners as well as the organisations, services and workforce that currently lie beyond the scope of this programme.

3. Process

Following the Call to Action surveys and events, a Clinical Reference Group comprising 50 senior clinicians from health and social care, along with patient representatives, met on November 20th 2013 to receive the results, from which a case for change was established and whole system design principles were debated and agreed.

The Clinical Reference Group met again on January 29th 2014, during which it confirmed the output from the first meeting, suggested what success would look like and how to measure it and discussed the clinical and design principles applicable to the three main areas of health care delivery:

- Acute and Episodic Care;
- Long Term Conditions / Frailty, and;
- Planned Care.
Three subgroups were formed to consider these areas further; each subgroup comprising approximately 30 clinicians from health and social care along with patient representatives. They each met for six hours during February 2014 to add more detail to the design and clinical principles, to establish high level models of care in each area and to begin a process of sense checking, testing and refinement of the models.

The core Clinical Design workstream, reporting to the Programme Team, has planned and overseen this process and will remain responsible for the next steps described at the conclusion of this report.

4. The Case for Change

4.1 Background

There are already some very good health services in Shropshire, Telford and Wrekin. They have developed over many years to try to best meet the needs and expectations of the populations served, including that of Mid-Wales. Nevertheless, when we look at the changing needs of the population now and that forecast for the coming years; when we look at the quality standards that we should aspire to for our population, as medicine becomes ever more sophisticated; and when we look at the economic environment that the NHS must live within; then it becomes obvious that the time has come to look again at how we design services so we can meet the needs of our population and provide excellent healthcare services for the next 20 years.

When considering the pattern of services currently provided, our local clinicians and indeed many of those members of the public who have responded to the recent Call to Action consultation, accept that there is a case for making significant change provided there is no predetermination and that there is full engagement in thinking through the options. They see the opportunity for:

- Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills
- Reduced morbidity and mortality through ensuring a greater degree of consultant-delivered clinical decision-making more hours of the day and more days of the week through bringing teams together to spread the load
- A pattern of services that by better meeting population needs, by delivering quality comparable with the best anywhere, by working through resilient clinical teams, can become highly attractive to the best workforce and can allow the rebuilding of staff morale
- Better adjacencies between services through redesign and bringing them together
- Improved environments for care
- A better match between need and levels of care through a systematic shift towards greater care in the community and in the home
- A reduced dependence on hospitals as a fall-back for inadequate provision elsewhere and instead hospitals doing to the highest standards what they are really there to do (higher dependency care and technological care)
A far more coordinated and integrated pattern of care, across the NHS and across other sectors such as social care and the voluntary sector, with reduced duplication and better placing of the patient at the centre of care. They see the need and the potential to do this in ways which recognise absolutely the differing needs and issues facing our most dispersed rural populations and our urban populations too.

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

4.2 The Challenges

Our local clinicians and respondents to the Call to Action also see this opportunity to systematically improve care as being a necessary response to how we address the many challenges faced by the service as it moves forward into the second and third decades of the 21st century.

These challenges are set out below - they are largely outside our control and we have to adapt our services to meet them:

4.2.1 Changes in our population profile
The remarkable and welcome improvement in the life expectancy of older people that has been experienced across the UK in recent years is particularly pronounced in Shropshire where the population over 65 has increased by 25% in just 10 years. This growth is forecast to continue over the next decade and more. As a result the pattern of demand for services has shifted with greater need for the type of services that can support frailer people, often with multiple long-term conditions, to continue to live with dignity and independence at home and in the community.

4.2.2 Changing patterns of illness
Long-term conditions are on the rise as well, due to changing lifestyles. The means we need to move the emphasis away from services that support short-term, episodic illness and infections towards services that support earlier interventions to improve health and deliver sustained continuing support, again in the community.

4.2.3 Higher expectations
Quite rightly, the population demands the highest quality of care and also a greater convenience of care, designed around the realities of their daily lives. For both reasons, there is a push towards 7-day provision or extended hours of some services, and both of these require a redesign of how we work given the inevitability of resource constraints.

4.2.4 Clinical standards and developments in medical technology
Specialisation in medical and other clinical training has brought with it significant advances as medical technology and capability have increased over the years. But it also brings challenges. It is no longer acceptable nor possible to staff services with generalists or juniors and the evidence shows, that for particularly serious conditions, to do so risks poorer outcomes. Staff are, of course, aware of this. If they are working in services that, for whatever reason, cannot meet accepted professional standards, morale falls and staff may seek to move somewhere that can offer these standards. It is also far more difficult
to attract new staff to work in such a service. Clinicians are a scarce and valuable resource. We must seek to deploy them to greatest effect.

### 4.2.5 Economic challenges

The NHS budget has grown year on year for the first 60 years of its life ......in one decade across the turn of the 21st century its budget doubled in real terms. But now the world economy, and the UK economy within that, is in a different place. The NHS will at best have a static budget going forward. And yet the changing patterns of population and resultant need, the increasing costs of ever improving medical technology, the difficulties in simply driving constant productivity improvements in a service that is 75% staff costs and that works to deliver care to people through people, mean that without changing the basic pattern of services then costs will rapidly outstrip available resources and services will face the chaos that always arises from deficit crises.

### 4.2.6 Opportunity costs in quality of service

In Shropshire and Telford and Wrekin the inherited pattern of services, especially hospital services, across multiple sites means that services are struggling to avoid fragmentation and are incurring additional costs of duplication and additional pressures in funding. The clinical and financial sustainability of acute hospital services has been a concern for more than a decade. Shropshire has a large enough population to support a full range of acute general hospital services, but splitting these services over two sites is increasingly difficult to maintain without compromising the quality and safety of the service.

Most pressingly, the Acute Trust currently runs two full A&E departments and does not have a consultant delivered service 16 hours/day 7 days a week. Even without achieving Royal College standards the Trust currently has particular medical workforce recruitment issues around A&E services, stroke, critical care and anaesthetic cover. All of these services are currently delivered on two sites though stroke services have recently been brought together on an interim basis. This latter move has delivered measurable improvements in clinical outcomes.

### 4.2.7 Impact on accessing services for populations living in two urban centres and much more sparsely populated rural communities

In Shropshire, Telford and Wrekin there are distinctive populations. Particular factors include our responsibility for meeting the health needs of sparsely populated rural areas in the county, and that services provided in our geography can also be essential to people in parts of Wales. Improved and timely access to services is a very real issue and one which the public sees as a high priority. We have a network of provision across Community Hospitals that can be part of the redesign of services to increase local care.
5. Acute and Episodic Care

5.1 Key Principles

5.1.1 Care close to home
An enhanced and integrated education and prevention programme, driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim, without which the sustainability and quality of services in the future will be seriously threatened. This is discussed further in the LTC section.

Easy access to understandable and trustworthy information about self care options and local services, combined with clear signposting to points of access appropriate for the level of urgent or emergency care required.

A single point of access for professionals to navigate patients to a wider range of integrated and community based services.

Urgent (not emergency) care delivered by expert community generalists as a default, with prompt access to specialist advice and opinion when required.

5.1.2 A needs led service
Patient access to urgent and emergency care should be dependant on the level of care they require. Quality, safety and achieving the best outcomes will come before choice. Services will be rationalised so they are more consistent in their quality and the services they offer. This will make it easier to effectively triage, signpost and brand to ensure more appropriate attendances at the right point of care, which should be the least intensive level required to fully meet every patient’s needs in order to maximise efficiency and reduce iatrogenic harm.

5.1.3 Integrated care
Integrated care records are a necessary component of an integrated health and social care system and their development should be of the highest priority. Patients regard them as a reasonable proxy for continuity of care.

Agreed pathways of care should run seamlessly across the whole system and span whole patient journeys. They should be consistent across all localities, 7 days a week. Local variation due to rurality should not obstruct integration.

There should be smooth transitions between levels of care. Providers should define their transitions as carefully as their core business.

Holistic assessments should be the default in all care settings.

5.1.4 Care by experts
An early expert opinion should be available from senior clinicians in all settings. A principle of right care first time: ‘triage – diagnose – treat / palliate’ should be the default.
An education, training and workforce review will be required and new roles developed in order to provide expert opinions in all settings 7 days a week.

5.1.5 Consistent and consolidated services

A single high acuity emergency centre, providing expert specialist and generalist led services, will provide multiple clinical benefits. It will consolidate resources, improve teamwork and integration, improve quality and safety, allow more effective generalist support in lower acuity settings and provide an economy of scale and high volumes of care to maximise expertise and improve outcomes.

‘Some’ community based urgent care centres, staffed by expert generalists with easy access to specialist support, will provide services closer to home but at a sufficient scale to ensure consistent, effective and sustainable ‘modular’ services.

5.1.6 Sustainable systems

The ‘critical mass’ of urgent and emergency care delivered by one emergency centre and ‘some’ urgent care centres will enhance recruitment and retention of staff.

Continuous monitoring and learning should be embedded to allow service evolution and improvements and to develop predictive forward planning.

Commitment to this model of care should be long term.

5.2 Model of Care for Acute and Episodic Care

5.2.1 Patient Flows

An internet ‘patient portal’, available on all platforms, will provide easy, trustworthy and localised information regarding self help, advice and signposting. This will include and integrate health, social and voluntary sector information.

A ‘Smart’ Single point of telephone access (111) will intelligently triage all requests for urgent care (defined as requests for same day assessment) and signpost patients to the right point of care, including the capacity to make appointments at their GP practice if less urgent, or at one of the urgent care centres. This service will be linked to a live demand and capacity management system to improve patient flow.

As a default, LTC urgent care should be ‘planned’ as active case management will detect exacerbation at an early stage.

There will be increased signposting to local pharmacies for low level urgent care advice and treatment. Pharmacies will ‘cluster’ with GP practices and develop closer working relationships.

5.2.2 One Emergency Centre

A single, fully equipped and staffed high acuity emergency centre with consolidated technical and professional resources delivering high quality emergency medical care 24hrs 7 days a week. A combination of expert generalists (Acute physicians, COE consultants and new roles etc) and specialists (ED consultants and specialists) will provide early expert opinions at all times. It will serve as a trauma centre with a co-
located critical care unit. Other adjacencies include facilities for ambulatory care and assessment units with multi-disciplinary teams (including mental health) specifically dealing with patients suitable for 0 day length of stay (LOS) pathways (ambulatory care) and <3 day length of stay (LTC and frailty syndromes). There will be also be full and immediately accessible diagnostic facilities, blood bank and pharmacy.

Access will be via 999 ambulance or co-located urgent care centre.

A single emergency centre will improve safety and quality of care and focus resources to improve teamwork. Integration and consolidation of the workforce will promote better working practices both within the unit and in providing support to generalists in lower acuity settings. Improved trust and relationships across different care settings will be embedded through partnership care and rotating / posts, some in new roles designed to promote integrated care and whole system pathways.

5.2.3 ‘Some’ Urgent Care Centres
Multiple units provided at ‘cluster’ GP practice level of ‘modular’ and consistent design to provide low and medium levels of urgent medical and care input. Some diagnostic facilities and a pharmacy will be available on site. Co-located with a range of mental health, community and voluntary sector services, GP Out of Hours, and in some centres medium acuity beds. Timely expert generalist opinion available 7 days. One Urgent Care Centre (UCC) will be co-located with the Emergency Centre and receive all the ‘walk in’ patients who will not be able to access the Emergency Centre unless transferred by a clinician from the UCC. Urgent Care Centres will be staffed by a combination of advanced practitioners and GPs from the ‘cluster’ of practices surrounding it. From a GP practice perspective, urgent care will be provided at cluster level, whilst LTC management and other non urgent work will remain at practice level. Continuity of care at urgent care centres will be achieved through integrated care records, whilst continuity of care for patients with LTCs will be through a named clinician or keyworker (in addition to integrated care records).

5.2.4 Partnership Care
Specialist support will be easily and quickly available to support generalists in lower acuity care settings, including urgent care centres. This will be in the context of the development of partnership care across all care settings with a re-definition of generalist and specialist roles to include a greater teaching and learning component to increase generic skills and improve the consistency of care. Communication between professionals will be frequent and direct (not via a third party) which will improve working relationships, feedback and learning. This model is described in more detail in the LTC section.

5.2.5 Professional Navigation
There will be a single point of access (SPA) for professionals to arrange further care and support for patients following their urgent or emergency care contact. This SPA will act as a portal to a wide range of community based integrated care options. For complex care issues, the SPA will initiate contact but care planning will then be finalised through direct conversation between professionals. For simple care issues,
a ‘handover’ will be managed through the SPA service with integrated care records serving as a valid proxy for continuity of care.

5.2.6 Integrated Community Care

Urgent and emergency care will be delivered in the context of whole system integration. Services will be provided by teams around the patient, not by a series of independent professionals working within their own organisations and professional boundaries. Community capacity will be built to keep people at home and out of hospital, deliver reablement in the community, enhance the role and involvement of primary care and consistently deliver the right care in the right place by the right staff. Access to these services will be available from all points of patient contact via the SPA. This is further discussed in the LTC section.

5.3 Diagrams of the Acute and Episodic model of care
6. Long Term Conditions and Frailty

6.1 Key Principles

6.1.1 Enable patient responsibility for prevention, self care, maintenance and accessing appropriate care

Enabling patient responsibility should be embedded in all models of care. Although there is mixed evidence of short term impact on admissions and cost, there is an overwhelming case for empowering citizens and communities to be co-responsible for managing their lives and social environment, whatever their health status.

Many long term conditions are preventable and systematic secondary prevention shows improved outcomes. The medium and long term potential for reduction in health and social care demand is great.

Targeted prevention activities in social care have demonstrated impact although there is currently no statutory obligation for Local Authorities to invest in prevention.

Public Health and all other stakeholders must be involved and particular focus is required for hard to reach groups. The prevention agenda should form part of the school curriculum.

Behaviour change, education and support will often be more effective and sustainable if delivered by peers rather than professionals.

Self management of Long Term Conditions is at an early stage of development with little hard evidence as yet to support significant investment. It is the view of the clinicians locally however that it is aligned with the principles of citizen empowerment and community mobilisation as well as the emergence of assistive technology, self care should be a central component of LTC management.

People with co-morbidities and who are frail have less capacity for self management and require a different approach, especially when they are ill. Frailty syndromes are now recognised as an independent risk of worse outcomes and do not fit well into pathway driven care which the patient can be co-responsible for. They require a named key worker or responsible clinician with whom they can share decisions and who can act as their advocate. This is also the case for other vulnerable groups such as people with learning difficulties.

6.1.2 Generalist care as a default, with partnership care between generalists and specialists and clearly defined indications for specialist care

Generalists perform holistic assessments as a default and should be available in all care settings. Workforce planning and redesign will increase the number of generalists, many of whom will also develop specialist skills. This includes GPs, community health professionals and acute care clinicians. They will be responsible for initial assessment as well as the co-ordination and continuity of care for the majority of patients.
Specialists will offer timely response to support generalist care. They will assume greater responsibility for education and learning to improve the generic skills of generalists in all care settings. They will continue to be responsible for the care of the most complex patients.

Partnership care between generalists and specialists will become the norm with a more dynamic and greater range of options to share the care of patients through meaningful and direct conversation, interaction and information flow. This will allow the care of a greater proportion of patients to be managed by generalists in a community setting with targeted specialist input when required. Resources must shift to support this.

Partnership care will be developed across the whole health and social economy. The integrated health and social care of a patient will be provided ‘in parallel’ (not ‘in series’ as is currently the case) with shared risk management.

Better relationships will allow ‘honest feedback’ and more effective mutual and case based learning.

Age transitions, especially in mental health and paediatric care are currently a problem which will be resolved when continuity of care is managed by a community generalist working across all age groups.

Integrated care records are a key requirement for partnership care.

6.1.3 Provide a better match between needs and levels of care through a systematic shift towards greater care in the community

People prefer to be cared for in their own home whenever possible, even when they are ill.

Too much care is currently provided at levels of care which are higher than patients require to meet their needs. This is not only resource inefficient, but also increases the risk of iatrogenic harm. Up to 30% (?) of people admitted to acute hospitals could be managed safely and effectively in a different care setting and at a lower level of care.

Patients cared for at home remain connected to their family and carers. Community support remains continuous and the patient is less likely to ‘decompensate’ by being cared for in a bed based acute environment which is also much more stressful. Individualised care can be delivered more easily by integrated teams. The potentially difficult and harmful transitions from home to hospital and back again are removed. Performing an accurate and holistic assessment of needs is much more difficult when a patient is not in their usual living environment.

Home will not be the right place to care for everyone who is ill. Some of course require high levels of care in an acute hospital bed, but other alternatives must be provided that offer a ‘medium’ level of care.
Community capacity must be built to accommodate this shift. The required shift in resources to achieve this poses a challenge. It is not necessarily cheaper to provide care at home when intensive input is required.

6.1.4 Move from reactive to proactive care, including risk stratification, care planning, early detection and intervention and ‘planned’ urgent care

The evidence base supports the provision of proactive care for a number of specific conditions but does not yet show improved outcomes for people with multiple co-morbidities and frailty. Nevertheless, the new GP contract and local clinician consensus both support a move to providing more proactive care. Clinical experience strongly suggests that it reduces the number and severity of crises and gives reassurance to patients, families and carers that they know what to do and who to contact in the early stages of exacerbation.

There is uncertainty about what percentage of the ‘at risk’ population would benefit from active case management. It is important not to shift resources into ineffective interventions and targeted proactive care will remain preferable until the evidence base is clearer.

6.1.5 Provide timely response to exacerbation and ensure enhanced recovery and rapid reablement with a minimum time spent in acute care settings

Integrated multi-disciplinary teams are needed to address all the issues, both in community and acute settings and care must remain joined up at all times.

An exacerbation related to an existing LTC should not require admission, but may require diagnostics.

Once in hospital, the LTC tends to be ignored in preference to the exacerbation and the patient has an ‘asymmetric’ experience of their assessment and care because of this. Holistic assessment as a default will address this.

Discharge planning must start at the time of admission, and patients think this should be done by the ward staff caring for them, not a separate team. Provide Estimated Dates of Discharge for all patients soon after admission.

Standardise simple discharge processes and provide bespoke planning for complex discharges.

Employ strategic operational planning to maximise 0 day length of stay (ambulatory care and <3 day length of stay (frailty teams) in acute settings.

‘Discharge to assess’ as default once medical condition stabilised. Reablement at home where possible and in community setting if not. Aim to return patient to original level of care.

Resolve governance issues around free NHS and assessed social care which currently inhibit integrated care.
6.1.6 Diagnose and plan the last year of life and stop sending people to hospital to die.

Once fully embedded, End of Life (EOL) care will become part of ‘the day job’ but this will require care co-ordination and equity of care for all terminal conditions. EOL care is currently unstructured and patchily commissioned. To improve this, a consolidated EOL package will provide better care and reduce costs. A roving palliative care team would be effective and cost efficient.

6.2 Model of Care for LTC

6.2.1 Prevention

An economy wide prevention strategy driven by a commitment to wellbeing as a primary health, social, economic, political and cultural aim.

Targeted primary prevention across all health and social care settings employing ‘make very contact count’ and upskilling the workforce in behavioural and motivational change techniques.

Systematic secondary prevention.

6.2.2 Partnership Care

Primary care generalists (mainly GPs) retain continuing responsibility for care and co-ordination with rapid access to specialist support as required.

A menu of options to facilitate timely and personal communication between generalist and specialist to share decisions and improve care planning for patients at all levels of acuity: routine, urgent, emergency and end of life.

Clinical conversations, mutual learning and honest feedback will improve working relationships and the quality of care.

Direct access for generalists to pathway driven diagnostics to reduce unnecessary secondary care referrals.

Specialists will continue to manage and be responsible for the continuing care of a smaller number of the most complex patients, but with a greater responsibility for education and upskilling the generalist workforce.

6.2.3 Self Management and Care Planning

Upscale self management programmes and combine with care planning as a routine for anyone with an LTC.

Active case management for those at high risk, targeted initially to those conditions where benefit is evidenced.

Upscale peer and community support programmes
6.2.4 Integrated teams

Integrated multi-disciplinary teams providing case management, timely response to exacerbation and facilitating discharge.

Strong links with primary care, ‘teams around the practice’ aligned with ‘teams around the patient’.

Specialist skills linked to and augmented by integration with acute care specialists.

Sustainability achieved through generic upskilling across professional boundaries, using individual specialist skills as the teaching resource.

Embed continuous learning and review within the teams to ensure maximum effect from integration

6.2.5 Increased levels of care

Timely and appropriate response to exacerbation through a ‘tiered’ increase in level of care:

- Low medical input provided by a ‘hospital at home service’ for minor exacerbations where short term additional care and rehabilitation at home allows the patient to continue living independently. With effective case management and early detection of exacerbation, this level of care will be appropriate for an increasing proportion of people with LTC exacerbations.

- Medium medical input provided in a community setting, but not in the patient’s home. ‘Step up’ higher intensity care and rehabilitation can be combined with more frequent and expert medical input to hasten recovery with the aim of returning to the original level of care. Integration of care in these settings with care provided in acute settings will improve quality and flow.

- High medical input provided in a single high acuity unit with a consolidated and integrated workforce as described in the key principles.

6.2.6 Reablement and rehabilitation

Discharge to assess as the default from acute care settings.

Reablement at home as the preferred option with the aim of a rapid return to the original level of care and the withdrawal of additional care and support.

Reablement in a community setting but not at home for those patients with slow to resolve exacerbations, people who will not return to their original level of care, including those awaiting care home placements. Aligned with ‘step up’ processes, an EDD and discharge planning will be standard for ‘step down’, using the same or similar criteria to those employed in acute care settings.

Identify and fill gaps e.g. neuro rehabilitation.
6.3 Diagram of the Long Term Conditions model of care
7. Planned Care

For the purposes of this report, planned care is defined as care that is non urgent and accessed either directly by the patient or through referral from a generalist to a specialist. LTC management includes much planned care and some urgent care is ‘planned’ if it is referred to a next day clinic.

7.1 Key Principles

7.1.1 Patient empowerment and navigation
The current planned care system is complex, fragmented and difficult to navigate. It disempowers and frustrates patients who then seek professional help to signpost and navigate when this should not be necessary. The initial referral has benefitted from the Referral Assessment Service (RAS) and the Telford Referral and Quality Service (TRAQS) but their roles do not extend beyond making the first appointment.

Patients want easy access to understandable and trustworthy information about self care options and local services to which they can gain direct access, as well as to information that guides them to seek professional help when necessary.

Patients find it understandably hard to distinguish ‘want’ from ‘need’ and, although clear information will resolve some of this, they often require professional expertise to distinguish between the two.

Once referred, patients want clear information about what is going to happen next and the timescale they should expect.

Navigation through the planned care system should be patient focused and facilitate self navigation wherever possible.

Professional or peer advocacy to assist in navigation should be the exception rather than the rule.

Some patient groups (e.g. people with learning disabilities) should be offered pro-active advocacy.

7.1.2 Pathways
Planned care should be largely pathway driven, with as few stages as possible to minimise error and delay.

Pathways will vary in type and complexity depending on the degree of diagnostic uncertainty and treatment options. Patients should be able to gain access to the simplest ‘out of hospital’ and diagnostic pathways without the need for a professional referral, whilst the most complex will require expert specialist decision making at an early stage because of diagnostic uncertainty.
7.1.3 Partnership care
Aligned with the principles described in acute and LTC care, a richer and more
dynamic conversation between referring generalist and specialist will result in higher
quality referrals, better outcomes and mutual learning.

7.1.4 Levels of care
In planned care, this is about ‘who does what where?’ There is a compelling
evidence base for a tiered arrangement of treatment centres, with the most complex
and risky surgery being performed in a site co-located with a critical care unit, but
the majority not requiring this. Separate treatment centres for routine surgery can
also benefit from being designed and delivered through a different business model.

There is a ‘critical mass’ issue to consider when planning the number of treatment
centres. For minor surgery, this is less of an issue, although the skill of the operator
still influences the outcome, whereas for intermediate treatment centres outcomes
are influenced by volumes – the larger the number, generally the better the result.

7.2 Model of care

7.2.1 Patient portal
Facilitated self management through a web based patient portal which provides
trustworthy localised information about common conditions, when to seek
professional help, options for self management and direct access to simple therapies
and diagnostics

7.2.2 Pathways
Systematic design, approval and implementation of whole system pathways driving
the majority of planned care. A tiered model:

• patient self referral and self management

• diagnosis or symptom complex known with direct GP / generalist access to
  the pathway

• diagnosis or symptom complex unknown requiring expert specialist decision
  making early in the pathway.

Reduce stages in all pathways to improve quality and safety and reduce errors.
‘Optimise’ patients prior to referral as a routine. Referral made by most appropriate
professional (e.g. could be physio for arthroplasty). Patient choice expressed at time
of referral assisted by navigator and / or Patient Recorded Outcome Measures
(PROMS) data. Eliminate duplicated diagnostics. Provide expert opinion at first out
patient appointment, preferably from the surgeon who will be performing the
procedure. Date of surgery agreed immediately after first out patient appointment.
Single multi-disciplinary pre-op assessment to include anaesthetist, physio and social
worker. Admit on day of surgery. Enhanced recovery with the shortest possible LOS.
Out patient follow up in the community as appropriate.
7.2.3 Navigation
A simpler planned care system requires less navigation. Patients should have access to updated information about their stage of the planned care journey and be able to self-navigate as a default. Some advocacy will be required which the RAS and TRACS teams may be able to provide. In more complex and serious situations, or when a patient has special needs, then a navigator / advocate will be required. This could be a peer group volunteer, specialist nurse, therapist, GP or other professional.

7.2.4 Levels of Care
Three tiers of treatment:

- Low professional input. Multiple centres for day case / minors, basic diagnostics and access to therapies

- Medium professional input. One or two centres for intermediates / day case. Beds available for low / medium risk orthopaedics. May or may not be co-located with high input centre. Advanced diagnostics (USS/CT/MRI/Nuclear etc)

- High professional input. One centre for majors, co-located but operating separately from single emergency centre. Co-located HDU. Advanced diagnostics. Potential for repatriation of elements, at least, of out of area specialist surgery (e.g. cardiac, neuro). Whilst it is appropriate that some work goes to specialist tertiary centres, there is opportunity to develop shared care models in which a concentrated local centre might provide pre- and post-operative care.
7.3 Diagram of Planned Care model of care.

**System Navigators**
- Patient
- Peer Worker
- Specialist Nurse
- Therapist
- GP
- IT

**Low Professional Input**
- Guided self care
- Multiple centres for day case/minors
- Basic diagnostics (X-ray/USG)
- Access to therapies

**Medium Professional Input**
- One or two local centres for intermediates/day case (may or may not be co-located with high input centre)
- Diagnostics (USG/Ct/CT/MRI/Nuclear etc.)

**High Professional Input**
- One centre for majors (co-located with but separate from emergency centre)
- HDU
- Diagnostics (USG/Ct/CT/MRI/Nuclear etc.)
- Referrals out of area for cardiac, neuro, etc.

**Information/Education**

**Communication**

**Informed Direct Access**
- Diagnosis known (simple)
- Diagnosis unknown (complex)

**Primary Care**

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

**Patients**
- Education
- Information
- Prevention
8. Cross Cutting Themes

A number of important cross cutting themes have emerged in all the clinical meetings thus far. The following is a summary of discussion from different clinical meetings.

8.1 Embedding compassion and healthy relationships

Although compassionate care requires the right attitude, this must be translated into action and supported in system design and team working practices. Every member of a team must have clearly understood roles and responsibilities, especially when working within complex systems and environments. However, over-definition of roles, especially when restricted to one care setting, can prevent professionals ‘going the extra mile’ to ensure compassionate care and seamless patient journeys.

Named key workers or responsible clinicians will improve co-ordination of care for vulnerable people.

Values based recruitment will become the norm and compassionate attitudes, behaviours and relationships will be more visible throughout the whole organisation.

8.2 Rural and Urban solutions

The problems of providing equality of access and quality of care to rural populations will be partially mitigated by achieving greater care in the community. Care provided by teams around the patient with home as the default can be provided equitably in both urban and rural settings. Access to services that require travel clearly require better transport solutions, but there is also a balance to be achieved between the advantages of providing truly local services for all levels of care and the better outcomes and reduced cost of providing care at larger scale in fewer units.

8.3 Workforce issues

Many parts of the health and social care workforce are in crisis. A full workforce review and plan is required as part of, or alongside the FutureFit programme in order to resolve this. 7 day working is a requirement across the whole system and brings additional workforce challenges.

Local clinicians expressed some strong views about potential components of the solution:

- Consolidate services to make posts more attractive by improving the quality of work, gaining more experience working in larger units, offering better rotations through fully staffed co-located departments and services, all in an improved working environment.
• Fill medical rotas to fit the available workforce and fill the gaps with new roles (Advanced practitioner, Emergency Nurse Practitioner, Physicians assistant etc.).

• Prototype and implement rotating (and split) posts through different care settings to improve mutual learning, understanding and trust, provide better risk management, encourage better use of shared protocols, pathways, training opportunities and shared documentation and improve consistency and quality of care through generic upskilling.

• Improve recruitment and retention of staff through more effective succession planning and better role development and CPD.

• Gain academic status by establishing an economy wide link to university and other education and training programmes to attract people to come to Shropshire to train and work.

8.4 Co-ordination, integrated and consistency across the whole system

There is universal agreement that improving the co-ordination, integration and consistency of care delivered across the whole economy is a necessary precondition for achieving sustainable improvements in quality and safety. The will to do this is evident; it is the barriers to it that require systematic identification and removal. These include a fragmented organisational structure, multiple incompatible IT systems, ‘old fashioned’ commissioning mechanisms and an overwhelming administrative burden. Where any pathway components are supplied under the ‘Any Qualified Provider’ system or through private sector tendering, these will need to be commissioned in a way which supports improved integration.

‘Siloed’ care does not incentivise clinicians to ‘go the extra mile’, and professionals are increasingly reluctant to fill gaps in care if it is not within their defined role. Clinicians should have more control over appointment systems.

8.5 Delivering effective high quality care with no extra money

Financial austerity is one of the key drivers for radical change. There is a need to move beyond organisational interests so that funding follows the patient. Pragmatism is required to find the ‘key enablers’ of change to concentrate our limited resources.

Currently, the status quo is incentivised with the need for organisations to show a surplus contributing to this.

‘Disruptive’ change is required to overcome the NIMBY (not in my backyard) problem.

From the clinical perspective, there was a clear case for unifying health and social care funding and to integrate acute and community care.
8.6 Social Care

Health and social care are clearly interdependent and should be designed to reflect this. There is currently an anomaly which makes closer integration difficult in that social care is means tested whilst health care is always free. To achieve integrated working, health and social care should run parallel and share risk, not run in series as is mostly the case at the moment. No-one enters the social care system without a health problem and currently both systems focus on those most in need and pay much less attention to prevention and self care. Although there is no statutory obligation for Local Authorities to invest in prevention, there was a clear consensus that health and social care must tackle prevention, education and patient empowerment to increase self reliance together. The Better Care Fund is a potential vehicle for this, but concern was expressed that, because its not new money, the opportunity would be missed.

The financial challenge in social care provision attracted specific comment and some suggestions to mitigate its effect were made:

- Increase community and carer input
- ensure more patients return to the same rather than a higher level of care
- manage patient and public expectations
- provide more education and information about options
- incorporate the voluntary sector as a core component of care provision
- implement the models of care described in this report which deliver timely response and intervention, enhanced recovery, early supported discharge and reablement

8.7 Mental Health

There was unanimous agreement that mental health should be integrated with primary, community and acute health care. The models of care described in the three main areas of Acute, LTC and Planned Care were all contributed to by mental health professionals and further detailing will demonstrate more clearly the potential for closer integration.

Partnership care in particular was felt to be a model which was equally applicable to mental health services. Psychological management of all LTCs should be ‘part of the day job’ and, within the context of partnership care, mental health specialists should have a greater role in education and upskilling of generalists. Young people have particularly stressed the need for support for problems with stress and self harm.

The RAID model of liaison in the acute sector was felt to be a good one, but it needed further development, especially in regard to education and training (the RAID effect)
8.8 Children

This area needs further exploration, but initial comments are: there is a lack of psychological and family support. There are big gaps, such as Autism (now 1:80) and age transitions. Obesity is not being systematically tackled. GPs and others are become more and more risk averse around children, Paediatric training for GPs should be mandatory. Partnership care is an excellent model for Paediatrics.

8.9 Therapeutics

Clinicians recognised that a whole system and strategic approach to therapeutics was required and that the importance of this was mostly under-estimated. Community pharmacies are not clustered with GP practices and do not have a defined working relationship with them. Community pharmacies can take a bigger role in minor urgent care and also in routine / repeat prescribing. They would need access to integrated care records to do this. Their impact in minor urgent care would be increased if some OTC medicines were free to stop unnecessary diversion to GPs. All pharmacies should have consistent and longer opening hours. In the acute sector, everyone should have a medication review <24hrs after admission. Evidence that if they are on 4 or more meds then 2 need changing due to acute presentation. These reviews should also apply to lower risk groups – often only the highest risk patients get them. More work with patients at home (e.g. the HARMS scheme) would add value (hoarding, poor compliance etc). There are too many admissions for technical therapeutics which could be done at home or in a community setting. There is little co-ordination of medication across care settings, dressings are a particular example.

9. Whole system synergies

There are a number of key principles and components of models of care which were repeated in slightly different but synergistic forms across all three care areas:
### Acute and Episodic Care

**Levels of Care**
- **Low Professional Input**
  - Multiple centres for day case/minors
  - Basic diagnostics (X-ray/USG)
  - Access to therapies
- **Medium Professional Input**
  - One or two local centres for intermediate/day case (may or may not be co-located with high input centre)
  - Diagnostics (USC/CT/MRI/Nuclear etc.)
- **High Professional Input**
  - One centre for majors (co-located with but separate from emergency centre)
  - Diagnostics (USC/CT/MRI/Nuclear etc.)
  - Referrals out of area for cardiac/urology/neuro etc.

### Planned care

**Low Medical Input**
- ‘Hospital at home’
- Low acuity exacerbation
- Low medical input but high care input
- Team around patient
- Sustainable community support

**Medium Medical Input**
- ‘Health Hub’ Community beds
- Medium acuity exacerbation
- Integrated Acute and Community services
- Designated and resourced private sector beds
- Potential urgent care centre adjacencies

**High Medical Input**
- One high acuity centre
- 7 day maximum LOS
- Early supported discharge
- Ambulatory care
- Subacute frailty assessment
- 3 day LOS
- Frailty
- Assessment units

### Increased Levels of Care for LTC

**Low Medical Input**
- Integrated teams
- Integrated care plans
- Reablement at home
- Generic workers

**Medium Medical Input**
- Intensive rehabilitation
- ‘Step down’
- Co-ordinated EDD and discharge planning
- Resolving exacerbation care
- Potential higher level of care required

**High Medical Input**
- Reablement in community
- ‘Step down’
- Co-ordinated EDD and discharge planning
- Resolving exacerbation care
- Potential higher level of care required

### Mental Health Beds

- Medicolegal place of safety
10. Next Steps

This report details the output of the Clinical Design workstream over the first 3 months of its activity. The models of care are emerging but are still at a high level.

A process of refinement will continue through a number of cycles where they will be repeatedly tested using patient scenarios, patient characteristics and flow volumes and financial impact.

A further detailed review of the evidence base around each component of the model will be undertaken.

External clinical assurance will be sought from an expert clinical team overseen by the West Midlands Clinical Senate.

Clinical engagement will be deepened, both by continuing involvement of the clinicians in the clinical reference group and subgroups, and through events, such as
webinars and meetings, designed to reach 2/3 of the clinical workforce of Shropshire and Telford & Wrekin.

Patient representatives and patient groups will continue to be involved and co-creating at every stage of the process.
Programme Update Report

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<tr>
<td>Subject:</td>
<td>Programme Update Report</td>
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<tr>
<td>Report by:</td>
<td>Peter Spilsbury, Programme Director</td>
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1 OVERALL

1.1 Programme Plan

1.1.1 Phase 1 - Programme Set-up & High-Level Vision
Following the approval of the Programme Execution Plan (PEP) at the last meeting of the Programme Board, the PEP has since been received by sponsor Boards as follows:

- Shrewsbury & Telford Hospital NHS Trust – approved 30\textsuperscript{th} January 2014;
- Shropshire Community Health NHS Trust – Case for Change approved 23\textsuperscript{rd} January 2014, PEP to be considered 20\textsuperscript{th} March 2014;
- Shropshire CCG – approved 12\textsuperscript{th} February 2014;
- Telford and Wrekin CCG – on agenda for 11\textsuperscript{th} March 2014, and;
- Powys LHB – to be considered on 16\textsuperscript{th} April 2014.

In approving the PEP the Programme Board deferred consideration of the question of Programme decision making processes. A proposal for these processes has since been delivered and is on the agenda for today.

The workstream updates below report on progress with developing key products for Phase 1 of the Programme and, where appropriate, these are substantive items on the Board agenda.

The Programme Administrator, Lorna Cheesman, took up her post in February, and Mike Sharon begins work as full-time Programme Director in April. At this point Paul Elkin will cease his current interim work with the Programme. I would like to put on record our thanks to Paul who has helped us hugely in the vital start-up phase, bringing his immense experience to bear in enabling the establishment of robust and highly professional Programme structure and processes.
1.1.2 Phase 2 - Development of Models of Care

The key task in Phase 2 of the Programme is to further develop the high level clinical models and to build activity and capacity projections which reflect those models. This will then enable a range of options to be identified in Phase 3. Outputs from Phase 2 on the current timetable are due to be considered by the Board at its meeting on 21st May.

The work completed in Phase 1 is, however, far more ambitious and wide ranging than had been anticipated. It is greatly to the credit of local clinicians that they have devoted such time and energy to leading the design process. There are major concerns that a clinical design that focuses simply on hospitals will not be radical enough to deliver a sustainable solution. Thus the notion of painting the full canvas has emerged, out of which the FutureFit Programme then takes forward the elements within its scope and will define the critical dependencies to be taken forward by commissioners outside of its scope.

To do justice to the emerging models, and to maintain and extend the engagement we have had to date, will require several more months of work. Without this there is the risk of moving too quickly towards a decision that will not stand up to subsequent scrutiny and, indeed, will not finally deliver the radical change that local patients and clinicians believe to be necessary. It is extremely important that we get the process right. This is truly a once-in-a-generation opportunity.

It would be possible to keep to the current timetable (with the clinical modelling work completed by the end of April) but this would greatly constrict the potential for further engagement and would not allow for adequate quality assurance of Programme outputs. In particular, the Clinical Design workstream wishes to undertake further work with the subgroups and others on testing the emerging models against a wide range of clinical and patient scenarios. It also wishes to ensure that there is full opportunity for iterative ‘sense-checking’ as numbers start to be applied to the models and for obtaining external clinical assurance.

As a result, the Programme Team is proposing a change to the current Programme timetable, as set out below:

- The clinical design and activity & capacity projections phase is extended to the end of August (instead of April);
- There is an 8-week period for extended public engagement on the model of care during October and November, with the outcomes of this being signed-off by the Board in December, and;
- Preliminary work to develop a provisional short-list of options commences in October and is brought to the Board for formal approval in December alongside the outcome of the engagement process.

During the proposed extended period, further work would also be undertaken before the May 2014 Board meeting on:

- The overall financial framework;
- The Engagement & Communications Plan, and;
- The options evaluation process.
The Future Fit process is one of genuine discovery. Nothing has been predetermined so, in order to produce for our patients a clinical model that is fully owned and understood (and that we are confident can be delivered), it will be essential to work through the emerging models in detail and to test them through several iterations, facilitated by extensive engagement with the public and with clinicians. The new timeline still however allows a major extended public engagement in October /November in line with expectations and also in line with recommended best practice (the Consultation Institute) which emphasises the criticality of allowing sufficient time to engage thoroughly on the model of care.

1.1.3 Phase 3 - Option Development & Appraisal
The purpose of Phase 3 is to develop and appraise a range of options for how the clinical model could be delivered, leading to the identification of a preferred option. It is also proposed that the timetable for this phase is extended to the end of May 2015 in order to allow for:

- A wide public engagement process during September to November on the proposed clinical models;
- Selection of a short-list of options to be worked up in more detail in December 2014;
- Development and appraisal of the options (January – May 2015), and;
- Phase 4 – Consultation & Business Cases (June – October 2015).

The revised Programme Plan is enclosed as Attachment A and the Programme Board is asked to approve the proposed changes.

1.2 Risk Register
The Programme Risk Register has been updated and is included at Attachment B.

The register contains one red rated risk relating to the inability of stakeholder organisations to release key staff for the Programme. It highlights the need for those organisations to agree with key staff the time and capacity required.

The Programme Team is due to further develop the register and associated risk management procedures for the Programme at an extended Team meeting on March 20th.

1.3 Benefits Realisation Plan
A Benefits Realisation Plan for the Programme continues to be developed including with some extremely helpful input from the Clinical Reference Group. The emerging draft is included as Attachment C and will be further developed under the leadership of the Programme Team over the coming weeks.

1.4 Gateway 0 Review
The national Government Gateway Review process seeks to provide an assessment of confidence in the ability of the Programme to deliver its stated objectives. It seeks also to provide recommendations, where appropriate, to improve the likelihood of successful delivery. Gateway 0 reviews are intended to support projects with constructive feedback in the earliest stages.
A wide range of some 26 stakeholders were interviewed by the Review Team from 3rd to 5th March, and a confidential report has been provided to the Programme’s Senior Responsible Officers. A verbal report will be made at the Board meeting. Where recommendations are made the Programme Team will develop and implement an appropriate action plan.

1.5 External Clinical Assurance
The Programme Board approved a proposal for External Clinical Assurance through the National Clinical Advisory Team (NCAT). Since that time it has emerged that NCAT is to cease to exist and its functions to be taken over by regional Clinical Senates. The Programme is currently approaching the West Midlands Clinical Senate with a view to agreeing arrangements for both informal and formal engagement around the clinical model of care.

2 WORKSTREAM UPDATES

2.1 Clinical Design
The workstream continues to meet fortnightly to oversee the clinical design work. It has prepared and facilitated a second successful meeting of the Clinical Reference Group (CRG) which was attended by 40 clinicians and others. Draft clinical model frameworks were reviewed and further developed, and very helpful input into the Benefits Realisation Plan was received. The next CRG meeting is on March 26th.

The outputs of CRG meeting have been used by sub group leads to inform the development of key clinical constraints and opportunities – ‘system drivers’ – which have subsequently been used as a basis for setting out high level models of care. This work has been undertaken by three sub groups: Acute & Episodic, Long Term Conditions & Frailty and Planned Care. Each group met twice during February. In addition, a series of patient focus groups have been held. A summary of this work is on the Programme Board agenda.

The sub groups now need to refine their models and to identify patient types at various points in their designs in order to enable activity and capacity modelling to be undertaken.

The workstream has been concerned about the extreme challenges of the original programme timeline, both in terms of enabling adequate patient and wider clinical engagement and of securing the necessary clinical input to the detailed work. The revised timeline proposed in this report has been developed in full discussion with the Clinical Design Team. Following the Board’s determination of the timetable for Phases 2 and 3, the workstream (working with the Activity & Capacity workstream) will set out a detailed activity plan for those phases including opportunities for engagement and further co-creation.

2.2 Activity & Capacity
Seven acute hospital workshops have been held to agree the clinical parameters on which activity and capacity modelling should be based. The projected impact of these parameters has been reported back and discussed by the workstream.

Two community hospital workshops have also been held. The group agreed that the results reflected the radical shift in the utilization of community hospital beds in terms of (a) reducing length of stay (b) increasing the proportion of admissions/occupied bed days for ‘step up’ rather than ‘step down’.
The outputs of the community workshops is on the Programme Board agenda along with a summary report, and the acute output is due to be available later this week.

A key conclusion of these workshops is that marginal change within the current service models would not, of itself, be sufficient to meet the economic challenges faced.

### 2.3 Engagement & Communications

An Engagement and Communications plan has been worked on but is now going to be developed through a co-production event with key stakeholders in order to respond to some of the concerns raised about this aspect of the Programmes activities. Activities to date include:

- Issuing of final branding templates;
- Work to develop a programme website;
- Publication of the first Programme Bulletin, and;
- Planning and delivery of 3 patient focus group events.

If the Board approves the revised Programme timeline, urgent consideration will also need to be given to the resources required to support the proposed extended engagement activities.

### 2.4 Finance

The workstream has established a schedule of meetings and agreed an approach to, and structure of, a single financial model for the Programme. Additional external resource has been procured to support the development of the model.

Work has also commenced to assess the likely future capital investment capacity of provider Trusts and of future recurring affordability envelope for Commissioners.

Finance leads have raised a concern about their ability to devote sufficient time to the Programme (see item 1.2 above).

### 2.5 Assurance

There have been three meetings of the Assurance Workstream:

- The first focused on a detailed review of the workstream responsibilities as set out in the Programme Execution Plan to ensure that each member had a common understanding of the nature, scope and extent of these responsibilities. There was an in-depth discussion on the development of the Assurance Plan which was circulated to all Workstream Members and all Workstream Leads for observation and comment.

- The second meeting focused on a line by line review of the Assurance Plan and areas for refinement and review. The Workstream also reviewed the arrangements for the OGC Gateway Review taking place over 3rd – 5th March 2014 and considered the first iterations of the Benefits Realisation Plan and Risk Register.

- At its third meeting the workstream agreed the final draft assurance plan for consideration by the Programme Board. A paper was also received setting out how the Programme might work productively with the Health Overview and Scrutiny Committee.
As part of developing the overall assurance plan, the workstream has prepared a matrix of key decisions required. The Programme Board is asked to confirm the key decisions identified after which further work will be undertaken to determine the action to be requested from individual sponsor Boards:

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<thead>
<tr>
<th>Programme Execution Plan/ Case for Change</th>
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<tr>
<td>Clinical Model of Care</td>
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<tr>
<td>Benefits Realisation Plan</td>
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<tr>
<td>Evaluation Criteria &amp; Process</td>
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<tr>
<td>Selection of short list of Options</td>
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<td>Selection of Preferred Option</td>
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<tr>
<td>Consultation Document</td>
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<td>Outline Business Case</td>
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In addition, the Joint Health Overview and Scrutiny Committee is advising the Programme which key decisions it would expect to consider formally. To date it has requested a Programme update for a meeting in late March, to include:

- Report on the Clinical Model of Care;
- Report on the Benefits Realisation Plan;
- Proposals for Developing the Evaluation Process and Criteria, and;
- Alignment with other Strategic Plans (e.g. the Better Care Fund).

Peter Spilsbury

Programme Director