2016

Future Fit

A COMMENTARY FOR THE WEST MIDLANDS CLINICAL SENATE

SHROPSHIRE, TELFORD AND WREKIN DEFEND OUR NHS

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Introduction

'Start with the patient and work backwards'

Roy Lilley, repeatedly and to many audiences

'We can't shift stuff out of hospitals unless there is somewhere to shift it to'

Roy Lilley, NHS Managers blog, 8th August

These are common sense points, but they seem to have been lost from the local health agenda.

As a campaigning organisation, Shropshire, Telford and Wrekin Defend Our NHS does not have access to the 'Future Fit' submission made by Shrewsbury and Telford Hospital Trust (SaTH) to the West Midlands Clinical Senate. The documents we are drawing on here include the two releases of the Sustainability and Transformation Plan (STP) recently submitted to NHS England, the Strategic Outline Case (SOC) of March 2016, the September 2015 version of the SOC, and the 2014 Clinical Models of Care (Clinical Model) document that detailed the original Future Fit vision. We have read many, many Future Fit Programme Board reports, and – now that the project has been subsumed into the Sustainability and Transformation Plan and its governance structures – reports from the new Future Fit Programme Manager. We attend Board meetings and Health Overview and Scrutiny Committee meetings. Our members are actively involved in Shropshire Patient Group, participate in Future Fit workstreams, and have attended many Future Fit public engagement events. We have had close involvement with the Future Fit project since its origins in the Call to Action work of late 2013. If information is in the public domain, we are familiar with it. Importantly, we have spoken to countless thousands of patients over this time – and we are local patients ourselves.

Our membership includes current and former clinicians and social work practitioners, and senior academics. We have welcomed some initiatives from local health leaders; we have been sharply critical of others. We firmly believe in a patient-centred approach, from a philosophical standpoint. Our own clinical background gives us a strong commitment to evidence-based healthcare, and we believe that service change must also be evidence-based.

We were impressed by the January 2015 report of the West Midlands Clinical Senate, following your review of Future Fit. We very much hope that you will apply the same rigour and scrutiny in your current review of Future Fit, and that you will also find the time to read this submission.

Future Fit: A project in chaos

The Future Fit project itself is in considerable chaos. There have been multiple delays, numerous changes of key personnel, and countless ad hoc changes of direction. The original two architects of Future Fit left their posts in the autumn of 2015. On 1st October 2015, NHS England determined that the project should be delayed for a year as all Future Fit options were deemed unaffordable. Future Fit project leads and project managers have come and gone with rapidity. Future Fit is now on its third clinical lead, after others have moved on. The acute model is in its third manifestation. The vision for community NHS services has changed out of all recognition. The lack of continuity is clear.

There is a case for change in NHS services and social care in Shropshire and Telford and Wrekin. It does not follow that current proposals are automatically correct. There is a real danger that the troubled history of this project has led to considerable pressure on local leaders to implement 'something' – even when they will admit in individual conversations (and on occasion in public) that current Future Fit plans are flawed.

Our belief is that the Future Fit proposals now being put forward contain significant risks, both clinically and financially. The proposals are also very far removed from the vision outlined in the Clinical Model of 2014, and the vision that has been 'sold' to patients and clinicians.

Activity and Capacity Modelling: Lacking an evidence base

Activity and capacity assumptions were agreed by a group of 19, meeting in late 2013 and into 2014. Of the 19, only eight were clinicians. We have been advised informally of tensions within the group, with a view from some participants that there was an overstatement of the level of activity reduction that was possible. The activity assumptions at the heart of Future Fit have been described by Shropshire Local Medical Committee as 'optimistic in the extreme'[1], and have also been queried by the West Midlands Clinical Senate in its first review of Future Fit.

The assumptions of Phase 1 and Phase 2 modelling[2] remain at the heart of the Future Fit strategic case and financial case. The assumptions were of major falls in activity by 2018/19 (i.e. predicted to *precede* the implementation of Future Fit acute hospitals restructuring, then projected to take place by 2020 at the earliest). These included a total reduction of 32% in emergency admissions for people with frailty or long-term conditions; a 15 to 20% fall in admissions related to smoking; a 20 to 50% fall in alcohol related admissions, and a 20% reduction in admissions for falls. Given that we are now half way through the period in which these falls in unplanned admissions were assumed to occur, it is now possible to assess the predictions against reality. SaTH's annual report for 2015/16[3] shows a consistent year-on-year rise in emergency admissions, including an increase of 5.04% from 2014/15 to 2015/16. We are plainly seeing an opposite pattern to that predicted by the activity and capacity subgroup.

Phase 2 modelling included estimates of reduced prevalence of a number of conditions[4], again assumed to occur between 2012/13 and 2018/19. In some cases, the numbers seem startlingly optimistic. It is assumed, for example, that the prevalence of circulatory system diseases will fall by 21%, cancer by 11.5%, and diabetes by 17.5%. This is over a six year period, in the context of a sharply ageing population in Shropshire, and deep cuts in spending on public health. We do not find these estimates credible.

The evidence on prevalence cited in the Phase 2 modelling report is itself not credible. It includes, for example, a BBC news report of a single patient dating from 1998. The source provided for many Phase 2 estimates of future prevalence is the Brighton and Hove Council Public Health Report of 2014, and this appears to have been a central piece of evidence utilised by the activity and capacity subgroup. We have checked as far as we can the evidence cited in the modelling report. It does not support the predicted falls in prevalence or demand.

If activity and capacity modelling is inaccurate, this is a fundamental problem. Predictions of the future level of acute activity have been used to determine required A&E and Urgent Care Centre capacity, and the required number of acute and planned care beds. The current SOC is explicit: *'The activity modelling was used to calculate the capacity requirements for the future'*[5]. If the modelling is wrong, the capacity of future hospital provision will be inadequate, for planned and unplanned care alike. The

[1] Local Medical Committee (2016). Letter to GP members of CCG Boards. 7th April 2016

[2] Midlands and Lancashire CSU (2014). Modelling the Activity Implications of the Future Fit Clinical Model. 24th December 2014

[3] SaTH (2016). Putting Patients First: Annual Report and Annual Accounts 2015/16. P9. August 2016.

[4] Midlands and Lancashire CSU (2014). Modelling the Activity Implications of the Future Fit Clinical Model. P30. Op.cit.

[5] Strategic Outline Case (2016; current). 2.3.5 Capacity Modelling. P16. March 2016

financial implications are equally significant. Last year, all Future Fit options were ruled out on the basis that they were unaffordable. The affordability of current options is dependent on reducing expenditure on both hospital-based and community NHS care. If the assumptions of falling demand are wrong, financial planning will also be wrong.

Part of the problem may be evident from Appendix 2c to the SOC, where we are told:

> *'The reference group reviewed materials comparing activity of these types at Shrewsbury and Telford Hospital NHS Trust with other trusts in the West Midlands, encompassing activity trends, comparative rates of change and detailed diagnostic breakdowns. Based on this contextual information and knowledge of planned or potential QIPP schemes, the group set their expectation for activity of this type to change over the next 5 years across the following activity categories…'*[6]

The Appendix then lists 23 acute sector activity categories. To us, this falls short of looking at clinical or research evidence. A small reference group, including only eight clinicians, looked at planned or potential QIPP schemes across the West Midlands. This exercise played a central part in forming their estimates of falling activity over the subsequent five years. Those estimates have been shown, to date, to be far removed from what has actually happened. We do not believe this has been a robust process. We do not believe this can be relied on to estimate required healthcare capacity in the future. The modelling process came dangerously close to planning on the basis of wishful thinking. This introduces a substantial level of risk into the current Future Fit proposals.

This has been recognised more widely. In April 2016, Shropshire Local Medical Committee (LMC) wrote to GP members of the CCG Boards asking them not to approve the SOC. LMC concerns, from the perspective of local GPs, included:

> *'The idea that admissions will fall 'largely as a consequence of improvements in primary care management' and reducing the prevalence of the risk factors that give rise to long term conditions' is optimistic in the extreme & not borne out by the experience of recent years'*[7]*.*

The Clinical Senate review report of January 2015 also expressed significant concerns over assumptions of falling activity:

> *The panel were of the view that the proposed reductions in activity through preventative strategies within FFP are ambitious, as reductions of this magnitude have not previously been achieved within the NHS, and it was yet to be evidenced whether this will result in a reduction in clinical need, activity and bed occupancy. The panel therefore urged FPP to keep remodelling the assumptions applied to the efficacy of public health interventions, using all available evidence to ensure they are realistic, in advance of the NHS England stage 2 review. The panel suggested that this should include broad socio-economic evidence such as that included within the Marmot Review report (2010) and the 5YFV*[8]*.*

[6] Appendix 2c to SOC (2016; current). CSU Activity Modelling Process. P3. March 2016

[7] Local Medical Committee. Letter to GP members of CCG Boards. Op.cit. The LMC represents GPs in both Telford and Wrekin and Shropshire

[8] West Midlands Clinical Senate. Shropshire and Telford Future Fit Programme. NHS England. Stage 1 Phase 1 Report. 8.6 Public Health Improvement and Integration. P16-17. January 2015

Sadly, that remodelling has not been done. The SOC and the STP emphasise that the previous modelling of activity and capacity has continued to be used[9] [10]. The only significant change is that the baseline to which activity assumptions are applied has been revised from 2012/13 to 2014/15[11]. If the modelling process was not robust, and the predicted falls in activity are over-optimistic, applying them to a different baseline is of little consequence. The *assumptions* of sharp falls in patient activity remain unchanged. The anticipated falls in activity of 32%, 20% and so on have just been applied to slightly more up to date data.

Over-optimistic predictions of reduced clinical need and reduced patient activity, inadequately supported by evidence, continue to be built into the case for Future Fit. In every area of SaTH activity – elective and day case admissions, emergency admissions, maternity admissions, Consultant-led outpatient activity, and A&E attendances – in all of these areas, patient activity has risen[12] since the new baseline of 2014/15. The modelling assumptions are flawed.

Concerns about the accuracy of activity assumptions have been acknowledged only recently by local NHS leaders. In May this year, at a Shropshire CCG Board meeting, a Patient Group representative argued that the assumptions were not valid and that the model therefore would not work; he described it as, in an IT analogy, a 'garbage in, garbage out' situation. The Chair of Shropshire CCG agreed with him. The minutes of the meeting[13] show *'Dr Povey reiterated that as a Board these assumptions could not be seen as accurate. They came to the Future Fit Board and one of the caveats was to re-look at the assumptions'.*

The eventual SOC letter of acceptance from CCGs to SaTH raises formal reservations about the activity assumptions and their translation into demand and capacity models[14]. The solution proposed by the CCGs is a request that SaTH carries out a detailed sensitivity analysis on the assumptions used. By itself, this is insufficient. At best, a sensitivity analysis will give an indication of areas and levels of uncertainty in the model. What it cannot do is re-write a clinical and financial case that is based on incorrect data – and it is therefore an inadequate response. There is a high level of risk inherent in implementing a model that is likely to result in an Emergency Department and two hospital sites that are too small. We do not believe that an Outline Business Case should be signed off and progressed when the doubts around activity assumptions are so high. It is not enough to recognise that a core problem might exist. There is an increasingly urgent need to resolve the problem, and to ensure that NHS planning can take place on the basis of a robust evidence base.

[9] Strategic Outline Case (2016; current). 2.3.3-2.3.5 Future Fit Activity Modelling. Sustainable Services Modelling. Capacity Modelling. P16-18. Op.cit.

[10] Sustainability and Transformation Plan (2016[2]). 4.18-4.22 Activity and Capacity Implications. P29-30. June 2016

[11] Strategic Outline Case (2016; current). 2.3.4 Sustainable Services Activity Modelling. P16. Op.cit.

[12] SaTH. Putting Patients First: Annual Report and Annual Accounts 2015/16. Summary of Service Activity. P9-11. Op.cit.

[13] Shropshire CCG Governing Body (2016). Meeting of 13th July, 4.2 Minutes of meeting held on 11th May 2016

[14] Shropshire CCG Governing Body (2016). Meeting of 29th June 2016. 4.1 Appendix 2. Letter of support for SOC

The Model for Acute Care

Three different models

From late 2013 through to March 2016, the preferred model for acute care was a single 'Emergency Centre', bringing together acute services and the Emergency Department on a single site. The Trauma Unit was to be included with the Emergency Department, subject to Trauma Network agreement. The second hospital was to become a Diagnostic and Treatment Centre with around 20 inpatient beds. The location of the Women's and Children's Centre could have been at either site, although in practice co-location with the Emergency Centre was always a far more likely outcome (and in line with the original Clinical Model). The model, put forward in the September 2015 SOC[15], was intended to resolve long-term staffing problems, and to lead to improved clinical effectiveness. A major 'selling point' in presentations to the public was that centralisation of clinical services was essential in order to achieve critical mass and ensure high quality specialist care.

Capacity modelling showed a need for 670 SaTH inpatient beds and 16 Paediatric Assessment beds; 686 SaTH beds in total[16].

In March, a very different acute model was proposed – to solve the exact same problems. The SOC now proposed two 'vibrant hospital sites'; a so-called 'hot/warm' model rather than the previous 'hot/cold' model. Both hospitals were to offer acute and planned care, although there was to be only one Emergency Department and one Critical Care unit. The model was not entirely convincing clinically, as it included a proposal to locate adult surgery at the site that did not have Critical Care, and a suggestion that the Women's and Children's Centre (treating obstetric and gynaecological emergencies, as well as paediatric emergencies) might also be located remotely from Critical Care. This is the SOC model that has been signed off by SaTH, by Shropshire CCG, and by Telford and Wrekin CCG. It is worth noting the Boards of both CCGs expressed deep-seated concerns over the SOC, each Board adding significant caveats to its support, and approving the document only on the third occasion it was placed before them.

The estimate of required beds was very different this time. The projected number of inpatient beds required had become 781, a significant increase on the 686 beds of a few months before. Again these are SaTH beds; a requirement for 'fit to transfer' community beds is shown separately. The model was explained to members of the public in a meeting immediately after the SaTH Board agreed its SOC. Confusingly, the presentation showed that there would be approximately 427 beds at one site and 302 beds at the other[17]. This gave a total of 729 beds – still rather higher than the estimate of 6 months before, but at odds with the SOC approved on the same day.

In July, a third acute model appeared, very different to the model outlined in the SOC. This is the current proposal for the reconfiguration of acute services. There is relatively little material on this third model in the public domain. We have seen a Future Fit Programme Director's report[18], and a more detailed set of PowerPoint slides in an Overview and Strategy presentation given by SaTH's Director of Corporate Governance to Shropshire Patient Group[19]. The Future Fit report noted *'The*

[15] Strategic Outline Case (2015). 9th September 2015

[16] Strategic Outline Case (2015). Table 14: Projected Inpatient Bed Requirements 2018/19. P28. Op.cit.

[17] SaTH (2016). Sustainable Services Programme Strategic Outline Case. Meeting with Patient Representatives (PowerPoint presentation). 31st March 2016

[18] Future Fit (2016). Programme Director's Report July 2016. Included with papers for Shropshire CCG Governing Body Meeting of 10th August 2016

[19] Clarke, Julia; SaTH Director of Corporate Governance (2016). Update. Presentation to Shropshire Patient Group. July 2016

emerging model now suggests that all acutely ill medical patients will be received by the EC site under a "Northumbria type" model'. (In practice a 'Northumbria type model' is not achievable in Shropshire and Telford and Wrekin. Northumbria's Emergency Centre is supported by three District General Hospitals and an extensive network of community hospitals, for a population of a similar size. The context is therefore quite different). From the more detailed presentation, we know there is a reversion to an Emergency Site and a Planned Care Site. Acute care is to be offered from the Emergency Site only. The Women's and Children's Centre, Coronary Care, and the Acute Stroke Unit will be based at the Emergency Site.

The bed numbers change again, with 414 inpatient beds at the Emergency Site and 253 inpatient beds at the Planned Care site. The projected requirement is therefore for 667 beds – fewer beds than either of the preceding models.

There was a considerable public 'sales pitch' for the second model: the 'two vibrant hospitals', each offering both acute and planned care. There has been a good deal less publicity given to the latest revision. It is remarkable, though, that after 30 months of work, there remains a strong sense of an unstable model that can be fundamentally changed with minimal explanation or discussion. The variation in the projected requirement for inpatient beds is of course concerning.

Recruitment

It is unclear that any variation of the model will solve SaTH's problems with medical recruitment. The assumption has been that centralisation of emergency care and critical care (and of a range of other specialities in some variants of the model) will result in more attractive jobs, better career pathways, and easier on call rotas, and that these things will automatically result in recruitment of Consultants to previously hard-to-fill posts. It has become almost an article of faith that this will come about.

The evidence for this is not compelling. Women's and Children's services were centralised at Telford in September 2014. SaTH's Operational Plan for 2016/17 notes that medical workforce fragility is *'an immediate principal challenge'* in many clinical areas – including Maternity and Neonates. Similarly, the March 2016 Business Continuity Plan, in a discussion of potential 'tipping points', lists Paediatrics as one of three clinical areas where the recruitment of middle grade doctors and Consultants is an *'overarching concern'*. The centralisation of Women's and Children's services does not seem to resolved recruitment problems in Maternity, Neonates, and Paediatrics.

A comparable example occurs with another centralised service. Acute Stroke Care was centralised at Telford in the summer of 2013, in response to a shortage of Consultants. In June this year, a failure to recruit to a vacant Consultant post in Telford's Acute Stroke Unit resulted in the closure of Shrewsbury's Stroke Rehab service; Shrewsbury's Consultants were required to transfer to Telford to maintain the centralised acute service. Again, centralisation did not resolve recruitment problems. Shrewsbury's Stroke Rehab ward remains closed.

The reality of course is that there is a medical workforce challenge across the UK, stemming from long-term issues around national workforce planning. SaTH offers posts in a small to middling sized hospital in a small to middling sized town - whether it provides its services from one acute hospital or two. Ambitious young consultants are more likely to gravitate towards a tertiary centre or a major city hospital. There are some measures that SaTH could take to support medical and other retention, and issues around an apparently unsupportive culture and reported bullying have existed for very many years. Spending several years publicising recruitment difficulties and promising the imminent closure of one of the A&Es and one of the acute hospitals is also unlikely to have attracted job applicants. The sad reality though is that current reconfiguration plans are exceptionally unlikely to resolve the local

reflection of an ongoing national problem. The same SaTH doctors will be left treating the same patients. Arranging rotas will be a little easier – but the intensity of work will be greater. Reconfiguring a problem does not make the problem go away.

An issue that we have raised several times with local NHS leaders is that the focus has been almost entirely on medical recruitment, and it is medical staffing problems that have been a key driver for change. We are aware that there are also significant recruitment problems in nursing, together with an ongoing exodus of experienced nurses across many areas (including Paediatrics, A&E and Intensive Care). There has been no attempt to consider the risk that consolidating services at one hospital site – be it Shrewsbury or Telford – will result in a loss of nurses (or AHPs, scientists and technicians, and support staff). Very many NHS staff are women with childcare or other caring responsibilities. The loss of a local job, and a requirement to work shifts in a hospital 18 miles away, might trigger the loss of a significant number of key staff. The impact of this could undermine the safety and continuity of care. The risk should at least be considered and evaluated.

Secondary Care Capacity

Capacity: Inpatient Beds

It is extremely hard either to prove or disprove the adequacy of the current projected figure for inpatient beds.

We have been told no new Future Fit activity and capacity modelling took place after the Phase 1 and Phase 2 work of 2013/14. The only acknowledged change is that the existing activity assumptions were applied to a different baseline in the March 2016 SOC: to 2014/15 data instead of 2012/13. This does not account for the extent of the variation between the three different acute models, nor for the two different projections for bed numbers that were given on the same day for one of these models.

The same activity and capacity modelling has resulted in projected inpatient bed requirements of, variously, 686, 781, 729 and, most recently, 667. They cannot all be right.

The number of overnight beds available at SaTH's two hospitals has remained remarkably constant: 749 in the first quarter of 2016/17; averaging 754.5 in 2015/16, 745.5 in 2014/15, and 758.25 in 2012/13[20]. These figures are from NHS England data returns, and should be accurate. Occupancy has been consistently high. Demand has increased, year on year, in a pattern that is very much at odds with the predictions of Future Fit activity modelling. SaTH has done well to manage demand with a stable number of beds (and with a bed to population ratio that is lower than the national average[21]).

The current model for acute reconfiguration proposes a reduction in inpatient beds of 11%. The shift of activity to community settings will need to be very substantial indeed for this to be accommodated.

Capacity: At odds with activity trends

The gap between Future Fit activity assumptions and 'real world' data is becoming very clear indeed.

[20] NHS England. Statistics: Bed Availability and Occupancy Data – Overnight. https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/ . Accessed 5th September 2016

[21] Verbal report from BMA General Practitioners Committee Rep for Shropshire, North Staffordshire and South Staffordshire. Shrewsbury and Atcham Labour Party Health Conference. April 2016

Three examples:

- The SOC uses a baseline of 47,151 Non-Elective (Emergency) Inpatient Admissions, and predicts this will fall to 42,902 by 2018/19[23]. The latest SaTH annual report shows 54,839 Emergency Admissions in 2015/16[24]. **There will need to be a 22% fall in Emergency Admissions over the next three years for the projected figure to be realised. There has been a 24% increase over the last three years.**

- The SOC uses a baseline of 47,431 for Elective Daycase and Elective Inpatient episodes combined, and predicts that this will rise to 49,581 by 2018/19[25]. The SaTH annual report[26] shows 61,315 episodes of Elective Daycase and Elective Inpatient care in 2015/16. **There will need to be a 19% fall in elective activity over the next three years for the projected figure to be realised. There has been a 15% increase in the last three years.**

- The SOC uses a baseline of 109,360 A&E attendances, and predicts that this will rise to 112,836 by 2018/19[27]. (This includes UCC and Walk-in Centre activity). The SaTH annual report shows that there were 121,105 A&E attendances in 2015/16[28]. **There will need to be a 7% fall in demand for A&E and UCC care over a three year period for the projected figure to be realised. There has been a 24% increase in the last three years.**

An extraordinary and unprecedented turnaround in the general health of the population of Shropshire, Telford and Wrekin, and Powys is required if planned capacity is to match patient need.

Capacity: the Emergency Department and UCCs

In 2015/16, there were 121,105 A&E attendances[29] (using a definition that includes UCC and Walk In activity).

The Future Fit estimates of required Emergency Department capacity vary**.** Different modelling assumptions have been used, have been applied to different estimates of future A&E attendances, and have resulted in different assumptions of required Emergency Department capacity.

The Future Fit Phase 2 modelling assumption was that 69% of 'front door urgent activity' (defined as incorporating A&E and several other urgent care services) would pass to Urgent Care Centres (UCCs), with the remainder to be managed at the Emergency Centre. 'Front door urgent care' was defined as A&E attendances, based on a projected 110,628 A&E attendances in 2018/19[30], ***and*** patient contacts at several other services (MIUs, the Walk In Centre, GP Out Of Hours consultations etc). It was estimated that the Emergency Centre would need to treat **around 68,000 Emergency Centre attendances in 2018/19,** with 155,000 Urgent Care Centre attendances managed separately in UCCS[32]. The figure of 'circa 68,000' patients requiring Emergency Centre care has been used

[23] Strategic Outline Case (2016; current). 2.3.4 Sustainable Services Activity Modelling. P16. Op.cit.
[24] SaTH (2016). Putting Patients First: Annual Report and Annual Accounts 2015/16. Summary of Service Activity. P9. Op.cit.
[25] Strategic Outline Case (2016; current). 2.3.4 Sustainable Services Activity Modelling. P16. Op.cit.
[26] SaTH (2016). Putting Patients First: Annual Report and Annual Accounts 2015/16. Summary of Service Activity. P9. Op.cit.
[27] Strategic Outline Case (2016; current). 2.3.4 Sustainable Services Activity Modelling. P16. Op.cit.
[28] SaTH (2016). Putting Patients First: Annual Report and Annual Accounts 2015/16. Summary of Service Activity. P9. Op.cit.
[29] SaTH (2016). Putting Patients First: Annual Report and Annual Accounts 2015/16. Summary of Service Activity. P11. Op.cit.
[30] Future Fit (2015). Summary of Key Programme Products. October 2015
[32] Future Fit (2015). Summary of Key Programme Products. P28. Ibid.

repeatedly in modelling documents and at public engagement events. It re-appears in both the September 2015 SOC[33] and the March 2016 SOC[34].

The September 2015 SOC also gives a separate and different estimate of Emergency Department activity. This uses a baseline 131,607 A&E attendances, rising to a projected 134,380 attendances by 2018/19[35]. It is anticipated that around 40% of these patients will require Emergency Department Treatment, resulting in approximately **54,000 Emergency Department attendances in 2018/19**. An estimated 60% will be managed in a UCC setting, approximately 80,000 attendances[36]. The figures are confirmed in the appendix on activity and capacity modelling[37].

In the SOC of March 2016, estimated Emergency Department activity has fallen by 25%. This quite radical change to the estimate of six months earlier is not highlighted or explained. The revised estimate uses a projected 115,771 A&E attendances by 2018/19. A 35% / 65% split is applied, resulting in 40,690 Emergency Department attendances and 75,081 UCC attendances[38].

The confusion between the widely used 68,000 estimate and the two lower figures may well be explainable by an inconsistent use of the terms 'Emergency Centre' and 'Emergency Department'. At times, 'Emergency Centre' is used to describe a high acuity hospital; at times, it describes the Emergency Department within that hospital. The 68,000 includes strands of work that are excluded from the modelling that produces lower figures (although it is unclear whether or not this exclusion will be reflected in patient pathways).

Even if the historic estimate of 68,000 is set aside, there are concerns regarding the current estimate of 40,960 Emergency Department attendances. This is based on a projected total 'A&E activity' of 115,771 by 2018/19 – but last year, A&E attendances stood at 121,105 in total. **For the Future Fit projection to be valid, A&E and UCC activity will need to fall by over 4% by 2018/19. Nationally and locally, urgent and emergency care attendances have increased markedly over recent years. There is no particular reason to expect this trend to be reversed in Shropshire, Telford and Wrekin, and Powys. The population is both growing and ageing.** There is a strong risk that the capacity of both the Emergency Department and the two urban Urgent Care Centres will fall short of what is required, because they will be based on projected levels of activity that are unrealistic.

The 25% fall in projected activity between September 2015 and March 2016 is also concerning. Although both SOCs reportedly utilised the same modelling approach, it is clear that different baselines were used, different assumptions were applied – and a much lower estimate of required capacity was arrived at in the 2016 plans.

The 'threat to life or limb' model

The original Clinical Model made some quite ambitious assumptions about the range of conditions that would be treated in Urgent Care Centres, but did not seek to limit Emergency Department attendances only to patients with an identified threat to life or limb. This was also not part of the September 2015 SOC. The 'life or limb' requirement emerges only in the current SOC of March 2016. The SOC states, *'For patients that are acutely ill with life or limb threatening injuries and require*

[33] Strategic Outline Case (2015). 2.4 Activity Modelling. P24. Op.cit.
[34] Strategic Outline Case (2016; current). 2.3.3 Future Fit Activity Modelling. P16. Op.cit.
[35] Strategic Outline Case (2015). 2.4 Activity Modelling Table 11: Activity: Baseline 2012/13 and Projected 2018/19 by activity type. P25. Op.cit.
[36] Strategic Outline Case (2015). 2.6 Table 15 System Assumptions. P29. Op.cit.
[37] Strategic Outline Case (2015). Appendix 4b, Activity and capacity modelling. Op.cit.
[38] Strategic Outline Case (2016; current). 2.3.2 Sustainable Services Clinical Working Groups Outputs. Figure 1: Emergency and Urgent Care Centre Patient Activity Numbers. P14. Op.cit.

immediate diagnosis and treatment, they would be taken to the EC'[39]. All other patients would be taken to or would self-convey to one of the two UCCs. The relevant SOC appendix confirms this: *'In 2014/15 over 115,000 patients arrived at the Shrewsbury and Telford Hospital A&E departments believing they needed immediate access to health care. The majority of these patients (about 75,000) were not in need of life saving intervention and therefore could be more appropriately seen in an Urgent Care Centre'*[40].

From the perspective of containing demand, it is an attractive approach. The challenge is that it rests on the assumption that it is always readily apparent that a patient does or does not have a life or limb threatening condition. We know from discussions with Emergency Consultants that this is simply not the case. The King's Fund points out that patients may well require specialist assessment in A&E even if no treatment is required[41]. It is a distinction that local NHS leaders have skirted around. GPs and Emergency Consultants (or Registrars working under Emergency Consultant supervision) inevitably have different areas of skill and knowledge, and their practice is characterised by different approaches to risk. In simplistic terms, Emergency Consultants hear hoof beats and consider zebras, while GPs are more likely to assume horses. These are different jobs, treating different populations.

Almost all A&Es in England are struggling to meet demand. NHS England supports UCCs as a mechanism for reducing the pressure on A&Es. The Royal College of Emergency Medicine (RCEM) also supports (co-located) UCCs, but disagrees with NHS England about the proportion of A&E patients who can be managed in a UCC setting. NHS England has advocated 40%; the RCEM – following a largescale study in 2013 – estimates that it is safe for 15 to 22% of patients to be managed in a UCC setting[42].

We discussed the local vision of UCCs treating 65% or 69% of patients with the Vice President of the RCEM. He laughed, said it was a complete fantasy, and if they managed to do it, it would be the equivalent of discovering the Higgs Boson particle. His view was that to try to restrict Emergency Department attendance to patients who have a clear and evident threat to life or limb would be both unachievable and clinically unsafe.

Are Urgent Care Centres a solution to A&E/Emergency Department pressures?

The national emphasis on UCCs as a solution to the crisis in emergency care is now beginning to translate into research on patterns of use, and how successful UCCs might be in reducing pressure on A&E departments. Studies are few in number, and conclusions can only be preliminary – but the research is nevertheless worth considering.

Cowling et al[43], found that an overall 17% of patients streamed (triaged) as being appropriate for a UCC setting subsequently required transfer to a full A&E. This increased sharply with patient age, with over 40% of people aged over 80 needing to be transferred. The finding could have significant

[39] Strategic Outline Case (2016; current). 2.3.2 Sustainable Services Clinical Working Groups Outputs. Emergency Centre and Critical Care. page 14

[40] Strategic Outline Case (2016; current). Appendix 2b Urban Urgent Care Centre draft service outline. Op.cit.

[41] Kings Fund. What's going on in A&E? The key questions answered. http://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters . Accessed 5th September 2016

[42] Royal College of Emergency Medicine (2015). The Royal College of Emergency Medicine and Urgent Health UK call for the colocation of urgent care services with A&E departments. Press statement. 4th November 2015

[43] Cowling, T; Ramzan, F; Ladbrooke, T; Millington, H, Majeed, A; Gnani, S. (2016). Referral outcomes of attendances at general practitioner led urgent care centres in London, England: retrospective analysis of hospital administrative data. Emerg Med J 2016;33:200–207. 2016

implications for Shropshire, especially in the context of a Future Fit model where UCCs are expected to treat such a high percentage of patients. This study raises the prospect of considerable numbers of very unwell patients, particularly elderly patients, being transferred by ambulance from Shrewsbury to Telford or vice versa. The number of patients could be significant, and consideration should be given to including this in planned Emergency Department and ambulance service capacity.

An important 2016 review of available research on UCCs should sound a note of caution. Ramlakhan et al[44] summarise their findings: *'A paradoxical increase in attendances has been described, which is likely to be attributable to provider-induced demand, and the evidence for improved throughput is poor. Marginal savings may be realised per patient, but this is likely to be overshadowed by the overall cost of introducing a new service'*. The authors conclude *'There is little evidence to support the implementation of co-located UCC models. A robust evaluation of proposed models is needed to inform future policy'.*

There is also recent evidence that patients with minor illnesses will attend UCCs instead of seeing their regular GP, rather than as an alternative to A&E attendance (doing so for reasons of speed of access and convenience)[45].

It does not follow from this slender and emerging evidence that we should *not* have UCCs in Shropshire and Telford and Wrekin. We support the development of UCCs. There is enough here, however, that it is unsafe to assume that UCCs are an easy and automatic solution to high levels of demand on A&E departments. Patients are complex creatures, and will not necessarily behave as health planners intend them to.

Anecdotally, the proposed Future Fit model may have unintended consequences. The plan is for a single Emergency Department with a co-located UCC in one town, Shrewsbury or Telford, and a stand-alone UCC in the other. Rural UCCs, sadly, have been dropped on cost grounds[46]. Many residents of South Shropshire are adamant that they would not travel 30 miles to a standalone UCC in Shrewsbury, when they can travel a similar distance to a 'proper A&E' in Hereford. There is a marked reluctance in South and South West Shropshire to consider accessing any acute care in Telford, because of the travel times involved. A quick straw poll of Telford residents suggests a slightly different pattern. The consensus from this (very informal) discussion is that for any condition causing real concern, or particularly where they were dealing with a sick child, they would not go to a stand-alone UCC in Telford, but in most cases would travel on to the co-located UCC at Shrewsbury, 'just in case' of a need to access the A&E/Emergency Department. A few would prefer to travel to A&E in Wolverhampton or Dudley, where these were accessible from people's homes. Again, it is simplistic to assume that patients will do as they are told. Patterns of attendance at the co-located UCC and the standalone UCC are likely to be different.

A&E Closure: The wrong model for a rural area

The single fixed point in Future Fit, while almost every other aspect of the project has changed, is that there must be a single Emergency Department. The public has been told that this will lead to better and more specialist care, and that this is a necessary move to recruit Emergency Consultants.

[44] Ramlakhan, S; Mason, S; O'Keeffe, C; Ramtahal, A; Ablard, S (2016). Primary care services located with EDs: a review of effectiveness. Emerg Med J 2016; 0:1 –9 2016

[45] Amiel, C; Williams, B; Ramzan, F; Islam, S; Ladbrooke, T; Majeed, A; Gnani, S (2016) Reasons for attending an urban urgent care centre with minor illness: a questionnaire study. Emerg Med J doi:10.1136/emermed-2012-202016. 2016

[46] Rural Urgent Care Services Sub-Group Report. April 2016

The clinical arguments presented to the public have not always been accurate. For example, the Future Fit website carries a blog, written by Dr Edwin Borman, Medical Director of SaTH, and Drs Steve James and Mike Innes, the current and previous Clinical Leads of Future Fit, stating that paramedics administer 'clot busting drugs' at home to seriously ill patients who live a long way from hospital, enabling them to be treated sooner than patients who live close to the hospital[47]. We are told, *'This is particularly relevant for the county of Shropshire and beyond, where travel times and distance can be significant'*. The claim is untrue, and has been challenged by staff in the West Midlands Ambulance Service as well as by members of Shropshire, Telford and Wrekin Defend Our NHS. The administration of clot busting drugs to a stroke patient before diagnostic brain imaging would be inappropriate and dangerous, and this is not part of a paramedic's role. Despite repeated calls for the claim to be withdrawn, the blog remains on the Future Fit website.

Similarly, an 'evidence review' by Dr Simon Walford, a Board member of SaTH, available in the SaTH library and publicised more widely by SaTH's Medical Director, includes quite misleading information – including a misinterpretation of a map of England, incorrect information about journey distances to hospital in Shropshire, and a misrepresentation of local ambulance response times for emergency calls[48].

There remains overwhelming public opposition to the closure of either A&E (and to the downgrading of either hospital). A&E closure is also opposed by Telford and Wrekin Council, Shrewsbury Town Council, Oswestry Town Council, Ludlow Town Council, and a number of parish councils.

There are sound reasons for this opposition. The area served by SaTH is 90% rural. This is a vast geographical area, spanning more than 2000 square miles (three times the size of Greater London, or equivalent to 19 Birminghams). Outside the two urban centres of Shrewsbury and Telford, journey times to hospital are typically long. Shropshire is one of the most sparsely populated counties of England, and Powys is the most sparsely populated area of Wales. Public transport is close to non-existent in many of our rural areas. Road networks are poor. Broadband provision is uneven, and even mobile phone signals are patchy and inconsistent. Rurality is a major issue for a majority of the people who depend on services offered by SaTH. Although health planners acknowledge rurality in passing, there is little evidence that it has been allowed to influence a decision that had already been made at the time of the Call to Action event in November 2013.

Two examples of the implications of rurality:

- Oswestry is, in Shropshire terms, a major population centre: the third largest town in the county after Telford and Shrewsbury. It has a population of around 17,000 people. The mean distance across England from home to emergency care is 4.4 miles[49]. This is straight-line distance. From central Oswestry, the straight-line distance to the Royal Shrewsbury Hospital is just over 15 miles – about 3½ times the national average. If the A&E closes at Shrewsbury, with services centralised at Telford's Princess Royal Hospital, the straight-line distance for Oswestry residents increases to 24.9 miles – which is 5.7 times the national average. Driving distance doubles, increasing from 16.7 miles to 33.1 miles. It is unsurprising that the Mayor of

[47] James, S; Innes, M; Borman, E (2016). Finding the balance between travel time access and clinical outcomes. Clot busting blog http://nhsfuturefit.org/our-news/blog/80-finding-the-balance-between-travel-time-access-and-clinical-outcomes . February 2016. Accessed 5th September 2016

[48] Walford, Simon (2016). Evidence Review: Are there clinical risks or benefits related to the distance a patient travels to hospital in an emergency? SaTH library. May 2016

[49] Roberts, A; Blunt, I; Bardsley, M (2014). Focus On: Distance from home to emergency care. The Health Foundation. Nuffield Trust. February 2014

Oswestry has made it a Town Council priority to campaign against A&E closure. Journey distances for Oswestry are unexceptional for our area, and are significantly exceeded by parts of South and South West Shropshire and by Powys.

- SaTH recognises the long ambulance transfer times from midwife-led maternity units in Shropshire's market towns to the Women's and Children's Centre in Telford. Women are warned on the trust website that they would have to be transferred to the Consultant-led unit at the Princess Royal Hospital in the event of problems occurring while giving birth. The estimated transfer times, from SaTH's website, are 68 minutes for Bridgnorth, 83 minutes for Ludlow, 87 minutes for Oswestry and 50 minutes for Shrewsbury. These are significant delays for the treatment of conditions that may be time critical. (These journey times were removed from the website last month, in an apparent response to publicity from campaigners).

Similar times would of course apply for any emergency patient being transported by ambulance from one of Shropshire's market towns to a single Emergency Centre at Telford. There are some particularly shocking examples. Future Fit analysis of ambulance data showed that over 50% of Powys patients with time critical conditions would face an ambulance journey time of over an hour to reach a Telford-based Emergency Centre. Currently, around 6% of these patients have a journey time exceeding an hour. In South Shropshire, the percentage with travel times exceeding an hour would rise from 4% to 14%. Ambulance response times and loading times would be additional to these journey times. Based on current ambulance performance, patients in more remote areas could easily face a wait of two to three hours before reaching the Emergency Centre.

If the single Emergency Centre were to be at Shrewsbury, a majority of Telford residents would face a delay of around 50 minutes before reaching emergency care. Telford is the largest population centre in the county, and it would be extraordinarily hard to justify the loss of local emergency care for 160,000 people. Whichever site is chosen, journey times will increase quite significantly for very many people.

Local health leaders have been dismissive of patient fears over increased journey times. They have stressed that centralising A&E care will result in better and more specialist care, typically citing the example of stroke care – one of two services currently offered at specialist units within the county. (The other is trauma care).

Care for *some* life threatening conditions has been transformed in recent years. For some cardiac conditions, for strokes, and for major trauma, there is no question that patient outcomes are better if patients access specialist care. (This is a minority of patients typically accessing Emergency Departments). For other conditions, access to emergency care is important, but specialist care much less so. For example, for haemorrhage, poisoning, anaphylactic shock, acute asthma attack, choking, or drowning, the key issue is speed, not specialism. This is an argument for bypassing the local A&E when a patient will benefit from specialist care, but a poor justification for closing down A&Es (especially in rural areas).

A 2007 Sheffield University study[50] is the most important piece of UK research on the relationship between journey length and mortality. This largescale study looked at survival rates for patients with life threatening conditions, relating this to the straight-line distance between home and hospital. For patients travelling up to 10 km, the overall mortality rate was 5.8%. For those travelling 11 to 20 km, 7.7% died. For people travelling 21 km or more, 8.8% died. The 'absolute risk' of death increased by

[50] Nicholl J, West J, Goodacre S, Turner J (2007). The relationship between distance to hospital and patient mortality in emergencies: an observational study. Emerg Med J. 2007 Sep;24(9):665-8. 2007

around 1% for each additional 10 km travelled, but relative risk shows the pattern more clearly. Overall, people who travelled more than 20 km to access treatment were 50% more likely to die than those living close to the hospital. Those with acute respiratory conditions fared even worse, and were around twice as likely to die if they had to travel the longer distance to access A&E.

More recent research confirms the pattern. A 2013 Japanese study[51] looked at distance to hospital for patients with acute heart attacks, strokes and pneumonia – a sub-set of the conditions examined by the Sheffield study. The study found a strong correlation between transport distance and mortality for acute heart attack and for ischaemic stroke; and a moderate correlation between distance and mortality for pneumonia and for subarachnoid haemorrhage.

A 2014 York University[52] analysis of Swedish data compared survival rates from myocardial infarction for people having to travel different distances to emergency care. The author concluded *'The results show a clear and gradually declining probability of surviving an acute myocardial infarction as residential distance from an emergency room increases'*. People travelling 50 to 60 km to emergency care were 15% less likely to survive than those living close to the hospital. Most of the excess deaths were of people dying on the way to hospital. The author noted an inherent bias in much medical research, as studies typically look only at outcomes for people who arrive alive at hospital. Those who die on the way are excluded. Most research also takes place in urban areas, with little research on the impact on survival of rurality and/or long journey distance. The few studies that do exist strongly support the case that longer journeys to A&E result in higher rates of mortality.

There is evidence from the USA of Emergency Department closure[53] having a strong 'ripple effect', with mortality increasing by 5% for patients at neighbouring Emergency Departments that remained open. Existing facilities can easily be overwhelmed by increased demand. A strong and growing body of anecdotal UK evidence is of severe pressure on A&Es that remain following the closure of a neighbouring unit.

Clinical Senate members may wish to read some of the press accounts or Trust Board papers on service reconfiguration at London's North Middlesex Hospital. Chase Farm A&E was closed in December 2013 and replaced with a UCC, while Chase Farm Hospital was downgraded. The North Middlesex Hospital was intended to become a state of the art emergency centre, with better consultant cover and world-class care. Promises were made to the public of integrated care, with better primary care, and better services in the community. None of the promises have materialised. The A&E has been threatened with closure on patient safety grounds; the hospital is mired in chaos; the integrated care is not there, community services have not materialised, and primary care is worse than ever due to severe difficulties with GP recruitment. The parallels between this project and Future Fit are close ones, with a project 'script' that is remarkably similar. The project was backed by the hospital's most senior clinicians, who sincerely believed that patients would benefit. The project failed. Good intentions do not deliver healthcare.

[51] Atsuhiko Murata, A; Matsuda, S (2013). Association Between Ambulance Distance to Hospitals and Mortality from Acute Diseases in Japan: National Database Analysis. J Public Health Mgt Practice, 2013, 19(5), E23-28. 2013

[52] Avdic, D (2014). A matter of life and death? Hospital distance and quality of care: evidence from emergency room closures and myocardial infarctions. HEDG: Health, Econometrics and Data Group. University of York

[53] Charles Liu, C; Srebotnjak, T; Hsia, R Y (2014). California Emergency Department Closures Are Associated With Increased Inpatient Mortality At Nearby Hospitals. Health Affairs, 33, no.8 (2014):1323-1329

We would be very happy to send Senate members further material on healthcare in rural areas. The priority issue for rural populations is not specialist care, but ***access*** to care, whether this is routine planned care or urgent/emergency care. The Royal College of Emergency Medicine has cautioned against closing A&Es in rural areas, arguing that any benefit is outweighed by longer journey times[54]. Closure of an A&E meets the perceived organisational needs of SaTH. Clinically, it is not in the interests of patients. Roy Lilley's point, 'Start with the patient and work back', is of great relevance here.

Ambulance provision

A move to a single Emergency Centre would of course increase the average journey for ambulances responding to calls, *and* transporting those patients to emergency care.

Data from the West Midlands Ambulance Service show that travel times for patients from Shropshire postcodes are ten to fifteen minutes less to the Royal Shrewsbury Hospital than to Telford's Princess Royal[55]. We would expect a similar pattern for Telford and Wrekin patients travelling to Shrewsbury. The increased journey time to hospital will be matched by an increased average response time for the ambulance to reach the patient in the first place.

This gives an indication of the quite substantial impact on ambulance service productivity that we can expect following centralisation of emergency care. With a significant average increase in time spent per patient, fewer ambulances will be available to respond to 999 calls. Without additional resources, it is hard to see how an already failing service will be able to cope. It is not difficult to understand that if ambulances are taking longer, on average, in responding to call outs, there will be a likely need for *more* ambulances. There is no mention of this in either the SOC or the STP.

Although some Future Fit work took place to look at very lengthy ambulance journey times, the results have not been publicised, and have not influenced the model being proposed for urgent and emergency care.

There is no realistic chance that additional pressures on the ambulance service can simply be absorbed. Ongoing difficulties with the ambulance service were reported to Shropshire Council HOSC in July[56]. In April and May this year, WMAS failed by a long way to meet national targets for Red 1, Red 2 and Red 19 calls in Shropshire. For example, in April, 59.1% of Red 1 calls and 56.7% of Red 2 calls received a response within 8 minutes. The national target is 75%. Only 84.8% of Red 19 calls received a response within 19 minutes, with the target being 95%. This is not atypical; it is rare for ambulance performance targets to be met in Shropshire. The data are also consistent with anecdotal accounts passed to Shropshire, Telford and Wrekin Defend Our NHS. It is not unusual to hear of people waiting 50 to 60 minutes for an ambulance following a Red 1/ Red 2 call.

Although the ambulance service performed rather better in Telford and Wrekin, the Red 1 target was missed in April, and the Red 2 target in May. Overall in Shropshire *and* Telford and Wrekin, a majority of postcode areas fail to meet Red 1 and Red 2 targets.

There is genuinely no spare capacity in the ambulance service. A spokesman for the West Midlands Ambulance Service recently said:

> *'It should come as no surprise to anyone that West Midlands Ambulance Service does not meet all of its response times in Shropshire. Independent reports have*

[54] Royal College of Emergency Medicine (2013). Written evidence to the Health Select Committee. May 2013
[55] West Midlands Ambulance Service (2014). Board of Directors, Minutes of meeting of 24th April 2014
[56] West Midlands Ambulance Service (2016). HOSC and Healthwatch. May 2016/2017. 6th June 2016. Report to Shropshire Health and Adult Social Care Committee of 25th July 2016.

shown for many years that the budget the trust receives is insufficient to meet the needs of the people of Shropshire'[57].

The Shropshire CCG strategy is to develop the Community First Responder service in rural areas, enabling local volunteers to respond to 999 calls faster than a Rapid Response Vehicle or an ambulance. The Community First Responder service has always offered patchy coverage, but is now increasingly troubled. We know of volunteers who are leaving the service because they feel they are being asked to substitute for paramedics without having the training or equipment to do this; they also believe that attendance by a Community First Volunteer delays the despatch of paramedics. It is a situation that is causing real distress to some volunteers. This is not a service that will be able to pick up the extra workload caused by a move to a single Emergency Centre.

It is now urgent that Future Fit proposals include a plan for additional ambulance provision. This is an issue that has been overlooked for too long. Without additional investment in the ambulance service, there can be little question that patients will face unacceptably long waits for ambulances to respond to both emergency and less urgent calls.

Planned care: Patient Access

The current model for secondary care is for one Emergency Centre and one Planned Care Centre. One will be in Telford and the other in Shrewsbury. The Planned Care Centre will host the Diagnostic and Treatment Centre and elective and day case surgery[58]. (This is a change from the March 2016 SOC, which made provision for planned care to be offered from both sites – as it is now).

Irrespective of the future location of the Planned Care Centre, many patients will face significantly longer journeys to access routine care. Previous proposals for *local* Planned Care Centres, a network of smaller centres offering care closer to home, have been dropped. There is an aspiration in the SOC that that 35,000 follow-up outpatient attendances could take place virtually, but no work has been done to progress this.

The Future Fit model is silent on the challenges that will face patients in accessing planned care where services are centralised to a single site. This is of particular relevance given the rurality of the area served by SaTH.

For example, a comprehensive 2014 review of rural healthcare needs notes:

> *'Accessing services is the foundation of health. Distance from services and support can have a great impact on rural health… In terms of getting timely services to people and getting people to services across primary, community, secondary/specialist and social care, access needs to be improved across the spectrum, from emergency survival to the convenient delivery of routine services'*[59]

A 2011 report on the implementation of the Welsh Rural Health Plan highlights the problems inherent in the centralisation of health care:

[57] Shropshire Star (2016). Shropshire patients with life-threatening conditions facing 20-minute wait for ambulances. (These were 'best' times per post code area). 15th August 2016

[58] Clarke, Julia; Director of Corporate Governance (2016). Update. Presentation to Shropshire Patient Group. Slide: Pathway of care for the admitted patient and the Potential OBC Solution. Op.cit.

[59] Longley, M; Llewellyn, M; Beddow, T; Evans, R (2014). Mid Wales Healthcare Study: Report for Welsh Government 3.4. Welsh Institute for Health and Social Care. September 2014

> *'However, this centralisation of hospital services has a disproportionate disadvantage upon those patients who live at a distance from their hospital'*[60].

An earlier review discussed the trend towards centralisation, and asked:

> *'What is the impact of these trends on remote and rural communities? There is an impact of centralisation and specialisation on access to care; services are taken up less often or later. This negative impact is disproportionately felt by those people who have low incomes, poor access to transport, and by elderly and disabled people'*[61].

There is local evidence that reconfiguration is likely to influence ability to access healthcare. Station Drive Patients Group (Ludlow), at the annual flu vaccination day in 2014, asked patients to complete a survey on travel and access[62]. By definition, these were older patients or those otherwise deemed 'at risk'. As expected, most patients used their own transport (or walked) to get to the vaccination location (Ludlow Community Hospital). That pattern of self-driving was not automatically repeated for travel to more distant destinations.

There was a marked difference between perceived difficulty of travelling to Shrewsbury and Telford. Only 1.7% said that the Royal Shrewsbury Hospital was too difficult to get to, compared with 12.9% - a surprisingly high figure – who said they would be unable to attend a routine appointment at Telford's Princes Royal.

The survey also showed that older people were less likely to drive to a hospital appointment, with greater reliance on public transport or on others driving them. For people aged under 55, 83% would use their own car to travel to hospital in either Shrewsbury or Telford. For over 75s, the number fell to around a half (higher for Shrewsbury, lower for Telford). Comments particularly from older drivers were that they felt able to drive around Ludlow, could drive to Shrewsbury, but lacked the confidence to drive to the less familiar Telford area. A similar pattern could be predicted for Telford and Wrekin residents travelling to Shrewsbury.

Public transport from Ludlow to both the Royal Shrewsbury and the Princess Royal exists but involves changes, frequently long waits, and travel times of up to 2 hours in each direction.

The local evidence is backed up by national evidence. A report published by Age UK last year concludes:

- *1.45 million of those 65 and over in England find it difficult to travel to hospital, whilst 630,000 of those 65 and over find it difficult or very difficult to travel to their GP. It is the oldest old who find it the hardest - less than half of people over 80 find it easy to travel to a hospital.*
- *It is the people with the worst health and the lowest incomes who struggle the most to travel to health services.*[63]

[60] Rural Health Implementation Group (2011). Delivering Rural Healthcare Services. 2.3. Welsh Government. March 2011

[61] Mungall, I J (2007). Ensuring equitable access to health and social care for rural and remote communities. Increasing centralisation and specialisation within the NHS: the trend has some adverse effects on access to care for rural and remote communities. http://www.markproctor.talktalk.net/ruralhealth/docs/full_report.pdf Accessed October 2015

[62] Station Drive Patient Group (2014). Survey Results. Future Fit website, 2014

[63] Holley-Moore, G and Creighton, H (2016). The Future of Transport in an Ageing Society. Age UK. June 2016

Public transport is limited or non-existent in rural areas and even in the urban centres is inconsistent and expensive. One of the authors of this paper had a 2pm appointment at Telford's Princess Royal Hospital; she had to leave home in Ludlow at 11.20 am in order to be there on time. The rail fare was £16, with an additional fare for the bus between the station and the hospital. In another example, for Clun, a community in South West Shropshire large enough to warrant its own GP Practice, it is impossible to travel for an appointment at Princess Royal Hospital in a single day by public transport. Leaving at 09:20 (only available on Mondays and Fridays), the patient would arrive at the hospital at 12:15 with three changes and involving 20 minutes walking. The last public transport returning is at 11:25, 50 minutes *before* the patient is due to arrive.

The assumption is often made by planners that almost everyone has access to a car. Travel access times are typically measured by car travel times, not public transport alternatives. Across the area there are localities where car ownership is significantly below the national average – in the more deprived areas of Telford and Shrewsbury and in all the market towns across rural Shropshire[64].

Alternatives to public transport are routinely unavailable. It is becoming increasingly difficult to recruit volunteer drivers locally as the retirement age increases[65]. Shropshire CCG has recently tightened its guidelines on eligibility for non-emergency patient transport. If a patient is deemed well enough to use public transport, they are ineligible for patient transport - even if no public transport actually exists.

There is some research evidence of a relationship between access and missed appointments. For example, the King's Fund review of this area reported on a Sandwell study of connections between DNA rates and transport:

> *'An Integrated Transport Study by Sandwell HAZ highlighted several connections between DNA rates and transport. It appeared that about 10% of DNAs were caused directly by transport difficulties such as "non-urgent ambulance did not arrive", "friend with car was unable to provide lift", "bus service inappropriate" and about 10% indirectly "hanging about for a bus is the last straw when you don't feel 100%" '*[66].

The centralisation of services – irrespective of site - will, with inadequate transport and longer journey times, almost inevitably lead to an increase in missed appointments. This in turn is likely to have the consequent effect of patients becoming more unwell, and therefore more likely to access emergency healthcare in the future. These are outcomes that are harmful to patients, and likely to increase the overall cost to the local health economy.

The Financial Case for Future Fit

The SOC shows that the financial case for Future Fit rests on a number of key items of income or cost savings[67], to be achieved on an annual recurrent basis:

- The largest cost saving is 'General efficiencies' of £32.8m.
- A second major cost saving is Workforce Savings of around £21.3m.
- Repatriation of out-of-county activity is to generate £8.6m if the Emergency Centre is at Telford and £12m if it is at Shrewsbury.

[64] Map available at: https://drive.google.com/open?id=1XzbGfp3aG3qhvDIJcRC2pjcqE50&usp=sharing
[65] Cllr Madge Shineton, Shropshire Council (for Cleobury Mortimer Division) at Ludlow Health Forum. 2016
[66] Hamilton, K and Gourlay, M (2002). Missed hospital appointments and transport. P20. King's Fund, 2002
[67] Strategic Outline Case (2016; current). 5.2 Overall Affordability and Key Planning Assumptions. P30. Op.cit.

- The Sustainability Fund is to provide £10.5m.

It is hard to comment on the viability of achieving 'General efficiencies' of £32.8m without knowing the detail of these and how they are intended to be achieved. It is a substantial saving.

The target of £21.3m saving on workforce costs represents a significant saving. Based on an average SaTH salary, this is consistent with the loss of around 540 posts – close to 10% of the workforce. A reduction in posts on this scale is surely dependent on the accuracy of Future Fit activity and capacity assumptions. It would require an extraordinary reversal of current activity trends for Future Fit assumptions to be realised. We are not convinced that staff savings on this scale are achievable.

Repatriation of out-of-county activity has been discussed at Board meetings as though it is 'a given'. The main item reported is the repatriation of specialist cardiac work. Of course we support this in principle. However, we know of an unsuccessful attempt to open a Cardiac Catheter Lab at Ystbyty Gwynedd Hospital in Bangor. The equipment was purchased, at considerable cost – but mothballed when it became apparent that it would not be possible to attract sufficient Cardiac Consultants to cover this work at both Ystbyty Gwynedd and Glan Clywd in Rhyl. This is not a remote example; some Shropshire residents are treated at Wrexham Maelor, part of the same Health Board as Ystbyty Gwynedd and Glan Clywd. SaTH has a history of struggling to recruit consultants. It is not automatic that Cardiac Consultants will be recruited to a new Cardiac Unit at Shrewsbury or Telford. It is also not automatic that local demand will make a Cardiac Unit viable in business terms.

The SOC shows an annual income to SaTH of £10.5m from the Sustainability and Transformation Fund. The *total* amount of STP funding to the local health economy is £33m, for the entire period 2016/17 to 2020/21. This clearly cannot include annual funding to SaTH of £10.5m per annum. The sums don't add up. We asked about this apparent anomaly at a SaTH Board meeting. The £10.5m – shown in the SOC and the STP as an annual recurrent item – in fact applies *only* to the current financial year, 2016/17. We were told by SaTH's Director of Finance that cost savings in future years were assumed to be equivalent to this, which is why it is shown as recurrent income. **It is a surprising approach to accounting. There is no obviously valid reason why an assumed annual cost saving should be shown as recurrent income from NHS England.** This also raises the possibility that there is some double counting taking place, if the assumed £10.5m cost saving is already included in 'General efficiencies' or 'Workforce savings'.

There are two additional areas of uncertainty. One is around the Trauma Unit, currently at Shrewsbury. We strongly suspect that the preference from health leaders would be to close Shrewsbury A&E and consolidate acute services at Telford; certainly the SOC is written to point in this direction. However, it has not been certain that the Trauma Network would give permission for moving the Trauma Unit from Shrewsbury to Telford, given that there is already a Trauma Unit at nearby Wolverhampton. The loss of the Trauma Unit, quite apart from being detrimental to patients, would result in a loss of income to SaTH. The possibility of this does not seem to be covered in financial planning.

Finally, Shropshire CCG is in deep financial crisis; under legal directions, subject to an 'intensive intervention' regime from NHS England, and instructed by NHS England to immediately implement an addition £3.6m cuts. To date, these are planned to primarily affect community services. The recent pledge from the Accountable Officer[68] is that every aspect of spending will be reviewed, and additional

[68] Verbal comments from David Evans, Shropshire CCG Board meeting of 10th August 2016 and Primary Care Commissioning Committee meeting of 17th August 2016

cost savings will also be applied to SaTH. The impact of this remains unknown, but the level of crisis in the local health economy is without question unprecedented.

The overall picture is an uncomfortable one. The single most important issue, though, is that the financial case for Future Fit rests on the accuracy of its modelling assumptions. This applies very obviously to staff costs, and also to the capital costs of estates development. Higher than expected hospital-based activity would increase SaTH's income – but to the financial detriment of a local health economy that is seeking to implement major cost savings. If activity and capacity modelling are incorrect, then financial modelling can be little more than guesswork.

Community Fit: The loss of a 'whole system' approach

Proposals for community NHS services and social care are entirely omitted from the SOC. This is a surprising omission, given that the Future Fit vision has always been one of whole system 'transformational change'. This is, interestingly, *not* a Future Fit SOC, but a SaTH 'Sustainable Services' SOC. It deals only with the plans for acute care, while the earlier vision for community services and primary care is entirely omitted. This is no accident. A decision was taken by the Future Fit Programme Board in November 2015 that *'SaTH would take forward the work on developing the SOC and OBC* (Outline Business Case) *for new acute hospital facilities. The Programme will no longer be resourcing or managing this work and the technical team have been stood down'*[69]. The Programme Board report added *'It was decided that this work sits outside of the Future Fit programme'*.

From November 2015 onwards, Future Fit therefore cannot be regarded as a 'whole system' programme seeking to achieve an integrated outcome. There was a conscious decision taken to separate acute and community workstreams, and to devolve work around acute sector development to SaTH. Our concern is that this has led to an increasingly 'go it alone' approach from SaTH. It is worth noting that the separation of hospital reconfiguration from Future Fit has not been misunderstood by us. The new approach was also confirmed in correspondence with the Chief Executive of SaTH in April 2016[70], and we have raised our concerns about this at CCG and SaTH Board meetings. **It is made clear in a related Programme Board report[71] that the Strategic Outline Case and subsequent Outline/Full Business cases are intended to focus on meeting the acute trust's short to medium term needs around workforce, emergency and urgent care. This is *not* the holistic vision of the initial Future Fit clinical model.**

The separation of acute and community strands of work coincided with a growing recognition by NHS leaders of the worsening financial crisis in the local health economy. The Future Fit Programme Board that resolved to separate acute and community work streams also noted '*The SROs* [Senior Responsible Officers] *would ask the Finance Directors to scope and define a whole system deficit reduction plan…*'[72]. This deficit reduction plan was described in November 2015 as *'a new key Programme dependency'* for Future Fit. The sharp change in direction of Future Fit has reflected wider financial pressures.

The viability of Community Fit proposals

One of the caveats of the CCGs' SOC letter of acceptance is around the viability of the Community Fit proposals. The issues here are as fundamental as the concerns around activity and capacity modelling.

[69] Future Fit (2015). Managing Key Programme Dependencies. November 2015
[70] Email correspondence on collaborative approach to achieving critical mass, Simon Wright to Gill George. 27th April 2016.
[71] Future Fit (2015). Report on Programme Interdependency. November 2015
[72] Future Fit (2015). Managing Key Programme Dependencies. Op.cit.

A strand of Future Fit has always been to transfer a significant amount of activity out of hospital settings and into community settings. Estimates of the proportion of activity to be transferred have at times been 30%, and at times 'up to 30%'. The descriptions have been used interchangeably in public engagement events.

This is a shift that we fully support – subject, of course, to adequate capacity being present in community settings. Roy Lilley's comment is an apposite one: *'We can't shift stuff out of hospitals unless there is somewhere to shift it to'*. We were pleased that Simon Wright, Chief Executive of SaTH, noted at a recent meeting, *'We've got to have the confidence on community services or we're building too small a hospital'*[73]. It was an important admission.

The original vision for community services, outlined in the 2014 Clinical Model, was a powerful one. This emphasised the need for adequate capacity in community care and primary care settings, **and** for adequate funding of these alternatives to acute care. For example, the Clinical Model argues, *'Community capacity must be built to accommodate this shift. It is not necessarily cheaper to provide care at home when intensive input is required. Although new ways of working will provide efficiencies,* ***there is an absolute need to shift resources into community care'***[74] (our emphasis). Similarly, we are told, *'The development of 'teams around the practice' is seen as a high priority by clinicians who recognise the need for significant investment of resources for this to succeed and for adequate 'community capacity' to be created*'[75]. Reablement at home is recognised as *'resource intensive'*[76] and it is recognised that *'Unfortunately the cost of keeping people at home is often greater than the cost of residential care'*[77].The approach here was a realistic one. Monitor has noted that well-designed schemes to move healthcare closer to home may deliver benefits in the long term, but that it is difficult to cut costs in the short term[78]. The evidence base tends to show that alternatives to hospital-based care cannot be conjured up without significant investment in money, time, and staff. Transformation is neither cheap nor quick.

That Future Fit commitment to building new and enhanced community and primary care services has been repeated again and again at patient engagement events, and has been implicit in literature developed for patients. Very explicit promises have been made about the provision of care closer to home and at home, local planned care to be provided across the county, a network of rural Urgent Care centres, community hubs, better preventive services… For example, there are commitments that every patient with a long term condition will have a care plan; that many problems currently seen at A&E will be dealt with in the community; that up to a fifth of people currently requiring inpatient acute care will be cared for at home instead; that care will be fully integrated, a 'seamless experience', and more person-centred; that community hospitals could be transformed into community hubs, offering not just in-patient beds but walk-in services and GP-led Urgent Care Centres as well; that there will be a geographic spread of Urgent Care Centres across the county, offering local care as an alternative to travelling to Shrewsbury or Telford; that planned care will be offered closer to home[79].

[73] Ludlow Health Forum (convened by Philip Dunne MP), August 12, 2016

[74] Future Fit (2014). Clinical Design Workstream, Models of Care. 5.1 'Home is Normal'. P12. May 2014

[75] Future Fit (2014). Clinical Design Workstream, Models of Care. 6.2.5.3 Active Case Management. P38. Op.cit.

[76] Future Fit (2014). Clinical Design Workstream, Models of Care. 6.2.7 Getting better – reablement and rehabilitation. P45. Op.cit.

[77] Future Fit (2014). Clinical Design Workstream, Models of Care. 6.2.7 P46. Op.cit.

[78] Monitor (2015). Moving healthcare closer to home: Summary.

[79] Future Fit (2014). Future Fit: Shaping healthcare together. Clinical Design Report Summary: pamphlet 'specifically created for the NHS Future Fit engagement workshops'. 2014, re-issued 2015

The consistent promises have been of *better* care, care closer to home, and the investment that will make these things real. These things have not been a detail. They have been central to the overall Future Fit programme. Those firm commitments of the past have now been replaced by a very different model.

An escalating financial crisis

As recently as August 2015, the intention was that the transfer of activity would be supported by annual recurrent funds of £5.3m from Shropshire CCG alone[80], with additional funding to be made available by Telford and Wrekin CCG. This funding included £2.8m, again on an annual recurrent basis, for a network of five Rural Urgent Care Centres in Shropshire. The investment and the plans have now been withdrawn.

We know from the former Chair of the CCG that the £5.3m is no longer available[81], and that any resources for developing community healthcare services will be drawn from the Sustainability and Transformation Fund. This will mean a sharp fall in funding for the transformation of community services. The STP shows that funds total £33m over a five year period. Of this, £10.5m is earmarked to support SaTH, and a further £6.5m to enable the local health economy to reach a financial surplus. The remaining £16m, spread across five years, is to support a myriad of other initiatives, including national initiatives on mental health, cancer and maternity services; implementing paperless technology, and supporting Local Authority Adult and Children's services cost pressures[82]. Extended GP access and investment in prevention programmes *are* listed, but no ring-fenced funding is identified. The actual sum allocated for investment in community services will necessarily be a small fraction of the amount that appeared to be available a year ago.

In practice, the picture is bleaker still. The Community Trust is required to implement new models of care that will *save* £6m a year[83] *and* to make efficiency savings of 3.6% a year[84]. The cuts in spending on community healthcare services will far outstrip any funding made available. The Future Fit requirement to invest in community-based alternatives to hospital care cannot be fulfilled.

This is in the context of a local health economy that seeks to implement cost savings of £147.5m[85] by 2020/21 to deliver its financial recovery plan, and to close a recurrent financial gap of £140.5m[86]. Shropshire CCG is one of the two most financially troubled CCGs in the country[87], subject to intensive intervention by NHS England, and with key financial decisions very strongly influenced by NHS England. It is cost reduction rather than building community and primary care capacity that is now the driver for change. A recent throwaway comment from David Evans, the Senior Responsible Officer of both CCGs, was *'In the current financial situation, while of course we would prefer to improve the quality of care our patients receive, that's very difficult to do'*[88].

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[80] Shropshire CCG Board meeting, August 2015

[81] Letter from Helen Herritty, then Chair of Shropshire CCG, to Gill George. 18th March 2016

[82] Sustainability and Transformation Plan (2016[2]). 5.16 Use of Transformation Funds. P37. Op.cit.

[83] Sustainability and Transformation Plan (2016[2]). 5.11 Resultant Action Plan and progress to Date – Methodology. P35. Op.cit.

[84] Sustainability and Transformation Plan (2016[1]). 5.10 Resultant Action Plan and Progress to Date – Methodology. P31. June 2016

[85] Sustainability and Transformation Plan (2016[2]). 5.13 Risk Profile of the Deficit Reduction Plan. P36. Op.cit.

[86] Sustainability and Transformation Plan (2016[2]). 5.9 Resultant Action Plan. P34. Op.cit.

[87] Dunhill, L (2016). NHS England forecasting first ever overspend. HSJ. 27th July 2016

[88] Shropshire CCG Primary Care Commissioning Committee, 17th August 2016

This has created a very different climate for the delivery of Future Fit and particularly for Community Fit. The funding that was previously seen as an absolute requirement for delivery of community-based care and care closer to home has now been replaced by a requirement for spending cuts.

Current cuts undermine the Community Fit vision

Shropshire CCG has already agreed new service cuts to achieve in-year savings of £3.6m[89], in addition to its planned QIPP savings of £12.6m. Its position appears to be a sharply deteriorating one, with the September Board papers revealing a doubling of the in-year cost savings necessary to meet the NHS England control total, a spiralling deficit, and a failure to meet statutory financial targets[90]. The CCG has previously acknowledged that it is making 'unpalatable decisions' and 'difficult decisions'; the Finance Director is now urging the CCG to 'think the unthinkable'. There is an overwhelming sense of financial crisis; of decisions being made that do not fit well with wider strategic priorities, but brought about by immediate and worsening financial problems.

Proposed cuts take us very much away from concepts of building community capacity, providing care closer to home, and reducing dependence on acute hospital provision. The practice and the vision are at odds. The single largest QIPP saving agreed by the CCG in July is for over £1.5m reduction in spending on the flagship admissions avoidance scheme, Integrated Community Services[91]. Cost savings proposed in August included cutting a voluntary worker who worked on integrating services from health, social care and the voluntary sector; closing beds in a Much Wenlock care home that have been used to avoid hospital admissions; ending a service that provides proactive care to the frail elderly care home residents who are most at risk of hospital admission; ending a Home from Hospital service, cost-effective and utilising volunteers, that provides very practical help and personal care for patients following hospital discharge or requiring support to avoid hospital admission; ending a Moving and Handling service that provides support to the carers of older people with dementia or mobility problems; and ending a specialist service that provides health screening, assessment and intervention for adults with profound learning and physical disabilities and additional sensory impairments. These are cuts that are very much at odds with the direction of travel outlined in Future Fit. It is overwhelmingly likely that the implementation of these cuts will result in *reduced* community capacity, and in increased pressure on acute services.

Other cuts proposed in August included the closure of a 'crisis house' for people with mental health problems, an end to the provision of counselling services in GP surgeries, and the closure of a best-practice service offering specialist support to people with mental health issues to enable them to remain in work. Again, the loss of these community-based services is likely to result in an escalation of health problems for a proportion of service users, and an increased dependence on emergency care. Implementation of cuts has been slowed down by campaigners insisting on respect for statutory requirements on patient and community involvement, but any reprieve is likely to be temporary.

These are crisis-driven cuts to cost-effective community-based services, achieving between them a small part of the CCG's intended cost savings in the current financial year. Shropshire CCG has already agreed significant cuts in funding for the Better Care Fund[92], the linchpin of the integrated health and social care that is necessary to support the Future Fit vision of whole system transformation. Service cuts under consideration for next year include a well-respected mental health crisis service, and the

[89] Shropshire CCG Board meeting 10th August 2016. Agenda item 8.4
[90] Shropshire CCG Board meeting, 19th September 2016. Agenda items 8.1, 8.2, 8.3a
[91] Shropshire CCG, Board meeting 13th July 2016. Agenda item 8.2 Appendix 2
[92] Shropshire CCG, Board meeting 13th July 2016. Agenda item 8.2 Appendix 1 Summary Financial Plan 2016/17. Reduction in Better Care fund spending of £997,000 shown.

rural sites for DAART, a GP-led multi-disciplinary service offering close-to-home assessment, diagnostic tests and intervention to keep patients out of hospital wherever possible. Current cuts amount to fire fighting in order to meet a control total determined by NHS England. They cannot possibly be part of the over-arching strategy for local health provision - and in practice actively undermine that strategy.

A changed vision for Community Fit

Even before the latest crisis-driven cuts, the model for Community Fit had changed substantially, reflecting the changed economic situation facing the NHS in Shropshire and Telford and Wrekin. The new vision is outlined in the STP. The initial Community Fit model quite rightly included an increased emphasis on preventive approaches, with strands also on community involvement and voluntary sector provision. In 2014 and 2015, these were a *part* of the solution, to be offered alongside the Urgent Care Centres, the Community Hubs, the real terms investment and so on.

This has changed. The model outlined in the June 2016 STP is a radically different one. Community Fit is now intended to transition into a new Neighbourhood approach[93], driven by a place-based 'prevention and wellness' agenda. There are two main strands within this. One is a priority of building community resilience and social capital; the other is a focus on promoting healthy lifestyle choices and reducing risk. These are both admirable aims. All of us would wish to live in a compassionate society where neighbours look out for one another and help out more vulnerable members of the community; all of us would hope to see individuals take greater responsibility for their own health.

Are these proposals enough, though, to create the capacity to manage a 30% shift of activity out of hospital settings, to fill the gaps if acute provision turns out to underestimate future demand, and to compensate for the £6m a year reduction in community NHS spending, an additional requirement for a 3.6% annual recurrent efficiency saving from Shropshire Community NHS Trust, and an overall recurrent reduction in NHS expenditure of £147.5m? The approval of the SOC by SaTH's Board[94] was preceded by a genuinely impressive and mature debate (unminuted as it was informal). SaTH Board members did not seem to have known about the absolute crisis in the funding of community services – and they said they would need to 'Press the stop button' and halt the reconfiguration of hospital care if the money was not in place for community-based alternatives. It may be time for that commitment to be revisited.

The plans for the new social capital and prevention approach had not been in the public arena prior to the end of June. To date, there has been no public engagement on this model, beyond a single presentation to a committee of the Shropshire Patient Group. The new Neighbourhood Groups have no public or Patient Group involvement. From the STP, these appear to be very high level plans – a direction of travel not yet fleshed out by detailed work. No evidence base is cited in the STP to show that these approaches will result in the substantial improvements in health that will be required to meet an apparent mismatch between demand and capacity.

Prevention

The STP commits to the systematic delivery of lifestyle advice[95] across primary and secondary care, through initiatives such as Make Every Contact Count, Health Trainers in hospitals, Health Champion volunteers, and Physical Activity Champions. Brief advice and referral will tackle harmful alcohol

[93] Sustainability and Transformation Plan (2016[2]). 3.1 Developing services around neighbourhoods. P17. Op.cit.

[94] SaTH Board meeting, 31st March 2016. A lengthy informal debate took place on Future Fit prior to the formal meeting.

[95] Sustainability and Transformation Plan (2016[2]). STP Improving healthier lifestyles and reducing risk. 2.11-2.17. P13-15. Op.cit.

consumption. Prescribed apps will help patients achieve their health and wellbeing goals. There will be a whole-systems approach to tackling the obesity epidemic, and comprehensive whole-system prevention plans to reduce cancer risk factors. There will be systematic improvements to the prevention, detection and management of hypertension and diabetes.

This is laudable, and should be welcomed. However, the 'hows' of implementing these initiatives are lacking, and it is not clear where the human or financial resources will come from. The required network of 'Champions' does not currently exist (and the 'Young Health Champions' scheme has recently been discontinued on financial grounds). Public health spending has been sharply cut in Shropshire, as elsewhere.

There are wider issues. A prevention agenda can succeed for some participants – but the difficulties of achieving largescale change should not be underestimated. This of course is of relevance not just to the proposed Community Fit approach, but to the assumptions around prevalence that have fed into the acute model.

The Welsh NHS performed a study into the effectiveness of their own health improvement programmes[96]. The study examined 25 health improvement programmes – and concluded *'Because of a lack of published evidence at the time of effectiveness, cost-effectiveness and impact on inequalities, the panel did not vote in any majority fashion to invest further in any of the 25 interventions under review'.*

An ambitious programme in Stoke-on-Trent of lifestyle change to promote weight loss in patients at risk of cardiovascular conditions was analysed to determine its effectiveness[97]. The conclusion was:

Introduction of the NHS Health Check service in Stoke on Trent led to significant reductions in estimated population cardiovascular disease risk and associated individual risk factors. There was no further reduction in risk measures from the additional lifestyle support package offered to patients. Uptake of the service was lower than anticipated and this may have implications for the overall effectiveness (and cost-effectiveness) of this national policy initiative. On the other hand, routine screening of electronic medical records is viable and offers potential for the proactive and systematic management of population cardiovascular risk.

Given weight loss initiatives are a major component of wellbeing programmes nationally, it seems doubtful that they can achieve a significant improvement in admission avoidance over the already implemented NHS Health Check. A comparable study in Australia reached a similar conclusion. A diet and exercise intervention reduced the total disease burden by 0.10% and a low-fat diet by 0.05%[98]. The authors conclude, *'Based on current evidence, the overall effect of these interventions on the obesity-related burden of disease is negligible. Evidence from tobacco control, alcohol and physical*

[96] Edwards, R; Charles, J; Thomas, S; Bishop, J; Cohen, D; Groves, S; Humphreys, C; Howson, H; Bradley, P (2014). A national Programme Budgeting and Marginal Analysis (PBMA) of health improvement spending across Wales: disinvestment and reinvestment across the life course, BMC public health, 2014, Vol.14, pp.83

[97] Cochrane, T; Davey, R; Iqbal, Z; Gidlow, C; Kumar, J; Chambers, R; Mawby, Y (2012). NHS health checks through general practice: randomised trial of population cardiovascular risk reduction. BMC Public Health, 2012, Vol.12, p.944-944

[98] Forster, M; Veerman, J; Barendregt, J; Vos, T (2011). Cost-effectiveness of diet and exercise interventions to reduce overweight and obesity. International Journal of Obesity (2011) 35, 1071–1078. The authors note: 'Our study modelled the Australian adult population, but given comparable disease patterns, health care expenditure, prices and culture, the results can be considered indicative for other western countries as well'

activity suggest that population-targeted interventions (for example, taxes and restrictions of advertising and sales) have the greatest impact on population health'.

There is evidence that high profile national initiatives, backed up by legislative requirements and sanctions, are most effective in achieving behavioural change (as with smoking in the UK)[99]; this is of course difficult to replicate at local level. It is genuinely disappointing that the Government seems to be retreating on a robust implementation of its childhood obesity plan. There is evidence that a self-management approach is of some benefit to patients with some conditions, including asthma and COPD[100]. Perhaps most important of all, the socio-economic determinants of health inequality are immensely powerful[101], and it is regrettable that this is not acknowledged in the Shropshire and Telford and Wrekin plans.

This is not intended to be defeatist. Seeking to empower patients, and support patients in making their own health decisions, is of course the right thing to do from a philosophical point of view, and – for some individuals – will result in improved health outcomes. We should not, however, expect the provision of lifestyle advice and other preventative programmes to substitute for the provision on community NHS services or acute healthcare provision on any significant scale – at least in the short-term. Even if some preventative programmes are effective, the time horizons for them to have an impact on required health service are far longer than those envisaged in Future Fit modelling assumptions. Professor Rod Thompson, Director of Public Health, explained to a recent meeting of the South West Shropshire Patients Group that the programme of HPV vaccination of teens would only decrease the occurrence of cervical cancer over a 25 year period[102]. Professor Thompson also noted that Shropshire receives one of the lowest public health grants in the country.

'Strengthening Communities and Developing Social Capital'[103]

The 2010 Marmot Review[104] powerfully explored the social determinants of health and health inequality, highlighting the impact of economic and social status, and – within that – factors including housing, income, education, social isolation and disability. Marmot advocated action across all the social determinants of health, including income, housing, and education, as well as community. The case for change was driven both by a desire for social justice, and by an economic need to reduce NHS and welfare spending by reducing inequality.

That was in 2010. That agenda of tackling health inequality through addressing socio-economic inequality seems now to have been replaced with a kind of 'Marmot-lite'; a focus on communities, but with those central issues of income, housing and education quietly disappearing. Concepts of social capital and community resilience are the new zeitgeist for health organisations and local authorities in an era of austerity. The concepts are drawn from the social sciences and from disaster relief theory; their application to health and wellbeing policy is a new phenomenon. The language is of

[99] Frazer K, Callinan JE, McHugh J, van Baarsel S, Clarke A, Doherty K, Kelleher C (2016). Legislative smoking bans for reducing harms from secondhand smoke exposure, smoking prevalence and tobacco consumption. Cochrane Database of Systematic Reviews 2016, Issue 1. Art. No.: CD005992. DOI:10.1002/14651858.CD005992.pub3.

[100] Purdy, S (2010). Avoiding hospital admissions: what does the evidence say? Kings Fund. 2010

[101] Marmot, M (2010). Fair Society, Healthy lives. The Marmot Review. Strategic Review of Health Inequalities in England post-2010.

[102] South-West Patient Group. Minutes of meeting of 7th April 2016. The minutes record Professor Thompson as saying 'Much Public Health work is long-term in nature. HPV immunisation (against cervical cancer) will take ~25 years to become evident in statistics'.

[103] Sustainability and Transformation Plan (2016[2]). 2.6-2.10. Strengthening Communities and Developing Social Capital. P12-13. Op.cit.

[104] Marmot, M (2010). Op.cit.

neighbourhoods, communities, mapping assets, social prescribing and the like. The context in which these new ideas are now being applied is one of cutbacks in spending on public services. These concepts, together with the prevention agenda, comprise the very changed Community Fit model.

The local approach is to be one of *'building community resilience as a golden thread'*[105]. There is relatively little detail on how this will be realised, and how this will translate into health and wellbeing gains. The plans for Shropshire, Telford and Wrekin are reported to include strengthening communities by taking action on the causes of poor health; supporting volunteer and peer roles; enabling collaboration and partnership in planning of services between communities and statutory organisations; and connecting individuals and families to community resources[106].

Rather different approaches are suggested for Telford and Wrekin and Shropshire. Telford and Wrekin is to have 'Neighbourhood Care Teams', albeit virtual ones, including professionals from GP Practices, community nursing teams, hospital outreach teams, third sector organisations, carers and local authority teams. These teams will support people with identified long term health conditions, promoting self-care and self-management[107].

In Shropshire, by contrast, the emphasis is on the 'Resilient Communities movement' which will be working with Community and Care Coordinators. Working within communities and with third sector partners, they will be *'developing social action, social value and asset based approaches to meeting need'*[108]. The Resilient Communities movement, coordinated by Shropshire Council, is already in existence, although a straw poll suggests it has a very low profile. The purpose of the Resilient Communities movement is that:

> *Community based health and social care professionals and volunteer Community Connectors will use hyper-local directories to signpost people to existing local community resources for support and activity. Where there is an identified gap in a needed resource or activity, the community will be supported to create something that can fill that gap[109].*

The Community and Care Coordinators are members of the community, based in GP surgeries, who will 'assess and signpost' for frail and vulnerable people, those at risk of admission or loss of independence, and those coming towards the end of their lives. They are not clinicians.

There seems to be a sharp contrast between Telford and Wrekin, where investment in community services is apparently to continue, and Shropshire, where the emphasis is on community assets, third sector organisations and volunteers. The Shropshire approach has been characterised by several members of the public as 'a DIY approach to health and social care'.

Part of the local commitment to achieving change is *to 'Fund prototypes to kick start the movement, illustrating what can be achieved'*[110]. This very much reinforces the lack of ongoing funding for this process of transformation in Shropshire. Foot[111] has argued that these broader social approaches are

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[105] Sustainability and Transformation Plan (2016[2]). 2.6 Strengthening Communities and Developing Social Capital. P12. Op.cit.
[106] Sustainability and Transformation Plan (2016[2]). 2.7. P13. Op.cit.
[107] Sustainability and Transformation Plan (2016[2]). 2.8 P13. Op.cit.
[108] Sustainability and Transformation Plan (2016[2]). 2.9 P13. Op.cit.
[109] Resilient Communities https://www.shropshirechoices.org.uk/resilientcommunities/ accessed 1st September 2016
[110] Sustainability and Transformation Plan (2016[2]). 2.7. P13. Op.cit.
[111] Foot, J (2012). What makes us healthy? The asset approach in practice: evidence, action and evaluation

not an alternative to properly funded public services, She has also cautioned against an 'asset-stripping approach' of using volunteers or community networks to substitute for services that are being withdrawn or reduced, arguing that this is a route to people becoming disillusioned quickly[112].

The challenge around the social capital and community resilience approach to healthcare intervention is that the evidence base remains sketchy. There is a great deal of vision, but little peer-reviewed research on the outcomes for health and wellbeing following intervention to *build* social capital and community resilience. Where successful outcomes are described in the literature, these are often anecdotal reports of localised small-scale projects. In some cases results are promising, with reports of social value achieved that outweighs investment – but there is not yet a robust evidence base for social capital approaches achieving health improvements on a large scale. It is not safe to assume, on the basis of what we know in 2016, that a small investment in communities will cover the gaps left by cost savings in health and social care in Shropshire and Telford and Wrekin. 1930s Britain was characterised by stronger communities and social networks than we have now, but population health reflected social inequality, the lack of reliable healthcare, and the absence of public health services and a welfare state.

This is a complex area. There is compelling evidence that *individuals* with strong social capital are healthier, both in terms of perceived wellness and health outcomes (including reduced mortality). The effect is a powerful one, and one that intuitively makes sense. People with extensive networks of social support will tend to be happier and are more likely to make positive health choices than people who are socially isolated. Individual social capital, as measured by a question on trusting other people, has been shown to correlate with a perception of better health[113]. There is also evidence that actual and perceived social isolation are associated with an increased risk of mortality[114]. Individual social capital appears to have a protective effect. However, studies do not always differentiate between correlation and causality. An additional issue is that of 'double causality'[115]: does good health result in someone having more social connections and higher social capital, or does higher social capital result in better health, or (most probably) both?

There is a sharp distinction to be made between *individual* social capital (real and probably important) and the concept of *collective* social capital, as measured by indicators such as rates of volunteering, social trust, and civic participation. There is a considerable lack of clarity around definitions, but a community with high levels of collective social capital could reasonably be regarded as having a high level of community resilience; the concepts overlap. Some studies have found a link between collective social capital and perceived health; others have not. Findings are inconclusive. Rocco and Suhrcke[116] argue that *'individual social capital increases the probability of being in good health if the community has sufficiently high social capital; however, community social capital does not affect health directly'*. However, they also argue that the finding should be interpreted with caution. The

[112] Foot, J (2012). Op.cit.

[113] Rocco, L; Suhrcke, M (2012). Is social capital good for health? A European perspective. World Health Organisation 2012

[114] Holt-Lunstad, J; Smith, T; Baker, M; Harris, T; Stephenson, D (2015). Loneliness and social isolation as risk factors for mortality. A meta-analytic review. Perspectives on psychological science, 10,2,227-237. March 2015

[115] Scheffler, R et al. 2010. Social Capital, Human Capital and Health: What is the Evidence? P33. OECD 2010

[116] Rocco, L; Suhrcke, M (2012). P13. Op.cit.

research is summarised well by Rostila[117], in his careful review of the links between social capital and health inequality.

There are further areas of uncertainty. Levels of educational attainment are consistent predictors of individual social capital[118]; educational attainment at least in part will reflect higher socioeconomic status. This raises the question of what it is that is being measured in surveys of individual social capital. When someone has a higher level of individual social capital, might this reflect that someone is generally successful with regard to income, housing, social status and control over their lives? If this is the case, should policy makers target the *determinants* of individual social capital, or social capital itself?

Unanswered questions of equal importance apply to collective social capital. Studies of collective social capital have tended to look at an existing community, rather than one which is the target for intervention. It remains unclear to what extent communities can be *made* resilient or their collective social capital built. The impact of such interventions on perceived or actual health and wellbeing is also unclear. Methodological issues abound.

This is an area of promise. Any approach that may lead to gains in health or wellbeing for individuals or communities is of course worth pursuing. It is also a very new area. In review after review, researchers highlight the unanswered questions and the need for further research. To attempt transformation of the bulk of community healthcare and social care before that work is done must carry a level of risk. A leap of faith is taking place, on the basis of an evidence base that remains restricted. David Oliver, former Older People's Czar, commenting on strategies to reduce hospital admission, argued that *'we need evidence based policy rather than policy based evidence'*[119]. The point is well made. Approaches based on community resilience and social value meet the needs of policy makers – so an approach that may be of future value is portrayed as a panacea.

There are practical problems too around a dependence on volunteers to provide services to the most vulnerable members of our communities, especially when they are taking on the management of health needs. Paid employees can be told what hours they will work, and when they can take their annual leave. Volunteers may not be able to offer the same level of reliability. Questions also arise around arrangements for supervision and training, the management of clinical risk, and the management of safeguarding. Clinicians are of course encouraged to recognise their boundaries and act within their own sphere of competence; they operate within professional codes that reinforce these behaviours. Volunteers may lack the knowledge, skills or training to consistently offer care on a safe basis. The pool from which volunteers are drawn may well decrease as the pension age rises. The issues are important, and require some more thought.

The voluntary organisations that are presumed to form the basis of resilient communities are themselves suffering from financial cuts imposed by Shropshire Council, and are unlikely to be able to take on any extra burden. The Shropshire Star reported in May 2016:

> *'Adult services – More than £4 million of red-rated savings have been identified in health purchasing and housing support. The savings could come from a range of contracts with voluntary sector organisations that the council says 'provide*

[117] Rostila, M (2013). Social Capital and Health Inequality in European Welfare States. Palgrave Macmillan 2013

[118] Scheffler R et al (2010). P17. Op.cit.

[119] Oliver, D (2014). We need evidence based policy rather than policy based evidence. BMJ 349 September 2014

essential preventative services' to support people living and remaining at home, rather than going into higher cost services. It could also come from housing services under two contracts which deliver 'early intervention and prevention to support individuals and families'[120].

The risks inherent in this revised approach to Community Fit are evident. Around 30% of hospital activity is to be moved into community settings. Activity and capacity modelling has been optimistic, so there may well be a shortfall in acute provision – resulting in a still greater amount of demand to be met by primary and community services. Local GPs are adamant that they are already working at capacity, with the LMC recently commenting, *'Primary care is struggling to the point of failure, with rising workload and recruitment and retention issues'*[121]. Health leaders are now offering a radically different model of Community Fit, with a strong focus on building social capital and resilient communities – and are doing so in the context of reduced spending on community healthcare, and an annual recurrent reduction in spending on NHS services of £147.5m. It *may* be that the new model will create the positive transformation in individual and population health that is envisaged. It is at least as likely that it will not.

Community Fit Phase One: Some Overstated Outcomes

We cannot be sure what information has been sent to the Clinical Senate regarding the outcomes of the initial phase of Community Fit. The information contained in the STP, produced at around the same time as the submission to the Clinical Senate, in our view significantly overstates the amount of work that has actually been done to progress models of community provision[122]. The account is at odds both with the phase one report[123], and with verbal reports of the work completed. The reality is that the focus of Future Fit has been almost entirely on acute work, and work on community alternatives to acute provision has lagged far behind.

Community Fit phase one was essentially an information gathering stage, an audit of existing services. In an additional and important piece of work, a cluster analysis was carried out to broadly identify categories, numbers and costs of patients. Because primary care was almost completely omitted from the analysis, it may not be completely accurate – but it highlights that small cohorts of the population (e.g. young adults with complex disabilities, complex frail elderly people) are high cost users of health and social care.

The final component of the work was to model demographic changes and their possible impact on future demand. The three models – pessimistic, optimistic, and intermediate – produced such discrepant results that they are not necessarily of great value for planning purposes.

It is not the case that phase one *'modelled and described the types of service which will be required in the community to absorb the activity coming out of the acute trust and the other changes which will impact on the use of primary and community healthcare services…'*[124]. If this work has been done since May, it is not in the public domain. It is not the case that there is *'an agreed estimate of the impact of demographic change on activity levels within these sectors'*. Rather, there is a very wide range of possible impacts documented (with a recent acknowledgement that the analysis requires further

[120] Shropshire Star (2016) http://www.shropshirestar.com/news/2016/05/18/shropshires-essential-services-no-longer-safe-from-cuts-as-full-extent-of-councils-black-hole-revealed. 18th May 2016

[121] Local Medical Committee (2016). Op.cit.

[122] Sustainability and Transformation Plan (2016[2]). 3.5 to 3.19 Outputs From Phase One of Community Fit. P17-21. Op.cit.

[123] Community Fit (2016). Report to the Future Fit Programme Board. May 2016

[124] Sustainability and Transformation Plan 3.5 P17. Op.cit.

work[125]). There is no description within the phase one work of *'the activity that the NHS Future Fit Programme models anticipate will move out of the acute setting'.* It is not the case that Community Fit phase one work made *'an assessment of the potential voluntary and third sector services contribution to the broader programme and suggestions of mechanisms and approaches that might be employed to maximise this contribution'*[126].

This is not just nit-picking. There is a misleading impression being given of work on primary care and community services that is well advanced, and of a seamless transition from Community Fit to the new approach based on prevention, social capital and community resilience. Careful planning of the work that can be transferred from hospital settings to the community is essential, but has not taken place. Careful modelling of the necessary additional capacity required in primary care and community healthcare has also not taken place. We are not aware that this work has taken place at all; if it has, it has been done at speed, without public involvement, and without being reported at Board level.

There are other concerns. The U-turn on Rural Urgent Care Centres has caused real dismay, and has greatly undermined the earlier vision of care closer to home.

Through 2014 and 2015, a great deal of work took place to develop a model for Rural Urgent Care Centres. The Rural Urgent Care Centres were the only element of Future Fit that received a high level of public support. The proposed centres genuinely had the potential to transform access to healthcare in Shropshire's rural areas. Public engagement events took place across Shropshire, with detailed discussion around the services and facilities people wanted to see in their own locality. A Rural Urgent Care Centre workstream involved clinicians and Patient group representatives. Plans were developed (and agreed by Shropshire CCG[127]) for a network of five Rural Urgent Care Centres, open at least 16 hours a day, offering X-rays, ultrasound, specialist services for children and older people, assessment beds for periods of observation, and a host of other services. Unfortunately, by March this year it became clear that Rural Urgent Care Centres were off the agenda, on cost grounds. Overwhelming anger over this was expressed at well-attended Rural Urgent Care workshops in Ludlow and Bishop's Castle, with strong concerns voiced not just by the public, but by GPs attending the events.

There has, however, been a conspicuous flurry of activity literally over the last few weeks. There has to be a strong suspicion that this has been in preparation for the Clinical Senate Review. Rural Urgent Care Centres have been replaced by a far more nebulous concept of 'Rural Urgent Care *Services'*, required to be cost neutral. The prototype for this concept was developed over a four week period, and is to be piloted for four weeks. It was launched at the best established of Shropshire's community hospitals, where staff and diagnostic facilities already exist. There is a strong concern from PPEC members that the intention is to demonstrate success rather than to explore how best to deliver urgent care across rural Shropshire. The prototype has been regarded as a 'soft option', and has caused real disquiet.

The other focus for a sudden burst of work has been a very hasty move to design pathways of care. The July 2016 Programme Director's report[128] announced the *'move into a phase of designing the community services models of care'.* The report continues, *'Long Term Condition (LTC) Pathway task and finish groups have been proposed for 6 pathways: Respiratory, Chronic Kidney Disease (CKD), Diabetes, Heart Failure, MSK and Frailty. Each will have a GP and acute consultant lead together with*

[125] Sustainability and Transformation Plan (2016[2]). 3.18 Impact of demographic change on primary care. P20-21. Op.cit.
[126] Sustainability and Transformation Plan (2016[2]). 3.7 P18. Op.cit.
[127] Shropshire CCG Board meeting, 12th August 2015. Op.cit.
[128] Vogler, D (2016). Future Fit Programme Director's Report. July 2016

other clinicians and will embrace any existing pathway work'. This is a welcome and overdue development – but the emphasis is on speed. One group, for example, has produced a draft pathway after a single meeting, at which the acute consultant was not present. It is a high level outline plan, with no content on how the shift of activity from acute to community settings will be achieved, and no indication of the numbers of patients who will be appropriate for different levels of care. We know of one pathway where participants were encouraged to complete in a 'few weeks'[129]; others are likely to have been given a similar timescale. The danger is that careful, detailed work will not be undertaken because of time pressures.

In line with the emphasis on positive presentation, the same report notes *'The approach to step changes in public health and prevention have been discussed and public health representatives now sit on the Clinical Design Group'.* Again welcome, but in and of itself, this will take us no nearer to achieving a step change.

The reality is that Community Fit has not been a priority. The lack of progress after two and a half years is genuinely shocking. Future Fit is a project that in practice has been driven by the organisational needs of SaTH. This is abundantly clear from the Strategic Outline Case.

There continues to be a mismatch between the Community Fit timetable and the timetable for agreeing acute service changes[130]. The Outline Business Case for changes to acute care is due to be completed before the end of October. The timetable for Community Fit remains open-ended, and is shown in current timelines as 'to be confirmed'. Despite reassurances, the progression of changes to hospital care is not dependent on clarity around the capacity of and resources for community services. The divergence of timetables reinforces the loss of the 'whole system' approach that initially characterised Future Fit. Our view is that this will add a level of risk to the overall project.

Information Technology/ Integrated Care Records

The 2014 Clinical Model stated:

> *'Integrated care records are the most fundamental 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'[131].*

This was an absolutely correct recognition of the clinical importance of sharing information between clinicians and across providers. Without effective information sharing, joined up care is unattainable.

Sadly, progress towards achieving this objective has been very slow. IT development typically requires significant capital spending, and money has not been available. Additionally, each provider organisation has had its own internal IT priorities, and these have typically come before implementation of a shared IT agenda.

A May 2016 report[132] on the '10 Universal Capabilities' makes depressing reading. Progress at best can be described as patchy, with providers continuing to use a variety of different systems, and sharing

[129] An email to members of a Clinical Pathway Group dated August 19: *'As you know we are working to tight timescales and I am keen that we reach agreement on the pathway in the next few weeks as we have 2 other tasks to complete in relation to quantifying the activity shift we think this pathway would deliver from acute to community and the workforce requirements to deliver it as we need to apply a confidence factor in terms of sustainability/ deliverability (these are templates 2 and 3 in the attachment).'*

[130] Future Fit timetable August 2016

[131] Future Fit (2014). Clinical Design Workstream, Models of Care. 5.4.3 Information Technology. Op.cit.

[132] Digital Strategy Group, 5th May 2016

data in ad hoc ways. For example, SaTH provides electronic A&E and ward discharge summaries to GPs, but SaTH's provision of Pharmacy reports to GPs is patchy (and not considered timely), Audiology does not provide information electronically and continues to use weekly paper summaries, and Radiology reports are accessed through a separate system. Shropshire Community Trust aims to provide this information to GPs by the end of 2017. South Staffordshire and Shropshire Foundation Trust does not provide electronic discharge summaries at present but reportedly aspires to do so. This is far removed from the concept of a clinician pressing a button and having real time access to a patient's clinical information.

There is a long way to go.

Conclusions

A Perfect Storm

The waiting list for cataract surgery in Shropshire is now around 18 months[133].

The wait for a non-urgent neurology appointment is about 9 months[134].

The view from SaTH:

> *High Demand Risks – The Trust continues to be experiencing exceptional levels of demand and concerns of capacity both in our inpatient and emergency areas. This has led to patients being escalated and occupying spaces that are sub-optimal in terms of our ability to care for them safely or with dignity and respect. In order to assess the current risks; the Trust is undertaking risk assessments of patients requiring boarding or escalating in non-ward areas prior to them being moved.*

The view from GP Locality Boards[135]:

> *'Dr M referred to a case of an elderly patient who had died which was considered related to the failure of social services of not providing care. Dr M relayed some brief details surrounding the patient's case who had had a care package but this had been increased. Social Services refused to pay and withdrew the care package putting it out to tender but no care agency had come forward. It was unknown whether this was an isolated case'.*
>
> *'Patient with unexplained rectoral (rectal) bleeding was referred on a 2 wk rule and was sent back as not appropriate. GP wrote back to say it was included in NICE guidance but bounced back and is still on-going'.*
>
> *'A 2-month old neonate with significant reflux problems was given an appointment in 7 months' time for review. When GP complained was advised appointment available in Sept'.*

A paramedic's comments on current mental health cuts:

> *'People's default position to get help will simply be 999, overloading Ambulance services and A&E with patients who would normally seek help from mental health services and social services, which happens now even though the Ambulance service, Paramedics or Technicians have no training in mental health and yet it is now their biggest patient call out reason'[136].*

A West Midlands Ambulance Spokesperson, explaining why a 10-year-old child was taken to hospital by fire engine:

> *'We can confirm that, on this occasion, we were unable to transport a patient to hospital from the scene of an accident in Telford in the early hours of Wednesday.*

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[133] Patient report. July 2016

[134] GP advice. September 2016

[135] Issues Log, Locality Board Meetings. 9th June 2016. In papers for July 2016 meeting of Shropshire CCG Board. GP initial changed for reasons of patient anonymity.

[136] Personal correspondence

At the time, four emergency ambulances had been delayed by over an hour each to handover their patients at the two Shropshire Hospitals.

In addition, ambulance staff were looking after patients in the hospital corridor at the time.

Two ambulances were dispatched to the accident but were stood down when the fire service informed us that they were transporting the patient.

The ambulance service has already raised the issue of long delays offloading patients with the hospital and commissioners on a number of occasions and will be doing so again. Whilst on this occasion no harm appears to have come to the patient, it is a completely unacceptable situation that we were unable to respond to an incident such as this'[137]*.*

The NHS is struggling in Shropshire, Telford and Wrekin. On a day to day basis, the pressures on staff are enormous, and some patients are now receiving sub-optimal care. Waiting times for urgent and routine appointments are becoming unacceptable. Proposed service cuts will leave some exceptionally vulnerable patients without adequate support. Social care, primary care, community healthcare services, mental health services, secondary care, and the ambulance services are all running at or above capacity much of the time.

Staff are telling us again and again of their fears for the future, and their lack of belief in the solution that is on offer. The frustration and demoralisation of staff are clear. Paramedics want to do their jobs, not to be parked up outside hospitals, or spending entire shifts working in hospital corridors because A&E is too busy. A&E nurses want to work in a safe system, but have described the current A&Es as 'a war zone' because of the lack of staff and the lack of capacity. Nurses do not find fulfilment in working as 'corridor nurses', or in working on wards that are so over-stretched that they struggle to find time for a toilet break. Community NHS staff report that they are stretched to the limit in an unsupportive system, with a new CQC report[138] highlighting the lack of staff as a particular problem. GPs are close to united in the view that they do not have the resources to absorb more and more work as the system comes under ever-increasing pressure. Crisis and near-crisis are becoming normalised. What is happening now is not sustainable – but the solution *cannot* be to make deep cuts in acute and community NHS services and social care.

In the spring, following an increase in respiratory infections, the situation was described to us by a nurse as 'a perfect storm', as areas of crisis came together. The ambulance service could not hand over patients, because both A&Es were full. Ambulances were off the road, because paramedics were caring for patients in the back of the ambulance. Other paramedics were caring for patients in hospital corridors until A&E cubicles became free and A&E staff could take on responsibility. Patients requiring admission could not be moved out of A&E, because there were no acute beds. Again, hospital corridors and other non-clinical areas were pressed into service to accommodate patients – for these patients, because there were no beds available on wards. Something has surely gone badly wrong when hospitals employ 'corridor nurses' to care for patents in non-clinical areas of the hospital. A major contribution to the shortage of beds was the chronic lack of community based care, with too few domiciliary carers, and a shortage of community hospital beds and CCG-funded care home beds. The

[137] Shropshire Star. Boy, 10, taken to hospital by fire engine after Telford crash because there were no ambulances. 31st March 2016

[138] CQC (2016). Shropshire Community NHS Trust, CQC report. 7th September

NHS effectively broke, despite the very best efforts of its staff. The system failed in the spring, and is only a hairsbreadth away from failure now.

For a few months in the spring, we had a small glimpse of the future – an NHS in Shropshire, Telford and Wrekin that stopped working. Since then, we have had an NHS that is (just) hanging on. What will happen, if Future Fit is rolled out in its current form? What will happen to patients? How will the ambulance service cope with longer average journeys, and with increased demand because admission avoidance schemes are being cut, when it is not to be given any additional resources? When our two A&Es become one, with capacity based on activity assumptions that are not evidence based, how will staff cope, and what will happen to patients when even the corridor space runs out? If SaTH cannot maintain patient flow with its current number of beds, how will it manage when those beds are cut still further? – because this is what the Future Fit model will do. Is it realistic to think that hospital staffing can be reduced by ten per cent without harm to patient care, and without pushing staff to breaking point? We hear horror stories now of the very fragile people in their 80s and in their 90s who can't be found a community hospital bed, or who are discharged home without a care package in place, who are left with unacceptable delays or gaps in their care. What will happen to them, when the official solution is that 'community resilience' will provide, and the solution to gaps is that statutory agencies will encourage the community to fill them?

The NHS in our county is on a knife-edge. Health workers are increasingly telling us that underfunding and staff shortages jeopardise its future. We do not believe that the solution to a simmering crisis is to implement a programme that is now about across-the-board cuts and closures.

Future Fit

The Future Fit model is effectively broken. The proposals now being put forward are very far removed from the original concept of whole system transformation, with its commitment to meaningful investment in primary care and community healthcare.

It is immediately apparent that the underlying activity assumptions are over-optimistic. The application of the same assumptions to updated baseline data does not in any way solve this problem. Rather, it reinforces that current activity trends are very different to those anticipated by the Activity and Capacity Working Group. These are not minor inaccuracies, and it is unlikely that they can be dealt with through slight refinements to the model between now and formal consultation in December. The activity assumptions lie at the heart of planning around capacity and finance. It would take an extraordinary and unprecedented change in the health of the local population for the current Future Fit model to work. The levels of clinical and financial risk that will arise from implementing this model are significant.

The lack of continuity and leadership have never been more apparent. Proposed acute models are subject to fundamental change without explanation. The model for Community Fit is strong on rhetoric and vision, but starkly lacking in detail and an evidence base. Future Fit has become a project of 'quick fixes' and carelessness. The numbers don't add up. Data presented in one section of a document conflicts with the next section, and with a document produced a few weeks later. Nobody seems to have a handle on the detail, and it has been nobody's job to drive the project forward in a coherent way.

Our strong fear is that Future Fit will be implemented even though everyone knows it cannot work – simply because calling a halt at this stage would result in a considerable 'loss of face'. This cannot happen. The risks to patients and to our local NHS are simply too great.

The challenges facing our health service are summed up well in SaTH's recent annual report:

> *NHS Services within Shropshire face an increasing challenge of delivering high quality, safe and sustainable acute services. This is within a climate of rising demand, reducing levels of funding and on-going changes within the workforce[139].*

This has never been a choice between change and no change, although this is how debates have been portrayed by health leaders. There is a need for change, but it must be change that is clinically safe, and that will deliver care that is accessible to a scattered population living across a vast and largely rural area. The model of care that works for an urban area is probably not the right one for Shropshire. Access matters. It cannot be regarded as a detail or an afterthought.

The new health mantra of 'Keep the Shropshire pound in Shropshire' makes no sense to us. This is an organisational approach, not a patient-centred approach. Local people access secondary care in Shrewsbury and Telford – and, for people living near Shropshire's borders, outside the county. In a rural area where journey times are long, there is no concept of an abstract loyalty to a hospital because it is 'Shropshire'. Our local Sustainability and Transformation Plan 'footprint' is the second smallest in England; it may well be too small. A vision of healthcare that focuses just on Shropshire and Telford and Wrekin is necessarily constrained. Our belief is that the way forward must be a far more collaborative model, in line with the Royal College of Physician's Future Hospital Programme. The Black Country Alliance provides a useful illustration of the advantages to acute hospitals in working together to achieve the critical mass to maintain specialist services, strengthening recruitment and retention, and cutting costs. The benefits are to the organisations *and* to patients. SaTH's 'go it alone' model, where patients are told 'We can't recruit so you can't have', is outdated and unhelpful. A useful starting point for SaTH might be to approach other acute trusts, perhaps Wye Valley and Worcestershire, to discuss building a networked model of care delivered on a collaborative basis. If this requires a review of the current STP footprint, our CCGs must make that approach to NHS England. There must also be a much clearer recognition of the needs of Powys patients, who will be fundamentally affected by changes to hospital-based care in Shropshire and Telford and Wrekin.

We fully support a transfer of acute work to primary care and community healthcare settings – but a necessary prerequisite **must** be the investment of resources (financial and time) to ensure the capacity is there, and it must be an evidence based approach. A whole system approach requires bottom up planning, rather than a muddled plan to cut acute care and hope that other services will meet patient need. There are real strengths in local healthcare: good GP care, a network of community hospitals, dedicated staff working across all strands of our NHS. Local change needs to be about a careful, planned approach building on these strengths.

Above all: start with the patient and work backwards.

Gill George, Chair
Julia Evans, Secretary

Shropshire, Telford and Wrekin Defend Our NHS
12th September 2016

[139] SaTH (2016). Putting Patients First: Annual Report and Annual Accounts 2015/16. I.1c P12. Op.cit.