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Dear Councillor

We are writing to you on behalf of the Shropshire Defend Our NHS campaign. This is a broad-based campaign of local people who care passionately about the future of our NHS. We are not party political, and our members include people of many political views and none. Our members also include people with substantial personal experience of working in the NHS and social care.

We wish to share our concerns regarding the future of NHS services in Shropshire. We make no apology for the detailed evidence we present here. We believe it to be important that you, as an elected representative of Shropshire people, have access to the information that we have. We want you to know why we believe that Shropshire CCG is following a course of action that will lead to profound harm to local healthcare.

The background to our concerns is set out in the supplement to this letter. As a short summary, our concerns include:

> Shropshire, a large rural area, will not have a 'Major Emergency Centre' under new national proposals. This has implications for healthcare, funding, and staffing as well as access. This is not a part of the Future Fit plans, and not a local decision; we would hope that CCG leaders will join us in calling for a Major Emergency Centre in this area.
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> Under Future Fit, a decision has been taken to have a single 'Emergency Centre' (A&E) to replace the two we have now. This will be based at the Princess Royal Hospital. It is clear from Future Fit paperwork that this decision has already been taken, although it has not been made public. This means longer ambulance journeys, with research evidence indicating that this will result in increased mortality.
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> Almost certainly, the single Diagnostic and Treatment Centre for planned care will be co-located with the Emergency Centre, because of compelling 'workforce and equipment issues'. Again, this will almost certainly be in Telford. For Shropshire patients, this means long journeys for planned care – in a large rural county with poor public transport.
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> Services such as very minor surgery for 'lumps and bumps' will be centralised, as will radiotherapy for cancer patients. This means very long journeys in order for patients to access care (with research showing that cancer patients simply opt out of radiotherapy when journey times exceed 45 minutes).

Urgent Care Centres will replace the existing Walk-In Centre in Shrewsbury and the four Minor Injuries Units in Bridgnorth, Ludlow, Oswestry and Whitchurch. It now seems likely that there will be only two or at most three Urgent Care Centres, with the only confirmed locations being the Princess Royal Hospital and the Royal Shrewsbury Hospital. This means a loss of local services for many Shropshire residents.

The plan to close the Walk-In Centre at Monkmoor and create a privately run Urgent Care Centre at the Royal Shrewsbury Hospital is unacceptable. This is an attempt to bypass the consultation promised in the Future Fit proposals.

The Future Fit focus has been on A&E care and 'bedded services'; a key priority has been a reduction in the number of patients treated in acute care settings. The detailed work has not been done to ensure the transformation of primary care and community care that would make this safe. We know that GPs are exceptionally concerned by the Future Fit proposals, because they do not have the capacity to take on the care of large numbers of seriously ill patients in community settings.

The resources are not being put into community NHS services, GP services or social care to ensure patient safety within a new care ethos that says 'home is normal'. Without these services being funded and in place, it is not safe to set stringent thresholds for hospital admission. The risks of patients being left with inadequate care are overwhelming.

The needs of Powys residents are being completely overlooked. We understand that this may not be your immediate concern – but it seems to us unfair that our neighbours will be even more at the losing end of an NHS lottery than we are.

Patient engagement in Future Fit – and please note that it is 'engagement' rather than 'consultation' – has been superficial. All meaningful decisions are being taken behind closed doors, long before formal consultation begins.

We hope that you will read the following pages carefully. We are asking you to take your responsibilities as an elected representative very seriously. Nye Bevan, the founding father of the NHS, said in 1948 *'The NHS will last as long as there are folk left with the faith to fight for it'.* We hope that you will ask challenging questions. We hope that you will publicly oppose NHS changes that will be harmful to Shropshire residents. We hope you will stand up for local people.

Yours Faithfully

Gill George

Joyce Brand

On behalf of Shropshire Defend Our NHS

3rd August 2014

NHS Reform in Shropshire: An Account of Concerns

Major Emergency Centre

Firstly, and very importantly, we wish to raise an issue that is not part of the local 'Future Fit' re-organisation proposals. There is a national review of urgent and emergency care taking place[1]. This makes a distinction between 'Emergency Centres' and 'Major Emergency Centres'. These, together with Urgent Care Centres, will replace the services we currently describe as 'A&Es'.

We know that Shropshire is **not** going to have a Major Emergency Centre. Caron Morton, Accountable Officer of Shropshire CCG, told a Future Fit meeting in Welshpool on 9th June that Shropshire will have an Emergency Centre, and that the linked Major Emergency Centre will be at the North Staffordshire Hospital, Stoke-on-Trent. This has been confirmed subsequently in at least three informal conversations with senior CCG representatives of Shropshire CCG and Telford and Wrekin CCG.

Does this matter? Almost certainly, yes. The national proposals differentiate sharply between Emergency Centres and Major Emergency Centres. 'Emergency Centres' will assess patients and initiate treatment. 'Major Emergency Centres' will have consistent levels of senior staffing and access to specialist equipment and expertise. Patients requiring specialist services will be transferred from the Emergency Centre to the Major Emergency Centre. The NHS England definition of specialist services, taken from the national proposals for emergency care, includes '*those for heart attack, strokes, major trauma, vascular surgery, critically ill children'.* The national process is now moving on to its 'delivery' phase, with the definition of proposals having concluded in November last year.

The nationally determined pathway would see seriously ill Shropshire patients taken by ambulance first to a local Emergency Centre, probably at the Princess Royal Hospital in Telford, and subsequently transferred to the Major Emergency Centre at Stoke. This would mean substantial delays – of three hours or more for patients in our more rural areas – before specialist emergency care was available. This would be a marked change to existing services, where patients with heart attacks and strokes are seen within county, as are critically ill children. We have no argument, of course, about patients travelling for the most specialist forms of care: major trauma, brain surgery, open heart surgery etc. Our concerns are about existing local services being relocated to Stoke.

Our local CCG Chairs have told us '*We are making the assumption that, if we organise local urgent and emergency care services effectively we will be able to retain and hopefully increase the amount of urgent and emergency care we provide locally'* [2]. We hope they are right, but this is very far from the secure assurance we need. Commissioning and funding of urgent and emergency care will come not from CCGs but from much larger bodies called Strategic Urgent Care Networks[3]. Without agreement for a Major Emergency Centre and, crucially, funding for a Major Emergency Centre, it is extremely unlikely that Shropshire CCG and Telford and Wrekin CCG will be able to maintain the levels of emergency care currently available within county.

We accept and understand that there are no *local* plans to move services to Stoke – but with no Major Emergency Centre in Shropshire, there is a strong risk that this loss of services will happen as a result of the new national model of care and the loss of funding that will go with it. Shropshire alone covers an area of 1235 square miles. The population depending on local emergency services, across Shropshire, Telford and Wrekin and mid-Wales, is over half a million. Our view is that there is a strong case to be made for a Major Emergency Centre in Shropshire, even if this means challenging the 'urban-centric' view of NHS England.

We request that you join with us in making common cause to NHS England with a simple shared message: "We need a designated Major Emergency Centre in county, together with the funding to pay for specialist diagnostic and clinical services".

A Single A&E

An extremely contentious proposal within Future Fit is that we will move from two A&Es (one at the Royal Shrewsbury Hospital, one at Telford's Princess Royal Hospital) to a single Emergency Centre.

This has not been consulted on, and effectively will not be. Although members of the public attending Future Fit engagement events were told 'nothing is pre-determined', we were shown slides of clinical models that varied in detail, but in each case showed a single Emergency Centre. The Clinical Models paper published in May 2014 reports 'One emergency centre'[4]. The paperwork for the Evaluation Panel, the group charged with drawing up a 'long list' of options, is on the Future Fit website[5]. The options available for participants drawing up a long list were strictly limited. Panel members were told that there would be **one** Emergency Centre and **one** Diagnostic and Treatment Centre. They were allowed to discuss the locations of these, and the number of Urgent Care Centres, but the single Emergency Care Centre was a given.

Formal public consultation is not set to begin until July 2015 at the earliest[6]. At no stage has there been or will there be meaningful consultation on the loss of one of the two A&Es. Consultation, in order to be meaningful, requires there to be some chance of changing the outcome. In this case, the decision that there will be a single Emergency Centre has very clearly been taken in advance. **We do not believe that is acceptable to bypass public consultation in this way.**

We stress that this campaign is whole heartedly opposed to 'playing off' Shrewsbury and Telford, calling for one site rather than the other to be closed. We support accessible and high quality care across Shropshire *and* Telford and Wrekin. It is important, though, to be honest about which A&E is most likely to be lost. We also note that the A&E at the Princess Royal Hospital is already functioning at or beyond capacity.

The Royal Shrewsbury Hospital has already lost Stroke services, inpatient Women's services and inpatient Children's services. We have suspected for a long time that this process of 'stripping out' of clinical services heralds the loss of the A&E and the running down of the hospital as a whole. This has now been confirmed in Future Fit paperwork. There can no

longer be any doubt that the A&E at the Royal Shrewsbury Hospital has been designated for closure.

How can we be so sure? The Future Fit Clinical Models report states quite explicitly *'The paediatric unit requires co-location with the main EC due to common needs for equipment, supporting expertise and the reality of patient flows in an emergency'.* This is not something that is merely being considered or discussed. We are told Future Fit **requires** the paediatric unit to be co-located (i.e. to be on the same physical site) as the single Emergency Centre[7]. Children's services are of course currently being transferred from the Royal Shrewsbury Hospital to the Princess Royal. The very service that **requires** co-location with the one remaining Emergency Centre will have moved from the Royal Shrewsbury Hospital to the Princess Royal Hospital by September this year.

It could be just possible that this is a mistake – but no, the small print of another Future Fit document confirms this picture, and strengthens the evidence that the A&E at the Royal Shrewsbury Hospital is to close. The paperwork for the Future Fit Evaluation Panel[8] includes a slide on the Emergency Centre. This shows that the Emergency Centre will be co-located with the Paediatric Unit *and* the Maternity Unit. Which is the second major service that is now being transferred from the Royal Shrewsbury Hospital to the Princess Royal Hospital? Women's Services, including the consultant-led Maternity unit. The Paediatric unit and the Maternity unit are listed in the document as '**required'** clinical adjacencies, again with no room for doubt. (There is an additional reference to required co-location of the Emergency Centre with emergency paediatric care and emergency maternity care. This simply states the obvious. Nowhere in Future Fit is there any suggestion that emergency paediatric care will be separate from the rest of paediatric care, or emergency maternity care based at a location away from the Maternity unit at the Princess Royal Hospital).

The decision has already been made, although the public has not been told. The single Emergency Centre in Shropshire is to be based with the Paediatric Unit and the Maternity Unit, which have already been centralised – at a cost of £28 million – at the Princess Royal Hospital. The Royal Shrewsbury Hospital is intended to lose its A&E. The new Emergency Centre is intended to be located at the Princess Royal Hospital in Telford.

The Future Fit clinical model is for the single Emergency Centre to be part of a single 'high acuity unit'[9], and the Emergency Centre is to be at the Princess Royal Hospital. It is overwhelmingly likely, therefore, that the high acuity unit will also be at the Princess Royal Hospital. The Royal Shrewsbury Hospital will not have an Emergency Centre and will no longer be a hospital that treats 'high acuity' patients.

There is also to be a single Diagnostic and Treatment Centre. Again, it is pre-determined that there is to be only one of these; this is spelled out in the paperwork that restricted the options available to the Evaluation Panel. The Panel document states that the Diagnostic and Treatment Centre will carry out 80% of planned surgery and will include 'major diagnostics'; a required clinical adjacency is said to be a High Dependency Unit[10]. The only co-location suggested is that it should be with the Emergency Centre, although 'operationally separate'. The Models of Care report broadly concurs, stating *'Workforce and*

equipment issues provide the most compelling reasons for co-locating the DTC with the EC. However, they must remain operationally separate and co-location is not essential'[11]. It is therefore just possible – albeit unlikely – that the Royal Shrewsbury Hospital will be the location for planned care. This would, however, necessitate the provision of two HDUs and two diagnostic centres – perpetuating the 'duplication' that was one of the initial drivers for change[12].

Of course we cannot be completely certain, but the very probable outcome is therefore for a single major hospital site. This will include the Emergency Centre, the high acuity centre for emergency and acute care, and the Diagnostic and Treatment Centre for planned care. This will be at the Princess Royal Hospital because of the requirement for co-location with Maternity and Paediatric Units. It is unclear what services are intended to actually remain at the Royal Shrewsbury Hospital, other than a privatised Urgent Care Centre.

Access to healthcare is of critical importance, especially in an emergency situation. For myocardial infarction (a heart attack where a coronary artery is blocked by a blood clot), for example, current NICE guidance states:

'Nearly half of potentially salvageable myocardium is lost within 1 hour of the coronary artery being occluded, and two-thirds are lost within 3 hours. Apart from resuscitation from any cardiac arrest, the highest priority in managing STEMI is to restore an adequate coronary blood flow as quickly as possible' [13]

Put that in layman's terms: every minute waiting for an ambulance or in an ambulance results in the death of more heart muscle, and a worse outcome for the patient. Clinical guidance is that rapid treatment is also important for strokes and for respiratory conditions.

Research evidence unsurprisingly shows that longer ambulance journeys are linked to increased mortality[14]. The West Midlands Ambulance Service is already failing to meet its targets for response times, and earlier this year was fined £2.6 million for persistent breaches[15]. Anecdotal evidence is of dangerously long response times in our more rural areas. If ambulances are making significantly longer journeys (from South or South West Shropshire to Telford; from Shropshire and Telford and Wrekin to Stoke) then turn-around time, response time, and journey time will all increase. There is no indication in Future Fit proposals that additional funding will be available for the ambulance service.

One of our supporters made an obvious but very true comment: You can have the best healthcare in the world, but if you're dead by the time you get there, it's of no use to you at all.

There remains a possibility that the preferred option will be a newly built hospital, and that all of these clinical services will be concentrated at a new site. This could be a welcome development; it could simply re-create problems with access. It would be foolish to evaluate the pros and cons of this when it remains purely hypothetical. However, we live in an era when public funding for major new initiatives is hard to come by. The Chair of Telford and Wrekin CCG has acknowledged that a new hospital, even if it were to get Treasury approval, would not be operational for 10 to 12 years.

Our concern is that the closure of one of our A&Es will take place before any new A&E and hospital are built. We do not believe that implementation of Future Fit proposals is intended to wait 10 to 12 years.

We would welcome your support in seeking a clear commitment from Shropshire CCG and from SaTH: that there will be no loss of emergency and other services from the Royal Shrewsbury Hospital until a new hospital is completed and ready to open. And if there is no new hospital? We hope you will join us in calling for the retention of emergency services at the Royal Shrewsbury Hospital.

This is something of an aside, but we have seen comments that seek to justify a move to one A&E on the basis that Shropshire cannot recruit enough emergency consultants. This problem is of course not specific to Shropshire. Health Education England has worked with the College of Emergency Medicine on a strategy to overcome the *national* workforce crisis in Emergency Medicine[16]. The crisis may, fortunately, be resolving now. Changes to training should ensure a greater availability of middle grade doctors to the service from 2014 onwards. The NHS is now offering four year programmes to appropriately qualified middle grade doctors from India who can both benefit from NHS training and support our health service. Yorkshire and Humberside is coordinating a nationwide pilot of a new training route into emergency medicine, with recruitment beginning this year.

Health Education England and the College of Emergency Medicine also support the more imaginative use of Speciality and Staff Grade doctors. For example, Wessex has pioneered a scheme where Speciality doctors are provided with additional support and training to enable them to work unsupervised out of hours (with the obvious potential to relieve pressure on consultants, as well as offering much greater flexibility in putting together rotas). Other areas are now following this example.

The HEE/CEM report is a useful one, summarising the important changes that are now taking place to ensure adequate staffing of A&E departments. Is Shropshire a part of any of these initiatives? Or is the priority simply to close down an A&E because SaTH has a deficit budget (to the tune of £15 million this year), and has now been formally designated as a hospital that is failing financially? It is worth noting, perhaps, that a failure to win a Major Emergency Centre for Shropshire would have a devastating impact on recruitment of specialist staff.

Urgent Care Centres

The central questions around Urgent Care Centres are simple ones: how many and where? In both the national and Future Fit proposals, there is no place for Minor Injuries Units; these will be replaced by the new Urgent Care Centres. We currently have four Minor Injuries Units in Shropshire: at Ludlow, Bridgnorth, Oswestry and Whitchurch. These will go when the Urgent Care Centres are established.

The Future Fit proposals have consistently referred to 'some' Urgent Care Centres. At the Future Fit engagement meeting in Welshpool on 9th June this had become 'several Urgent Care Centres'. The only two that have been confirmed are to be co-located with the existing A&Es at the Royal Shrewsbury Hospital and the Princess Royal Hospital, effectively acting as

'gate keepers' to the service. Informal reports are indicating that the current intention is for two or at most three Urgent Care Centres, including those at Telford and Shrewsbury.

GP surgeries are to be given the option of seeing 'same day' appointments at Urgent Care Centres rather than the surgery[17]. The difficulties that this would cause for patients in rural areas are quite rightly noted in the Future Fit Models of Care report. If this were to happen, it would sharply reduce access to primary care for many Shropshire residents.

We support the concept of Urgent Care Centres. We note, however, that they are not a 'magic trick' for saving A&Es, with the College of Emergency Medicine's recent study showing that only 15% of current A&E patients could have been safely managed in a GP-led service[18]; specialist *assessment* is often required even where specialist treatment is not. Training, dedicated specialist support and robust staffing arrangements become crucially important here. A recent verbal report from Caron Morton (at an engagement event in Monkmoor on 4th August) was that the privatised Urgent Care Centre at the Royal Shrewsbury Hospital will see 60% of existing A&E patients. This is at odds with the evidence from the College of Emergency Medicine. There must be a level of risk here.

Urgent Care Centres will not provide care 'closer to home', the aspiration of the national review[19], if there are few of them. It will be an exceptionally poor outcome for those of us in the rural parts of Shropshire if we lose our Minor Injuries Units and have to travel to Shrewsbury even for a same day GP appointment.

With the role of community hospitals remaining poorly defined in Future Fit, their role in providing diagnostic services and out of hours GP appointments could be undermined when these services are based at Urgent Care Centres. Our community hospitals are valued community resources, and we hope to see them strengthened in any NHS reforms. They cannot simply become sites for 'medium acuity' beds.

Our view is that, in a rural area with poor public transport, Urgent Care Centres must exist not just at the Royal Shrewsbury Hospital and the Princess Royal Hospital, but also as a minimum at our existing community hospitals: Bishops Castle, Bridgnorth, Ludlow, Whitchurch; and at Oswestry Health Centre. The needs of Powys patients have largely been overlooked in the Future Fit review, and we would also support an Urgent Care Centre in Powys. We have been told informally that clinicians supported the creation of eight Urgent Care Centres; this is a number that can readily be justified to ensure adequate access to healthcare.

We support Urgent Care Centres. There must be enough of them, and in the right places, that access to urgent care does not become worse. Patients must not be left travelling longer distances to urgent care, same day GP appointments, or out of hours GP care. Patients requiring specialist emergency care (assessment or treatment) must continue to have access to this. The role of our community hospitals must be safeguarded. Please join us in asking for Urgent Care Centres to be co-located with our community hospitals, and at Oswestry and in Powys.

A final point on Urgent Care Centres. The public consultation on Future Fit is not due to take place until June 2015 at the earliest. Extraordinarily, Shropshire CCG has reached an in-

principle decision to create an Urgent Care Centre at the Royal Shrewsbury Hospital, awarding the contract to a company called Malling Health, without any public consultation and without putting the contract out to tender. The public events now rather grudgingly being organised are engagement not consultation; i.e. they are 'one way' meetings where members of the public are told what is to happen, with no requirement that the views of the public are subsequently considered. From December this year, 60% of users of existing A&E services at the Royal Shrewsbury Hospital will be forced to use a privately provided service[20]. An additional and major concern: in the process of setting up the Urgent Care Centre at the hospital, the CCG will be closing a valued Walk-In Centre in Monkmoor, Shrewsbury, currently used by 34,000 patients a year.

This is genuinely scandalous. Malling Health has a questionable record of walking away from contracts that are unprofitable – and many of us would not want this company running 60% of our A&E. There are clinical risks in fragmenting urgent care and emergency care by introducing separate providers, with a genuinely frightening example from Mayday Hospital Croydon, where Virgin runs the Urgent Care Centre[21]. The decision to award the contract to the private sector without going to tender denies Shropshire Community NHS Trust or Shropshire's GPs the opportunity to bid for the service. A precedent is created that Urgent Care Centres will be privatised. The Future Fit consultation process is simply bypassed. Overall, this is an approach that is contemptuous of NHS users, both the users of the Walk-In Centre and the wider public.

We hope that you will join us in ensuring adequate consultation on the proposal to close Monkmoor Walk-In Centre and create a private sector Urgent Care Centre at the Royal Shrewsbury Hospital instead, and that you will ask for NHS providers to have the opportunity to offer any new service.

Other Future Fit Proposals

This letter does not seek to provide a comprehensive review of Future Fit, although we do pick out some key areas. There are plenty of good ideas within Future Fit, but there are also overwhelming weaknesses.

We are concerned that the 'long list' of options for future healthcare was drawn up in a single day by a panel of only 14 people, two of these for half the session each. Of these, around a half will have had a clinical background at some stage in their careers; probably two or three panel members remain practising clinicians. There were only three patient representatives present; one each from Healthwatch in Shropshire and in Telford and Wrekin, and only one from the Shropshire Patient Group[22]. It is very unclear how panel members were guided by and accountable to the organisations they represented. Panel members were expected to reach decisions before any work has been done to look at the detail of which services will be offered by new facilities; what the capacity of new units will be; to what extent new community care initiatives can reduce the demand for acute services. They were 'flying blind'. It was simply far too early in the process for this meeting to take place, as participants lacked the information to inform their decisions. The long list of options matters; it theoretically shapes healthcare in our county for decades to come. The record of the meeting, however, suggests that it was close to a 'tick box' exercise, to ensure

that a timetable was progressed. It was not the careful, informed and exhaustive process that was merited.

The central question behind Future Fit is a basic one: can it be made to work? Future Fit was conceived as a project that looked just at emergency services and 'bedded services' (acute and community hospitals). Its scope has widened as campaigners and GPs have repeatedly raised the hard truth that it is unsafe to restrict access to hospital beds without having robust community NHS and social care services in their place.

Belatedly, the leaders of Future Fit now acknowledge the need to look at dependencies and inter-dependencies between services, and will be re-assembling groups of clinicians to do this. They will also be looking at a more detailed specification of the services to be provided from each unit, recognising that the existing clinical model fails to provide a basis for planning changed services. Mike Sharon, the Future Fit Programme Director, told the July Shropshire Community NHS Trust Board meeting that Future Fit was *"like building the top of the pyramid when you don't yet have the foundations".* The Shropshire Community NHS Trust Board noted the report but did not support it. It is telling that the Future Fit project is actively opposed by many GPs, and is not supported by the leaders of the Community Trust. The Programme Director expresses his concerns about the lack of foundations, the Clinical Models report repeatedly refers to the 'challenges' of implementing Future Fit, and clinicians are now going back to the drawing board. This is a project that is in crisis.

We believe that Future Fit cannot provide safe patient care unless the scope of the project broadens to look at transformation of health and social care as a whole (including, for example, mental health services; models of GP care and availability of same day appointments and home visits; pharmacies; and investment in ambulance services and training of paramedics to play an enhanced role). This genuinely transformative approach is the one advocated in Sir Bruce Keogh's national review. Future Fit continues to fall far short of this.

Future Fit creates thresholds for admission to the high acuity unit and to medium intensity units[23]. Frail elderly patients who are admitted will typically have a hospital stay of three days[24]. Patients will be discharged from the high acuity hospital not when they are recovered or 'fit to transfer', but once they are 'stabilised'[25]. Our community hospitals will be therefore be treating very unwell patients, including those who are *'high dependency 1:1"*[26] This has major implications for staffing of community hospitals, for medical and nursing staff, for Allied Health Professionals such as physiotherapists and speech and language therapists, and for support staff. This does not seem to be acknowledged in the Future Fit proposals.

The new mantra is that 'home is normal'[27], even for patients who are really very unwell. This means that GPs will be expected to take on responsibility for additional care of large numbers of patients with a high level of need. We know of the existing workload and workforce crisis facing our local GPs, and we are well aware of the huge concerns of many GPs regarding Future Fit proposals. Discharging people from hospital without ensuring a high level of community support is a recipe for disaster.

Future Fit notes the need for community services. We are told for example *'intensive support and care given to a patient at home changes the level of care without changing the care setting'*[28]. However the planning and provision of these services has been regarded as beyond the Future Fit remit. We are very, very pleased that the leaders of Future Fit now acknowledge the need to look more widely at inter-dependencies between different strands of NHS care (and, indeed, social care); we worry about the remaining gaps in the approach being taken.

As a minimum, there is an enormous piece of work to be done in creating new community services that will support seriously ill patients. Equally important, primary and community care services must be developed to prevent patients requiring acute admission in the first place. This work MUST have central involvement of GPs and other frontline staff working in community settings. The money must be identified to create high quality community services – NHS and social care – BEFORE thresholds are applied that lead to many fewer patients being seen in acute hospital settings. Creating new services takes time, and costs money. We see little evidence that this has been recognised. We flag up here a concern that adult social care is both limited and means tested. Who will pay for the patients in their homes who need help with feeding, washing and toileting? Is there a hidden agenda here of the burden of care (and cost) shifting from the state to the individual?

We are of course aware of the Better Care Fund – but we also note that the clinicians who designed the Future Fit clinical model believe it may have limited impact on collaborative working between health and social care because there is no new investment[29].

We hope that you will publicly support our call for high quality community NHS and social care services, free at the point of need, to be available before tighter thresholds for hospital admission and discharge are applied. We hope that you will support sufficient funding for the NHS and social care in Shropshire that it is possible for these services to be created.

As a footnote, what are we doing about death? The community hospitals where many local people die will be full of acutely ill people instead. Many more of us will die at home. That can work well, and is what many of us would wish for. If support is not available, though, this can be a frightening and painful experience for the person who is dying, and immensely distressing for family members. Again, GPs will be left to pick up a higher level of care. The suggestion in the Future Fit Clinical Models paper is that *'A roving palliative care team would be effective and cost efficient if it concentrated on those patients identified as having complex needs or who are marginalised'*[30]. Perhaps when we are dying we could all be seen as having complex needs? We urge the Future Fit clinical team to look again at this.

Conclusions: So much is about money

Another fundamental question is that of resourcing. There are many proposals in Future Fit that are admirable – but without adequate funding, the overwhelming risk is that they cannot be realised. We support the proposal to offer up to 70% of assessment, diagnosis and follow-up appointments 'closer to home' than a Diagnostics and Treatment Centre[31], although we would obviously wish for this to be thought through and made concrete (and

the phrase 'up to' is open to interpretation). We fully support broader concepts of care closer to home, of pro-active planning for long term conditions, of holistic care plans and better integrated services. We welcome the local clinical consensus for active case management of the most vulnerable and frail patients with long term conditions[32] - but we would rather this applied to **all** patients with significant long term conditions, because this is how the NHS can best support people in staying healthier. The issue here is clearly one of resources.

We are concerned by the proposed centralisation of MRI and CT facilities at the Emergency Centre and Diagnostics and Treatment Centre[33]. This will translate into long journeys for patients. We do not support Future Fit proposals for the centralisation of 80% of planned surgery at the Diagnostics and Treatment Centre, including really very minor surgery for 'lumps and bumps'. Good practice would surely be for minor surgery, particularly day cases, to be offered from community hospitals. We are concerned also by the plan for radiotherapy to be co-located with the high-acuity centre, almost certainly to be at the Princess Royal Hospital. The Clinical Models paper recognises the evidence that patients opt out of radiotherapy if travel times are greater than 45 minutes[34]. How many Shropshire patients will be unable to access the Princess Royal Hospital within 45 minutes? As with surgery, the agenda here is driven by cost and by the convenience of the NHS – not by the needs of patients. We note and agree with the comment in the Clinical Models paper: *'The current workforce crisis and financial constraint creates a huge challenge to deliver effective case management'*[35]*.* Without adequate resources, the worthwhile aspirations of the clinicians who have worked on Future Fit will not be realised.

Members of the public attending engagement events have been told repeatedly that Future Fit is not about money and is not about cutting costs. This was and remains untrue. The Clinical Models paper notes that *'financial austerity is one of the key drivers for radical change'*[36]. We are told in the paper of the assumption behind Future Fit: *'that there will be no increase in overall budgets over the next ten to twenty years, and that in the face of an increase in population care needs and life expectancy, in real terms there will be a reduction in investment'.*

The question of funding is centrally important. There is a growing consensus now that the NHS simply does not have enough money. The Nuffield Trust's report of July 2014 notes that '*the NHS is heading for a financial crisis this year or next*'[37]. NHS expert Chris Ham, the Chair of the King's Fund, comments on a major King's Fund study on NHS finance. He notes the *'serious and growing financial pressures'* on the NHS and comments that *'the NHS is rapidly approaching a major crisis'*[38]. Former Health Minister Paul Burstow said in June this year that he believed the NHS needed an extra £15bn from the Treasury over the next five years, adding *"if you don't want the system to collapse during the course of the next parliament"*. Stephen Dorrell, a former Secretary of State for Health and Sarah Wollaston, Chair of the House of Commons Health Select Committee, say that with the economy growing the NHS must receive a real terms increase in spending over the next five years if it is to function properly[39].

We question if it is right to design a new NHS in Shropshire and Telford and Wrekin on the basis of real terms cuts for ten to twenty years. The two leading health think tanks in the

UK, together with politicians with NHS experience and an understanding of NHS finance, believe that the NHS cannot provide high quality care without significant additional resources. The political pressures for changes to NHS funding are growing. The outcome of this particular debate of course remains unclear – but we believe it is wrong to assume a long term reduction in real terms investment and to reconstruct our healthcare services accordingly.

Cuts have consequences. The Clinical Model proposals comment *'A financially constrained environment will provide a huge challenge to the system to collectively develop the necessary level of 'courage to change' and 'appetite for risk'*[40]. But if it's you, or your Mum, or your child, do you want to see a doctor with an 'appetite for risk'? Probably not.

We are told elsewhere that *'Patient expectation and demand also needs to be reset'*[41]*.*

No. Patients have a right to expect and demand high quality healthcare. They have a right also to healthcare that is within reach; access is a crucial issue in a rural area. We have a world class NHS and we need to retain that. Future Fit: full of good ideas, but with the potential to cause massive harm to Shropshire's NHS.

Notes

[1] NHS England (November 2013). Transforming urgent and emergency care services in England - Urgent and Emergency Care Review End of Phase 1 Report. This national document outlines the relative status of Emergency Centres and Major Emergency Centres (e.g. pages 8, 23 and 26)

[2] Dr Michael Innes and Dr Helen Herritty (30th June 2014). Response Letter to Shropshire Defend Our NHS, Future Fit website

[3] NHS England (30th May 2014). NHS England News. Networks will be the cornerstone for urgent care change: Professor Jonathan Benger, National Clinical Director for Urgent Care for NHS England, updates on the Urgent and Emergency Care Review

[4] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.1.3 page 28

[5] Future Fit (17th June 2014). Evaluation Panel Workshops 1 and 2, Slides 24 and 26

[6] Future Fit (17th June 2014). Evaluation Panel Workshops 1 and 2, Slide 46

[7] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care,7.8 page 58

[8] Future Fit (17th June 2014). Evaluation Panel Workshops 1 and 2, Slide 24 op. cit.

[9] Future Fit (17th June 2014). Evaluation Panel Workshops 1 and 2, Slide 26 op. cit.

[10] Future Fit (17th June 2014). Evaluation Panel Workshops 1 and 2, Slide 26 op. cit.

[11] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 7.2 page 55

[12] Future Fit (January 2014). The Case for Change, Opportunity costs in quality of service, page 3

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[16] NHS Health Education England (December 2013). Emergency Medicine: Background to HEE proposals to address workforce shortages

[17] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.1.2 page 28

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[22] Future Fit (June 2014). Evaluation Panel Summary, 17 June Sign-In Sheet page 13

[23] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 8 page 60

[24] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.2.6.2 page 44

[25] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.2.6.1 page 42

[26] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 8 page 60 op. cit.

[27] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 8 page 61

[28] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.2.6.1 page 42 op. cit.

[29] Future Fit (May 2014), Clinical Design Workstream Final Report: Models of Care, 6.2.7 page 47

[30] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.2.8 page 48

[31] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.3.6 page 53

[32] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.2.5.3 page 40

[33] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.3.5 page 52

[34] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 7.7 page 58

[35] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.2.5.3 page 40 op. cit.

[36] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 5.3.1 page 20

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[41] Future Fit (May 2014). Clinical Design Workstream Final Report: Models of Care, 6.2.7 page 47