26th August 2015

Future Fit: Briefing Notes

Briefing notes on NHS reform in Shropshire and Telford and Wrekin

Shropshire Defend Our NHS

Contents

Foreword to second edition

These notes have been revised in late August 2015, at a time when the Future Fit appears close to collapse. A great deal has changed in the last month.

Crucial decisions on timescales and on the content of Future Fit are being made on an increasingly irrational basis.

SaTH, the organisation running our acute hospitals in Shrewsbury and Telford, is threatening to unilaterally close services unless Future Fit delivers the cuts it wants in the timescale it wants. Telford and Wrekin and Shropshire Clinical Commissioning Groups seem reluctant to challenge this.

The timetable – effectively driven by the organisational needs of SaTH - is now rated by the Future Fit Programme Board as 'high risk' on almost every component. It may not be achievable.

Rural Urgent Care Centres – supposedly a central strand of Future Fit – are suddenly an optional extra. Local decisions will be taken on whether to spend (very limited) funding on an Urgent Care Centre or on investment in over-stretched community services. This is a cost-driven approach.

Future Fit depends on the availability of beds in community hospitals, to treat patients who will be discharged from the acute hospital after a reduced length of stay. With apparent disregard for this, Shropshire Community Trust is developing a strategy of closing community hospital beds. Shropshire Clinical Commissioning Group seems unable to intervene to resolve this.

The likely loss of the 'network of Urgent Care Centres' and the continued loss of community hospital beds invalidate the assumptions that lie behind the Future Fit clinical model.

It has finally been confirmed that there will be no new 'super A&E' and no new hospital. This means the almost certain closure of the A&E and acute hospital at Shrewsbury. The evaluation criteria are fixed to ensure that cost determines the outcome – and last year's move of Women's and Children's Services to Telford makes retention of the Princess Royal Hospital the cheaper option.

The promises of care closer to home, of joined up care, of high quality care for the next 20 years and so on are looking very hollow indeed. The Future Fit proposals are conspicuously not in the interests of patients.

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Executive Summary

What does Future Fit offer us? **A retired Shropshire GP summed it up in one sentence: *"Undertaking will become more profitable".***

What else?

- **Future Fit is not about better patient care; its purpose is saving money.**
- **If A&E and all acute services go to the Princess Royal Hospital, which is the almost certain outcome, people in Telford and Wrekin will be losers just as much as people in Shropshire. The remaining A&E will be swamped, and the (reduced) number of hospital beds will not be sufficient to meet patient needs.**
- **The pressures on an already failing ambulance service will increase.**
- **The money is not there for new community services to plug the gaps that will be left by hospital cuts.**
- **The repeated games playing around rural urgent care centres can leave no confidence about the future of urgent care in our market towns.**
- **Our Minor Injuries Units in Bridgnorth, Ludlow, Oswestry and Whitchurch face closure, and there is a genuine risk of our Community Hospitals being catastrophically undermined.**
- **The whole project is based on dodgy data and assumptions that are not based on hard evidence. Experts say it isn't going to work. It's time to pull the plug on Future Fit.**

Our hospitals. We currently have two District General Hospitals: the Royal Shrewsbury, and the Princess Royal Hospital in Telford. Because they're both District *General* Hospitals, each of the hospitals offers good quality 'acute' services to meet most of our needs when we are ill, in addition to planned care such as cataract surgery or a hip or knee replacement. Both hospitals offer accident and emergency care. We also have specialist care locally e.g. the Royal Shrewsbury has a trauma unit and is the main centre for acute and emergency surgery, and for oncology (cancer care) and haematology (disorders of blood and bone marrow). The Princess Royal is the main centre for inpatient head and neck surgery.

Our hospitals cover a huge geographical area. Include Telford and Wrekin, add in the area of Powys that relies heavily on the Royal Shrewsbury as its closest hospital, and we're looking at 540,000 people living across 2000 square miles. Over 90% of the area is rural, and well over half the population live in places officially designated as rural. Rurality is not a fringe issue.

Both hospitals (and both A&Es) are valued and well-used. In an area of this size – with two urban populations and a widely dispersed rural population – we need both our A&Es and our two hospitals.

Future Fit: Cutting costs. As part of far-reaching cost-cutting proposals, NHS chiefs plan to close all acute beds and services at one of the hospitals. They intend to close the A&E as well. We would be left with only one hospital offering emergency care, beds and healthcare for people who are seriously ill. Only one hospital would offer treatment for cancer (including radiotherapy). The second hospital would be sharply downgraded to a planned care centre; as an acute hospital or District General Hospital it would close.

The rhetoric around this 'Future Fit' project is misleading. Descriptions of patient empowerment, holistic care, care closer to home and the like are not matched by the reality: a project that has focused

almost entirely on closing a hospital and an A&E. There will not be a 'new super-hospital', as this would be too expensive. Instead, all services will be crammed into the hospital that is left.

The driver is cost. The organisation running our hospitals – Shrewsbury and Telford NHS Hospital Trust or SaTH - is in deep financial crisis. It intends to borrow £18 million this year just to keep the doors open and pay its staff and suppliers. SaTH will also make deep cuts this year. The Board of the hospitals has decided that the only way they can deliver the savings they need, though, is to close one of the A&Es and all the acute beds and services at one of the hospitals. They now argue that offering care at two A&Es and two hospitals is 'duplication'.

A second organisation is driving the proposal to close an A&E and acute hospital. This is Shropshire Clinical Commissioning Group ('CCG'). The CCG is the body that 'commissions' (plans and buys) NHS services for people living in Shropshire. The CCG has been badly hit by changes to NHS funding that have cut the allocation to rural areas and to areas with an older population. Shropshire will therefore receive future funding increases that are less than those of almost all other areas of the country. The pressure to cut costs by cutting services is enormous. CCG leaders also describe our two A&Es and two hospitals as 'duplication'.

Even the clinical model for the Future Fit changes admits that *'financial austerity is a key driver for radical change'.* Future Fit is a cost cutting exercise.

The Royal Shrewsbury is most at risk – but Telford and Wrekin people lose out too. It is an open secret that the Royal Shrewsbury is the hospital selected for the loss of its A&E and its acute beds and services. The evaluation criteria have been engineered to ensure this is the outcome. Under the clinical model, the Lingen Davies Cancer Centre would close as well (just as the children's Rainbow Unit has already closed). The official position is that 'no decision has been taken', but this is no longer credible. Major service areas are already being stripped out of Shrewsbury and centralised at Telford's Princess Royal. This includes Women's and Children's Services, and Stroke care. Building upgrades and routine maintenance have been put on hold at Shrewsbury.

Whichever A&E closes, it will be a disaster for people in **both** areas. There have been attempts to present this as 'Shrewsbury versus Telford', but this is simply wrong. Recent research shows that closing an A&E causes a deadly 'ripple effect', with a 5% increase in death rates for patients at neighbouring hospitals. A&E closures in London have led to chaos as neighbouring A&Es are swamped. The downgrading of the A&E at Stafford Hospital means that the A&E at Stoke routinely has patients waiting for hours on trolleys before they are given the help they need.

The closure of either of our A&Es would also mean longer journeys to hospital for hundreds of thousands of local people – with research showing that this would mean an increase in mortality, with people dying unnecessarily.

An ambulance service that can't cope. The ambulance service is already under-funded and failing to meet targets for the most urgent 999 calls. People can wait an hour or more for an ambulance in our rural areas. Longer journeys to hospital would add to the pressure on ambulance services – but there are no plans to increase ambulance funding. Longer travel times would also affect relatives travelling to the remaining hospital to visit a sick or dying loved one. Public transport is very poor, and we are unlikely to see investment in improved public transport or road networks in our region.

Cuts to hospital bed numbers. Future Fit is also about cutting the number of hospital beds. There are 835 beds now at the two hospitals. This could be reduced to as few as 450. GPs, community NHS

services and social services are intended to somehow pick up the extra work, as very sick people are discharged from hospital or not admitted in the first place – but the investment that could support this is completely inadequate.

Many clinicians do not support A&E and hospital closure. Local NHS chiefs say that Future Fit must be a good thing because clinicians support it. This isn't really true. Many clinicians are opposed to closing an A&E and hospital. This includes hospital doctors, A&E nurses and other hospital nurses, and community NHS nurses. Many GPs are opposed to Future Fit, believing it would mean a 30% increase in their workload. Public and patient views have also been side-lined. Patients do not want to see the loss of an A&E and hospital. Patients care about access, transport, and the needs of people living in rural areas. These have been regarded as fringe issues by the senior managers who are driving Future Fit.

We're told also that an A&E has to close because it's impossible to recruit A&E consultants. It's no wonder they can't recruit when they keep threatening to close down one of the A&Es! It's telling, though, that our hospitals have not taken part in any of the national programmes to recruit new staff and take the pressure off A&Es. This is a convenient excuse for the real agenda – cutting services to cut costs.

Urgent care is no substitute. NHS leaders have promised 'care closer to home', with a network of Urgent Care Centres replacing the lost A&E. The 'network' may end up as two, one in Telford and one in Shrewsbury. Rural Urgent Care Centres have now been 'kicked into touch'; they are no longer regarded as a core component of Future Fit. With Urgent Care Centres in smaller towns now regarded as an optional extra, the future for rural urgent care is uncertain. Even MIUs may well close, putting existing services at community hospitals at risk. Urgent Care Centres, wherever they end up, can be no substitute for A&E. They will be staffed by nurses with GP support, and cannot possibly offer the care of a consultant-led A&E department.

Future Fit is full of holes. The modelling work is based on unreliable and incomplete data. The assumptions behind Future Fit, used to justify cutting hospital care, are not based on reliable evidence. An expert review of Future Fit (carried out by leading clinicians in the West Midlands Clinical Senate) found that it was unsafe and was not evidence based. Future Fit is unravelling fast.

OUR NHS. The NHS belongs to us, the people who use it. We all need the NHS, and if our local NHS is cut so deeply, all of us will suffer. We therefore need to have a common message, *'No, you will not close our A&E, you will not close our hospital'*. It's time to build a broad and powerful coalition of ordinary people and the organisations to which we belong. We have to stand together in defence of our A&E and our hospital. They are too important to lose.

Shropshire Defend Our NHS
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Our area and our NHS

Shropshire's a big county. Include Telford and Wrekin, add in the area of Powys that relies heavily on the Royal Shrewsbury as its closest hospital, and we're looking at 540,000 people living across 2000 square miles. Over 90% of the area is rural, and well over half the population live in places officially designated as rural. Rurality is a centrally important issue.

We currently have two District General Hospitals serving this area: the Royal Shrewsbury, and the Princess Royal Hospital in Telford. Because they're both District *General* Hospitals, each of the hospitals offers good quality 'acute' services to meet most of our needs when we are ill, in addition to planned care such as cataract surgery or a hip or knee replacement. Both hospitals offer accident and emergency care. Offering care for most of our needs doesn't stop our hospitals developing different areas of expertise for more specialist care. For example, the Royal Shrewsbury has a trauma unit and is the main centre for acute and emergency surgery. It is also the main centre for oncology (cancer care) and haematology (disorders of blood and bone marrow). The Princess Royal is the main centre for inpatient head and neck surgery.

It's not a perfect arrangement, but it's generally worked well enough for us. The urban populations of Telford and Shrewsbury have convenient access to their own local hospital. It is clearly harder for people in the rural areas of Shropshire and Powys, especially as public transport has been run down in recent years. Shrewsbury, however, is the urban centre for rural South and West Shropshire and in practice is also the major centre for much of mid-Wales. Transport links and historic patterns of travel from these areas are directed to Shrewsbury rather than Telford. The Royal Shrewsbury Hospital is the local District General Hospital for these areas. For people in the rural areas of North Shropshire, some will have easier access to the Princess Royal, and others to the Royal Shrewsbury.

Both hospitals are valued; both hospitals are well-used; each hospital offers care to different populations across our enormous geographical area. You might almost say, 'If it works, don't fix it'. Instead, our local health services are to be turned upside down through a project summed up by NHS chiefs as 'radical change'.

What are NHS leaders trying to do?

Local NHS chiefs have a taken a decision to move from our two A&Es and our two District General Hospitals to only one. This is part of a cost-cutting scheme called 'Future Fit'.

There's a lot of rhetoric around Future Fit. At public engagement events, we are told of services fit for the next twenty years, of holistic care, of empowerment, and being healthy and staying well. There are promises of transformational change and a whole system approach, of services that will include an Emergency Centre, a Diagnostic and Treatment Centre, care closer to home, a network of Urgent Care Centres… It can be made to sound wonderful.

The language is misleading. Future Fit to date has not been about a 'whole system approach'. The remit of Future Fit has been urgent and emergency care, and 'bedded services' (i.e. inpatient hospital care). Even with this narrow remit, the awkward bits are being parked. Rural Urgent Care Centres would be costly. They are now to be regarded as an optional extra, with no ring-fenced budget, and with decisions to be taken after public consultation on A&E and hospital closure has concluded. Almost no work has been done on developing the community services that will take on 30%[1] of the work stripped out of hospitals. The overwhelming focus of work to date has been the closure of one of our A&Es and the closure of one of our hospitals.

Even here the words used are confusing. They talk about the creation of a new 'Emergency Centre' – but there won't be one of these. The reality is that our two A&Es will be replaced with one A&E. It's even worse than that. When they talk about an Emergency Centre, this means not just one A&E but a single 'high acuity hospital' on the same site. The plan is that we move from two A&Es to one, and from two acute hospitals to one[2] [3].

Is there going to be a new hospital?

Future Fit leaders came very close last year to promising a new 'super A&E' together with a new hospital, to be built between Shrewsbury and Telford. At public engagement events in the spring, this was routinely spoken of as a likely outcome of Future Fit. Media coverage gave a similar impression[4].

Now, in August 2015, our Clinical Commissioning Groups have finally acknowledged that there will be no new hospital[5]. It has been ruled out as too costly.

This comes as no surprise at all. Local NHS leaders have known for around ten months that it would cost a prohibitive £600 million in capital costs to build a new hospital, with ongoing revenue costs that would be unaffordable. They acknowledged to the Patient Group that a new A&E and hospital were effectively ruled out. It is disappointing that it has taken so long for this information to be shared with the public. Cynics might think that there has been a deliberate attempt to mislead.

We are therefore left with a plan that *either* the Royal Shrewsbury Hospital *or* Telford's Princess Royal Hospital will remain as a 'proper' hospital, with an A&E, emergency surgery, critical care, medical care for seriously ill patients etc. – but the second hospital will be sharply downgraded. At best, it will offer routine planned care. As an acute hospital or a District General Hospital, it will close, with the loss of all acute beds and medical services.

Which A&E and hospital will close?

So which acute hospital will stay, and which will be downgraded or closed? It's an open secret that the Royal Shrewsbury Hospital will lose its A&E and all its acute services. The Future Fit 'evaluation criteria' have been adjusted to create this as an almost inevitable outcome.

In practice the decision was taken long ago. We have heard this from senior clinicians, and from political representatives who have been told of the decision by members of the Future Fit Programme Board. Major clinical services are already being stripped out of the Royal Shrewsbury Hospital. Women's and Children's Services have been closed down at the Royal Shrewsbury and centralised at the Princess Royal, at a cost of £28 million. Stroke services have been moved from the Royal Shrewsbury and centralised at the Princess Royal – initially on an 'interim' basis, but with this apparently now consolidated as a permanent move[6]. Building work to create new Women's and Children's outpatient units at the Royal Shrewsbury has been delayed, pending the outcome of Future Fit[7]. It only takes a quick visit to the Royal Shrewsbury to confirm that routine maintenance has been cut back sharply, as paintwork is left to peel and patient information signs fall down.

The loss of Children's Services is particularly significant. The Future Fit Clinical Model states very clearly *'The paediatric unit requires co-location with the main EC* [Emergency Centre] *due to common needs for equipment, supporting expertise and the reality of patient flows in an emergency'*[8]. The Paediatric Unit will be located on the same site as the single Emergency Centre. The Paediatric Unit has just been relocated to the Princess Royal Hospital – at a cost of £28 million, and after several years of planning and new building work. Attempts have been made in Future Fit engagement events to claim that the Paediatric Unit could be moved back to the Royal Shrewsbury, or that the requirement for co-location

could perhaps be less of a requirement – but there is a strong appearance here of a decision that has long since been taken.

Children's cancer care has already been lost from the Royal Shrewsbury, with the specialist Rainbow Unit closing in late 2014. There's a lovely sculpture of two children holding a rainbow coloured umbrella left in its place – but real care for real children would be better! The closure of the Rainbow Unit caused a high level of anger, especially as local residents had worked tirelessly to raise £800,000 to fund the centre.

It is becoming clear that the well-respected Lingen Davies Centre at the Royal Shrewsbury Hospital is likely to follow. This is a state-of-the-art cancer care facility, founded (largely through charitable donations and local campaigning) to provide cancer care for the population of Shropshire and mid-Wales. Pat Davies, widow of one of the founders of the Lingen Davies Trust, told the BBC, *"The whole idea was so that patients suffering from cancer could have their relatives close by them and wouldn't have to travel"*[9].

The Future Fit Clinical Model has this to say:

'The main oncology centre (including radiotherapy) should be located with high acuity centre, where clinical standards and workforce are main drivers... Radiotherapy planning and cover for planned care and urgent care together (acute oncology needs access to ITU and anaesthetics support) is more manageable on one site'[10].

It is a virtual certainty that the plan at this stage is to close the A&E and all acute services at the Royal Shrewsbury Hospital. If the single high acuity centre is to be at Telford, then it is clear from the Future Fit Clinical Model that the Lingen Davies Centre will either close or be relocated to Telford. The aims of the existing Centre – to provide local care for the residents of Shropshire and mid-Wales – will be sharply undermined.

Is the Princess Royal Hospital safe?

NHS leaders have consciously and deliberately played a divide and rule game, posing this as a question of 'Shrewsbury or Telford, but not both'. The reality of course is that an area of this size, with our dispersed population, needs the two hospitals we have now.

The divide and rule game has, to an extent, worked for them. Telford councillors and MPs have focused on the question of the A&E, and lobbied for the retention of the A&E at Princess Royal. Telford and Wrekin Council in particular has done an excellent job on this. They are correct in seeking to support the people they represent; sadly, they have failed to understand the complexity of the threats to our local NHS.

As an aside, Shropshire Council has consistently refused to take any position at all, and will presumably stand by while its local hospital is destroyed. A small minority of councillors have stood firm in defence of the Royal Shrewsbury, but they are very much an exception. Shropshire's MPs have taken a variety of positions. Ludlow's Philip Dunne has said that he wishes to wait for full business cases or for 'all the information'; a challenge when we are so close to a decision being taken. Shrewsbury and Atcham's Daniel Kawczynski has publicly supported the retention of his local hospital – but rather quietly. North Shropshire's Owen Paterson consistently said he supported a new hospital, until it was announced that there wouldn't be one; now he says he supports the new Urgent Care Centres (that are increasingly unlikely in rural areas), and that he supports Future Fit. He has not acknowledged that his constituents face the loss of an A&E, the loss of an acute hospital, and unacceptable pressure on

services at the hospital that is left. It is pleasing that Glyn Davies, MP for Montgomeryshire, has recently called for Shrewsbury A&E to remain open, but there is little evidence currently of his willingness to campaign or lobby for this position. He may not have realised that the acute hospital is at risk, along with the A&E. MPs can make a difference – and we urge them to use their influence.

Future Fit is not just about closing an A&E and acute hospital. It is about deep overall cuts to hospital care. This is why it is a disaster for the people of Telford and Wrekin, just as it is for Shropshire residents, even if the A&E remains at the Princess Royal Hospital. The mantra behind Future Fit is that 'home is normal'[11], and the intention is that patients will be discharged from hospital after a stay of 0, 3 or 7 days[12] – and that they will be discharged not when they are well, but as soon as their condition has stabilised[13]. This means that patients will be discharged home when they are still very unwell indeed, and also needing help with, for example, toileting, eating and drinking, and washing. GPs simply do not have the resources to provide medical care to these patients in the community.

There is virtually no money to develop effective community based NHS services to care for these people. The Shropshire CCG Board has discussed investment of 'up to' £2.6 million in community services – which will not come close to paying for the increased demand on services as a planned 30% of activity is transferred out of hospital settings[14]. It seems likely that part of the budget previously intended for rural urgent care will now be allocated to community services instead – but the process risks becoming one of continually directing crisis around and around the system. The whole of the new investment into community services and Urgent Care centres together will be, at most, £5.3 million by Shropshire CCG. This includes funding for the Urgent Care Centre in Shrewsbury. This is for a Community Trust that is expected to make £4.4 million cuts this year through 'efficiency savings'. This is not an amount of money that can transform care and pay for vastly increased demands on the service. Telford and Wrekin investment is not known at the time of writing; funding for rural UCCs will not apply, and the allocation for remaining community services is unlikely to be significantly out of step with that made by Shropshire CCG.

Social care has already been cut sharply, increasing the pressure on the NHS. Some NHS money has been ring fenced to support joint working with social services – but even the architects of Future Fit do not believe that this 'Better Care Fund' can fill the gaps[15]. 'Home is normal' means that people who require hospital care - and who currently receive it - will instead be discharged home to the care of their families (if they are lucky enough to have them). This is in the interests of none of us, whether we live in Shropshire or Telford and Wrekin.

As part of the Future Fit project, discussions are taking place about a sharp reduction in the number of acute hospital beds. The last few weeks have seen a sudden flurry of verbal assurances that Future Fit is about a stable inpatient bed base, perhaps in response to the first release of these notes. However, a reliable verbal report from Shropshire Patient Group was that discussions have taken place on reducing the total number of acute beds to 450 (from the 835 reported by the Care Quality Commission in January this year). Concerns about the risks of a reduction in bed numbers were also raised by a Non-Executive Director at the May 2015 meeting of SaTH (the hospital Trust). We currently have around half the number of beds that we would have if we followed the English national average for acute bed numbers, and proposals to reduce them further are genuinely frightening.

The Care Quality Commission (CQC) is the independent national body responsible for inspecting and regulating hospitals. The CQC reports that the Royal Shrewsbury and Princess Royal have current bed occupancy rates of 90%; higher than the national average and at a level that the CQC believes is damaging to patient care. Bed occupancy in local intensive care and high dependency units now stands

at 86%. The CQC notes *'Persistent bed occupancy of more than 70% suggests that a unit is too small, and occupancy of 80% or more is likely to result in nonclinical transfers that carry associated risks'*[16]. Local bed occupancy for coronary care is at a shocking 99%. This is not clinically safe.

There is no scope for cuts in hospital services and acute bed numbers unless there is huge investment in community alternatives – but that investment is not taking place, and the money is not there to enable it to take place. An under-funded, high risk and failing hospital on its doorstep would clearly not be a victory for Telford and Wrekin.

And if we move to a single A&E? There is growing evidence now that closing A&E units has a sharp 'knock on' effect at neighbouring A&Es. A recent American study showed an overall 5% increase in death rates at neighbouring hospitals[17]. A&E closures increased the risk of heart attack deaths by 15%, stroke deaths by 10% and sepsis deaths by 8%. The lead researcher commented, *"Emergency department closures are affecting many more patients than previously thought. Most importantly, people who live in the area of nearby closures, but whose own hospital did not close, are still negatively affected by increased wait times and crowding in their own emergency department"*. In London, the ripple effect of closing A&Es at the Central Middlesex Hospital and the Hammersmith Hospital has led to chaos at neighbouring A&Es in Ealing and Northwick Park. Hospital bosses in London had claimed that patient care would not be harmed – but the reality is very different[18].

As a local example, the County Hospital in Stafford has been downgraded with the A&E moving to 14 hours daily opening. A GP is on duty overnight to treat 'less serious cases'. The immediate and direct result has been chaos at the neighbouring Royal Stoke Hospital. The Royal Stoke now has some of the worst A&E waiting times in the country, and simply cannot cope with the volume of patients. It declared a major incident in January, closing its doors to emergency patients. The problems were not confined to the winter period, and the chaos continues. The son of a patient recently contacted the press to express his disgust at the treatment of his mother[19]. He described emergency patients waiting for 12 hours to be treated, with trolleys lined up in corridor after corridor. The Royal Stoke is a brand new cutting edge 'Major Emergency Centre' (and is intended to treat a growing number of Shropshire's patients in a new national model of emergency and urgent care). The catastrophe of the Royal Stoke provides a very graphic illustration that closing an A&E – with centralisation supposedly delivering better and more specialist care – is more likely to have disastrous results for patients.

Are the needs of a failing hospital trust determining the Future Fit agenda?

SaTH's Annual Report, approved by the Board on 30th July, noted:

> *'When we initiated FF in early 2013 we anticipated a far faster timescale to identify a preferred solution. However, the programme of work and public engagement has meant that the choice of the preferred option is now expected to be made later in 2015, with consultation commencing in December 2015 and an outcome to consultation in April/May 2016.*
>
> *The highest risk the Trust has carried for many years, however, is that there may come a 'tipping' point when we are unable to safely medically staff the two Emergency Departments or Critical Care Units, although potential staffing issues in Acute Medicine are also a major pressure point. We believe, therefore, that the*

> *clinical safety and quality imperatives demand a more radical timeframe for delivery and this will be a key part of our strategy for 2015/16'*[20].

The staffing problems at SaTH are real. This reflects a national shortage of skilled NHS clinicians, as well as local issues around staffing A&E departments and hospitals that have been at risk of closure on and off since 2009. A SaTH management style that in some areas is extremely unsupportive of staff is also a contributory factor. However, these paragraphs from the Annual Report amount to issuing an ultimatum to every other organisation in the local healthcare economy. The message is 'Future Fit is too slow for the needs of our organisation; we're looking to do our own thing'. This is unhelpful in the extreme. To close areas of acute work in a poorly managed way, without careful joint working with NHS partners, would put patient lives at risk. It is perhaps no wonder that this confrontational approach has resulted in a skewed approach to Future Fit, where the perceived need to close an A&E and acute hospital has been prioritised above every other consideration.

Is this fanciful? Probably not. Caron Morton, Accountable Officer of Shropshire CCG, was recently asked at a meeting why the overall Future Fit timetable could not be slowed to allow the re-introduction of rural Urgent Care Centres. She replied, *'If we delay, the Future Fit programme will run into significant difficulties at the acute trust, and we may not have an A&E at all'*[21]. The comment confirms the extent to which the short-term organisational needs of SaTH are dominating what needs to be a much larger project.

Community NHS services and GPs are expected to pick up the 30% of activity to be transferred out of acute hospital settings. The additional resources made available for this are slight. There is a fine line between 'joined up care' and 'dumping'.

Why do NHS chiefs want to close our A&E and hospital?

The organisational needs of SaTH, the hospital Trust, are one reason. Behind this is an even more central reason: money. The most important thing to remember is that Future Fit is a cuts programme. More than anything else, this is about cutting costs and reducing the money spent on patient care. By way of illustration, SaTH has been told it must make cuts in excess of £20 million in the current financial year. Around a quarter of this is to be redirected into the 'transformation' of community services.

The organisation running our hospitals is in absolute financial crisis

This year's budget for SaTH (the NHS Trust running the Royal Shrewsbury and the Princess Royal) details the absolute financial crisis faced by our two local hospitals[22]. SaTH expects to deliver a deficit in the current financial year of £18.2 million. The national tariff (which funds hospitals for providing care) penalises them for many emergency admissions. The result of this is that SaTH will *lose* £4.787 million just for doing its job and admitting patients who require hospital treatment.

All hospitals are required to make annual efficiency savings, known as CIPs (Cost Improvement Programmes). CIPs used to be easy to achieve, by changing a supplier, or making minor tweaks to procedures. Year on year 'efficiency savings', however, mean that there is very little slack left in the system. CIPs now, in very many hospitals, mean cuts that damage patient care. Our two hospitals are aiming to make CIP savings this year alone of £15.27 million – which works out as cutting spending by 4.7%. Over £12 million of this is expected to be a recurrent cut in spending. The local NHS commissioning bodies (Clinical Commissioning Groups or CCGs) are passing on part of their own required CIPs to the hospitals and demanding that an additional £4.5 million savings are delivered from the hospitals budget. SaTH is not even going to attempt to deliver the cuts demanded by commissioners (which will in turn exacerbate the financial difficulties of the CCGs). In addition, SaTH

is required to make £5.3 million of euphemistically entitled 'Quality Improvement Productivity and Prevention' savings, to pay for the new investment in community services in the Shropshire CCG area; the SaTH contribution to community services in Telford and Wrekin is not yet known.

It is possible that the eventual financial outlook will be even bleaker than this summary suggests, as regulators Monitor and the TDA have now issued a joint letter to all NHS provider organisations instructing them to take tough measures to achieve further efficiencies[23].

The picture is one of absolute financial crisis – two hospitals that are borrowing money to keep the lights on and the doors open. The Medium Term Financial Plan, agreed by the SaTH Board in March 2015 as part of its budget plan, gives their solution:

> *'The Trust is expecting to record deficits in each of the years 2015/16 – 2018/19. In order to become financially sustainable it is necessary for reconfiguration to take place so as to release substantial levels of duplicate costs'*[24].

Two hospitals? Duplication. Two A&Es? Duplication. Two places providing cancer care and respiratory care and surgery? Duplication. This is where patient needs and budget demands are sharply at odds. As patients, we believe we have two hospitals and two A&Es because we need them. Hospital chiefs believe they must close one down in a frantic attempt to balance the books. There is a conflict of interests.

It is worth noting that the financial crisis affecting SaTH, our hospital Trust, is not about bad management or poor decision making. Changes to NHS funding have left a majority of hospitals in deficit, with small to medium hospitals and rural hospitals affected most severely. In particular, it is downright bizarre that our local hospitals end up *losing* money by treating emergency patients. Ultimately NHS funding is of course a political question, and the role of our MPs is therefore an important one.

The financial difficulties of Shropshire CCG

There is other evidence of financial constraints lying behind local NHS decision making. NHS structures are complex and confusing now, but locally we have Shropshire Clinical Commissioning Group (Shropshire CCG) and Telford and Wrekin Clinical Commissioning Group (Telford and Wrekin CCG) as the organisations that buy NHS care from the hospital Trust and from other providers. They are therefore key bodies in our local NHS. Shropshire CCG is very much the dominant partner behind Future Fit, with CCG Vice-Chair Bill Gowans acting as co-Clinical Lead for the project.

The formula used to calculate NHS funding to Clinical Commissioning Groups has changed, reducing the funding made available to rural areas and to areas with a high number of older people. This has been devastating for Shropshire CCG, given our demographic. The minutes of the South Locality Board of January 2015[25] (a meeting between local GPs and Vice-Chair Bill Gowans) note:

> *'With regards to future budgeting, it was highlighted that it was understood that not one penny of the Chancellor of the Exchequer's George Osborne's promised £1.8 billion health spending rise over the next five years would be coming to Shropshire. This was because the funding formula had been revised making Shropshire worse off with the over-65s and rurality components having been removed from the calculation. It was the view this had not been seen in the local media and a request was made to see whether this information could be placed in*

> *the public domain. With the forthcoming General Election it was considered reasonable if MPs could represent Shropshire's views and challenge that decision'.*

The frustration is clear. The money coming into Shropshire to buy NHS care is being squeezed and squeezed. NHS England believes Shropshire's NHS to be over-funded, and plans to peg any future funding increases to a level well below that of most CCGs. There is simply no understanding at national level of the specific needs of rural areas, combined with a reduced commitment to areas with an older population. Shropshire CCG has struggled considerably over the last year to meet financial targets, and has had to undertake an 'informal financial recovery plan'. In recent months the CCG has been at significant risk of being put into special measures by NHS England. The financial difficulties of Shropshire CCG are documented month on month in financial reports to CCG Governing Body meetings (all of these in the public domain).

The May 2015 Governing Body meeting agreed a financial strategy for the current financial year together with a 'forward view' to 2019/20. The Executive Summary opens with a stark summary of the CCG's financial position:

> *'The CCG has been constituted during a time of national recession and economic instability as well as organisational destabilisation; these issues have resulted in unforeseen financial challenges that will have long term implications on the services being delivered to Shropshire patients'*[26].

This is not business as usual. Shropshire CCG, as the major organisation buying local hospital care, finds itself in considerable financial difficulty. SaTH, as the organisation that delivers that hospital care, is in financial freefall. For both organisations, saving money has come to be the priority. It is no wonder, then, that the Clinical Model for Future Fit notes that *'financial austerity is a key driver for radical change'*[27]. The analysis within the Clinical Model is that investment in the NHS will fall in real terms over the next ten to twenty years. Future Fit is, more than anything else, about the implementation of NHS cuts. The quickest and easiest way of achieving large scale cuts is seen to be the closure of one of our two hospitals. Quick and easy? Up to a point. In the interests of patients? Certainly not.

"Clinicians support Future Fit" – and why this isn't quite true

There is also another claimed reason for change. All the public statements issued about Future Fit assert that the project is led and supported by clinicians, and therefore it must be the right thing to do.

The claimed clinical support is not by any stretch of the imagination consistent. In one public engagement event, for example, Bill Gowans, Future Fit Clinical Lead, commented in a small group discussion that most GPs were opposed to Future Fit because they were worried about a 30% increase in their workload. This is borne out by individual discussions with GPs. For example, one GP was dismissive of the erstwhile GPs now in senior managerial roles in Shropshire CCG, saying. *"What do they know about strategy? They've had the same training as me"*.

We know also of consultants at the Royal Shrewsbury Hospital who are furiously lobbying behind the scenes for the protection of what they believe is a vital resource for patients.

Hospital nurses have told us of their horror at the prospect of one of the A&Es and one of the acute hospitals closing. A&E nurses in particular are clear that people will die if an A&E closes. One said *"They talk about time critical care, but they're setting things up so that people will die before they ever*

get to hospital". Other SaTH nurses have told us that they do not believe for one second that closing one of our hospitals is in the interests of patients.

We've spoken to local community nurses who are opposed to the Future Fit proposals. Community hospital nurses know that they do not have the resources to care for the much sicker patients who will need to be looked after in community settings as hospital beds are cut; others are worried about the increasingly uncertain future of Minor Injuries Units in rural areas. The district nursing service is already badly under-resourced, and community nurses tell us there is no possibility of the existing service providing care of any acceptable quality to a sharply increased number of patients at home.

The architects of Future Fit boast of the large numbers of clinicians and members of the public involved in the design of the Future Fit proposals. It is certainly true that significant numbers of people have participated in *discussions* about Future Fit. It would be a great leap indeed to conclude that the participants in these discussions played a leading role in designing the proposals. There is a very great difference between getting together for a couple of hours to brainstorm ideas and playing a leading role in designing a new model of healthcare for the next 20 years!

A few things emerge, though, through a detailed look at the written record of these discussions[28]:

- Participants in Future Fit workshops were presented with a plan for a single Emergency Centre (i.e. one A&E and one acute hospital) that was absolutely pre-determined. There was to be no danger of participants rejecting this – and the strong disagreements expressed in public engagement sessions appear to have been largely airbrushed from the record.

- Many of the discussions of clinicians contain – as you would expect from this type of brainstorming session – a 'ragbag' of ideas, many of them contradictory, some good, some bad, and most of them effectively assertions with no cited evidence base. It cannot reasonably be claimed that this is evidence of far reaching clinical support for Future Fit.

- Many of the clinicians involved in key discussions were working at senior management level. Their day to day experience and concerns may well have been different to those of their 'hands on' colleagues. Frontline staff were under-represented. Nurses and Allied Health Professionals were under-represented. Community NHS staff were under-represented.

- The priorities of clinicians/clinical managers and the priorities of patients are significantly different. The Clinical Reference Group brings together a core of senior clinicians and clinical managers across organisations, and – as it met four times to discuss Future Fit – it will have had a greater opportunity to influence the direction of travel of Future Fit than the clinicians involved in slightly random 'brainstorming' events. In the notes from four meetings, there is not a single mention of 'rurality' or the needs of rural areas – not a shred of evidence that the participants acknowledged the relevance or importance of our catchment area being more than 90% rural. There was one mention of 'access' (in relation to self-referral rather than medical referral service models, rather than the ability of patients to physically get to healthcare). There were two mentions of 'transport' – one solely in relation to Powys, and the other a bizarrely self-congratulatory comment that the programme had 'even considered details such as transport'. There is a strong sense that they just don't get it.

- The priorities expressed by the Patient Focus Groups are sharply different: a variety of attendees, from different parts of our area, but the same themes coming up again and again and again. There is a repeated insistence on the importance of transport (including public transport), on access (with an emphasis on actually being able to get to the healthcare you require), and on the particular issues patients grapple with in rural areas. There are literally dozens of comments on these issues.

- Patients also care passionately about primary care (GP services), and expressed this strongly in public engagement sessions. The remit of Future Fit is one of looking at 'bedded services' – the services provided at our District General Hospitals and our Community hospitals. Again, the patient agenda and the NHS management agenda are different.

We are left, therefore, with a situation where many clinicians disagree with Future Fit, and some clinicians – many now in senior management positions – agree. Their motives will be mixed. 'Sustainability' is the new national code word for NHS cuts, and there is a strong emphasis in Future Fit on sustainability and building a 'sustainable' NHS (i.e. one that offers reduced services and that runs with a real terms reduction in investment). Some clinicians will also have a sincere belief that centralisation is intrinsically good, as it may offer opportunities for more specialist care, and gives more flexibility in arranging doctors' rotas. Patient views are different. Patients in rural areas (hardly a fringe issue for Shropshire and Powys) want good quality healthcare that they can get to – so transport is very important indeed. Patients understand the absolute centrality of GP services. Patients care about access, particularly in an emergency situation. You can have the best healthcare in the world – but it's of no use to you if you're dead by the time you get there.

There are many clinicians who disagree with A&E and hospital closure, and with the likely reduction in hospital bed numbers. Will any of them be able to speak out? It's very difficult for them. There is a culture of bullying throughout the NHS; there always has been, and many health workers report a perception that this is getting worse.

The NHS carries out a staff survey every year, and the 2014 staff survey results from SaTH (the hospital Trust) make genuinely shocking reading[29]. The Trust scores very poorly indeed for staff experiencing work related stress and pressure of work. Staff are unhappy. They do not feel supported by their immediate managers, and fewer than one in four report good communication between senior management and staff. The Trust is in the lowest 20% in the country for staff who feel secure in raising concerns about unsafe clinical practice, and less than a half of staff are confident that their concerns would be acted upon.

A staggering 67% - two thirds of staff at the Royal Shrewsbury and Princess Royal – do not believe that senior managers in their organisation are committed to patient care. This is genuinely shocking. Frontline staff at our local hospitals do not trust senior managers, do not believe that their managers are acting in the interests of patients – and very many staff believe that it is unsafe for them to raise their own concerns.

These were not rogue findings. The Chief Executive and the Care Quality Commission have commented on the 'permafrost' that exists between the Senior Management team and leaders at ward and departmental level[30]. Our local hospitals are not good places to work.

The fear of staff is not just misplaced paranoia. A few years ago, A&E nurses at the Royal Shrewsbury Hospital raised significant concerns about the service they worked in. They were not supported by senior managers. Rather, a re-organisation took place. Nurses were made to re-apply for their own jobs. Some nurses – and we are told it was the nurses perceived as trouble makers – were forced out. A&E Consultants resigned in support of their staff. The new Board has been trying to change the bullying culture of the Royal Shrewsbury and Princess Royal Hospitals, but progress has been slow. To interpret the silence of staff as support for closing a hospital, as the leaders of Future Fit pretend, is nonsense. We hope that these staff will be able to challenge the closure of our A&E and hospital; we will understand if they are unable to do so. Raising concerns through trade union officials could perhaps be a way forward. Senior doctors may find it easier than nurses or other staff to challenge bad decisions, but it remains very hard for them to do so.

Disappointing reports of bullying are now emerging from parts of the Community Trust, and from two community hospitals in particular. Most recently, staff at one community hospital have been instructed that they are not allowed to discuss ward closure and the loss of beds at their hospital, and threatened with disciplinary action if they sign an online petition on these issues. This is a management style that will not encourage staff to challenge damaging service cuts and future threats to patient care.

GPs are perhaps best placed to challenge Future Fit – but our Clinical Commissioning Groups have recently decided to directly commission GP care, in place of existing arrangements where GP care is commissioned by NHS England. This means that the strapped-for-cash bodies that want to force through hospital closure will have sharply increased power over GPs. Bill Gowans has responsibility for GP commissioning in Shropshire. He has said he will use the CCG's new powers to *"incent"* GPs to fall into line with Future Fit – effectively a loss of income for those who don't.

Nevertheless, GPs are primarily independently employed, have strong local and national organisation, and will experience a sharply increased workload if Future Fit rolls out. They will also understand the implications for patients of cuts to hospital care without community services being put in place to fill the gaps. We hope that GPs will find themselves able to challenge A&E and hospital closure.

Can Urgent Care Centres substitute for the loss of an A&E?

The justification for closing an A&E has consistently been that the single remaining A&E will be supplemented by 'a network of Urgent Care Centres'. That network of Urgent Care Centres is a central component of the Future Fit clinical model. At Future Fit public engagement events, members of the public have repeatedly raised concerns over the loss of an A&E, and the risks to health of a long journey from, for example, South Shropshire or Powys in order to reach emergency care in Telford. Typically, reassurance has been given that there will be a network of local Urgent Care Centres instead. Shropshire MPs have been given the same advice.

In an astonishing U-turn, the promised network of Urgent Care Centres is now unlikely to be created. The Governing Body of Shropshire CCG met in public on 12th August. They gave no indication at all that Urgent Care Centres might no longer be regarded as a core element of Future Fit. After the public had been asked to leave, the Governing Body held a closed discussion on urgent care. The outcome, recorded in a somewhat confusing letter to GP Practices[31], is that the urban UCCs in Telford and Shrewsbury are intended to go forward. Rural UCCs, however, seem to have been decoupled from Future Fit. The rural UCCs are not to have a ring-fenced budget, their number and location are uncertain, and the (very unclear) decision making process is intended to take place *after* Future Fit public consultation has concluded. An essential part of Future Fit has suddenly become an optional extra. The window dressing for this major retreat is around local decision making and *'Agreement and recognition [by the Governing Body], that this allocation of funding could be spent either on staffing and providing UCC and/or, other community care provision'* (*sic*). The implicit recognition here is that the investment being made available is insufficient to cover adequate community services and rural Urgent Care Centres on anything close to the scale that has been promised. It seems likely that tough decisions on how to spend inadequate resources will be delegated at least in part to GP localities. Local decision making is admirable in principle – but will not conjure up the money to create UCCs already deemed too expensive by the CCG Governing Body.

It is unclear how a decision of this magnitude could come to be taken by the Governing Body of Shropshire CCG acting alone, rather than by the Future Fit Programme Board. Shropshire Community

Trust does not appear to have been part of the decision making process, although it would be a likely provider of rural UCCs, and the host for any UCCs developed on community hospital sites. The 'Rural Urgent Care Centre Workstream' – the group with delegated authority for taking forward the development of rural UCCs - was not involved in the decision. There was of course no patient representation. This is a way of working that highlights the unsatisfactory 'firefighting' approach that now dominates the Future Fit project.

The complex history behind rural Urgent Care Centres

There is a history behind this particular retreat. Campaigners believe that the core group at the heart of Future Fit have not wanted rural Urgent Care centres at all, regarding them as costly, inefficient and inconvenient. The Clinical Model refers to 'some Urgent Care Centres'[32]. In the final few public engagement events of 2014, this was quietly revised to 'a few Urgent Care Centres'. An informal report is that a decision was taken in 2014 to have only two Urgent Care Centres: one in Telford, and one in Shrewsbury. In February 2015 a decision was taken that these two urban UCCs would be prototyped[33], while work on rural UCCs stalled. (The prototyping decision was a formality for Shrewsbury. A new Urgent Care Centre at the Royal Shrewsbury Hospital opened last December, with services provided by a private company called Malling Health. Public consultation on this major service change was mysteriously bypassed).

Following considerable pressure from Shropshire Patient Group, with the support of some Shropshire Councillors, a working group was set up to progress work on rural Urgent Care Centres.

Inexplicably, Future Fit leaders insisted on 'Minimum System Requirements' that were exceptionally costly, and identical for every UCC, whether it was to serve Telford (with its 155,000 population) or Ludlow (with 10,000 residents). The model was not clinically driven. The requirements included: 16 hours a day radiography provision, ultrasound provision, a minimum of four clinical staff on duty at any time, a range of different assessment and treatment rooms, therapy assessment areas, observation beds, separate facilities for patients with mental health difficulties, and separate waiting areas for adults and children. It's a model that works for a large town – but not for a small Urgent Care Centre, with an estimated foot fall of, for example, 1.55 an hour in Ludlow; 1.75 an hour in Bridgnorth; and 1.33 in Bishop's Castle[34].

Campaigners have believed that there has been a process of 'games playing' here; that the Minimum System Requirements were overstated with the intention that rural Urgent Care Centres would be demonstrably unviable. The insistence on this standard model would have not been viable clinically; in an obvious example, a radiographer could not sustain their skills on the basis of a couple of plain film X-rays a day. The model also resulted in costs that were unsustainable: e.g. £143 per patient visit in Ludlow and £167 per visit in Bishop's Castle.

It was these costs that were challenged by Shropshire CCG Governing Body, and that must have led to the sudden disappearance of the network of Urgent Care Centres from Future Fit. It is pleasing that, finally, the 'Minimum Service Requirements' have been dropped. It is much more concerning that there is no guaranteed future for rural Urgent Care Centres. This is not a minor issue. For patients in our predominantly rural area, local Urgent Care Centres were the single positive component of Future Fit. There is an important fight ahead to secure their future. The Future Fit model, of course, has been based on assumptions of a network of Urgent Care Centres that will reduce A&E visits and acute hospital admissions. It has been claimed, for example, that Urgent Care Centres will treat 75% of the patients who currently use the two A&Es[35]. The capacity of the planned single Emergency Centre has been based on modelling that assumes the existence of rural UCCs. To remove one core component of Future Fit, without careful planning and re-modelling, calls into question the validity of the Future Fit model itself.

Urgent Care Centres are not A&Es

There will be two urban Urgent Care Centres, one alongside the single Emergency Centre in Telford, acting as a gatekeeper to the Emergency Centre, and the second in place of the A&E at Shrewsbury. There *may* be further rural Urgent Care Centres.

This may be stating the obvious – but UCCs are not A&Es. A&Es are run by Emergency Consultants – highly qualified doctors who are experts in emergency care for critically ill patients. UCCs, by contrast, are to be run primarily by nurses, with part-time support from GPs (in their spare time, perhaps?). These staff will undoubtedly do the best job they can, but the skills sets are very different. For someone who is critically ill, an Urgent Care Centre is of little use. The best chance of survival lies in being seen by an Emergency Consultant or an experienced Specialist Registrar or Staff Grade Doctor working under Consultant supervision. Longer journeys to an A&E in Telford would mean higher mortality rates for patients in much of Shropshire and in Powys – and Urgent Care Centres cannot by any stretch of the imagination fill the gap. The single remaining A&E is intended to have no Walk In access[36] – removing an important route to critical care for patients who now ask friends or relatives to drive them to hospital in an emergency. This has been an essential safeguard in a county where ambulance services are failing, and where, especially in our rural areas, it can take an hour or more for an ambulance to respond to a 999 call.

The threat to Minor Injuries Units

The Future Fit Clinical Model simply does not make provision for Minor Injuries Units. The Accountable Officer of Shropshire CCG acknowledged at public engagement events last year that Minor Injuries Units are intended to close. The intention has been that the closure of Minor Injuries Units will partially fund Urgent Care Centres. The position that Minor Injuries Units *will* close down has been slightly softened in the last month or two, but the NHS lead for Urgent Care was unable to make any commitment to the continued existence of Minor Injuries Units at a rural Urgent Care workshop in Ludlow in June 2015[37]. Will Minor Injuries Units be reprieved if rural Urgent Care Centres are no longer part of the Future Fit model, or if we revert to the 'one in the North, one in the South' model that briefly found favour earlier in the year? At this stage we have no idea at all. Our existing Minor Injuries Units (currently in Bridgnorth, Ludlow, Oswestry and Whitchurch) cannot be regarded as secure.

Patients in rural areas potentially face a double or even triple whammy: the loss of our A&E and acute hospital, Urgent Care Centres provided only in the urban areas of Telford and Shrewsbury, and the potential loss of the Minor Injuries Units we have now. The loss of Minor Injuries Units, together with the likely private sector provision of urban Urgent Care Centres, could well undermine the viability of existing Community Hospitals and the services provided from these. 'Radical change' and 'transformation' are not necessarily good things.

Good news for Shrewsbury and Telford?

Even for patients in urban areas, Urgent Care Centres carry potential clinical risk. There is a myth fostered by popular newspapers that A&E Departments are swamped by patients who have nothing wrong with them and who do not need to be there. The College of Emergency Medicine, the professional body representing Emergency Care experts, disagrees[38]. They say that only 15% to 22% of typical A&E patients could be safely seen in a GP led service. Their view is that *evaluation* by a skilled Emergency doctor is needed by most patients, even if they subsequently need little or no direct treatment.

The model for the newly created Urgent Care Centre at the Royal Shrewsbury Hospital is that 65% of patients will be managed at the GP and nurse led Urgent Care Centre. For Future Fit, this figure has now been inflated to an extraordinary 75%[39]. (The clinical rationale for this has not been made public. We suspect that a mistake has been made either in data modelling or in the interpretation of the data

by Future Fit leaders). The national experts say 15% to 22% of patients can be managed safely in this kind of setting. Our local NHS leaders, desperate to save money by dumbing down service provision, pretend that in Shropshire the figure is three or four times as high. These are the people who are giving us Future Fit.

There is no good reason to suppose that A&E patients in Shropshire are less sick than A&E patients anywhere else in the country. Either there is something seriously askew with the ability of local health leaders to model service change; or they are willing to take grave risks with the health of local people. The reality may be a combination of the two.

Does closing an A&E really matter? It's not that much further to travel

NHS chiefs tell us that they have to move to one A&E – not just for financial reasons, but because they can't recruit enough staff to cover two A&E departments. Sometimes they go on to claim that a single A&E will give better care because it will be more specialist. The arguments are worth a more detailed look.

Evidence from the UK and USA, already cited, shows that mortality rates increase when A&Es are closed, with a 'ripple effect' across the areas covered by neighbouring A&Es. Research evidence from the UK also shows very clearly indeed that mortality rates increase as journey times to emergency care increase[40]. Doctors talk about 'time critical care' for a reason. Some patients can travel a bit further and it doesn't matter too much. For other patients, every single minute matters. A patient in cardiac arrest or who is no longer breathing needs help within minutes or they will suffer irreversible brain damage. For patients with anaphylactic shock or severe respiratory difficulties, a longer journey to hospital means a greater chance of death. The closure of either A&E – irrespective of which one goes – will lead to an increase in patients experiencing severe brain damage and an increase in patients dying.

This is not an argument against specialist care. Patients with multiple injuries are best treated in a major trauma centre. Patients with severe brain injury require specialist neurological care. These things are not currently available within county. Where it is in patients' interests, it is of course appropriate to transfer patients to the unit where they will receive the very best care – or to take them straight there if their condition allows this. This is *not* an argument for closing down local facilities in the full knowledge that patients will die as a result. Two very different issues are being deliberately confused in order to justify cuts.

Is it true that they can't recruit enough consultants? Recruitment to A&E is a national problem, and there is a national strategy to deal with it. Health Education England has worked with the College of Emergency Medicine on a detailed plan to overcome the national workforce crisis in Emergency Medicine[41]. The crisis may, fortunately, be resolving now. Changes to training should ensure a greater availability of middle grade doctors to the service over the next few years. 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 taking place 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 report from Health Education England is a useful one, summarising the important changes that have begun to take place to ensure adequate staffing of A&E departments across the country. Is Shropshire a part of any of these initiatives? Not as far as we know. The priority is simply to close down an A&E because Shropshire CCG and SaTH have financial difficulties.

There are specific difficulties affecting local recruitment. Shropshire's A&Es and hospitals have been insecure since 2009. Announcing repeatedly that you are going to close one of your A&Es isn't the best way to recruit to it! We also know that poor support from senior managers has led to the resignation of SaTH's A&E consultants in the past, and is continuing to lead to an exodus of experienced A&E nurses. Closing one of our A&Es will not resolve this. The pending closure of the acute hospital in Shrewsbury will also be affecting recruitment of medical staff. It is worth noting that closure of the A&E and acute hospital will probably lead to the loss of Shrewsbury-based nurses, particularly those with family responsibilities, who are unable to commute to Telford. Closure is not a solution to recruitment and retention problems.

There is an additional and very real threat to our local healthcare that is simply being accepted by local NHS leaders. Under national proposals, some A&E departments will be 'proper' ones – designated as Major Emergency Centres, with strong consultant cover and access to a full range of specialist diagnostic equipment[42]. Our A&E in Telford will not be one of these, and will offer a much lower level of care. Our nearest Major Emergency Centre is intended to be in Stoke. This is absolutely not in the interests of patients – and will hardly help with the recruitment of Consultants in Shropshire.

If we lose an A&E, this isn't just about longer ambulance journeys in an emergency. All the acute beds will be at the Emergency Centre – the one acute hospital that is left. Patients who are admitted will by definition be seriously ill. An important part of the healing process is acknowledged to be contact from family and friends. Making it more difficult to travel to an acute hospital will sharply reduce that important element of support. Equally importantly, every one of us would hope to have the opportunity to say goodbye to a loved one at the end of their life. Public transport has already been cut. It is already difficult, very often, for visitors to get to the Royal Shrewsbury Hospital from Powys and South or South West Shropshire. Additional journey time from, for example, Bishop's Castle to Princess Royal Hospital (or from Newport to the Royal Shrewsbury) would exacerbate an existing problem. It is not just public transport that is the issue. There is local evidence[43] that older people who drive their own cars quite often feel unconfident about driving longer or less familiar routes. Health typically worsens with age. Older people would therefore be more likely than others to travel to the single Emergency Centre; for example, to visit a husband or wife in hospital, or to access radiotherapy or other treatment for themselves. Their needs are important.

More holes than a Swiss cheese

There has to be a strong suspicion that the modelling work around Future Fit is being done too hastily and too cheaply, and that serious concerns are either overlooked or ignored in the hope they will go away. The holes in the project are becoming increasingly apparent.

Ambulances

Our local ambulance service is in trouble. Recent reports from the rural areas of Shropshire are of seriously ill patients waiting up to an hour for an ambulance response to the most urgent 999 calls. In one recent example, a seriously injured Ludlow resident waited for 50 minutes, in great pain, for an ambulance to arrive; this was followed by a further wait for a staff member qualified to transfer the person to the ambulance. We've spoken to the people concerned; we know of the distress of the victim, and the distress also of the members of the public who did their best to give help in a desperate situation.

The Chief Executive of the West Midlands Ambulance Service has stated publicly that Shropshire CCG underfunds the service[44] and that national targets for 999 call responses therefore cannot be met. The response from Shropshire CCG to missing national ambulance response time targets? They decided at the September 2014 Governing Body meeting to opt out of the national targets altogether – the only Clinical Commissioning Group in the country to do so. They did this with no attempt at all to model the impact on patients. Waiting times are already unacceptable and putting lives at risk. In Shropshire, this is a service that is already failing. In the words of the Chief Executive of the Ambulance Service, *"the level of funding made available to the ambulance service is not sufficient to meet those national targets on a local basis… We've been very, very clear since we took over the West Midlands; very, very clear, that we don't have sufficient ambulances, we don't have sufficient paramedics"*.

We have obtained data from West Midlands Ambulance Trust[45] that shows that travel times for patients from Shropshire CCG are ten to fifteen minutes quicker to Royal Shrewsbury Hospital than to Telford's Princess Royal. Of the top ten busiest postcode sectors, eight of them currently transport primarily to the Royal Shrewsbury. This is of course a graphic illustration of how the loss of an A&E in Shrewsbury will be detrimental to a majority of Shropshire's patients – but there is another problem. Already, we have too few ambulances. What is to happen when Shrewsbury's A&E closes, and emergency patients all travel to Telford? The ambulances we have will be spending longer on most of the journeys made to Shropshire postcodes – ten to fifteen minutes longer to take the patient to hospital, and an increased time also to return to Shropshire and pick up the next patient. The impact on ambulance productivity will be substantial.

Alarmingly, not only is there to be no additional investment in ambulance provision – but local NHS leaders also seem to have no idea how many ambulance journeys will be made in the future, and are not taking the trouble to use accurate figures for modelling purposes. Currently, there are around 28,000 ambulance journeys each year to the A&Es at the Royal Shrewsbury and the Princess Royal. Future Fit anticipates that there will be over 68,000 patients travelling to the Emergency Centre every year. As patients will only be able to get into the Emergency Centre by ambulance or by an emergency referral from a UCC or GP, we can assume most of these will require an ambulance. Additionally, there will be an unknown number of additional ambulance journeys to Urgent Care Centres.

Are Future Fit leaders really claiming that the number of ambulance journeys is set to double, at the same time as they implement all these new strategies to keep patients out of hospital? Or have they just made a huge mistake with their numbers and they haven't noticed? The work being done is astonishingly shoddy. This is not a rational approach to planning healthcare for the next twenty years.

Mistakes notwithstanding, for Future Fit to work, there would need to be significant investment in the ambulance service. There is, however, no extra money being made available. The problem is simply being ignored. This is a very big hole indeed.

Community hospitals and community services

'Home is normal' under Future Fit. The intention is to control acute hospital stays very tightly, to set a standard length of stay of 0, 3 or 7 days. Most patients will be discharged much sooner than they are now – some to their homes, and others to community hospitals. They will not stay in hospital until they have recovered, nor even until they are 'fit to transfer'. Rather, they will be discharged as soon as their condition has 'stabilised'. Many will not be admitted to hospital in the first place, even if they are really quite unwell. This is how the planned reduction in hospital beds is to be achieved[46]. This is fine – if and *only* if a high level of care is available in community settings.

Although we are told 'home is normal', it is acknowledged in Future Fit plans that some of these patients will still need inpatient hospital care. They will be admitted to one of our community hospitals: Bishop's Castle, Bridgnorth, Ludlow or Whitchurch. These will be 'medium acuity' patients,

rather than the 'low acuity' rehab or palliative care patients who are now cared for in our community hospitals. There is even a suggestion in the Future Fit Clinical Model that community hospitals will care for patients who are high dependency and requiring 1:1 care[47].

Shropshire Community Trust is seeking to develop its services in a very different direction. Ludlow Hospital has cut beds from 40 to 24 since July 2014. Of the remaining 24, six are insecure 'Discharge to Assess' beds (that, from a recent Board paper, may be replaced with provision in independent care homes[48]. As the two remaining wards were merged into one, members of the public have become aware of the loss of beds at the hospital and have asked for explanations. The running down of beds, at Ludlow and at other community hospitals, seem to reflect a very deliberate strategy. An email from Chief Executive Jan Ditheridge to a member of the public stated *'we are hopeful that through the Future Fit Programme that we will attract more services to Ludlow - we will always need some beds (I believe) but with improved care close to or at home not as many as in the past'*[49]. In a recent meeting organised by Ludlow MP Philip Dunne, Jan Ditheridge said there was a need for 'a conversation' about community hospital beds, asking *'Is it really bed-based services in the future or something else?'* Jan went on describe emptying beds as community services develop. On the Future Fit requirement for community hospitals to take higher acuity patients, Jan added *'On acuity, we need a conversation, it will depend on what local communities feel they can support'.*

The informal remarks are confirmed by the 'Discharge to Assess' paper presented to the Community Trust Board on 30th July. This document seems to be a significant one, as it makes reference *to 'the shape of future commissioning of the Trust's hospital beds and community services'.* There are explicit references to *'a shift away from bed-based commissioning'* and to *'changes to provision of rehab in a bed-based setting to a community setting'.* There is also an emphasis on *'improved flow through the community hospitals'*, which is consistent with the Trust's recent priority of reducing the length of stay in community hospitals.

There is of course nothing wrong at all with treating patients in the community where there is no clinical need for a community hospital bed. The difficulty here is that the different organisations that must work together to implement Future Fit appear to be pulling in very different directions. The CCGs and the hospital Trust say that Future Fit requires a stable bed base in community hospitals, to enable the early discharge of medium acuity patients from acute settings. The Community Trust has an evolving strategy of reducing the bed base in community hospitals. Recent anecdotal evidence is of community hospitals discouraging the admission of even slightly higher acuity patients (perhaps because of the current emphasis on 'improved flow' and a reduced length of stay). The drivers are likely to be financial ones. The financial interests of the hospital Trust and the Community Trust are different in this situation. The risk for patients is that they fall victim to the gaps in service boundaries.

The problems are already stacking up here. We know of three patients who are *currently* waiting for a bed at Ludlow Hospital; there are ten or twelve who have failed to get a Ludlow Hospital bed in the last few weeks; we know of a patient who on the advice of their consultant can be cared for readily and easily in a community hospital, but the community hospital has argued that the person's care is too complex for them to be admitted. Patients are experiencing quite significant stress, and in some cases are being put in a situation of 'bed blocking' completely against their wishes. Other significantly unwell patients are being cared for at home because a local community hospital bed is unavailable – and this creates an increased workload for GPs. We are experiencing a small foretaste now of a problem that will escalate sharply if it remains unresolved.

There are no obvious 'bad guys' in this situation. Our community hospitals currently care for patients who require a relatively low level of medical and nursing care. If community hospitals shift to taking much sicker patients, as required by Future Fit, the need for nursing and medical care will increase substantially.

There will simply not be enough nurses to cover a greatly increased workload. There seem to be no plans to increase investment into community hospitals to pay for increased nursing care for these patients. There is simply an assumption that this will sort itself out. It won't. This is about stumbling towards an entirely predictable disaster.

Medical input to community hospitals is currently provided by local GPs, most of them already stretched to the limit. With Future Fit, and a greater number of medium acuity patients in community hospitals, the workload of GPs will inevitably increase. GPs will also take on responsibility for the medical care of home patients – those who would now be inpatients at the Royal Shrewsbury or Princess Royal, but who will in the future be discharged home much earlier or not admitted to hospital in the first place. The current intention is that 30% of existing acute hospital activity will transfer to the community. Do GPs have the capacity to take this on? GPs have a workforce and workload crisis of their own, and are not well placed at all to take on a substantial increase in workload. There is little point rescuing the hospital Trust from crisis if the impact of change is simply that crisis is created elsewhere. It is no wonder that many GPs are unhappy with the Future Fit proposals.

Exactly the same problem arises with wider community NHS services, of course. We have services that are struggling to cope with existing demand (including a district nursing service that is seriously understaffed). These services are in no shape to absorb the 30% of activity to be passed across by the acute hospitals. The Better Care Fund is positive – but not enough, and does not compensate for poorly resourced core services. The ICS initiative, for example, offers enhanced support to patients following hospital discharge. It worked well in Shrewsbury, but tended to suck in staff and resources from core services as it was rolled out to rural areas. Patients also reported significant unmet need after short-term ICS support was withdrawn. The pressures on Better Care Fund projects *and* on core community services will increase hugely as Future Fit is implemented.

Shropshire's Community NHS Trust (covering Shropshire and Telford and Wrekin) does not have the resources to expand service provision to any significant degree. The Trust's Annual Plan for 2015/16[50] notes that it anticipates a net increase in generated income of £0.5 million, but this is set against an imposed savings plan of £4.4 million (£0.9 million higher than last year). The Community Trust's Annual Plan anticipates a workforce *reduction* in the coming year. Telford and Wrekin's Future Fit investment is not known at the time of writing; the planned £2.6 million investment by Shropshire CCG is a very, very small amount of money to cover the increased demand for community services that will be created by Future Fit. Social care has also been sharply cut. Social care, unlike NHS care, is means tested – so many patients will find themselves paying for care that they would now receive free of charge as hospital inpatients.

The Future Fit proposals are not about saving money by eliminating inefficiency. The plan is to save money by reducing acute hospital services – but not meeting the patient needs that are created in other parts of the healthcare system.

Do the experts think Future Fit can work?

At the end of last year, a formal review of Future Fit was carried out by expert clinicians in an organisation called the West Midlands Clinical Senate. This is an expert body set up by NHS England. Its job is to give advice on whether or not proposed NHS changes can work. They published their findings in January this year.

The experts did not believe the claims that hospital beds and hospital services can be reduced in the way Future Fit leaders claim. They said, *'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 experts did not believe the claims that Future Fit will solve workforce problems. They said that Future Fit plans may lead to *'further destabilisation of the workforce' and added 'it was not possible to express an opinion over the reasonableness of the workforce plans at this stage'.*

The experts warned that the changes to acute hospital care had *'not previously been delivered successfully at such scale elsewhere in the NHS'.* They commented on the *'clinical and financial risks' in Future Fit and its 'range of untested, underpinning hypotheses'.* They were scathing about the lack of an evidence base for Future Fit, saying *'Some of the assumptions upon which the proposal was based are novel and the causal relationships asserted are not established through published studies or experience of successful reconfigurations and service/pathway modernisations'.*[51]

It is almost unprecedented for a formal clinical review to condemn a project as robustly as this. The experts are telling us that Future Fit will not work. It is a shame that our local NHS leaders will not listen.

Current evidence is proving the Clinical Senate are right to be wary of the Future Fit projections. Future Fit has based its model of Urgent Care Centres on that developed by the North West Ambulance Service. Halton CCG, which was one of the pilots for this model, has projected only a minimal reduction in hospital admissions: *'So far the evidence suggests that with the proposed model, NHS Halton CCG will see a 2.8% decrease of unnecessary hospital admissions in 2015/16'*[52]*.* That is a far cry from the over-optimistic assumptions in Shropshire, with plans to reduce hospital activity by 30%, to slash the number of acute beds, and to close one of the acute hospitals altogether.

Do our hospital leaders believe that the grand plans of Future Fit can work for patients?

Astonishingly, the answer is probably that they don't. The SaTH Two Year Operating Plan confirms the intention of hospital chiefs to centralise all acute, emergency and critical care facilities on a single site. The document outlines Future Fit and the 'transformation change' promised by the Future Fit proposals. Their comment on Future Fit? *'Whilst we whole heartedly support the development of alternatives to hospital care, the potential success and cost effectiveness of such alternatives and the scale of their likely impact on mitigating additional demand arising from the growing elderly population remain highly uncertain'*[53]*.* Highly uncertain? This is hardly a vote of confidence.

Who needs doctors when you can go to the library?

At a public meeting last year[54], we were told of the alternative to the NHS and to local government services. Bill Gowans, the lead clinician for Future Fit, explained that in the future, when we were ill or had a social care issue, we wouldn't see a doctor or go to the local council. Instead, we would ask a neighbour or pop along to the library for help. This would apparently be the mark of a 'resilient community', which would increasingly substitute for formal service provision.

Several members of Shropshire Defend Our NHS tried this approach. It didn't work!

What happens next?

The Future Fit Appraisal Panel was due to take a decision on its 'preferred option' on 12th June 2015. The meeting was cancelled. Instead, the Future Fit Programme Board released a statement[55] that said very little – that confirmed the intention to close an A&E and hospital, and that talked vaguely about relating Future Fit to government priorities and possible spending plans.

The statement included a rather chilling sentence:

> *Dr Caron Morton of Shropshire CCG and Mr David Evans of Telford & Wrekin CCG said: "We have to make sure we make the best decisions before we choose a preferred option that we will consult the public about as this will be a crucial stage for NHS Future Fit" [56].*

It's a revealing comment. Dr Morton and Mr Evans are the Accountable Officers of our Clinical Commissioning Groups; the two most senior NHS officials in our area. Their perception is that *they* take the decisions, *they* choose the preferred option, and then and only then will they get around to consulting the public. Consultation will take place on what is intended to be a done deal.

The most significant recent development has been the mid-August announcement by Future Fit leaders that a new hospital for Shropshire is – in the words of the news release - 'unaffordable' and that options involving a greenfield site have therefore been discounted[57]. David Evans told the Shropshire Star on the same day that keeping both hospitals as they are would have to be 'technically considered' but that *'the reality was that retaining emergency units on both sites would not be economically viable, costing in the region of £8 million a year'*[58]. The decision to close an A&E and acute hospital has very clearly been taken many months before public consultation even begins – and options for future hospital provision are now being ruled out on the basis of cost alone.

We know, from Patient Group reports, that health bosses are increasingly worried about the affordability of their remaining options for re-organising hospital services. It has even been suggested by some of them that none of the options will be affordable. The methodology to be used to select the preferred option is also known. It effectively allows 'affordability' to completely dictate the outcome, while the decision making process will take place even more behind closed doors than it has done so far.

The process may appear complex and careful, but in reality it amounts to little more than a trick to allow final decisions to be taken on the basis of cost rather than patient need. Health chiefs have claimed cost will represent 50% of the decision making – but this isn't true. Cost will determine the outcome.

A shortlist of five options was determined in January by an 'Evaluation Panel' consisting mostly of clinicians. The panel moved from a 'long list' to the shortlist of five by rating options on criteria of affordability, accessibility for patients, quality of care, workforce and deliverability. They determined a score for each option. Panel members agreed the weighting of criteria themselves. It is clear that clinicians did not understand the importance of access to patients. The main differentiator between the non-financial criteria – can patients get to the hospital safely – did not receive the top rating, and many of the clinicians saw no difference in access between the options (and therefore scored them all similarly). The outcome was a striking one. On non-financial criteria, with access not seen as being of primary importance, the difference between options was less than 10%. By contrast, the projected difference in costs between the most expensive and least expensive of the short-listed options was 240%[59].

In the next phase, work will be taken forward by an 'Appraisal Panel' – larger than the Evaluation Panel, again dominated by clinicians, and with minimal patient representation. They will score each remaining option on the shortlist. It is likely that patient access will again be an afterthought, as it has been throughout the Future Fit project. This time, though, discussions about affordability will be taken away from the Appraisal Panel, to be dealt with through 'separate technical financial appraisal'. The two appraisals are then to be brought together in 'an overall economic (value for money) appraisal'. This will be conducted by the 'core team', meaning the most senior NHS officials in our local area.

This is where money will determine the outcome. The method of choosing the preferred option will be simply dividing the cost by the score. In January, the Future Fit Evaluation Panel arrived at scores for the non-financial criteria for short-listed options that varied by less than 10% from top to bottom. The projected difference in costs between the most expensive and least expensive of the short-listed options was 240%[60]. It is very likely indeed that this pattern will be replicated in the next phase of work. Simple mathematics will tell you that dividing hugely varying costs by scores that are broadly similar will ensure that the lowest cost option will automatically come out on top.

Complex? Yes. Hard for the public to understand? Yes. Lacking in transparency? Without a doubt. This is a process that is indeed utterly lacking in transparency; where the decision to close an A&E and hospital was taken at the outset, with no public consultation at all; where affordability outweighs every other consideration, with patient access and quality of care far down the agenda; and where there will be no public or patient representation in the discussions that really count – those about money.

We had expected the announcement on 12th June to be that Princess Royal Hospital would become the single Emergency Centre, while the Royal Shrewsbury Hospital would be downgraded to become a Diagnostic and Treatment Centre (a planned care centre for routine surgery and diagnostic tests). This may still be the outcome, but it is certainly possible that things will be even worse than this. There has to be a suspicion that the current appraisal process represents a panicked response to the realisation that the money is not there to implement any of the short listed options, and that Future Fit leaders are casting around for a fall-back position.

What does it mean for patients if this and other shortlisted options are unaffordable? Informal reports suggest this could be the case. The Future Fit Team has been assuming significant capital funding from a government quango called the Trust Development Authority. This would be necessary in order to change the focus of the two hospitals - to move equipment, upgrade buildings etc. If capital funding, post-election, is less than they had expected, then everything is up in the air. It may be that the new 'preferred option' will suddenly be the one that isn't on the shortlist at all: one of concentrating *all* services in Telford, abandoning even the sop of retaining planned care in Shrewsbury. It may be that the necessary building work at Telford doesn't take place, so the county's single Emergency Centre is run from inadequate premises from the very beginning. It could even be that Clinical Commissioning Group leaders end up walking away from Future Fit, but give a nod and a wink to hospital chiefs to close an A&E and a hospital. SaTH bosses are of course threatening to do precisely that. At this stage we simply don't know.

Until June, the timetable for Future Fit was to seek Trust Development Authority approval in July, go to Board and CCG approval in August, and seek Department of Health and Treasury approval by early December. Public consultation was to take place from early December 2015 to early March 2016. Rural Urgent Care Centres were to be kicked safely into touch, with prototypes and/or business case development seemingly set to wait until next year.

The first part of this timetable has obviously now slipped. The Appraisal Panel is now due to meet on 11th September, three months later than planned, with the Programme Board taking a decision on its preferred option on 1st October. The current plan is to seek Board and CCG approvals, and to rush through approvals from the Trust Development Authority, the Department of Health and the Treasury before 1st December. Support will also be sought from Shropshire Council and Telford and Wrekin Council. Public consultation is intended to begin in early December and run for 15 weeks. This is an exceptionally tight timetable. Currently, all but one of the work streams shown on the critical path

diagram[61] are designated as 'high risk'. The timetable may not be achievable. The only work area that is low risk is 'Rural Urgent Care solutions' – now kicked into touch even more surely than in the previous timetable.

Patient Group reports confirm a desire by Future Fit leaders to complete public consultation before the Welsh Assembly election, taking place in May 2016. During a two month pre-election period, NHS organisations have to refrain from taking decisions or making policy announcements which are significant or may be politically contentious. Future Fit proposals have major (and detrimental) implications for many people in mid-Wales, so the decision making has to be done and dusted before 'purdah' applies – or delayed for several months. If public consultation begins at the very start of December, and assuming the decision from NHS chiefs has in practice been taken already, the process can just about be squeezed in. This timetable would also, of course, have the benefit of preventing Future Fit becoming an election issue in Wales.

Health chiefs are worried that if the timetable is extended beyond next May, momentum will be destroyed, and it will be much more difficult to get their changes agreed. They are trying to get pre-agreement from the NHS Trust Development Authority, the Department of Health, and the Treasury, all of whom have to say 'Yes' before public consultation can take place. An artificially tight timetable may be helpful in gaining the necessary consents. There is also concern that SaTH, the hospital Trust, may simply go ahead and implement cuts on its own terms. This was made very clear indeed by Caron Morton, Accountable Officer of Shropshire CCG, at a meeting in Ludlow on 19th August[62].

At some point, it makes sense to stop, and take a step back. The original Future Fit model has all but disappeared. Ad hoc modifications are being applied around the content and implementation of Future Fit in an attempt to keep the project afloat. If Future Fit does go forward on this basis, this is unlikely to be in the interests of patients. It is also unlikely that this poorly thought through approach to change will solve the economic or organisational challenges faced by Shropshire's NHS.

A Welsh wild card

There is a Welsh 'wild card' where Future Fit is concerned. Discussion on the rights of Powys Health Board took place at the March Board meeting of Shropshire CCG[63].The minutes explain*: 'Dr Gowans acknowledged that the process was complex and asked what the process was for making the final decision. Dr Morton reported that the Future Fit Programme had undergone its second Gateway Review and that their view was that final decision on the short listed options would lie with the commissioners (i.e. Shropshire and Telford & Wrekin CCGs). It was noted that Powys Local Health Board could declare their preferred option, but the ultimate decision would be made by the two CCGs, as the key commissioning organisations'.* Powys Health Board would appear to have the right only to express an opinion.

Later in the meeting, however: *'Mr Timmis sought clarity with regards to Powys Health Board (PHB) and whether they would be part of the formal decision making process. Dr Morton advised that the CCGs had a duty to with consult PHB due to some Welsh patients receiving treatment in England and that their views would be taken into consideration. Consultation was also taking place with Montgomeryshire Council and through other public consultation events'.* Suddenly there is a duty to consult with Powys Health Board, and a right for Powys Health Board to have its views taken into account.

A third item of discussion becomes most interesting of all. We are told*, 'In addition, Mr Tulley advised that from a commissioner point of view there was no NHS England guidance on cross-border*

arrangements and it was, therefore, unclear legally how PHB would be part of the decision making process. From the provider perspective, if a case was to be made to the Trust Development Agency (TDA) for capital funding, then the provider would require the support of all commissioners who had more than 5% activity with them, ***this would include PHB****'* (our emphasis).

This is important. SaTH will almost certainly require capital funding from the Trust Development Authority (the use of the word Agency in the minutes presumably being a CCG mistake). Moving to a single hospital cannot be achieved without considerable investment in buildings. It is hard to see how this can be achieved without capital funding from the TDA.

The legal position given here appears to be that SaTH cannot progress A&E and hospital closure unless Powys Health Board agrees, because Powys Health Board commissions and pays for a significant percentage of SaTH's business. (A figure of 10% has been suggested by Powys Council). The likely closure of the A&E and acute hospital at Shrewsbury will plainly be detrimental to many people in mid-Wales. Will Powys Health Board be brave enough to represent their interests? Will Powys Council or Welsh Assembly members seek to stop the closure of the A&E and acute hospital used by so many Powys people?

Can Future Fit work?

There are some excellent ideas in Future Fit. Clinicians suggested positive changes around care closer to home, care that is integrated across hospitals and community services, the integration of health and social care services, integrated care records so that clinicians can access information at the touch of a button. They talked about partnership care, care planning and active case management; about holistic care, and prevention and wellbeing. They shared ideas around living well with long term conditions, and providing improved support for frail elderly people. These are the things that are increasingly recognised as being good practice in healthcare; these are the things we need locally. Change in the NHS, where it is about improving care to meet our needs better, would be positive and welcome.

There is a problem, though. These are the things that were discussed by clinicians and written down as part of the Clinical Model – but that's where it stopped. Despite the talk of a 'whole system plan', the main thrust of Future Fit in reality has been the rapid closure of an A&E and hospital. There has been no work on planned care or on long term conditions. There has been no work around care planning, holistic care, prevention and the like. There is absolutely no understanding of the careful work and the cost involved in creating integrated care records across several organisations.

Rather, the work that has taken place to date has consciously and deliberately restricted the scope of Future Fit to emergency and urgent care and 'bedded services' – the care that takes place in hospitals. Only now, over a year after the publication of the Clinical Model, are the first tentative discussions on primary care and community care beginning. To begin a 'whole system plan' by deciding to close a hospital and then a year later nodding vaguely in the direction of the wreckage is not a managed approach to change. Talking about care closer to home does not deliver it. The starting point for Future Fit should have been a careful review of the care that could be delivered by primary care and community services, and the investment that would have been required to make it work. Then and only then should there have been any consideration of changing hospital services. The loss of an A&E, in this large and primarily rural area, is simply misconceived. Similarly, the loss of an acute hospital would be detrimental to patient care. The drive to save money has led Future Fit in entirely the wrong direction.

There is a contradiction at the heart of Future Fit. Future Fit leaders pretend that community care will save money. Independent experts are very clear that it will not, and that it takes additional funding to create high quality community services in the first place.

For example, a recent King's Fund report on community care[64] notes *'Home care packages… appear to be equivalent to the cost of direct patient care in hospital'*. The cost is not less; it is broadly the same. A Nuffield Trust report evaluated *'whether service changes have led to a reduction in emergency admissions and the associated cost to the NHS'*[65]. Answering its own question, the report concludes *'Using these indicators, the results have been almost overwhelmingly negative'*. Experts agree on the need for investment of new money in order for restructuring to take place. For example, the King's Fund report notes *'the absence of any major funds to allow providers to restructure is a significant problem that will inhibit progress'*. A recent report on the care of frail older people in community settings[66] concluded *'Efforts to shift care closer to home have foundered on this lack of alternative investment'*.

An A&E and hospital are to be closed to save money. Because this is about achieving cost savings, adequate funding has not been released to provide the substantial investment in primary care, community NHS care and social care that would be required to make a new approach work. The Clinical Model notes the existence of the Better Care Fund – and then adds 'its impact may be limited since there is no new investment'[67]. The emerging chaos around rural urgent care reflects a catastrophic lack of funds. Future Fit leaders have admitted, off the record, that there is no money. The 'preferred option' for the location of the single A&E and hospital was to have been announced on June 12th – but has been delayed as it becomes clear that the outcome will be determined by financial constraints.

Without significant funding for primary and community care, for planned care and the pro-active management of long term conditions, and for urgent care in rural areas, the outcome of Future Fit will be detrimental to patients. Future Fit then becomes about the loss of an A&E, the loss of a hospital, fewer hospital beds, and patients pushed out of hospital when they are still very unwell.

What can we do?

It's an old fashioned notion, maybe – but the NHS belongs to us, the public. It is publicly funded and publicly owned. We have the right to meaningful consultation, rather than the entirely sham process that is actually taking place. We also have a right to high quality healthcare; healthcare that can save lives, and provide a decent quality of life.

Shropshire Defend Our NHS supporters have spoken to thousands of people in Shropshire and Telford and Wrekin over the last year. We can recall only one person who agreed with closing one of our two A&Es and one of our two hospitals. She added that it didn't matter to her anyway, because she'd arranged to have all her own healthcare in Birmingham. Everyone else has expressed their strong opposition to what health bosses are trying to do.

Can it happen anyway? That may be up to us. If all we do is grumble a bit, we will lose an A&E, and a hospital, and we will see a rising tide of chaos in the hospital that is left and in our overwhelmed community NHS services. If we unite, and build the biggest possible campaign to defend our health service, then we stand a chance of succeeding. Of course we cannot guarantee success. There's an old saying though, that fits this situation: If you fight, you may not win. If you don't fight, you are sure to lose.

We need to build the biggest possible coalition of dissent, a broad movement of ordinary people and the organisations we belong to. All of us will lose out if our local NHS is cut so deeply. Wherever we live, whatever our age, whatever our political affiliations (or lack of them) – we all have a common interest in working together to keep the NHS services we have.

We need to create a common message, 'No, you will not close our A&E, you will not close our hospital'. The nuances of the message will differ, and that's fine – but unity around that core message is essential. It's important that we reject any Telford-Shrewsbury divide, as that is the road to defeat. We have two A&Es because we *need* two A&Es. We have two District General Hospitals because we *need* two District General Hospitals.

We will have to create a public message of opposition not just from individuals, but from the voluntary organisations representing patients, old people, and children; from faith groups; from political organisations; residents groups; community organisations of all kinds. Our parish and town councils are beginning to express their concerns, and it is vital that we build on this important start.

What of our other elected representatives? This is where, as citizens, we may need to bring pressure to bear. In Telford and Wrekin, it would help for MPs and councillors to understand that the health economy functions as a whole, and to recognise that Telford and Wrekin people will be harmed whichever A&E and hospital are lost. In the context of deep NHS cuts, an outcome that retains the A&E and acute hospital in Telford is no victory.

The people of Powys will be harmed by the loss of the A&E and acute hospital in Shrewsbury. There is an opportunity for their representatives to stand up for mid-Wales, and to work hard to influence the outcome.

There's also a job of work to be done in lobbying our MPs in Shropshire and our councillors on Shropshire Council, as they perhaps have not yet understood why this issue is so important. The role of councillors in Telford and Wrekin and Shropshire will be key. Health Scrutiny Committees have a legal right to block service change that they believe to be harmful, and to demand a review by the Secretary of State for Health. They will have a straight choice to make: to nod through damaging NHS cuts, or to make a stand. We will have to ask our councillors to do what's right. And when the message goes to the Secretary of State for Health? It has to include a very blunt request for the funds that our health service so clearly needs. It has to include also a *requirement* for recognition of our needs, as a largely rural area, with a relatively older population.

When ordinary people come together, we can be very, very powerful. We can make a difference. It's time to unite for our local NHS.

Footnotes

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[11] Clinical Design Workstream, Final report Models of Care. 5.1 'Home is normal'. May 2014
[12] Clinical Design Workstream, Final report Models of Care. 6.2.6.2 Improved flows – 0, 3 and 7 day length of stay in the high acuity unit. May 2014
[13] Clinical Design Workstream, Final report Models of Care. 6.2.6.1 Tiered levels of care – 'home is normal'. Defining the need for a bed. May 2014
[14] Shropshire CCG. Papers for Extraordinary Meeting of Governing Body. 12th August 2015 (Op. cit.)
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