

**AGENDA ITEM 4
APPENDIX A**

National Clinical Advisory Team

**Developing Health and Health Care
A Strategy for Shropshire, Telford and Wrekin**

NCAT Visitors:

Dr Chris Clough, NCAT
Consultant Neurologist, King’s College Hospital

Dr Steve Ryan, Specialist Advisor
Consultant Paediatrician and Medical Director Alder Hey Hospital Liverpool

Dr Marion Waters, Specialist Adviser
Consultant in Emergency Medicine Countess of Chester Hospital NHS Trust

Visit by NCAT Team 13 January 2009

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Agenda for the Day and Attendees

09.00 – Briefing

John MacDonald	Project Director
Dr Catherine Woodward	Director of Public Health, Telford & Wrekin PCT
Dr Debbie Short	Robert Jones & Agnes Hunt NHS Trust
Dr Jane Povey	Medical Director, Shropshire County PCT
Richard Webb	Telford & Wrekin Council
Allan Johnson	Shrewsbury & Telford Hospital NHS Trust

10.00 - Telford & Wrekin PCT

Simon Connelly	Chief Executive, Telford & Wrekin PCT
Dr Andy Inglis	PEC Chair, Telford & Wrekin PCT
Dr Catherine Woodward	Director of Public Health, Telford & Wrekin PCT
Dr Claire Old	Director of Commissioning & Service Improvement, Telford & Wrekin PCT
Julia Almond	Non Executive Director
Pam Bickley	Director of Quality Assurance, Telford & Wrekin PCT
Richard Webb	Telford & Wrekin Council

11.00 - Shropshire County PCT

Paul Tulley	Deputy Chief Executive Shropshire County PCT
Dr Jane Povey	Medical Director, Shropshire County PCT
Janet Graham	Non Executive Director
Karen Taylor	PEC Member
Dr Kieran McCormack	GP, PEC Member
Dr Liz Fennelly	GP, PEC Member
Liz Nicholson	Shropshire County Council

13.00 - Emergency & Urgent Care

Simon Kenton	Chair Urgent Care Network Board
Mr Alan Leaman	Clinical Lead A&E Shrewsbury & Telford Hospital NHS Trust
Claire Old	Director of Commissioning & Service Improvement, Telford & Wrekin PCT
Dr Kieran McCormack	GP, Shropshire County PCT
Dr Steve Evans	Medical Director, Shrewsbury & Telford Hospital NHS Trust
Dr Andy Inglis	Telford Wrekin PCT

14.00 - Shrewsbury & Telford Hospital NHS Trust

Tom Taylor	Chief Executive, Shrewsbury & Telford Hospital NHS Trust
Dr Steve Evans	Medical Director, Shrewsbury & Telford Hospital NHS Trust
Debbie Vogler	Director of Strategy, Shrewsbury & Telford Hospital NHS Trust
Trish Rowson	Director of Service Delivery, Shrewsbury & Telford Hospital NHS Trust

15.00 - Children's Pathway Development Group

Dr Richard Brough	Paediatrician & Lead of Children's PDG
Dr Catherine Woodward	Director of Public Health, Telford & Wrekin PCT
Dr Shailendra Allen	GP
Julie Davenport	Parent
Dr Martyn Rees	Paediatrician
Dr Pippa Winter	GP
Jane Povey	
Dr Chris Pearson	GP

15.45 - Maternity and New Born PDG

Mr Andrew Tapp	Consultant and Lead Maternity and New born PDG
Dr Alison Moore	Neonatologist
Dr Catherine Woodward	Director of Public Health, Telford & Wrekin PCT
Debbie Vogler in attendance for Trish Rowson	Director of Strategy, Shrewsbury & Telford Hospital NHS Trust

17.00 - Feedback

Dr Andy Inglis and Dr Catherine Woodward	Telford & Wrekin PCT
Dr Debbie Short	Robert Jones & Agnes Hunt NHS Trust
Dr Jane Povey and Paul Tulley	Shropshire County PCT
John MacDonald	Project Director
Dr Steve Evans and Debbie Vogler	Shrewsbury & Telford Hospital NHS Trust

Reports Received and reviewed

1. Shropshire & Telford Executive Group report to Shropshire County and Telford & Wrekin PCT Boards 25-11-08
2. Children's Pathway Development Group Report for the Clinical Leaders Forum – 18-4-08
3. Children's Pathway Development Group Second Report for the Clinical Leaders Forum 31-10-08
4. Report from Clinical Leaders Forum; Report Two Challenged Services Strategies, November 2008
5. External Review feedback to Mr John MacDonald 30-10-08
6. Report from Clinical Leaders Forum; Report One – Overarching Plan for Healthcare in Shropshire, Telford and Wrekin – Care Pathways and Models of Care November 2008
7. Maternity and New Born Pathway Development Group – Maternity Matters in Shropshire, Telford & Wrekin, October 2008
8. Emergency and Urgent Care in Shropshire, Telford & Wrekin – Final Report from the Acute Pathway Development Group, October 2008

Background

In November 2007 the Chief Executives of the four NHS organisations in Shropshire, Telford and Wrekin (Shropshire and Telford Executive Group – STEG) commissioned the Clinical Leaders Forum (CLF) to lead the development of the 8 Darzi clinical pathways, and to carry out an assessment of the challenged services to establish whether there were clinical viability issues or concerns about sustainability of services. The CLF were asked:

- To review the evidence in respect of the options and to make recommendations for the future pattern of clinically safe general hospital services, serving the populations of Shropshire, Telford & Wrekin, and the catchments of the provider organisations.
- To consider options and make recommendations to Shrewsbury and Telford Executive Group (STEG) of an overall picture of the future shape of hospital services, within the context of a modern NHS. To give early consideration to A&E services, services for children and also to cover maternity and neonatal services, emergency surgery and urology services.
- In doing so the CLF will need to liaise with the clinical pathway groups meeting at a West Midlands-wide level (associated with the 'Our NHS, Our Future' exercise), to give information and also to receive and consider information from these clinical pathway groups.
- To conduct the work of the CLF in a structured manner and to describe a clear process of dialogue and consideration which leads to your recommendations which are evidence based.
- The CLF will need to take into account future patterns of demography. Also to consider the issues around sustainability within the context of the European Working Time Directive (EWTD) and Medical Manpower Careers (MMC).
- The CLF will make recommendations which meet the following principles: that recommendations will be clinically safe and also make sense to the communities we serve.
- Financial saving is not a driver for this work. However, recommendations would need to be affordable within available resources, and be clinically sound and viable for the future

The final report from the CLF sets out the clinical service options for the challenged services strategy (see CLF final report November 2008). These are described below

Clinical Service Option	Princess Royal Hospital (PRH)	Royal Shrewsbury Hospital (RSH)
1	Level 3 A and E, urology	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates
2	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates	Level 3 A and E, urology
3	Level 3 A and E with inpatient paediatrics, urology	Level 2 A and E with acute surgery, obstetrics and neonates
4	Level 2 A and E with acute surgery, and inpatient paediatrics	Level 3 A and E, obstetrics and neonates, urology

The eight models of care have been developed to provide an overarching plan within which the services of the people of Shropshire, Telford and Wrekin can be improved. These models of care will be built into the two PCTs strategic plans, together with the projects and initiatives that have been identified by the Pathway Development Groups.

The role of NCAT

NCAT has been asked to advise on the strategic direction as advised by the Clinical Leaders Forum (CLF). The CLF has concluded that the challenges facing acute surgery and paediatrics need to be resolved over the next 2-3 years with consolidation of acute surgery and inpatient paediatrics. Specifically NCAT has been asked whether there are models of working that can split inpatient paediatrics from acute surgery, so that these services could, if need be, be split between two sites. The Children's Pathway Development Group identified three critical linkages

1. acute surgery and inpatient paediatrics
2. paediatric inpatients and neonatology
3. the need for anaesthetics to support out of hours cover on both sites

Views heard by NCAT

Throughout the day, all attendees strongly supported the idea that services for the acutely ill and injured needed to be concentrated on one site alone. Nobody dissented from the view that a single acute hospital for Shropshire, Telford and Wrekin was needed, and all supported the plans for a 2020 vision for a single site. This would enable the development of single site acute services for emergency medicine, surgery, paediatrics, acute medicine, obstetrics and gynaecology and critical care. All interviewees supported the single acute site centre with other sites delivering urgent care and elective care, and cold site surgery

We heard that:

- In advance of moving to a single site, there were safety issues regarding the delivery of acute inpatient services in paediatrics, acute paediatrics needed to be co-located with acute surgical services for safety reasons for those children admitted with acute abdominal surgical problems, and also to enhance critical care delivery to children.
- Inpatient paediatrics should be co-located with neonatology (which always has to lie alongside obstetric services) but the main reason to do this would be for workforce issues to help consultants and trainees meet the requirements of EWTD for out of hours cover.
- There was a need to develop adolescent services.
- There were inadequate high dependency unit (HDU) facilities on both acute sites (adult and paediatric) and a need to improve these as soon as possible.

- There were good plans to improve Hospital at Home care for children, and that these should proceed whatever interim arrangements are made.
- Local ambulance services had been consulted, but there was a lack of clarity from the PCTs and health service providers about the strategic plans for development of ambulance services, in particular regarding pre-hospital care. Welsh ambulance services have not been contacted.
- The population of Telford & Wrekin is more deprived than that of Shropshire County with significant health inequalities. Some wards in Telford & Wrekin are significantly more deprived than the national average position
- Making progress with interim plans had proved difficult because of historic stances from PCTs on movement of inpatient services it had proved difficult to persuade some local politicians of the need to reorganise hospital services in order to improve quality and safety outcomes.
- The Welsh population was a significant user of Royal Shrewsbury Hospital services, and this was likely to be a continuing requirement in the future. Full consultation with the devolved administration responsible for Welsh health services had not taken place, (this was outside the remit of the CLF).
- There is a requirement to provide a network of urgent care services closer to people's homes. Emergency care and urgent care needs to work closely together to ensure that patients receive the right treatment first time. Systems need to be put in place to identify those patients attending emergency and urgent care centres who could be seen by primary care clinicians.
- There was a good case for bringing together neonatology with inpatient paediatric services. Firstly clinical, eg the case of a recently born small baby with infection brought to paediatric services who required neonatal ICU (it was accepted that this was a rare occurrence). Secondly it would help solve workforce problems, ie provide acceptable rotas at consultant and middle grade trainee level conforming to EWTD.
- Since the two hospitals had been brought together under a single trust, there had been effective team building with most clinicians understanding they are working within single services. However, when questioned, some clinicians clearly retained a strong loyalty to their own hospital and did not always see that they were part of a team working across both PCTs. (This potentially could lead to a confused model of care and different service delivery).
- Shrewsbury & Telford Hospitals NHS Trust had developed an excellent obstetric service working across 2 sites with a midwife led service at Telford working together with a consultant led service at Shrewsbury
- The eight clinical pathways were at different stages of development, some more highly developed than others, and there was a requirement to continue working hard on these, in particular specific clinical pathways need to be developed in established areas such as stroke, acute coronary intervention etc.
- There was a pressing need to reorganise acute surgical services onto a single site so that specialist surgeons such as the breast surgeons could be

released from the acute rota and for particular services such as vascular surgery to have its own rotas.

- The consequence of this is that accident and emergency services on the two sites would be designated as either level 2 or level 3. This would depend on whether acute surgery was on site. If only one site had acute surgery it would need to be clear how the site without surgery was supported and how patients might be moved from one site to the other if appropriate. Additionally it would require effective working with the ambulance service to ensure that the sites were used appropriately. Neither site would fulfil the requirements of a trauma centre, thus complex injury, in particular patients requiring neurosurgery, would be transferred to Birmingham or Stoke-on-Trent in the usual way.
- Paediatric surgery would continue to be provided elsewhere, in particular Birmingham Children's Hospital. Local services needed to cope with simple acute problems in children such as appendicitis rather than transfer patients unnecessarily to Birmingham. This was in keeping with parents' desires, which was made clear by the patient representative. It would mean that the surgeons and anaesthetists involved with children's care would need to be trained appropriately and would need to maintain their continuing professional development in liaison with a provider of children's surgery.

Conclusions

1. We accept the Clinical Leaders Forum's conclusion that there is an urgent requirement to change the configuration of acute clinical services to improve patient safety, allow better alignment of workforce to aid compliant rotas (meeting the requirements of the European Working Time Directive), to improve training, and lastly to allow the development of sub-specialisation (breast surgery, vascular surgery).
2. We strongly support the development of a single acute services site to provide for the population of 450-500,000 for Shropshire, Telford and Wrekin. This would enable the development of safe effective specialist services led and delivered by consultants. A feasibility study should proceed as soon as possible with a view to full public consultation. This should become the main strategic objective of Shrewsbury & Telford Hospital Trust which we hope will enable those working across the two PCTs to work together more effectively. Whilst the development of an acute single site is important, it should be remembered that it is only one component of an integrated health service which extends from the community through to secondary care. Nevertheless we recognise that this type of reconfiguration will be contentious. The local populations of Telford, Shrewsbury and Wrekin will need to recognise that Shrewsbury & Telford Hospital Trust will provide services for all the population in an equitable manner with the goal of providing high quality modern services. Whilst we cannot prejudge the result of any feasibility study, or options for a single site service, it was clear to us that a single acute hospital would need to be closest to the larger population base with the greatest clinical need not only for issues of ease of access, but to improve health and employment chances within that community.
3. We accept that, whilst this is a long term vision, there is an urgent need to reorganise acute surgery and paediatric services. Our view is that, wherever

possible, acute services should be brought together firstly to improve clinical safety by having appropriate clinical adjacencies, and secondly to solve workforce issues and improve training for all clinicians. Whilst it may be possible to split the acute inpatient paediatric service from acute surgery, we think overall it would be best to co-locate these services. Similarly acute surgery is best close to the obstetric and gynaecology services, and there are considerable advantages to bringing together neonatology and paediatrics. Thus while there may be political reasons to separate these services, this does not make any clinical sense. We would support two simple options both of which configure acute surgery with inpatient paediatrics, with obstetrics and neonatology. This would have a knock-on consequence for the classification of both emergency medicine departments. Whilst we recognise that one site may have a stronger claim to bring together all these services in the short term, both PCTs would need to agree that whatever solution is decided it would only be an interim and temporary solution to provision of these services whilst Shrewsbury & Telford Hospital Trust is making plans for a single site with a single emergency medicine department (A&E service).

4. Specialist and out of hours general surgery needs planning across both hospitals to create an appropriate out of hours general acute surgical service and to release specialist surgeons (eg breast and vascular surgeons) from the on call rota. Specialist surgical services such as vascular surgery need a dedicated out of hours services.
5. The needs of the Welsh population served by the RSH need to be firmly established to enable proper planning for the future. Whilst it may be difficult to identify any other providers able to meet these needs, this will need to be established with the Welsh health services and may need to involve consultation with the Mid Wales population.
6. Services provided by Shrewsbury & Telford Hospital Trust should be seen as single services provided across both PCTs. There needs to be a strong message that the Trust is responsible for providing high quality, equitable services for all the population.
7. The planning of urgent care centres needs to be carefully considered. Protocols need to be in place to ensure the right treatment is delivered at the right time within the urgent care centres and that, where necessary, patients are referred to the Accident & Emergency Departments at RSH and PRH as appropriate. This will become even more important when there is a single A&E service for the whole population. Whilst it is conceivable that an urgent care service co-located with an A&E Department might reduce attendance within the A&E Department, there is little evidence that this is possible, or is a cost effective model. Removing easy to treat simple cases to urgent care centres inevitably increases the cost per case within the A&E department, thus the financial consequences of shifting care needs to be considered carefully. We strongly support the motivation to provide services closer to patients' homes. Inevitably it needs to be recognised that smaller services, delivered closer to patients' homes, may well cost more. Other models should be considered, for instance co-locating and jointly commissioning primary care services within the A&E department, which would mean that a single triage can take place more efficiently, and those patients who attend A&E departments who could use primary care services are appropriately identified. Urgent care centres/minor injury units are more profitably used to deliver care to distant or rural populations.

8. The work on the eight clinical pathways needs to continue with appropriate stakeholder involvement. We considered that some of the plans currently presented are not clear and lack sufficient detail. We do not intend to comment further on the clinical pathways at this stage.
9. Continuing dialogue with the ambulance services is important. Our expectation is that the ambulance services are developing a strategy for pre-hospital care. This will become all the more important as Shrewsbury & Telford Hospital Trust moves to a single acute site as it will be argued by those populations with longer travel times that this will impinge on clinical outcomes. Presently there is little evidence that small increments in travel times adversely affect clinical outcomes, but there is good evidence that one of the better ways to improve acute care is to ensure that patients are treated appropriately at the scene of the accident, or within their own homes when there are acute medical problems, prior to transfer to hospital. It is important that the ambulance services have appropriate plans to develop the critical care practitioner role and work with the acute sector – emergency medicine services and acute medical services – to ensure that there are protocols in place for all acute clinical care pathways.
10. The development of clinical pathways is an appropriate way forward to resolve strategic issues and the four Trusts are to be congratulated on bringing together the appropriate stakeholders and clinical workforce to do this piece of work. We would encourage the pathway development teams to be bold and consider new ways of working to meet the stated strategic goals. Inevitably much of the emphasis on the strategy so far has focused on the acute care setting because of the political considerations. However the true gains for improving the health of the local population are to be had elsewhere, thus attention to preventative medicine is crucial, but also looking at ways of dealing with the real problems of the future, eg long term conditions. Here there may be an opportunity to consider the development of strong community based services, which reach into hospitals and acute care providers, rather than the traditional model. Many specialties which are presently provided by secondary care providers might more reasonably be commissioned within the community but reach into hospitals; for instance diabetes and endocrinology, elderly care, rheumatology, neurology and new models of children's care provision.
11. Thus far there has been little discussion about mental health care, in particular child and adolescent mental health services. Further work needs to be done here. Additionally transitional services in general between child health to adult services are an important topic which needs specific plans.

Our overall conclusion is that there is an opportunity here to develop first class services for the populations of Shropshire, Telford and Wrekin along with a wider population base. We think the public should be consulted on proposals which are clearly progressive and show how, over time, the services will strengthen across the population base and be provided in an equitable fashion. In order for this to happen, all stakeholders need to be properly involved and there is a requirement for strong clinical leadership in both secondary and primary care.

Recommendations

1. The Shrewsbury and Telford Executive Group (STEG) commission a feasibility study for a single site acute hospital as soon as possible, and consult on this along with plans for interim changes to the services.
2. A small number of options need to be presented to the population for consultation. The interim arrangements should bring together acute surgery on one site with the other acute services supporting emergency medicine services. These include inpatient paediatrics, obstetrics and gynaecology services and neonatology.
3. Further work needs to be done to emphasise to the population that Shrewsbury & Telford Hospital Trust is providing single services across two PCTs. Clinical leaders in both hospitals need to champion the proposed service model. Further team building should continue so that clinicians on both sites feel part of a single service.
4. The needs of the population of Powys and Mid Wales should not be neglected when considering service reconfiguration. We suggest that urgent consultation takes place with NHS Wales.
5. Further discussions are required with the ambulance services to ensure that the impact of service reconfiguration is fully understood, and that the ambulance service is making all appropriate plans to develop pre-hospital care. This must include Welsh ambulance services as well as more local services.
6. Further work is required on all the clinical pathways, which need to be across primary and secondary care, involve patient groups and other key stakeholders.
7. The acute general surgical rota should be staffed by surgeons with the appropriate expertise, that is general surgeons and/or upper gastrointestinal and colorectal surgeons. This may mean that specialist surgeons eg breast surgeons and vascular surgeons are no longer on the acute rota.
8. Vascular surgeons should create their own dedicated service and out of hours provision (NB this may require a collaboration between Shrewsbury & Telford Hospital Trust and adjacent trusts so that there are enough surgeons with an appropriate population base to generate sufficient activity).

Dr Chris Clough, Dr Marion Waters and Dr Steve Ryan

National Clinical Advisory Team

12 February 2009