Shropshire Council

Date: Thursday, 12 February 2015

Time: 2.00 pm

Venue: Wilfred Owen Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

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JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

TO FOLLOW REPORT (S)

4 Future Fit (Pages 1 - 20)

An update on the progress of the Future Fit Programme will be provided by the Senior Responsible Officers.

The Committee will then consider the responses to the questions submitted to NHS and Local Authority Representatives regarding the Programme (attached)

Papers which support answers to some questions will follow when they become available after a Future Fit Programme Board meeting on 4 February 2015.

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Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 6 February 2015

Joint Health Overview and Scrutiny Committee – Papers to Follow

Date: **Thursday 12 February 2015**
Time: **2.00 pm**
Venue: **Wilfred Owen Room, Shirehall, Shrewsbury, SY2 6ND**

Agenda Item 4 – Future Fit

Please find attached the following documents which support the responses to questions asked by the Committee (previously circulated with the agenda)

Question 5

- Report on the Shortlisting Process and Board Decision
- Answers provided to questions asked by Joint HOSC Chairs

Question 8

- Acute Service Template

Questions 15 and 16

Please note that verbal responses will now be provided by Caron Morton and David Evans as the Programme Board did not consider a written report

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Report on the Shortlisting Process

The purpose of this report is to present the Programme Board's proposed shortlist of options and to summarise the process undertaken by the Evaluation Panel in developing its recommendations to the Board.

Sponsor organisations and other stakeholders are invited to consider these proposals as set out in the table below:

Key Decision Documents	Programme Board	CCGs	Other Sponsors	Joint HOSC	Health & Wellbeing Boards
Selection of Short List	Approve	Approve	Endorse	Consider	Receive

Executive Summary

The Programme Board received recommendations from the Evaluation Panel appointed by its sponsors and other stakeholders.

The Board had an extensive discussion of the Panel's recommendations in the light of all the evidence provided (including a minority report from a patient representative). Following this discussion the Board agreed the following acute services shortlist:

- Emergency Centre (EC) and Diagnostic & Treatment Centre (DTC) on a New site;
- EC on a New site, DTC at Princess Royal Hospital (PRH)
- EC on a New site, DTC at Royal Shrewsbury Hospital (RSH)
- EC at PRH, DTC at RSH
- EC at RSH, DTC at PRH
- Do minimum (existing dual site acute services maintained, provider and commissioner efficiency strategies implemented but no major services change).

The Board also agreed that there should be further debate on the best and safest configuration of obstetric services within these scenarios. This should include reviewing the clinical evidence and workforce models to understand whether obstetrics could operate on a site alongside a DTC, alongside an Emergency Centre or alongside either.

On Urgent Care Centres (UCCs) Programme Board agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

Next steps include:

- A further round of pre-consultation public engagement which kicks off with two 'pop-up shops', one in Telford Shopping Centre on 20/21 Feb and Shrewsbury Darwin Shopping Centre 27/28 Feb. Events in Powys are also being planned. Many more events will follow and will be publicised via the NHS Future Fit website;
- Detailed development of the shortlisted options (including estates, workforce and finance).

It is expected that the Board will be able to propose a preferred option later in the year. Formal Public Consultation would then commence from December 2015 (subject to the timing of national approvals).

Background

Each sponsor and stakeholder organisation was given the opportunity to nominate a member of the Evaluation Panel. Some changes in membership had to be made through the course of the Panel's meetings. The final panel for the shortlisting process was comprised as follows:

Dr Bill Gowans, Vice Chair	Shropshire Clinical Commissioning Group
Chris Morris, Executive Lead for Nursing and Quality	Telford & Wrekin Clinical Commissioning Group
Victoria Deakins, Lead Therapist for North Powys	Powys Local Health Board
Mr Mark Cheetham, Scheduled Care Group Medical Director	Shrewsbury and Telford Hospital NHS Trust
Dr Emily Peer, Assistant Medical Director & GPSI	Shropshire Community Health NHS Trust
Pete Gillard	Shropshire Patient Group
Christine Choudhary *(unable to attend)*	Telford & Wrekin Health Round Table
Vanessa Barrett, Board Member	Healthwatch Shropshire
Kate Ballinger, Manager	Healthwatch Telford & Wrekin
Kerrie Allward, Better Care Fund Manager	Shropshire Council
Liz Noakes, Assistant Director and Director of Public Health	Telford and Wrekin Council
Mark Docherty, Director of Nursing, Quality & Clinical Commissioning	West Midlands Ambulance Service NHS FT
Dave Watkins, Locality Manager, North Powys	Welsh Ambulance Services NHS Trust
John Grinnell, Director of Finance	Robert Jones & Agnes Hunt Hospital NHS FT
Alison Blofield, Associate Clinical Director/Nurse Consultant *(unable to attend)*	South Staffordshire & Shropshire Healthcare NHS FT
Dr Jessica Sokolov	Local Medical Committee/GP Federation
Ian Winstanley, Chief Executive	Shropshire Doctors' Cooperative Ltd.

NHS England and Montgomeryshire Community Health Council declined to nominate members because of their subsequent assurance and scrutiny functions. The Chairs of the

Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin were in attendance as observers.

The Panel's earlier work had included the development of a wide range of potential scenarios from which the longlist was created following the Panel's recommendation to Board. A number of pre-consultation public engagement events also informed the development and evaluation of options.

The Long List

<table>
<tr><td>1</td><td colspan="2">Do Minimum - Provider & Commissioner efficiency strategies implemented but no major service change. Existing dual site acute services (including A&E).</td><td>Four community hospitals and MIUs providing services as currently.</td></tr>
<tr><td>2</td><td>EC with UCC & LPC at RSH; *</td><td>DTC with UCC & LPC at PRH;</td><td rowspan="7">Two to five further UCCs ideally co-located with LPCs & CUs</td></tr>
<tr><td>3</td><td>EC with UCC & LPC at PRH;</td><td>DTC with UCC & LPC at RSH;</td></tr>
<tr><td>4</td><td>EC with UCC at new site; *</td><td>DTC with UCC & LPC at PRH; UCC & LPC at RSH;</td></tr>
<tr><td>5</td><td>EC with UCC at new site; *</td><td>DTC with UCC & LPC at RSH; UCC & LPC at PRH;</td></tr>
<tr><td>6</td><td>EC & DTC with UCC & LPC at RSH; *</td><td>UCC & LPC at PRH;</td></tr>
<tr><td>7</td><td>EC & DTC with UCC & LPC at PRH;</td><td>UCC & LPC at RSH;</td></tr>
<tr><td>8</td><td>EC & UCC with DTC at new site; *</td><td>UCC & LPC at PRH & RSH;</td></tr>
<tr><td colspan="4">* the potential to locate consultant-led obstetrics either at the Emergency Centre or at PRH should be considered as a variant to these options.</td></tr>
</table>

In December 2014, the Board agreed that there should be a differential approach to the identification of shortlists for the consolidated and dispersed elements of the proposed networks of care.

Evaluation Criteria

The Evaluation Panel was also responsible for recommending the criteria against which longlisted options would be evaluated. A number of pre-consultation public engagement events also informed the development and weighting of the criteria.

Four criteria were proposed initially, to which Board added a fifth by separating out workforce considerations from wider quality impacts. The Board delegated to its Core Group the task of confirming the final set of measures to be used by the Programme Team to provide evidence for the Panel. These measures focused on evidence pertinent to the differentiation of acute scenarios rather than to the overall evaluation of programme proposals. That subsequent evaluation will only be possible once shortlisted options have been developed in more detail.

The agreed criteria are set out below with a brief explanation of the nature of the information provided to the Panel. That information was presented in three tiers:

- **Tier 1** - an overall summary of acute options and obstetric variants, criterion by criterion, plus the programme Team's proposed approach to a shortlist for UCCs;
- **Tier 2** - a summary description of each option summarising all the measures available; and
- **Tier 3 –** the underlying sources of information, including
    - The Clinical Design Report
    - Phase 1 Activity and Capacity Modelling
    - Latest Summary of Phase 2 Activity and Capacity Modelling
    - Baseline Impact Assessment Report
    - Reports on Pre-Consultation Engagement Activities
    - Feasibility Study Report
    - Financial Assessment of Feasibility Study (includes additional scenarios from long list)
    - Acute Services Template (setting out the views of acute clinicians of key co-location issues)
    - Summary Affordability Report
    - Commissioner Funding Scenarios
    - Accessibility analysis.

All three tiers were made available to Board to inform its decision-making on shortlisting. They are subsequently being made available to the public, too, (where not already published) to help people to form their own views on shortlisted options as part of ongoing pre-consultation engagement and impact assessment activities.

To enable a high-level view to be taken of equity impact, the information provided highlighted any adverse differential impacts on particular social groups. The Panel had requested that these groups should include Older People (75+), Children (0-5), people with Long Term Illness, people on Low Income and people with no access to a car or van.

The weighting applied to the criteria was determined by the Panel, informed by public views. Members initially submitted their own weighting proposals, the results of which were presented to the Panel when it met. Following discussion, a final set of weightings was

agreed. These are recorded against the criteria below which appear in ranked order.

1. **QUALITY – 29.4%**

   Evidence for this criterion focused on

   - The extent to which each option support the delivery of key programme benefits (which reflect health service need criteria). This was informed by the content of the Clinical Report and by the assessment of acute clinicians. Given that all change options respond to the Clinical Report, which sets out to design quality into the system, only a limited amount of information was available at this stage to support the differentiation of options. When options are fully developed they should be more amenable to a more detailed quality impact analysis.

   - The impact on patients with time-critical conditions for the most serious cases conveyed by the ambulance service. The data provided was based on West Midlands Ambulance Service conveyance times. West Midlands Ambulance response time information was also made available to the Panel. Welsh Ambulance Service data has only recently become available and will be used to inform subsequent evaluation.

2. **ACCESSIBILITY – 26.5%**

   The Clinical Model envisages the development of networks of care covering urgent and emergency care, planned care and long term conditions. At the present time it is not feasible to undertake detailed accessibility analysis on these networks, given the number of potential combinations of acute and community options. The system-wide impact will be assessed as part of the full evaluation later in the year. For the time being, the accessibility of consolidated acute services has to be looked at in isolation. This may unavoidably advantage the 'Do Minimum' option (Option 1) but this is not material at this stage given that this option is a required component of the shortlist in any case. The Programme Team expects that subsequent modelling will demonstrate improved overall accessibility for all other options once local facilities are factored in (UCC, LPC, CU). It is in these dispersed facilities that a significant amount of future activity is expected to take place, as demonstrated in the Phase 2 Activity and Capacity modelling. Whilst it has been possible to include theoretical public transport information for the New site, the provision of public transport would clearly be subject to change should a new site be constructed.

   The travel time analysis provided was based on Phase 2 activity projections for 2018-19. These were derived by taking SaTH activity levels (using a 2012-13 baseline) and applying to these the expected impact of:

   - Provider and commissioner efficiency strategies (as set out in Phase 1 activity and capacity modelling);

   - Demographic change (using projections from the Office for National Statistics);

- The Clinical Design Report (as set out in Phase 2 activity and capacity modelling).

The measures reported cover emergency care (ambulance/car only) and planned care (car plus 3 public transport time windows – weekday morning, weekday evening and weekend morning) plus consultant-led obstetrics. Average travel times and distances reflect the potential impact of change (subject to patient choice) on patients and their carers/visitors, including where they may in future travel to out of area hospitals.

3. WORKFORCE – 25.0%

This criterion (previously a component of the Quality criterion) was informed by the assessment of senior local acute clinicians about the advantages and disadvantages of the changes proposed under each option. Again, only a very high-level assessment is possible at this stage but there were three key factors:

- Options consolidating emergency care on a single site are expected to significantly improve recruitment and retention for EC and acute medicine;
- Options locating DTC and EC on separate sites are expected to be attractive for surgical recruitment as a result of separation of planned care services, resulting in a reduced impact from medical outliers; and
- Options with a greater proportion of new facilities are expected to be more beneficial for recruitment of staff.

4. DELIVERABILITY – 10.3%

Evidence under this criterion drew on the Programme's Feasibility Study work (both the original study and as subsequently expanded to cover all longlisted options).

The information provided included high level estates and financial information indicating the likely scale, duration and cost of the physical work required. It was highlighted that this information was not intended to propose final site configurations since these may evolve significantly during subsequent design phases.

In addition to this estates-based information, the Programme Team also provided a view on the likely acceptability of each option so far as it could reasonably be judged at this stage.

5. AFFORDABILITY – 8.8%

The Programme Board determined in December that no options could conclusively be identified as unaffordable on the basis of the information currently available. The affordability criterion was therefore treated in the same way as other criteria.

The Panel was provided with:

- High-level estimates of acute costs from the expanded feasibility work;

- Estimates of the investment required in Urgent Care Centres;

Although the Panel were clearly not being asked to undertake an economic appraisal (which will form part of the next stage evaluation), it was invited to view options in the light both of wider demands on the resources of the Local Health Economy and of the relative inferiority of any options when benefits are compared with costs. This was in line with guidance in the DH Capital Investment Manual. Four cost categories were reported in the summary documentation:

- **25 Year Capital Costs**

  These costs set out both the initial capital cost of each option and the impact of future lifecycle costs over the following 25 years (in line with national guidance). This reflects the fact that, under the different options, differing proportions of the facilities will be operating in "New", "Refurbished" or "Retained" condition. Given the age of some of the existing estate, total replacement of some retained facilities is required within the 25 year period. Costs are discounted to current levels. They reflect the total cash investment required over the period. No assumption has been made about the source of this capital funding at this stage (e.g. public funds, private finance or a combination of the two).

- **Net Increase in Capital Charges**

  Capital funding resources are expected to come from outside the Local Health Economy but the relevant provider must be able to service the impact of that funding. This is expressed as an annual charge on the resources available to the provider. Net figures are provided in which the annual impact of new funding is offset by any savings from facilities no longer required under a particular option.

- **Total Change in Acute Revenue Costs**

  These are also annual costs borne by providers. In addition to the net increase in capital charges, these figures also reflect estimates of savings in maintenance energy and utility costs and savings in clinical efficiency (arising from a reduction in two-site working).

- **Estimated Overall Cost Change with 4 UCCs**

  These figures take the total change in acute revenue costs, remove the costs associated with urgent care activity which (under the options for change) would not be provided in an EC and add estimated costs for running 4 UCCs. This gives a view, therefore, on the potential net impact on the Local Health Economy of the Programme's proposals.

Urgent Care Centres (UCC)

The Panel was presented with a proposal from the Programme Team about the potential make up of a shortlist for UCCs. This proposal built on clinical design work, patient and public engagement and financial, activity and travel time modelling. A proposal from Bishops Castle Patient Group was also made available.

The proposed approach took account of the need to understand in greater detail how UCCs would work, how they would relate to other components of the Clinical Model and how they would be staffed. The Programme Team had concluded that there was a need to proceed with caution and to adopt a prototyping approach in setting up an initial number of UCCs. This would allow testing of:

- Whether staff with the right skills can be recruited;
- Whether confidence in the model can be built amongst both patients and ambulance services;
- How a variety of patient pathways would be delivered in a networked EC/UCC model;
- How UCCs would link to 24/7 primary care services;
- What services envisaged in health hubs could be provided from UCCs;
- The need for co-location with beds (CUs) and certain planned care services (LPCs); and
- Whether the number and type of patients who would attend UCCs has been accurately estimated.

The Programme Team's recommendation was that four UCCs should be subject to prototyping initially: one each in Shrewsbury and Telford and two more in rural areas to test the quality, deliverability and viability of the models.

The Evaluation Panel accepted the proposed approach, subject to some amendments, although a minority report was submitted by one patient representative.

Both documents were made available to Programme Board which agreed to proceed to work on:

- Prototyping two urban Urgent Care Centres, one in Shrewsbury and the other in Telford; and
- Exploring the most appropriate rural urgent care solutions in partnership with local communities and considering current facilities/services. All existing Minor Injuries Units will be considered as potential sites for Urgent Care Centres.

Emergency Centre (EC) and Diagnosis & Treatment Centre (DTC)

The Evaluation Panel received a presentation of the summary of acute options. It was then able to put detailed questions (covering all tiers of information provided) to a group of expert advisors who had been involved in the accessibility analysis, feasibility study, affordability analysis and pre-consultation public engagement.

At the conclusion of these detailed discussions the Panel was asked to undertake an initial scoring of each option (and obstetric variant). It was agreed that would be done individually and confidentially. Panel members awarded a score for each option/variant against each of the evaluation criteria using a scale of 0-7 (where 7 is a stronger score). Initial scores were collated, totalled then weighted to produce a single overall score for each option/variant. Sensitivity analysis was applied to show the effect of changing the weightings of the evaluation criteria. These initial results were reported to the Panel to inform further discussion on the evidence presented, and to begin to enable the Panel to consider which options would best form part of a balanced recommendation to the Board.

Following discussion, individual panel members were then given the opportunity to alter any of their initial scores if they wished to. The revised results were then presented and discussed. The following table summarises those results.

Rank	Option Description (number)	Score	Difference from best	Gap
1	EC, DTC & Obs on new site (8a)	71.9	0.0%	
2	EC/Obs at new site, DTC at RSH (5a)	69.9	2.7%	2.7%
3	EC/Obs at new site, DTC at PRH (4a)	69.4	3.5%	0.8%
4	EC/Obs at PRH, DTC at RSH (3)	67.2	6.4%	2.9%
5	EC/Obs at RSH, DTC at PRH (2a)	65.9	8.3%	1.9%
6	EC & DTC on new site, Obs at PRH (8b)	63.8	11.2%	2.9%
7	EC, DTC & Obs at PRH (7)	63.2	12.1%	0.9%
8	EC at new site, DTC/Obs at PRH (4b)	61.9	13.9%	1.8%
9	EC, DTC & Obs at RSH (6a)	61.3	14.7%	0.8%
10	EC at new site, DTC at RSH, Obs at PRH (5b)	59.3	17.5%	2.8%
11	EC at RSH, DTC/Obs at PRH (2b)	56.4	21.5%	4.0%
12	EC & DTC at RSH, Obs at PRH (6b)	54.5	24.2%	2.7%
13	Do Minimum (1)	51.2	28.8%	4.6%

The Panel felt that the top five ranked options provided a good balance of feasible options for further development and evaluation alongside the 'Do Minimum' comparator.

Sensitivity analysis demonstrated that levelling the weightings did not significantly change the results, although Option 7 (EC and DTC at PRH) rose from 7th to 2nd because of the impact of increasing the relative affordability weighting on the lowest cost option. Option 8a moved from 1st to 6th. When the weighting for affordability is increased to about 25% (and other criteria maintain relative weightings) the most noticeable impact is the reduced performance of New site options which start to fall out of the top five.

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Assurance of Shortlisting Process

The Programme's Assurance Workstream was asked to provide assurance to the Programme Board about the process through which shortlisting proposals were developed. To facilitate this, the Workstream has been provided with the Shortlisting Pack developed to assist panel members navigate the many relevant information sources. The workstream was able to provide positive assurance that the process had been carried out as previously determined by the Programme Board.

External assurance is being sought from the Health Gateway Review Team when it visits in mid-February, and Joint HOSC Chairs are amongst the Review Team's interviewees. The report of the Review is expected to be published once it becomes available.

In advance of the Assurance Workstream meeting, a number of questions had been raised on behalf of the Joint HOSC Chairs. Responses to these questions are summarised below:

1. **The Joint HOSC chairs were informed in August that all of the options that would be on the shortlist would be financially viable and that £300million was the maximum limit for affordability. However at the shortlisting workshop the weighting of the financial criteria was very low and Derek is concerned that this did not give sufficient weight to this issue. Are all the shortlisted options financially viable?**

   The Programme has not identified a maximum limit for affordability. It would be possible to form a high level view on this by considering capital costs in relation to provider turnover. At this stage, however, capital costs are high level estimates and the impact of each option on provider turnover has not yet been assessed. Any definitive judgement on affordability would, therefore, not be robust and would be subject to challenge. Programme Board received a summary of the affordability work undertaken at its meeting in December. From this it concluded that -

   The financial outlook for the NHS (and local government) is challenging. All of the long listed scenarios could be considered to be affordable within the context of a benign view of long term funding. Within the context of a pessimistic view, all of the scenarios appear problematic. The analysis undertaken so far has demonstrated that there is significant further work to be undertaken before greater confidence can be placed in an affordability analysis. Given these uncertainties it would seem premature to rule out any of the longlisted scenarios on the grounds of unaffordability. Further work on the development of shortlisted scenarios over the course of the next five months will need to address these uncertainties as far as possible before a view is taken on proceeding to public consultation. All of the analysis is working on the assumption that the health economy is currently broadly in financial balance. This is unlikely to be the case.

   In light of this it would have been difficult for the Panel to justify a different view.

   In terms of the weighting of criteria this was solely a matter for the Panel to determine. It was clear that, at this stage, it wanted to give a low weighting to affordability. Sensitivity analysis was shared with the Panel (and is being provided to Board) which showed the effect of changing the weightings in various ways. The Panel did not wish to change its original weightings. The Panel's recommendation is not binding, however, but is subject to the approval of the Programme Board which will, in turn, seek further approval from Commissioner Boards.

2. **The process for the shortlisting workshop meant that it was difficult to take in all the information that was provided in the time allowed**.

   It has been important to provide the Panel with all relevant information to support its recommendations. The same information is being made available to the Programme Board and will be published to inform public consideration of the issues. This is in line with advice received from the Consultation Institute.

   To help the Panel manage the full range of information it was separated into three tiers. The third tier was the underlying sources. This was summarized in the second tier into high level descriptions of each option in terms of the five evaluation criteria. In addition, the highest tier gave an overview of the data to enable an 'at a glance' comparison of options, with members able to dig down into the lower tiers as desired.

   Much of the tier 3 information has been published for some time; other elements were circulated early in the New Year following an email on Tuesday 6th January. Tier 1 and Tier 2 information was sent to the panel on Friday 16th January, ahead of the evaluation on Tuesday 20th January.

   This was undoubtedly a complex and challenging task for the Panel (as should be expected for such a decision) but information was structured in a way intended to make the task as manageable as possible. The Panel did not suggest that it might have come to a different decision if it had had more time. It should also be noted that the Panel was not delegated to make a final decision but to initiate a process of further approval through Programme Board and through Commissioner Boards.

3. **The discussion at the shortlisting workshop was dominated by one person which has resulted in the decision of the group being overly influenced by a particular view. In deciding who would be on the Evaluation and Shortlisting Panel was consideration given to whether people had a pre-determined view and were therefore not basing their views on the information provided?**

   As is often the case in workshops and other meetings, some members speak more often than others. It was important that those facilitating the workshop did not unduly constrain the panel's deliberations. No members were prevented from speaking if they wished to.

   We have no evidence that the views of any one person overly influenced the views and actions of others. No feedback to this effect was received from Panel members on the day or subsequently.

   Programme Board determined that the identification of Panel members was solely a matter for the nominating bodies (the sponsor and stakeholder members of the Programme Board). Panel members were, however, presented with the Programme's Code of Conduct and were required to submit Declarations of Interest. This information was available to the Board when it considered the Panel's recommendations.

FutureFit Acute Services Design Template

Introduction

The purpose of this document is to provide a description of the advantages and disadvantages of each of the FutureFit Clinical design scenarios FROM A CLINICAL DESIGN PERSPECTIVE
The document will be used by the Programme Board and by the Evaluation panel as evidence that supports the evaluation of options.

The FutureFit acute services scenarios

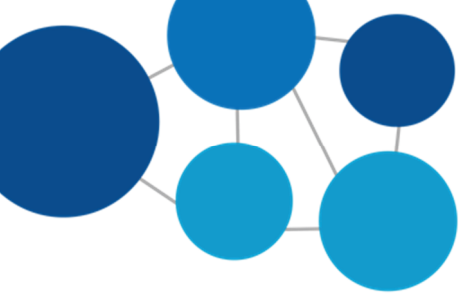
The programme has agreed a longlist of options that encompass the following dimensions for acute services:

- A single Emergency Care Centre(EC) and a Diagnostic and Treatment Centre (DTC) either co-located onto a single site (but physically separate) or in separate sites.
- An Urgent Care Centre (UCC) is to be located in front of the Emergency Care Centre and both Shrewsbury and Telford would have a UCC
- It has been assumed that outpatient activity and Radiotherapy services will continue to be provided from their present locations.

The service adjacencies insofar as they have been described to date are as follows:

Services within a single EC

- Assessment and treatment space for acutely unwell patients
- Radiology & Pathology
- CT/MRI complex imaging
- Blood bank
- Pharmacy
- Critical Care Unit
- Emergency surgery – trauma and general
- 20% of planned surgery
- Short Stay Beds – at least for <3 day LOS
- Longer stay acute beds for acute phase of care
- Medical specialty beds (eg Cardiology)
- Paediatric unit
- Theatres including imaging intensifiers for major emergencies



Services within a single DTC

- 80% planned surgery
- Theatres including imaging intensifiers
- Most day case
- Specialty beds beds (e.g. planned orthopaedics)
- Major diagnostics – including U/S, MRI, CT, Nuclear
- Planned endoscopy
- Pathology
- HDU

The location of consultant led obstetrics is described as a variant, allowing for location either with the EC or DTC. It is assumed that neonatal care would be co-located with consultant led obstetrics under all scenarios.

Midwifery led obstetrics is assumed to be located separately form consultant led obstetrics and could be on either the EC or DTC site or elsewhere.

The template

The template below sets out the clinical design arguments for and against three of the key location variables set out in the long listing scenarios;

Scenario	Clinical quality advantages	Clinical Safety advantages	Clinical quality disadvantages	Clinical safety risks	Workforce implications expressed in as much details as possible in terms of rota implications and staffing numbers	For scenario 2: What additional mitigations need to be put into place to meet essential quality and safety standards
1 **EC and DTC on a single site with Obstetrics co-located**	• Maximises use of planned care facilities • Acute to planned care transition • Implementing 7 day working • Diagnostic Access • Flexibility and resilience • Pharmacy consolidated • All specialties co-located • Collaborative working maximised • All clinical linkages are strengthened • Single trauma service would allow emergency sub-specialisation (eg upper and lower limb specialists) • Single critical care unit should achieve national standards • Speciality co-location • Single critical care unit • Maximises utilisation of available beds at the risk of impacting elective care but ensures flexing of beds at times of high emergency demand • All acute specialities available to each other for comprehensive patient management. • Minimal duplication of workforce to cover more than one site. • Sharing skills for MDT working. • Rare events catered for • No need for work around solutions creating complex patient pathways • All radiological specialities on same site • Easy to implement single 'duty' radiologist to keep interruptions of others to a minimum	• Emergency Obstetric response • Beds on other site to "play with" • Easy access to critical care and obstetric and DTC patients • More personnel to deliver 7 day standards • Immediate access to required clinical skills in the majority of secondary care scenarios. • No loss of skills from one site whilst another site is being services. • Team learning and knowledge is easier to acquire. • Interventional radiology on same site as obs & gynae • OOH radiographers for CT and MRI	• EC impact on DTC (Travel times) • Infection control in DTC • No beds on same site to "play with" • Temptation for bed managers to park outliners in DTC may reduce efficiencies • Non separation of patient flows may result in bed occupancy problems for elective care	• Increased travel times for patients potentially increased risks – by mitigated by co-location • Some loss of benefits of separation of elective and emergency work in terms of hospital acquired infection • If medical staffing at single unit is no adequate for the volume of work as this is a trade-off for cost or an assumption of configuration then clinical safety and timely care is at risk • Non separation of patient flows creates a great opportunity for wrong patient in wrong place within the DTC. • Single rotas for radiologists and radiographers	• Co-location • Minimum number of rotas – no duplication • Anaesthetic rotas consolidated • Most likely option to support recruitment and retention • Single rota for ▪ General surgery (4 tiers), ▪ ENT (3 tiers), ▪ Urology, ▪ T&O single trauma service would need consultants on site in day ▪ Maxillofacial (3 tiers) • Single critical care unit improves recruitment for staff • Single site allows for specialist rotas in anaesthesia including paediatrics. • Clear configuration makes it more attractive to recruit and retain staff. • For Women & Children's this has no significant rota implications unless there is significant development of treatment centres requiring paediatric specialist input	

Scenario	Clinical quality advantages	Clinical Safety advantages	Clinical quality disadvantages	Clinical safety risks	Workforce implications expressed in as much details as possible in terms of rota implications and staffing numbers	For scenario 2: What additional mitigations need to be put into place to meet essential quality and safety standards
2 **EC on one site** **DTC on another site**	• DTC as a day case facility preferable, or surgical team employ trust grade staff, who are of variant quality and availability • Separation of patient flows • Workforce clearly aligned to activity and speciality in DTC • Predictable requirement of senior staff in DTC • Radiologists based at DTC relatively free from interruptions	• If DTC demands on site medical cover then there is no advantage of having a single EC. This would demand separate on call rotas and very isolated juniors in poorly supervised and of limited education value. • Separation of patient flows	• This will revolve around out of hours care. There will be generic skills for hospital at night practice with the requirement of separate senior non-resident rotas within all specialities covering the DTC. • The availability of HDU/ITU will limit patient acuity • Separation of speciality senior rotas will limit availability of senior Drs to the EC • Splitting of some modalities eg nuclear medicine will probably lose economies of scale if 1 nuclear medicine scanner on each site • CT and MR (but to a lesser extent) • Interventional radiology would be on one site only therefore has to be EC	• The patient becoming suddenly and critically unwell may well be disadvantaged requiring multiple speciality input and facilities • This will limit the acuity of patients having surgery and determine the capacity of DTC • Limited investigations within a DTC out of hours would also have a negative safety effect. • Staffing too many separated areas may result in reduced pool for EC.	• Option 1 – comprehensive DTC with full staffing • Option 2 – day case only DTC with limited cover • Option 3 – for Ortho use RJAH for longer stays. • Hospital at night rotas will be mainstay of DTC • May well be difficult to staff with training medical staff as this is separate from speciality training • DTC will pool on pool of Drs for EC (particularly anaesthetics) • Single radiology rota at EC • Would need off site 'oncall' radiographer rota for DTC depending on complexity of surgery being performed • Splitting of CT/MR expertise would lose economies of scale vs. all on 1 site.	• Will much depend on what the DTC will provide • If low acuity, then low out of hours staffing requirement • If high acuity, need more extensive rota cover • This depends on the placement of some paediatric and gynae surgery. If paediatric surgery in on the DTC then access to paediatric specialist (medical and nursing) care will need expansion as there is considerable sharing of skills and bed base with a single site. This has significant implications for Head and Neck along with some general surgery and gastro. • With this scenario gynae surgery would require support for overnight care and emergency gynae would be separated from elective gynae. In most instances a hospital at night service will suffice but speciality knowledge/skills required. With a significant separation (distance and time) a separate Consultant Gynae rota (6 docs) will be required for the cover for the unusual returns to theatre etc. as this could not be supplied by the gynae consultant on for gynae emergencies at the EC/second on call obstetrician • With the separation from emergency gynae there are also nursing skill implications. • Would need off site 'oncall' radiographer rota for DTC depending on complexity of surgery being performed

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2a **Obstetrics co-located with EC** **Option 1 preferred but 2a next best** **DTC – Diagnose only**	• Separation of elective surgery reduces risk of cancellation • Single trauma service would allow emergency sub-specialisation (eg upper and lower limb specialists) • Single critical care unit should achieve national standards • Consultant obstetric practice requires, on occasion, all the specialities presumed to be at EC including blood transfusion and pathology support. This model avoids work around solutions and keeps neonatology with paediatrics which supports some work force issues (mid grades). It also keeps obstetrics with emergency gynaecology and likewise resolves some potential work force issues (mid and junior grade)	• Speed of access for obstetric patients requiring critical care or interventional radiology • Easy access to surgery and medicine for obstetric patients • Reduced risk of hospital acquired infection for patients having elective surgery • Immediate access for patients to required specialist; critical care; blood transfusion; pathology • Interventional radiology on same site as obstetrics for PRH	• Risk of theatre productivity falling on EC site as can no longer mix day cases with in patients. • Separation from elective gynae creates some workforce issues at senior level and speciality knowledge for hospital at night and nursing teams.	• Small number of patients undergoing surgery will need access to critical care or medicine (these patients will have to be transferred) • This revolves around the workforce set up for the DTC in relation to gynae and availability of appropriate speciality and pathology support on the rare occasion.	• "Surgical patients" in DTC will need on site medical cover (this could be a single multispecialty specialty doctor rota) • Will need separate consultant rota in anaesthetics, general surgery and orthopaedics • Smaller specialities such as urology, ENT and maxillofacial will struggle to supply two consultant rotas and will have to cover two sites (this may reduce recruitment opportunities. • Interventional radiologist would be co-located with obstetrics • EC benefit from co-locating with clinical staff trained in management of obstetric emergencies • Problematic hospital at night team • Need a DTC non-resident senior rota separate from the 2 senior rotas at the EC	• Would need to be prepared to initiate critical care on the DTC site and transfer the patients out • All surgery needing access to interventional radiology would need to take place on EC site. • 1 in 6 non-resident consultant rota in addition to rotas for DTC in addition to rotas for EC
2b **Obstetrics co-located with DTC**	• Separation of elective surgery reduces risk of cancellation • Single trauma service would allow emergency sub-specialisation (eg upper and lower limb specialists) Single critical care unit should achieve national standards • A neonatal unit, as part of this unit, would be human resource intensive for middle grades and radiology (and other support services) • This separates Obs/elective gynae from emergency gynae and neonatal paeds from acute paeds (not sure where paediatric surgery would take place?) • This separates consultant obs from other acute specialities. This has no clinical quality advantage	• Reduced risk of hospital acquired infection for patients having elective surgery • This separates Obs/elective gynae from emergency gynae and neonatal paeds from acute paeds (not sure where paediatric surgery would take place?) • This separates consultant obs from other acute specialities. This has no patient safety advantage.	• Potential separation of ill mother (on EC) and baby (on NICU at the DTC) • Risk of theatre productivity falling on EC site as can no longer mix day cases with in patients • This requires work around solutions for the support of obstetrics by emergency specialities; radiology; blood transfusion; pathology and critical care • All solutions will create more complex care pathways for pregnant and post-partum women • Separation of mid- grade tier in neonatology from paeds will create a clinical quality issue for either of these specialities. • No interventional radiology on site	• Poor access to critical care or interventional radiology for obstetric patients (patients needing these services would need to be transferred) • Poor access to surgery and medicine for obstetric patients • Requires many "back-up" professionals with added risk • Work around solutions and complex pathways results in unnecessary risk of failure of timely delivery of care • No interventional radiology on site and probably no angio room • All interventional radiology will be at EC & cardiology will presumably be at EC also • Therefore very unstable patients would require transfer to EC	• EC rotas ▪ General surgery (4 tiers) ▪ ENT (3 tiers) ▪ Urology ▪ T&O single trauma service would need 2 consultant on site in day ▪ Maxillofacial (3 tiers) • Single critical care unit improves recruitment for staff • Difficulties for anaesthesia; would require 4 rotas (general and critical on EC and general and obstetric on DTC) *Paeds/Neonates:* • Additional mid-grade staff (9)as rota currently shared • *Gynae:* loss of support of acute gynae to emergency obstetrics therefore need a 1 in 6 resident and non-resident gynae consultant rota for EC (current gynae rota supplies 2nd consultant obs as col-located with EM and Obs) Mid-grade and junior rota required for emergency gynae on one site creates the need for additional rotas • *Anaesthetics:* Obs co-located with DTC will require current resident mid-grade rota and day time resident consultant but will require additional non-resident consultant out of	• The DTC staffing would need to be enhanced to provide support to the obstetric unit. This would require, as a minimum, a CT in medicine. • The surgical rotas would have to be speciality specific (i.e. separate rotas for general surgery, urology and orthopaedics) • Enhanced risk that consultants on call for DTC would need to return to assess obstetric patients • Drs will need to choose between: ▪ Stand alone, self sufficient capacity (even if co-located) ▪ Or linked with other specialities • Radiographer on site OOH for neonatal unit

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					hours to supply back up/2nd pair of hands. This may be supplied by anaesthetic cover for DTC as this will be relatively quiet. • *Resus:* Obstetric unit will require a resus team although this should be in place of the DTC • *Imaging:* The obstetrics unit will require access to in hours and out of hours imaging and therefore consultant radiology resident and non-resident rota • *Medicine/Cardiology:* The most common emergency consultations in consultant obstetric practice are with medicine although a 10 minute travel is acceptable. This will result in the loss of staff to the EC • *Surgery/Urology:* 10 minutes travel is acceptable but this will result in loss of resource from the EC. • Immediate inter-operative attendance is rare but the absence of intervention radiology means that vascular assistance will very occasionally be required • Pathology: obstetrics and neonatology will require on site blood transfusion services and pathology (haematology and biochemistry) • Pharmacy: on-site support and IV feeding for neonatology • Therapies • Interventional radiology provision to cover cross-site if there is angio room at DTC	

- In all the options Microbiology and Cellular pathology wold remain on one site only. Therefore it would be blood sciences (haematology, including blood bank, and biochemistry) that would be affected. We would provide a 24 hour, 7 days a week service at PRH, RSH and an on call service at RJAH.
- One EC and DTC together would require a fourth laboratory with equipment and estimated 10 more BMA staff to run a forth 24/7 service
- For separate EC and DTC that potentially increased the blood sciences laboratories to five with increased staff numbers.
- Obstetrics as stand alone would create significant blood bank problems which could be resolved with a remote blood bank system.

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