Committee and Date	Item No
Joint Health Overview and Scrutiny Committee	**A**
	Public

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 9 JULY 2012

4.00 P.M. – 6.00 P.M.

Responsible Officer Fiona Howe
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Present

Shropshire Council:
Gerald Dakin (Chairman), Tracey Huffer, Karen Calder and co-opted members Liz Cass and David Beechey.

Telford and Wrekin Council:
Derek White (Chairman), Veronica Fletcher, John Minor and Co-opted Members Jean Gulliver, Dilys Davies and Richard Shaw.

In Attendance

Adrian Osbourne, Communications Director, (SaTH)
Kate Shaw, Programme Manager, (SaTH)
Chris Needham, Associate Director of Estates, (SaTH)
John Ellis-Tipton, Estates Manager (Environment & Risk), (SaTH)
Niki McGrath – Communications and Engagement Manager (SaTH)
Gordon Frost, General Manager (Arriva)
Barry McKinnon, Area Manager, (WMAS)
Gavin Ashford, Road Safety & Sustainable Transport Technical Specialist (T&W)
Stuart Freeman, Highways & Transport Service Delivery Manager (T&W)
Emma Bullard, Travel Shropshire Promotions Manager (SC)
Fiona Howe, Committee Officer, Shropshire Council (SC)
Stephanie Jones, Scrutiny Officer, Telford and Wrekin Council (TW)
Fiona Bottrill, Scrutiny Officer, Telford and Wrekin Council (TW)

9. APOLOGIES FOR ABSENCE

9.1 Apologies were received from Councillor John Minor (TWC), and co-opted member Mandy Thorn (SC).

10. MINUTES OF THE LAST MEETING

RESOLVED:
That the Minutes of the meeting held on 1 June 2012 be approved and signed by the Chairman as a correct record.

11. SHREWSBURY AND TELFORD HOSPITAL TRUST: TRAVEL AND TRANSPORT PLAN

11.1 The Area Manager, West Midlands Ambulance Service was in attendance, and addressed members of the Committee. He provided responses to issues raised through the work undertaken by the Joint Health Overview and Scrutiny Committee on the configuration of hospital services, and the impact the changes would have on the Ambulance Service.

11.2 Mr McKinnon responded to a number of questions, which had been submitted by the Committee prior to the meeting:

- Did the ambulance service have any concerns over the additional travel time to Princess Royal Hospital for some children transported by car and ambulance.
  Response: The Committee was assured that travel times would not increase in excess of 20 minutes, and in an emergency travel time would be significantly reduced. It was stressed that in an emergency situation a child would always be transported to the nearest A & E facility, which in some cases would be Royal Shrewsbury Hospital.

- Has the Ambulance Service been engaged with the development of clinical pathways of the Travel and Transport Plan.
  Response: The Service had been engaged throughout the process and had given input where appropriate.

- Was the Ambulance Service in a position to provide an update on the current 111 proposals.
  Response: Members were advised that as the West Midlands Ambulance Service was a perspective bidder, they would be unable to comment at this stage.

- A request was made to provide an update on the 'Make Ready' system.
  Response: The transformation of service delivery would see the centralised service of ambulance vehicles. Hubs would enable efficiency measures to be achieved, and enable crew turnaround times to be improved. Members were assured that the Ambulance Service was not intending to reduce vehicle numbers, but the current station provision was not viable within the current funding climate. With the introduction of the new system, paramedic cars would be ring fenced to an area, with the addition of an ambulance vehicle being put on standby for emergency patient transportation. It was noted that a paramedic car would only move out of a designated area if there was a life threatening situation in another area. Services in Donnington, Bridgnorth, Market Drayton and Tweedale were already in place. Staff had not migrated into Shrewsbury yet, but

it was expected that the hub would be online in October 2012. Community Paramedics would be based around the county to support service provision. Members were assured that efficiencies and cost saving were being achieved through the transformation process, whilst enhancing existing provisions.

- Workforce development needs – recruitment and training of paramedics, advanced paramedics, coverage and training of community first responders.
  Response: The Trust had a wide ranging training and development programme, and it was noted that the Service was not recruiting in Shropshire at the present time, as they had exceeded their staffing requirements, but work was being undertaken to develop the existing staff skills mix. Members were assured that there would be an advanced paramedic in each outlying area, and out of team of 35, 25 had undertaken appropriate training to achieve the required standards. Training in different treatments and diagnostic skill sets need to be undertaken to ensure that patients received the right care in the right place, and that crews were able to identify appropriate care pathways. The skill mix that the Ambulance service has set is 70% qualified paramedics and 30% skilled technicians. (All vehicles will have a paramedic on board)

- Where will first responders be based?
  Response: It was noted that first responders would be based across the market towns, with the hubs being based at sites in Donnington and Shrewsbury.

- Identify where standby stations are to be sited across the county?
  Response: Provision was being made in Newport, and the service is considering Church Stretton as another appropriate site, although there were still questions to be answered over the site. There was also a need to consider seasonal influx within market towns, including Ellesmere and Ludlow, and identify the best place to site existing response resources.

- What provision had been made to mitigate the additional transport costs incurred do to Shrewsbury & Telford Hospital NHS Trust transformation process
  Response: It was confirmed that any additional transport costs would need to be taken into consideration through the commissioning process, and confirmed that the matter would be discussed further with the Primary Care Trust and Clinical Commissioning Groups to ascertain if there would be a detrimental impact to travel costs. The service did not expect to see a significant change, but they would be able to evaluate impact once the reconfiguration had taken effect.

11.3 In response to questions raised by members of the Committee at the meeting, the Area Manager advised that the site for the Shrewsbury Hub had been identified on Longden Road. It should be noted that each vehicle entering and leaving the site would not be responding to emergencies, but Members stressed the need to ensure that they site had quick access points.

11.4 WMAS could not see that changes to acute services would but patients at risk, as they routinely take patients to out of county specialised facilities, to receive the most appropriate care for their condition, and would continue to take patients to the most appropriate centre for care. The West Midlands was now part of a Trauma Care

network, and if a patient needed to be stabilised they would be taken to a local acute hospital in the first instance.

11.5 In response to a question raised in respect of safer cross border routes from Wales and the south of the county, members were assured that crews would assess the most appropriate route based on a patient's condition, for example, a cardiac patient would normally be taken to Stoke, but the final decision would be down to the individual crew to make the appropriate judgement. Each vehicle had been fitted with satellite navigation and mapping systems, but crews could use their own local knowledge of the area to decide on the safest route for the patient's condition. Discussions on cross border collaboration had concluded in December 2011, and new systems would be put in place to ensure that all cross border ambulance crews were able to access patient case histories electronically. Members were advised that cross border working had proved difficult in the past as dispatch systems had not been compatible, and the changes being put in place meant that the nearest available unit could respond.

11.6 Concern was raised over the accuracy of postcode information available through satellite navigation systems, which delayed emergency response times, and could put a patient at further risk. Members were advised that information tracking was used to identify a precise location of landline callers, and GPS tracking could be used to identify the location of callers using mobile phones. However, it was accepted that postcodes were not always reliable.

11.7 Members were assured that concerns raised previously over ambulance waiting times at acute hospitals had been resolved with the implementation of corridor nurses, and Shrewsbury and Telford Hospital NHS Trust had also reviewed its discharge policies to improve flow through. There were still times when delays were incurred, but this was due to capacity creating a bottle neck in front line services. The turnaround times for Shropshire County were much better than other areas in the West Mercia area, who were still reporting turnaround problems on a regular basis, but no delays had been reported in Shropshire.

When asked about the future arrangements for commissioning the WMAS services through CCGs or the National Commissioning Board Members were informed that this would need to be answered by the Commissioners.

11.8 The Chairman thanked the officer for his attendance, and assistance in clarifying outstanding concerns raised previously by the Committee.

11.9 Representatives of Shrewsbury and Telford Hospital NHS Trust (SaTH) were in attendance, to present the Travel and Transport consultation document to the Committee. Mr Chris Needham, Associate Director of Estates, addressed the meeting, responding to a number of questions raised by Members prior to the meeting.

Could SaTH confirm average length of stay for patrons utilising parking facilities?
Response: Attendance patterns were not recorded, but the Trust had looked at the overall picture for parking provision, and indicated that each space showed a

turnover of 3 to 3 ½ times a day. This could equate to stays of less than 2 ½ hours each time, but there is no evidence to confirm the assumption.

How much revenue is currently achieved through parking charges.
Response: Commissioning arrangements for parking were broken down into three areas; a guaranteed sum paid to the Trust based on the number of spaces available; operating costs of the car parks; and a profit component of 6-8% in line with a commercial agreement which equated to a total revenue stream of £1.3 million, with the Trust receiving £800,000. Members were advised that the contract would continue and the Trust would renegotiate schedules and extensions. An agreed minimum number of parking staff would be on site, but their role would change and an emphasis would be put on providing more assistance, instead of policing of the parking areas. In response to an additional query, it was confirmed that the first 20 minutes of parking would be free to enable patients to be dropped off and picked up without incurring unnecessary charges.

Are staff parking charges being reviewed, and are staff living close to the facilities, being encouraged/required to use alternative transport methods than their own vehicles.
Response: Consideration was being given to a whole range of measures in respect of staff parking and alternative provisions, and it was important to receive feedback on proposals through the consultation process to evaluate the most appropriate solutions.

It is important to ensure that delays in treatments are addressed, as this could unnecessarily increase parking costs to the individual patient.
Response: The Trust was looking at best practice across the country, and would look at a scheme to rebate charges to patients if delays were incurred. The Trust recognised the problem and assured Members that it would be taken into account in the final Travel and Transport proposals.Members were informed that a hospital in Hereford had a scheme whereby patients could claim a rebate on the additional parking charge incurred f this was a result of a clinic over running.

Concerns had been raised over the increase in day charges. It was proposed that the Trust consider implementing a maximum charge of £3.00 instead of the higher tiered rates being proposed.
Response: All comments would be fed back to the Chief Executive and the Trust Board for their consideration. It was noted that the structure of the tariff had been developed following feedback received from information forums, which had seen a large concensious to implement a charging policy which would see the removal of a midnight expiry period for tickets.

There needs to be provision made for 'mother and baby' parking bays in the proposals.
Response: The Trust would be considering parking needs at the Princess Royal Hospital with the development of the new Women's and Children Unit. The Trust was working with the Local Authority and West Midlands Ambulance Service parking facilities.

Was there going to be a provision for additional bicycle racks to encourage healthier travel plans.
Response: Additional facilities would be considered at both sites, and they would be sited in a convenient location and properly promoted.

Would 'weekly tickets' and '10 park pass tickets' be transferrable between hospital sites.
Response: The multi tickets would be transferrable between both sites. In response to a request made to clarify the definitions of the multi tickets, Members were advised that a weekly ticket could be used at any time of day for a 7 day period, whereas a 10 park pass could be used for 10 separate visits. The Trust recognised that there was a need to promote these tickets more widely, indicating that information would be made available on signage, by machines and on the web, with confirmation on where and how they could be purchased. A request was made to promote all concessions and multi-ticket option in doctor's surgeries.

Who would be operating the Shuttle Bus service.
Response: It had not been determined whether the Trust or a commercial partner would provide the service, and consideration would be given to the most appropriate option. The Trust would ensure that a very clear specification for the service be drawn up, identifying service requirements.

Were there any plans to introduce a charge for the Shuttle Bus provision.
Response: A full economic appraisal would need to be undertaken before any proposals on a charging structure were considered, but it would be preferable that additional travel costs would not be incurred on travelling between sites. There was still work to be done to consider if the bus service would be used to transfer medical records and equipment.

It is important that patients do not incur additional travelling expenses to access services once a service is transferred to either Royal Shrewsbury Hospital or Princess Royal Hospital. Would the Trust consider introducing a 'Park and Ride' style scheme to allow patients to park at either site and make use of shuttle services with the parking fee already paid.
Response: Members were advised that a full range of options needed to be considered to help reduce costs, and review the availability of connecting with other facilities like Park and Ride in the future. Members referred to possible collaboration with sites, such as Shrewsbury Football Club, to utilise their facilities as a 'Park and Ride' site, and route the provision past the hospital. The Committee requested that further consideration be given to the proposals, and were assured that all proposals would be considered when the Trust developed its final proposals for the Travel and Transport Plan.

Are the operating times being proposed (7.00 a.m. – 7.00 p.m.) extensive enough for staff and patients needs.
Response: The times laid out in the consultation document covered a 12 hour peak period, but stressed that there would be a degree of flexibility if needed. The Trust had no evidence to support a wider scheme, but believed that it was an appropriate place to start.

11.10 In response to questions raised by members of the Committee at the meeting in respect of bus services impinging on Local Authority services, the Highways and Transport Service Delivery Manager, Telford and Wrekin Council, reported that work needed to be undertaken on servicing the wider needs of the community before a service was commissioned, and consider how the costs would be met, considering limited funding and commercial viability.

11.11 Members stressed that the Trust needed to understand that this was a real opportunity to undertake cooperative working between SaTH, the Local Authority, and Arriva to get people out of their cars, and cut down on vehicle emissions. The Trust reported that it was an exciting opportunity for all parties to sign up to. The Highways and Transport Service Delivery Manager, advised the meeting that proposals would be looked at, but the Local Authority would not consider a scheme that would cause detriment to the plans SaTH want to deliver.

11.12 A discussion ensued about the use of concessions on shuttle bus services, and were advised by the General Manager (Shrewsbury) Arriva, that the use of concessionary fares would hang entirely on how the service was set up.

11.13 The Chairman thanked the officers for their attendance, and assistance during the Committee's deliberations.

RESOLVED:

(a) That the Joint Health Overview and Scrutiny Committee note the content of the Travel and Transport consultation document, and endorse the work undertaken by the Trust to date.

(b) That all comments raised through the deliberations be taken into account in the development of the Travel and Transport Plan.

(c) That Joint Health Overview and Scrutiny Committee scrutinise responses to the consultation, and consider how they had been taken into account in the full Travel and Transport Plan.

12. UPDATE FROM SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

12.1 Mr Adrian Osbourne, Communications Director, was in attendance, and gave a presentation on the future configuration of hospital services, regional updates, and strategic priorities for the year ahead.

12.2 Mr Osbourne advised Members that as part of Foundation Trust status progress, a Governance Risk Rating had been carried out to identify areas of most challenge, and give assurance that the Trust can get the treatment pathways right for the patient. Figures for June 2012 had shown that the Trust was achieving A & E targets, and it was expected that by July 2012 the Trust would achieve the 18 week RTT admitted and cancer waits. Service Performance targets had shown that the Trust had hit, and maintained, its 18 week non-admitted targets, and were expected to hit the 18 week admitted target in July 2012. A & E 4 hour wait performance failed to hit target in April and May, but they were on track to achieve the target in July. It

was noted that the Trust had recognised a need to improve discharge processes, and get patients through the system quicker.

12.3 Consideration was give to SaTH's Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Morality Ratio (HSMR), and Members were advised that SHMI included deaths outside of an acute setting, which had seen a decline in numbers since April 2010.

12.4 Members were advised that a Net Promoter Question had been introduced across the country to improve the patient experience. The Trust was already surveying 10% of inpatients, and plans were being drawn up to survey 10% of outpatients. The Net Promoter score for May 2012 had recorded a 65% satisfaction rate, which was just above average. It was important to get measures right, and the Net Promoter Question was part of a wider scheme of plans to improve the patient experience.

12.5 Consideration was given to the Financial Plan for 2012/13, taking account of the changes to the way the Trust was paid on tariff, and if a patient was readmitted within 30 days of treatment, the Trust would not receive funding for the first length of stay. This could see the Trust losing £6 million in funding revenue, which strengthened the need to ensure patient's received the right treatment first time. The local QIPP Programme would be reduced by a £11.3 million putting demand on managing health in the community, and £22.1 million needed to be saved through cost pressures such as inflation. The Trust would receive an uplift of £2 million in respect of demographic growth income, and a further £2 million in respect of CQUIN income growth. If the Trust achieved all planned efficiency savings it would see a surplus of £2 million at the end of 2012/13, which would allow the Trust to plan for future needs. Members were advised that in order to move forward and achieve Foundation Trust status they were required to show a 1% surplus to ensure they were financially viable.

12.6 Final preparations were underway to consolidate adult inpatient surgery at Royal Shrewsbury Hospital, with the Surgical Assessment Unit and the Surgical Short Stay Unit were due to open later in July 2012. Those units would provide better ambulatory care, and were located close to A & E to ensure service cohesion. The Trust extended an invitation to the Joint Health Overview and Scrutiny Committee to undertake a site visit to see the development of the surgical units.

12.7 The Head and Neck inpatient services would move to Princess Royal Hospital in early September 2012, allowing empty surgical wards to change over unhindered. From 18 July 2012 all elective adult vascular, upper GI, colorectal and urological inpatient surgery would take place at Royal Shrewsbury Hospital, and from 2014 emergency and unplanned paediatric surgery, and surgical admissions would take place at Princess Royal Hospital. Assurances were given that time had been spent with GPs, Clinical Commissioning Group, and West Midlands Ambulance Service, to ensure that the Trust get service provision right, and ensure that the transition was a smooth as possible and safety nets were in place.

12.8 In response to a question raised by a member of the Committee, the Communications Director advised that some staff had been affected by the Surgical Assessment Unit and Surgical Short Stay Unit moves. It was noted that some staff members had looked at other opportunities open to them at Princess Royal Hospital,

while others had decided to move with the service and develop their skills. The Trust had always supportive of its staff through the configuration changes, and would offer coaching to help them through the process. Many staff were excited at the range of care available and the opportunities it would provide them.

12.9 Members requested clarification on how the Trust received their rating in respect of the patient experience, and it was agreed to bring back Quality Performance measures to a future meeting to provide further detail on the policy priorities. The Chairman requested that the Trust provide quarterly updates to the Committee to enable them to monitor progress.

12.10 Concern had been raised over registered nurse and midwife compliance complaints. Members were assured that although the nursing national body had faced backlogs dealing with poor performance of nursing staff, there were internal performance measures in place to protect patients. The Trust would always work with the Nursing and Midwifery Council if they had a concern over registration, or poor performance.

12.11 Detailed work was ongoing to understand the thinking of Neonatal Nurses on the moves, and Midwifery staff were already rotating between the two centres without any issues arising.

12.12 Concern was raised over the lack of communication over delays in waiting times for services such as outpatients, and were assured that communication complaints were high on the Trust's agenda, and in terms of openness had produced quality indicators to show where the Trust was failing to satisfy patient expectations. This was an area that the Trust needed to focus on and address.

12.13 Concern had been raised over the continued lack of assistance from nursing staff, where reports had been raised by relatives over meals and washing facilities being left out of a patients reach. The Communications Director stressed the importance of feedback in respect those types of issue, as it enable the Trust to act quickly on the concerns and ensure all areas of care were to the standard required, and expected, by the Trust.

12.14 Pathology Update - The Carter Review had been published in 2008, which had identified the need to bring back-office services into a single site, to make it more cost efficient. In order to look at the proposals further a regional review was being undertaken across the East and West Midlands, and a procurement process was underway led by PCTs across the region for direct access pathology tests. This meant that the procurement process would be open to private providers as well as the NHS. There was a need to make the service cost effective, but retain quality, and in order to do this the service was likely to be based around a large geographical area. SaTH was working in partnership with Walsall and Wolverhampton, but as Wolverhampton already had an extensive laboratory facility it was likely that this would be the preferred site. Members were assured that urgent testing would continue to be available in-house, but other standard tests would be carried out at an area facility. In response to questions raised, it was confirmed that staff would be affected by the change of service provision, and work would be undertaken in the coming months on how the service would work.

12.15 A regional Stroke Service Review was to be undertaken in 2012 to confirm service standards, and ask providers how they measure up to those standards. Over the summer the Trust would undertake an assessment of services, and look at their plans and provisions into 2013. The Trust was looking at providing angioplasty in one the acute hospitals, and bring cardiac services back to the county, but would require support from Staffordshire Heart and Stroke Network to enable it to happen.

12.16 Members were advised that other developments had been ongoing in recent months, including the approval of a replacement Linear Accelerator for Cancer Services, and the expectation that the Lingden Davies Centre would be open in the near future.

12.17 In conclusion the Trust's strategic themes would shape and guide their plans and priorities for the years ahead. The priorities include; putting the patient first, Foundation Trust status, rural health and integrated care, Telehealth network, and the development and reconfiguration of services.

12.18 The Chairman thanked the officers for the extensive update on developments affecting SaTH.

RESOLVED:

(a) That the future configuration of hospital services, regional pathology services, stroke services, and strategic priorities for the year head, be supported.

(b) That details on the policy priorities in respect of Quality Performance measures be considered at a future meeting of the Joint Health Overview and Scrutiny Committee.

13. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE: TERMS OF REFERENCE

13.1 Consideration was given to the proposed revision of the Joint Health Overview and Scrutiny Committee Terms of Reference (a copy was tabled at the meeting).

13.2 Members confirmed that consideration should be given to patient experience and quality data, following reconfiguration to measure the Trust's performance, and ascertain what differences, if any, to patient outcomes.

13.3 It was noted that details of the questions raised through the patient experience survey should be made available to the Committee, along with change over times, and what the Trust had done to address, and improve, those areas recording a low score. Clarification was requested on at what point in their treatment patients were being asked to complete the survey.

RESOLVED:

That a report be brought to the next meeting to consider the outcomes of the patient experience survey, and identify improvements to low scoring areas.

14. FUTURE AGENDA ITEMS AND MEETING DATES

14.1 It was noted that future agenda items had been identified through the work programme, tabled at the meeting, and the date of the next meeting is to be confirmed.

Chairman:……

Date:……

Creating Better Health and Care Services
Shaping Emergency Department Care for Shropshire, Telford & Wrekin and mid Wales

Briefing to Joint Health Overview and Scrutiny Committee on 28 November 2012

When people are taken to hospital as an emergency, they want prompt, safe and effective treatment that alleviates their symptoms and addresses the underlying causes of their illness. In short, they want care that is aimed at getting them better, quickly and safely.

These expectations are reasonable and achievable.

Getting patients better, quickly and safety requires the systematic implementation of known good practice; a consistent approach by all clinicians; collaboration within and between organisations; full and ongoing engagement with the people who should benefit from these services; and, visionary and courageous leadership.

Locally we are taking a fresh approach to delivering better health and care – not just in emergency care, but in all of our services.

Using a simple four-step approach our aim is to ensure a wide debate between patients, service users, carers, clinicians, wider NHS staff, partner organisations and more that asks and answers four key questions:

- Step 1: What does good look like?
- Step 2: How are we doing?
- Step 3: What does this mean?
- Step 4: What action do we need to take?

Through this we can together set out the future of emergency department care in our hospitals as part of the wider network of health and care services for the communities we serve across Shropshire, Telford & Wrekin and mid Wales. This process must be shaped by all of us and we welcome your views on the issues discussed in this report, and your involvement in the work ahead.

In support of this work, this briefing includes:

- Annex A: Report of an Engagement Event on 17 October 2012, containing:
    - Overview of the Better Health and Care process
    - Overview of the Engagement Event on 17 October 2012
    - Summary of Group Work and Feedback at the Event
    - Terms of Reference of the A&E Steering Group, part of the Pan Shropshire Urgent Care Network arrangements

- Annex B: Presentation slides from the Engagement Event on 17 October 2012, including:
    - Overview of Urgent Care Networks arrangements and goals
    - Patient perspective
    - Clinical perspective
    - Organisational perspective

- Annex C: Overview of the Pan Shropshire Urgent Care Network arrangements

?	Copies of the report, the slide presentations and other useful information is available from **www.sath.nhs.uk/betterhealth**

Annex A

The Shrewsbury and Telford Hospital NHS
NHS Trust

Creating Better Health and Care Services

Shaping Emergency Department Care for Shropshire, Telford & Wrekin and mid Wales

Report of an Engagement Event on
17 October 2012

Step One
What does good look like?

⇨

Step Two
How are we doing?

⇨

Step Three
What does this mean?

⇨

Step Four
What action do we need to take?

1. Introduction

When people are taken to hospital as an emergency, they want prompt, safe and effective treatment that alleviates their symptoms and addresses the underlying causes of their illness. In short, they want care that is aimed at getting them better, quickly and safely.

These expectations are reasonable and achievable.

Getting patients better, quickly and safety requires the systematic implementation of known good practice; a consistent approach by all clinicians; collaboration within and between organisations; full and ongoing engagement with the people who should benefit from these services; and, visionary and courageous leadership.

In The Shrewsbury and Telford Hospital NHS Trust we are taking a fresh approach to delivering better health and care – not just in emergency care, but in all of our services. Using a simple four-step approach our aim is to ensure a wide debate between patients, service users, carers, clinicians, wider NHS staff, partner organisations and more that asks and answers four key questions:

- Step 1: What does good look like?
- Step 2: How are we doing?
- Step 3: What does this mean?
- Step 4: What action do we need to take?

This report describes some of the work underway to shape the Emergency Department care we provide, using this four-step approach. It summarises an engagement event on 17 October 2012 that focused on the first two steps – what does good look like? how are we doing? – and set out the journey ahead for the final two steps.

Through this we can together set out the future of emergency department care in our hospitals as part of the wider network of health and care services for the communities we serve across Shropshire, Telford & Wrekin and mid Wales. This process must be shaped by all of us and we welcome your views on the issues discussed in this report, and your involvement in the work ahead.

Adrian Osborne
Communications Director
The Shrewsbury and Telford Hospital NHS Trust

2. What is the "Better Health and Care" review process?

The "Better Health and Care" review process is a rapid assessment process to engage patients, communities, staff, partner organisations and other stakeholders in:

- Deciding what "better health and care" looks like
- Understanding how local services measure up
- Agreeing whether there any gaps
- Recommending actions to address those gaps

It follows a four step process which is summarised below:

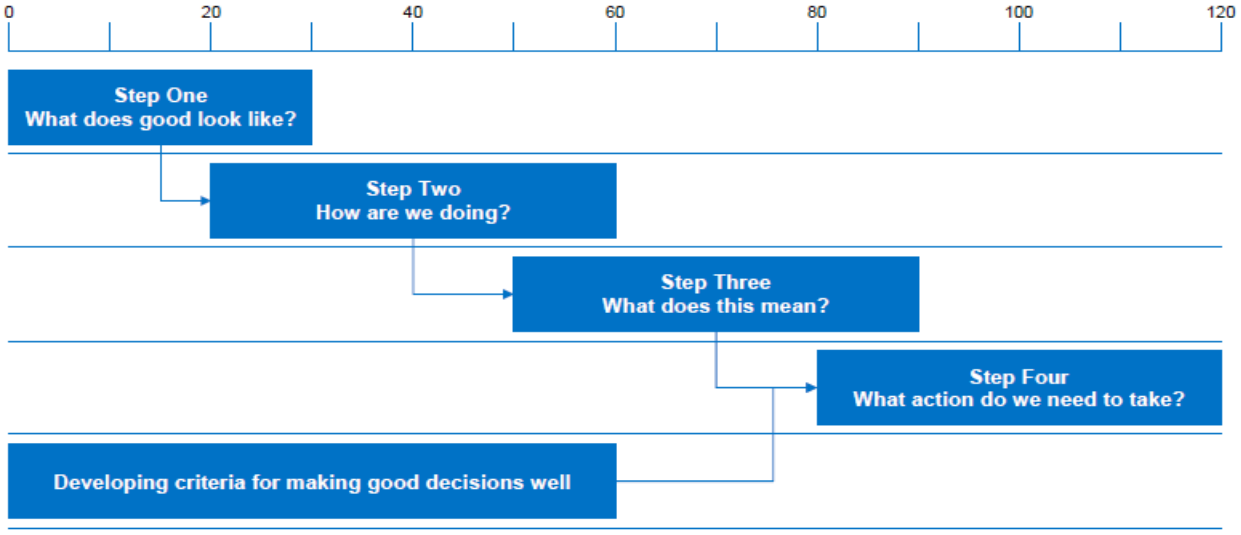
Step One **What does "good" look like?**	Identifying the outcomes and standards that services should be delivering – drawing on a wide range of sources such as national service strategies, NICE recommendations, patient feedback.
Step Two **How are we doing?**	Assessing how we are doing against these outcome and standards. Sharing our assessment widely and testing it against people's real experience.
Step Three **What does this mean?**	Identifying gaps that need to be addressed, and discussing and developing a range of options for doing this.
Step Four **What action do we need to take?**	Agreeing recommendations for ensuring safe and sustainable services, including formal consultation as appropriate.

Each step is an opportunity for patients, members of the public, doctors, nurses, therapists, social workers, support staff, managers and many more people besides to share their ideas, their hopes and their concerns. Together they can "co-produce" a shared understanding of what we would like services to look like, how our current services measure up and the steps we can take to improve.

It is important that this process takes place rapidly, with pace and energy. Health services are both very complex and very simple at the same time. It is vital that we do not get too bogged down in "analysis paralysis" and instead set out a visionary journey for better health and care. The diagram overleaf gives an example of how a four-step review might take place over a four month period (120 days).

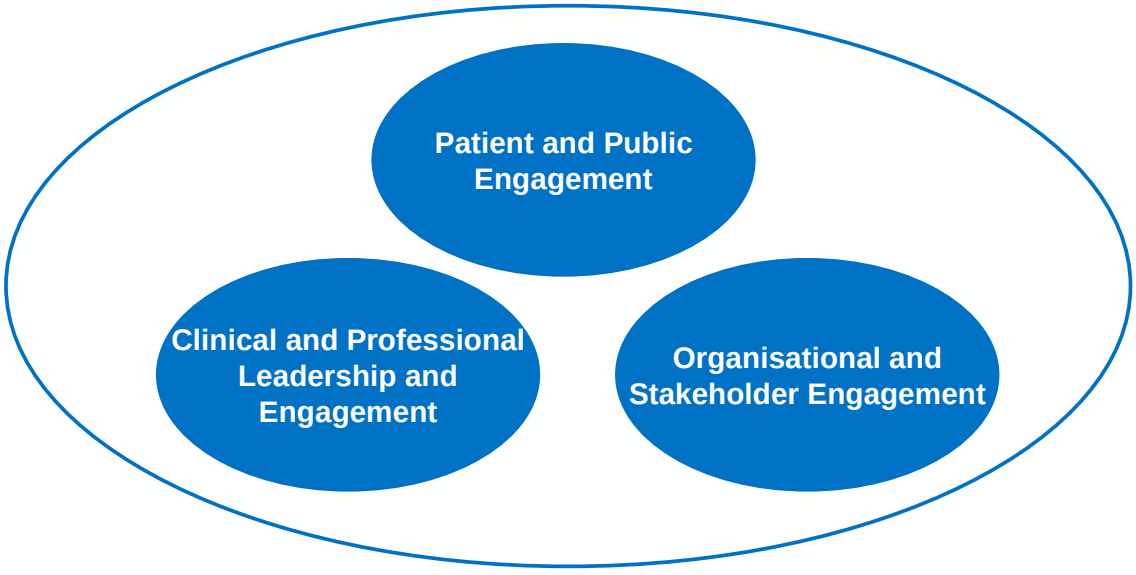
In parallel with these steps it is important to keep an eye on the future. A wide range of ideas, options and recommendations are likely to emerge. We need to have an idea of how those recommendations will be assessed and the best way forward agreed. So, an important part of the work is to develop the criteria that will help us all make good decisions well. You can find out more about this in the Appendix to this report.

Diagram indicating an indicative timeline for a 4-month four-step review:



The review process also recognises that it is vital to look at any health and care issue from at least three perspectives:

- Patient, public and carer engagement – the views and perspectives of the people we are here to serve
- Clinical and professional engagement – the views and perspectives of the people responsible for the directly delivery of health and care services
- Organisational and stakeholder engagement – bringing views and perspectives for the wider service, context and environment



Bringing together these three perspectives will ensure that we develop a fuller picture of the challenges and opportunities we face, and that we deliver better plans for future development.

?	Find out more about Better Health and Care reviews at **www.sath.nhs.uk/betterhealth**

3. How are we using the "Better Health and Care" review process for local emergency departments?

Across Shropshire and Telford & Wrekin, organisations are working together to develop and deliver a strategy for the future or urgent care. This review takes into account not just the way in which services are delivered in these areas but also who they serve – for example, patients and communities in mid Wales.

The overall aims of the urgent care strategy are as follows:

To provide, by 2014, comprehensive, unscheduled, urgent and emergency care services, delivered by integrated teams of people who share collective responsibility for every patient journey.

This work is guided by the following statements developed by patients:

- **Be "joined up" and responsible for my care**
- **Help me understand the urgent care service**
- **Let me access it appropriately**
- **Assess and treat me promptly in the right place**
- **Admit me to hospital only when necessary**
- **Make my stay in hospital short, safe and effective**
- **Try to care for me at home, even when I am ill**

The development of our strategy is overseen by an Urgent Care Network.

An A&E Steering Group has been established as part of these wider Urgent Care Network arrangements in the county. This group is co-chaired by Mr Kumaran (Emergency Department Consultant, The Shrewsbury and Telford Hospital NHS Trust) and Dr Mike Innes (local GP and Chair of NHS Telford & Wrekin Clinical Commissioning Group).

The A&E Steering Group includes patient, clinical and managerial representatives from Shropshire, Telford & Wrekin and mid Wales. It supports the local NHS to achieve sustainable improvement in the overall system and service for unscheduled care in the area.

This Steering Group is overseeing this Better Health and Care review to:

- understand the opportunities and challenges facing emergency department services for patients and communities in Shropshire, Telford and Wrekin and mid Wales
- decide what great services look like and how we currently measure up
- agree the main issues and gaps, and set out ideas and recommendations for addressing them

This review therefore has a specific focus on emergency department care but is also mindful of the wider urgent care system (e.g. self-care, pharmacy, NHS Direct and NHS 111, primary care including GP out of hours, minor injuries units and walk-in centres, trauma networks and tertiary services).

The timetables for all of this work are dependent in each other – for example, our work on NHS 111 influence how we shape emergency departments for the future and vice versa – but the broad timelines are as follows:

- September/October 2012 - Clinical and patient engagement to develop picture of “What good looks like” and “How are we doing”
- 17 October 2012 – Engagement Event
- November 2012 – Share Event Report
- December 2012 / January 2013 – Continue work on “What good looks like” and “How are we doing”
- January / February 2013 – Follow Up Engagement Event
- Further ahead – Timetable to be established based on working between December 2012 and February 2013

If you are interested in getting involved you can:

- Find out more from **www.sath.nhs.uk/betterhealth**
- Email us at **consultation@sath.nhs.uk** with the subject **“betterhealth”**
- Write to us c/o **Better Health and Care: Emergency Care, Communications Director, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**
- Follow us on Twitter **@sathNHS** and join in the debate using the hashtag **#betterhealth**

?	Find out more about Better Health and Care review for emergency department care at **www.sath.nhs.uk/betterhealth**

4. An overview of the engagement event on 17 October 2012

As part of this "Better Health and Care" review, a half-day engagement event took place on 17 October 2012 at the Shropshire Education and Conference Centre, Royal Shrewsbury Hospital.

The event included:

- Patient and community representatives from Shropshire, Telford & Wrekin and mid Wales (for example, through Local Involvement Networks, Community Health Councils, Practice Participation Groups and other organisations and networks)
- Clinical, professional and managerial staff from organisations involved in the delivery and planning of urgent and emergency care services in Shropshire, Telford & Wrekin and mid Wales
- Local and national speakers and presenters

The event, chaired by Adrian Osborne (Communications Director, The Shrewsbury and Telford Hospital NHS Trust) and attended by 54 participants, included:

- An introduction to the event and to the Better Health and Care review process (Adrian Osborne, Communications Director, The Shrewsbury and Telford Hospital NHS Trust)
- An overview of work underway across the area to review and improve urgent care, including the role of the Urgent Care Network (Dr Bill Gowans, local GP and Chair of the Urgent Care Network)
- Four perspectives on "What does good look like?" and "How are we doing?":
    - Patient Perspective – from Shropshire Patient Group members Suzanne Lawler and Charles Morris, and from Telford & Wrekin Health Roundtable facilitator Sharon Smith with additional Powys input from Cllr Aled Jones (Montgomeryshire Community Health Council) and Adrian Osborne
    - Clinical Perspective – from Consultant in Emergency Medicine Dr Adrian Marsh
    - Organisational Perspective – locally from The Shrewsbury and Telford Hospital NHS Trust's Unscheduled Care Champion Dr Kevin Eardley, and nationally from Dianne Fuller, National Intensive Support Team, Department of Health
- Group work sessions where participants reflected on what they had heard and discussed any gaps in the picture of "What does good look like?" and "How are we doing?"
- Group work sessions where participants discussed what practical steps might need to be taken locally to ensure "Better Health and Care" in local emergency departments
- Closing plenary feedback and next steps

?	The presentation slides from the event are available from the website of The Shrewsbury and Telford Hospital NHS Trust at **www.sath.nhs.uk/betterhealth**

5. Group Work and Feedback

Participants worked in six mixed table-top groups, each group focusing on the four steps in turn.

For Steps 1 and 2, participants were asked:

What's missing? What else do we need to do to develop our picture of:

- **"what does good look like"?**
- **"how are we doing?"?**

What practical steps do we need to take to build a fuller picture?

For Steps 3 and 4, participants were asked:

Based on what you have heard, what does this mean for us in Shropshire, Telford & Wrekin and mid Wales?

What steps might we need to take?

A facilitator on each table captured the main comments on themes and these are transcribed on the following pages.

The notes on the following pages intend to capture the issues raised at the event. They may represent the view of one individual and do not necessarily reflect a consensus or majority view.

?	An overview of the group work instructions is included in the presentation slides from the event. The slides and the feedback templates for the group work are available from **www.sath.nhs.uk/betterhealth**

1	What does good look like?
	• Ensure stay is as short as possible, but as long as necessary. • Communication to public- where is most appropriate to go; Knowing what's happening →what stage in process; Avoid jargon • Made aware of what's happening e.g. wait for diagnosis → know not forgotten. • Told if possible to return next day • Key holder/continuity in care and communication →who to ask? /named nurse • Clear information as you enter the ED; Better patient information Screen • Look at ways to inform/communicate with the services users who cannot access usual methods/barriers to understanding. • Look at workforce possibilities – not just Medical and Nursing – Therapies and others also. • National IT System. • Geographical →Distance →Disability → Access (Transport) • Respect and Dignity • Treat as intelligent human being • Expert knowledge of condition • Flagging ED to know what's wrong – 1st Appearance clean /professional. • Realistic → what can be there? • No waits – Reception through to Senior Review – be seen by appropriate Specialist Doctor. • Seen in appropriate place (alternative to ED) • Minimise duplication of info. Know who does what.. • Sufficient call faculties – Avoid admissions. • Missed – times given for time critical patients e.g. cardiac/stroke patients/HI's • Major Trauma are these patients being prioritised? Paediatric figures also. • Integration community services and PC • No's of patients turned away because they are in the wrong place. • Data/information please →informed decision /local picture. • Data about the current state; How we are doing boards in A/E – simple feedback mechanisms, real time;Patient satisfaction • Do we understand minor services in PCT? & why patients are not accessing. • What works well elsewhere? Is there learning from good practice elsewhere. • Review of "at site" treatment. Look at Ambulance, Air Ambulance (Links with ---workforce development to assist this)

2	How are we doing?
	• Difficulty of knowing how to start the puzzle of implementing changes. How do we help the Trust to start /complete this? • Group of clinicians meeting together to discuss the issues. • We need to challenge the constraints – do we accept the constraints rather than challenge. • Need to understand the whole pathway rather than focus on ED. • Need better understanding of data. So service users understand the targets; Performance indicators – want to know more. • Aspiration v ability to achieve • Want to hear "GOOD" positive news • Understand what are ED's doing well. • Customer relations ➔what information • Has been collected + the actions taken. • Education for G.P and wider community (want to hear more from all users). • Impact of current performance for the future. • Inappropriate admissions. This needs to be captured. • ED – Know how we are Doing Boards. • Flow – Have we got internal ED issues in order? • Is it just problems (where are the problems) outside E.D • Live knowledge of demand. • What defines unsafe levels of staffing • Patients take it for granted that "cutting edge / state of the art treatment/diagnosis" is being provided is this really available. • Pathways are of A/E need to be developed and functional because this is crucial to flow in E.D.

3	What does this mean?
	• We have 2 models of delivery across SATH. Why is this? Inconsistently between services is this acceptable? • Can we sustain two A/E departments? E.g. Barnett Model, what problems would this solve and what problems would it create. • Insufficient staffing,(permanent, Qualified); Senior decision making presence; • ↑ no of qualified and experienced nurses. • Looking at possibilities of workforce flexibility/how to retrain of attract medical staff or other staff; Shropshire Hospitals not implementing alternative skill mix – although happening elsewhere for years • See ED as part of jigsaw. • Access to G.P/ Primary Care Intervention; Standardised alternative service e.g. MIU • Effective and efficient Shropdoc/ alternatives to admission/sign posting. • Directory of services across LHE; Patients find it challenging to navigate the system and choose well • Lack of minor decision makers. • Waiting • Communication • Information • Staff training – dignity, respect, customer relations. • Efficiencies – what can we actually do? • Prioritise flow throughout system. • IT system →Redesign roles – incentive. • Raise standards in whole hospital. • Transfer of info from ED across LHE boundaries • Sustained performance/use of predictors →Do resources meet predicted demand. • How long it takes to access ED services for people in outlying communities.

4	What action do we need to take?
	• How do we help the population to understand their responsibility in using ED appropriately? • Unlocking the puzzle, understand the data, clinician's forum to understand this. • Co-locate services, GP/ED/AMU • Closer working relationships with Authorities • Customer Care Training/ provide timely information. ↑ GP access • Explore alternative models of service delivery; Increased range of community services; treat by ambulance; e.g. advanced level paramedics, treat patient in own home without transfer. • Use primary care staff + other workforce • Educate patients when "not" to use ED; Educate patients when they've used ED inappropriately; Community →Education + self management. • Improve information on discharges • Programme and talking to patients and families have to choose – alternatives increase understanding. • Joined up IT system ; I.T system "Fit for purpose" • Early supported discharge to home physical environment. • Future proofing • Nurses – trained across disciplines • Recruitment of senior staff – incentives to work here? • Co-producing with the clinicians. Public and patients the way forward. • Efficient use of resources. • Major patients → Access to diagnostics → Access to specialists. • Involve all users not just the conference attenders and different solutions for different conditions. • 111 Service will help. • ? Could CCC improve signposting? • WMAS /Welsh Ambulance Service →alternatives to ED, take to MIURAID will help • F & C • Nursing homes for opinions = attendance to ED /alternatives. • Transport issues. • Need for different skill mix – ENP/Consultant nurse /ANP's including peads. • Better guidelines to care homes about access to A/E – risk avoid, need escalation plan. • Telehealth + linking MIU • More staff at the front door – simple advice, straight away + more triage. • Community urgent care centres. • Learning from best practice

6. Summing Up and Next Steps

The event closed with summing up and next steps.

Each table-top group was asked to share one key message from their discussion. These messages were:

- Access to GPs is critical to people's use of Emergency Departments. We need to focus on giving people a reason *not* to use EDs (for example, because the alternatives are accessible and understood). Patients and communities need good information about the choices and alternatives available to them, and reassurance about how and when to use them.

- We should not reinvent the wheel. There are lots of great examples out there. One example is about working closely with nursing homes to reduce the need for hospital attendance. What else is happening elsewhere that we can learn from

- Information technology is critical – making patient information available at the point of care so that all care providers have access to information that helps them make the best decisions

- More information, data and modelling is needed – information is available to help predict demand but how effectively is it being used across the urgent care system? How well does capacity match demand?

- We need to focus on some quick wins – there are some challenges to the way current services are provided, but at a more grass-roots level there are some simple improvements that could be made to customer service and communication. We could also develop

- It is a complicated puzzle/jigsaw. There are some factors that are *intrinsic* to how an ED operates and there are other factors that are *extrinsic*. We need to be able to differentiate between these factors in order to make the best decisions going forward in relation to our model of ED services. For example:

    - If someone is waiting longer in A&E this may be because they are awaiting a bed in another parts of the hospital, which in turn is not yet available as another patient is waiting to leave hospital. A concerted focus on early supported discharge might improve flow and thereby improve quality of care in A&E.

    - We need to understand the likely future impact of the introduction of NHS 111 on demand and capacity locally.

    - There are differences in the way that the two hospitals currently operate, so there are opportunities either to move to a consistent approach or to recognise that there won't necessarily be "one size fits all" solutions.

- There are some big questions facing our communities. Can we sustain 2 A&E departments safely in our hospitals vs. widespread public expectation that 2 A&E departments will be sustained? A really important issue for patients and communities is their real or perceived travel time to their nearest A&E department.

- The review process needs to hear more voices than those here today

In terms of next steps, the audience was invited to answer the question “If we met again in this room in two months time, what should have happened?”

The main messages were:

- We will have delivered some “quick wins” for example, in relation to communication and customer service in the A&E departments
- We will have a better picture of the implementation of NHS111 and what this will mean for A&E demand
- As part of the wider work on Urgent Care, we will have a better picture of how we signpost people to the right service
- There will have been broader engagement in this debate. More people will have had the opportunity to participate.
- We don’t want to come back and find that the two A&E departments are merging vs. we need to be mindful that the issues we have discussed today raise questions about whether two A&E departments can be sustained safely
- We will be closer to a definitive list of “problems” and starting to identify solutions – both long term and short term
- We will have shared more of the data and information that will be needed to help us build a picture of the future

7. Evaluation Forms

Participants were invited to complete an evaluation form about the event. The responses are transcribed below.

A	**What did you find useful?**
	• Opportunity to gather and discuss experience and ideas. • That the discussions were wide ranging and varied • The insight given • Presentation by Diane Fuller very interesting • All of it. • Collective working • Good overview • Gaining information about many aspects that I was unaware of. • Group discussions really useful. Overview of situation useful. Diane's presentation very informative. • All the information from this presentation and from networking with colleagues. • Diane Fuller presentation. • Useful to get varied perspective of issues. • General discussions • Listening to what patients have to say in Shropshire County. • Opportunity to consider issues with a range of different people never met before. Presentations. • Group Work. • Interaction between participants. • The failings and what can and should be done. • The information. The exchange of ideas. Putting patient perspective forward. • Meeting other NHS professionals and service users. General discussions. • Hearing the concerns and solutions of others. • Discussions, information with different points of views from speakers. • Good discussion
B	**What did you least useful?**
	• Shortness of time • Inevitable "talk the talk" • Did have difficulty in group work hearing what was being said on my table with surrounding noise level. • Time constraints • Data /Statistics • All useful • The coffee wasn't very strong. • Sound system. • Over load of presentation material. • Some talks to be kept to a minimum or within time constraints.

C	**What would you like to have been included?**
	• More specialist groups. • Implications elsewhere in hospital • A presentation by local authority social care • Mental Health team input • Next date to meet • More time in group discussions but we would have talked all day probably. • All very good • Why G.P seem to have no input. • Wider range of patient engagement • Difficult to say as it's the first meeting. • Cost. • Copy of slides (Can these be circulated). • Information re:- age of population therefore effect on ED services and flow. • More time on solutions. A clear evaluation of the problem. • Examples of other challenges LHE and ED and how they turned situation around.
D	**What is the one thing you will take away from today?**
	• More awareness of difficulties • But please do make sure this translates into action/real co-production of solutions. • Hope that changes will be made in ED and are useful to the department. • Answers not easy. • Need for change but hopefully no reduction in access to E.D in both hospitals. • Excellent knowledge of what patients want a good E.D to look like • We are all working together to improve the ED in both hospitals. It is not just an ED problem but Trust wide. • Need work on the Primary Care Trust • As long as we move forward. Need action now. Short and long term project goals. Especially short term ED improvement in patient contact. • Reassurance that in spite of financial constraints attempts are being made to improve the current situation. • Action needs to happen we all have to participate. • A better understanding of the problems. • Capacity of decision making • Understanding of the desire to change. • General good co-operation and atmosphere. • Trust has started to listen. • A better understanding of issues. • A lot of work needs to be done. • That we are being listened to. • Loads of useful information to pass on to other groups. • The hope that the concerns and comments from all the groups are taken on board to guide the changes or adaptations of work practice. • Planning for future. • That the time for change should be now, hopefully not to wait until the situation is critical e.g. Mid Staffs E.D • Information with thoughts from a patient point of view.

8. Get Involved

Better Health and Care Reviews are an opportunity for everyone to be involved and co-produce the future.

You can do this in a variety of ways. Here are some examples:

- Share this report with your family, friends, local networks and find out what they think. What's missing? Are there any surprises?
- Use the four step process to discuss emergency department care with your patients, networks and colleagues (What does good emergency department care look like from your perspective? How are we doing? What does this mean? What action do we need to take?). You can use the presentation slides and feedback templates on your website if you want!
- Read the more detailed reports and briefings available on our website at **www.sath.nhs.uk/betterhealth**
- Let us know of other publications and reports that we can share via the website.
- In future we may need to decide together about the right shape for health and care services. If so, we will need to decide how those decisions should be made. Read Appendix 1 to find out more, and let us know your views.

You can contact us via our website, email, by post or via Twitter:

- Find out more from our website at **www.sath.nhs.uk/betterhealth**
- Email us at **consultation@sath.nhs.uk** with the subject **"betterhealth"**
- Write to us c/o **Better Health and Care: Emergency Care, Communications Director, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**
- Follow us on Twitter **@sathNHS** and join in the debate using the hashtag **#betterhealth**

Appendix 1: Making Good Decisions Well

It is important to keep an eye on the future. A wide range of ideas, options and recommendations are likely to emerge. We need to have an idea of how those recommendations will be assessed and the best way forward agreed.

So, an important part of a “Better Health and Care” review is to develop the criteria that will use to make decisions.

Based on what we have heard so far, and experience of other reviews, we have identified seven questions that might be used to assess different options and recommendations. These are summarised below. We have tried to set these out using a simple question in terms that most of us might understand and recognise, along with more detailed information outlining issues and factors relevant to this question.

<table>
<tr><th>The Question</th><th colspan="2">Some issues to take into account</th></tr>
<tr><td rowspan="3">Is it good for patients, families and carers?</td><td rowspan="3">Quality and Outcomes for Patients: Services meet best practice and demonstrably improve:</td><td>(i) clinical outcomes and quality of life outcomes</td></tr>
<tr><td>(ii) patient experience</td></tr>
<tr><td>(iii) patient safety</td></tr>
<tr><td>Is it good for the public purse?</td><td colspan="2">Cost Effectiveness and Financial Sustainability: Services are cost effective and financially sustainable</td></tr>
<tr><td>Is it fair?</td><td colspan="2">Equity: Service provision is geographically and socio-economically equitable, reaching the whole area population, mindful of the need for access to timely services.</td></tr>
<tr><td>Is it joined up?</td><td colspan="2">Integrated Care Pathways: Services support the whole pathway, end-to-end, (e.g. from prevention to long term care or end-of-life care)</td></tr>
<tr><td>How does it impact on other services?</td><td colspan="2">Impact on other Services: The impact on the delivery of other services has been assessed and understood. This includes assessment of the impact of patient/population flows into, and out of, the area.</td></tr>
<tr><td>Is it clinically sustainable?</td><td colspan="2">Clinical Sustainability: Service provision is clinically sustainable, with a staffing model that is fit for the future – including training, teaching, workforce and human resources requirements.</td></tr>
<tr><td>Can we do it?</td><td colspan="2">Feasibility: The process of change must be feasible and deliverable</td></tr>
</table>

- Are these the right questions and issues?
- Is there anything missing? Is there anything that should *not* be included?
- Which questions and issues are most important? Which are least important?

Use the contact details in Section 8 of this report to let us know your views.

Appendix 2: Attendance List

The following people attended the Engagement Event on 17 October 2012:

Name	Organisation
Dr Adrian Marsh	Emergency and Critical Care Centre, The Shrewsbury and Telford Hospital NHS Trust
Adrian Osborne	Communications Director, The Shrewsbury and Telford Hospital NHS Trust
Dr Alison Moore	Women and Children's Centre, The Shrewsbury and Telford Hospital NHS Trust
Dr Bill Gowans	Chair of Shropshire and Telford & Wrekin Urgent Care Network Vice Chair of NHS Shropshire County Clinical Commissioning Group and local GP
Brian Bennett	Shropshire patient/public representative
Carol Aldridge	Emergency and Critical Care Centre, The Shrewsbury and Telford Hospital NHS Trust
Carol McInnes	NHS Shropshire County
Dr Caron Morton	Accountable Officer, NHS Shropshire County Clinical Commissioning Group
Cecelia Walden	Shropshire patient/public representative
Charles Morris	Shropshire patient/public representative
Cllr Aled Jones	Montgomeryshire CHC
Cllr Gerald Dakin	Chairman, Shropshire Council Health Overview and Scrutiny Committee
Dave Ladd	Continuous Improvement Team, The Shrewsbury and Telford Hospital NHS Trust
David Beechey	Vice Chair, Shropshire LINk
David Watkins	Welsh Ambulance Service NHS Trust
Deb Hopkins	Telford & Wrekin public/patient representative
Debbie Jones	Diagnostics Centre, The Shrewsbury and Telford Hospital NHS Trust
Derek Hall	Telford & Wrekin public/patient representative
Dianne Fuller	Department of Health Intensive Support Team
Eira Davies	Telford & Wrekin public/patient representative
Fiona Bottrill	Scrutiny Officer, Telford & Wrekin Council Health Overview and Scrutiny Committee
Fiona Howe	Scrutiny Officer, Shropshire Council Health Overview and Scrutiny Committee
George Rook	Chairman, Shropshire LINk
Dr Gill Clements	ShropDoc
Gilly Scott	Shropshire Community Health NHS Trust
Graham Shepherd	Shropshire patient/public representative
Ian Hulme	Shropshire patient/public representative
James Moraghen	Shropshire patient/public representative
Jill Dale	Therapies Centre, The Shrewsbury and Telford Hospital NHS Trust
Dr John Morgan	Montgomeryshire CHC
Judith Caroll	Telford & Wrekin public/patient representative
Karen Taylor	Shropshire Community Health NHS Trust
Keith Downes	Shropshire patient/public representative
Kerry Malpass	Emergency and Critical Care Centre, The Shrewsbury and Telford Hospital NHS Trust
Dr Kevin Eardley	Unscheduled Care Champion, The Shrewsbury and Telford Hospital NHS Trust
Louise Speed	Telford & Wrekin public/patient representative
Margaret Evitts	Montgomeryshire CHC
Mel Jackson	Shropshire patient/public representative
Dr Mike Innes	Co-Chair of Shropshire and Telford & Wrekin Urgent Care Network A&E Steering Group Chair of NHS Telford & Wrekin Clinical Commissioning Group and local GP
Pamela Small	Telford & Wrekin public/patient representative
Paul Golbourne	Shropshire patient/public representative
Paul Jacobson	Musculoskeletal Centre, The Shrewsbury and Telford Hospital NHS Trust
Pauline Downes	Shropshire patient/public representative
Peter Herring	Chief Executive, The Shrewsbury and Telford Hospital NHS Trust
Rachel Redgrave	Emergency and Critical Care Centre, The Shrewsbury and Telford Hospital NHS Trust
Dr Rob Law	Emergency and Critical Care Centre, The Shrewsbury and Telford Hospital NHS Trust
Roland Brown	Shropshire patient/public representative
Rosemary Milns	Shropshire patient/public representative
Roy Norris	Montgomeryshire CHC
Dr S Kumaran	Co-Chair of Shropshire and Telford & Wrekin Urgent Care Network A&E Steering Group Emergency and Critical Care Centre, The Shrewsbury and Telford Hospital NHS Trust
Sharon Smith	NHS Telford & Wrekin
Sian Huszak	NHS Telford & Wrekin
Suzanne Lawler	Shropshire patient/public representative
Terry Davies	Telford & Wrekin public/patient representative
Tracey Jones	NHS Telford & Wrekin

Appendix 3: Supporting Documents

The following documents are available from our website at **www.sath.nhs.uk/betterhealth**

- Presentation slides from the event, including:
    - Introductory slides (Adrian Osborne)
    - Overview of the wider context of urgent care (Dr Bill Gowans)
    - Shropshire patient perspective (Suzanne Lawler and Charles Morris)
    - Telford & Wrekin patient perspective (Sharon Smith)
    - Organisational perspective (Dr Kevin Eardley)
    - National perspective (Diane Fuller)
    - Event facilitation slides (Adrian Osborne)

- Useful documents and references:
    - “Driving Improvements in A&E Services” (Foundation Trust Network, October 2012)
    - Effective approaches in Urgent and Emergency Care: Paper 1 - priorities within acute hospitals
    - Effective approaches in Urgent and Emergency Care: Paper 2 - rapid assessment and treatment models in emergency departments
    - Clinical Quality Indicators for A&E Departments in Shrewsbury and Telford

Appendix 4: Summary Terms of Reference of A&E Steering Group

This appendix summarises the terms of reference of the A&E Steering Group

1.1 Purpose

The group has been established as part of the wider Pan Shropshire Unscheduled Care Strategy to achieve sustainable change within the overall unscheduled care system that will contribute to the achievement of the overall aims of this strategy as detailed below

To provide, by 2014, comprehensive unscheduled, urgent and emergency care services, delivered by integrated teams of people who share a collective responsibility for every patient journey.

And expressed through the following patient statements

- Be ‘joined up’ and responsible for my care
- Help me understand the Urgent Care service
- Let me access it appropriately
- Assess and treat me promptly and in the right place
- Admit me to hospital only when necessary
- Make my stay in hospital short, safe and effective
- Try to care for me at home, even when I am ill

1.2 Specific Purpose of ED Project Group

The specific role of the ED project group, within the wider strategy, is to design, develop and implement contemporary ED services within Shropshire and Telford & Wrekin.

- To work in partnership with key stakeholders to develop a sustainable model for the delivery of A&E services within the county.
- Where appropriate, to redesign and integrate the primary and secondary care emergency services both in and out of hours.
- To forge alliances between primary and secondary care emergency medical services and explore opportunities to remove structural and financial barriers associated with service delivery.
- Maximise use of skill-mix to provide most appropriate care at the point of access
- To demonstrate high levels of patient satisfaction

1.3 Responsibilities of members

Chair:

- The meeting will be chaired by the Project Sponsor as designated by the Programme Board and Urgent Care Network board.

- The Chair is ultimately responsible for the project, supported by the Project Manager and project team.

- The Sponsor's role is to ensure the project is focused and delivers the projected outcomes.

- To provide regular updates in verbal and written format as required to the Urgent Care Network Board with regard to the progress of the project group

- To escalate issues adversely affecting the agreed project outcomes to Urgent Care Network Board if they remain unresolved at project group level.

Project Manager:

- The Project Manager will be designated by the Programme Board and this nomination supported by their line manager or equivalent who acknowledges and recognises this work as a priority within their portfolio.

- The Project Manager has the authority to run the project on a day to day basis on behalf of the project sponsor and team within the framework agreed by them.

- The Project Manager will be responsible for the co-ordination and distribution of agendas and papers relating to the project group

- Project Managers will provide regular written updates on project progress to the programme management office using a format as designed by the Programme Management Office

Group Members:

- To act as champions within their own organisations and at wider forums for the principles of the group.

- To accept and promote within their own organisations and at wider forums the goals as expressed by patients in 1.1 of these terms of reference.

- Members will be expected to participate in and actively engage other members of their organisation with regard to the achievement of project objectives through a wide range of activities including but not exhaustive data collection, service review activities, education events both as attendees and providers , patient focus groups

- To be responsible for the delivery of specific tasks allocated to them either collectively or individually (following agreement of the remit of the task) within the agreed timescales.

- To attend formal ED project group meetings send apologies and a designated deputy with authority when this is not possible.

- To contribute to email discussions and telephone meetings when appropriate.

- It is expected that at all times communication between group members is of the highest standards of courtesy recognising that as stakeholders with differing remits there may be potential for areas of conflict.

- If group members fail to meet any of the above responsibilities the Chair reserves the right to request alternative membership from CEO of member organisation.

Last updated October 2012

Creating Better Health and Care Services
Shaping Emergency Department Care for Shropshire, Telford & Wrekin and mid Wales

Report of an Engagement Event on 17 October 2012

The Shrewsbury and Telford Hospital NHS Trust

Princess Royal Hospital
Grainger Drive
Apley Castle
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The Shrewsbury and Telford Hospital NHS
NHS Trust

Creating Better Health and Care Services

ED Workshop
17 October 2012

The Shrewsbury and Telford Hospital NHS
NHS Trust

Setting the Context: The Urgent Care Network

Dr Bill Gowans,
Local GP and Chair of Shropshire and Telford & Wrekin Urgent Care Network

NHS
Shropshire
Clinical Commissioning Group

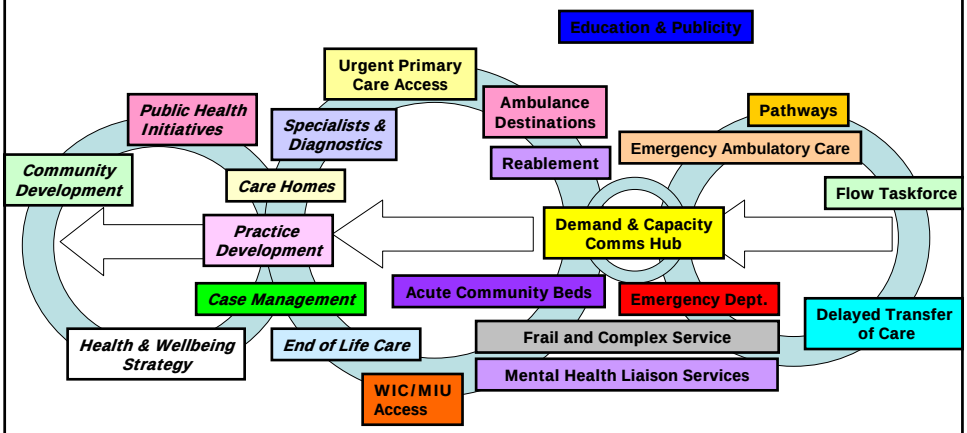
Patient Statements:

‘Be ‘joined up’ and collectively responsible for my care’
‘Help me understand the Urgent Care service’
‘Let me access it appropriately’
‘Assess and treat me promptly and in the right place’
‘Admit me to hospital only when necessary’
‘Make my stay in hospital short, safe and effective’
‘Try to care for me at home, even when I’m ill’

No.	Project Descriptions	Strategic Themes
2	Demand and Capacity Management (Winter 9)	Demand & Capacity Communications Hub
3	111 – Local Implementation	
4	DOS including NHS Pathways	
1	Education & Publicity	Access
5	Walk in Centres/MIUs Reconfiguration	
6	GP Surgery Urgent Care Audit-> Primary Care Access	
13	Paramedics&MIU’s co-location->Ambulance destinations	
16	A&E	
8	Mental Health Liaison	Mental Health Liaison (RAID)
14	Emergency Ambulatory Care	Flow
9	Pathways for Urgent Care Diagnostics	
15	Case Management & Discharge Planning	
17	Delayed Transfer of Care (DTOC)	
18	Reablement -> Under Health & Wellbeing Board	*Reablement Joint Commissioning*
7	Acute Frail & Vulnerable Pathways	Frail and Complex Service
10	Virtual and Community Hospitals	
19	Active Case Management	Case Management
11	End of Life Care	
12	Clinical Support to Care Homes	
20	Paediatirc Urgent Care	Paediatrics

System Plan and Challenge

NHS Shropshire Clinical Commissioning Group



NHS Shropshire Clinical Commissioning Group

URGENT CARE NETWORK

'To be responsible for the development and implementation of the Pan Shropshire Unscheduled Care Strategy .'

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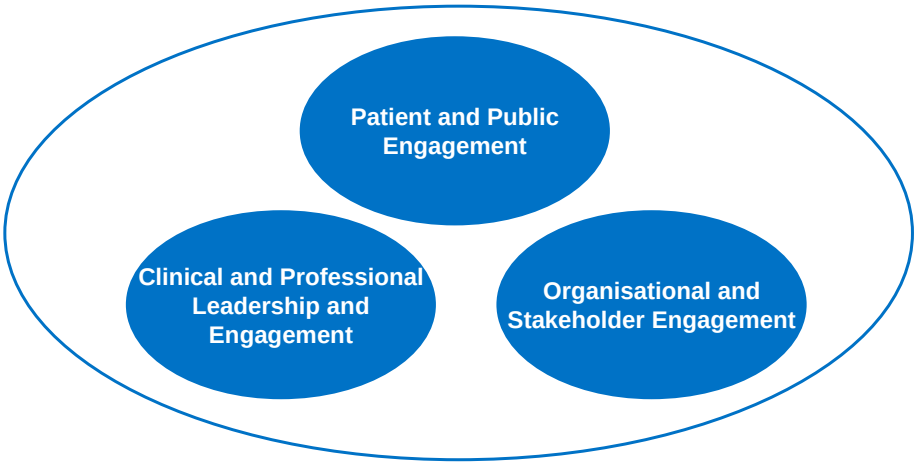
Reviewing Emergency Care
The Four Step Process

Adrian Osborne
Communications Director, The Shrewsbury and Telford Hospital NHS Trust

Engagement is Everyone's Responsibility



The Four Steps

Step One **What does "good" look like?**	Identifying the outcomes and standards that services should be delivering – drawing on a wide range of sources such as national service strategies, NICE recommendations, patient feedback.
Step Two **How are we doing?**	Assessing how we are doing against these outcome and standards. Sharing our assessment widely and testing it against people's real experience.
Step Three **What does this mean?**	Identifying gaps that need to be addressed, and discussing and developing a range of options for doing this.
Step Four **What action do we need to take?**	Agreeing recommendations for ensuring safe and sustainable services, including formal consultation as appropriate.

The Four Steps

Step One
What does "good" look like?

Step Two
How are we doing?

Step Three
What does this mean?

Step Four
What action do we need to take?

Patients, the public, staff and wider stakeholders are involved in each of the four steps.

In addition to this, we work with stakeholders to agree the criteria that we will use to make decisions about the action we need to take.

Making Good Decisions Well

For each review it is important to develop the criteria that will be used to make decisions. This will help to ensure that good decisions are made well, in an open and transparent way. As part of each review we work with stakeholders to develop specific criteria that will be used to judge the options developed during Step 3 and Step 4.

Our outline criteria are:

(a) **Quality and Outcomes for Patients:** Services meet best practice and demonstrably improve:
(i) clinical outcomes and quality of life outcomes
(ii) patient experience
(iii) patient safety

(b) **Cost Effectiveness and Financial Sustainability:** Services are cost effective and financially sustainable

(c) **Equity:** Service provision is geographically and socio-economically equitable, reaching the whole area population

(d) **Integrated Care Pathways:** Services support the whole pathway, end-to-end, (e.g. from prevention to long term care or end-of-life care)

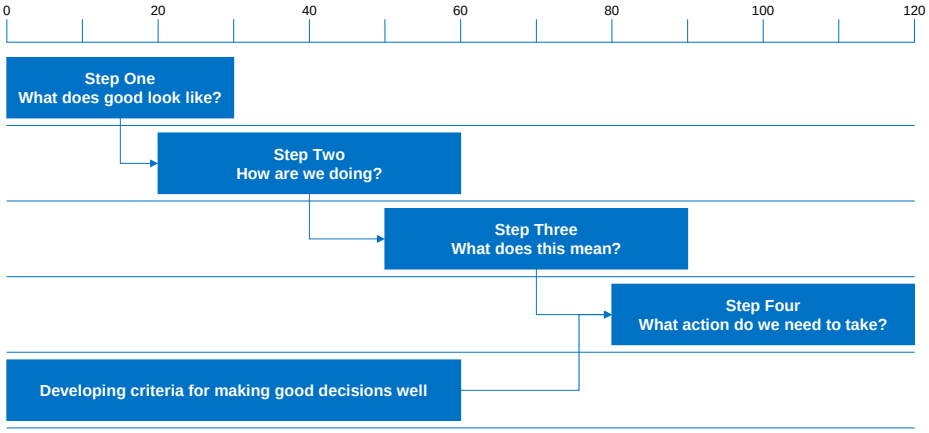
(e) **Impact on other Services:** The impact on the delivery of other services has been assessed and understood. This includes assessment of the impact of patient/population flows into, and out of, the area.

(f) **Clinical Sustainability:** Service provision is clinically sustainable

(g) **Feasibility:** The process of change must be feasible and deliverable.

Making Good Decisions Well

Reviews take place with pace and engagement. The timeframe will depend on the nature and complexity of the issue, but typically it should take no more than three or four months from the launch of the review to the conclusion of Step Four (except where proposals may need formal consultation), e.g.



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Reviewing Emergency Care
Patient Perspective 1

Shropshire

SHROPSHIRE PATIENTS' GROUP

The Patient Perspective

Suzanne Lawler
Bridgnorth Patients' Group
Charles Morris
Broseley Patients' Group

What does Good look like? A&E Shropshire

- High Standards of care
- Priority triage
- Status update
- Adherence to written guidelines
- Minimum repetition of personal details
- Genuine emergency referrals
- Sharing of good practice

What does good look like? A&E Shropshire

- ✓Waiting
- ✓Information
- ✓Building patient relationships
- ✓Clean & comfortable environments
- ✓A more child-friendly environment
- ✓High quality, co-ordinated care
- ✓(A safe, reassuring environment)

Improving the patient experience in Accident and Emergency Departments

Document type:	Publication
Author:	The Department of Health
Published date:	21 August 2003
Primary audience:	Professionals
Gateway reference:	2003
Pages:	10
Copyright holder:	Crown Copyright

This document provides key aims, work in progress and useful links about improving the patient experience in accident and emergency departments.

•So why are we here today?

•What has been going on for the last 9 years?

•Will today make any difference to the next 9 years?

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Reviewing Emergency Care
Patient Perspective 1

Telford & Wrekin

Telford & Wrekin Patient Perspective

EMERGENCY DEPARTMENT

- Information
- Confidentiality
- Person Centred
- Shorter waiting times
- Access to Social Care
- Professionalism
- Respect
- Good signposting
- Having a say
- Good follow up
- Quality
- Better comm's in dept.
- Calm, clean & safe
- Non-judgemental
- Access
- Parking
- Inclusion of caring group
- LISTEN
- Staff downtime, not in public arena
- Support

Right care from the right people

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Reviewing Emergency Care
Patient Perspective 1

Montgomeryshire

What does a good emergency department look like for Powys patients?

Montgomeryshire
Community Health Council

In addition to the comments already made by Shropshire and Telford & Wrekin patients:

1. Updating patients at intervals during a long waiting period so that they are informed and do not become anxious and think they have been overlooked. People need reassurance and need to feel that they haven't been forgotten.
2. Very clear staff labels
3. Improved ICT systems to allow information to be passed efficiently to A&E to ensure details do not have to be given more than once.
4. Swift 24 hour access to all other departments that support A&E to meet the immediate emergency situation

NB Oral input was provided at the conference on 17 October 2012; with a written update requested from Montgomeryshire CHC following the conference. Comments from the CHC have been included on this slide.

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Reviewing Emergency Care
Clinical Perspective

Dr Adrian Marsh
Emergency Department Consultant, The Shrewsbury and Telford Hospital NHS Trust

The Shrewsbury and Telford Hospital NHS
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What does the ideal Emergency service look like?

Dr Adrian Marsh
Consultant Emergency Medicine
Shrewsbury and Telford NHS Trust

Putting Patients First | Honesty And Integrity | Being a Clinically-Led Organisation | Working and Collaborating Together | Encouraging Individual Ability and Creativity | Taking Pride in our Work and our Organisation

Contents

- What we deliver now
- What does ideal look like?
- Challenges now
- Challenges in the future

Putting Patients First | Honesty And Integrity | Being a Clinically-Led Organisation | Working and Collaborating Together | Encouraging Individual Ability and Creativity | Taking Pride in our Work and our Organisation

What we deliver

- 1 Emergency Service
- Based over 2 departments
- Guaranteed 24/7 care for patients with illness and injury of all severities and in all age groups
- Time-critical interventions for example:
  - Leading trauma teams for the severely injured patient
  - Identification of heart attacks requiring immediate intervention

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What we deliver

- Rapid clinical assessment
- Resuscitation and stabilisation as required
- Focused investigations including imaging
- Avoidance of unnecessary expensive hospital admissions and unsafe discharges

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Guarantee

We provide a safe and robust service to all patients 24 hours a day, 365 days a year within the constraints set upon us

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What does ideal look like?

- We were asked to define what “good” looks like
- As a health care professional “good” is inadequate
- What follows is what ideal looks like…

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Staffing

- ED Consultant present in the department 24 hours a day 7 days a week
- Adequate numbers of ED medical staffing as per the College of Emergency Medicine guidance
- No need for locum doctors

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Staffing

- Adequate numbers of Nursing Staff
- Adequate numbers of HCAs
- Adequate numbers of Reception/Ward Clark Staff
- Adequate numbers of other support staff

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The Rest

- Physical space and layout fit for purpose
- Adequate bed capacity
- No need for triage
- Medical Assessment Unit co-located with the ED

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- All services on site
- If not available
  - Adequate transport services available (timely and with the correct skill set)

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- Point of care testing
- Access to imaging on the same day to allow discharge
- Access to imaging next day for clinics
- Equipment to exceed West Midlands QR requirements
- IT fit for purpose

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- Accessible clinical pathways
- Easy access to out-patient clinics
- Joined up working across the whole of the health care community
- Align to other services e.g. Frailty team and RAID

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- Robust escalation plan
- Robust multidisciplinary governance systems
- Audit

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- Excellent Patient Safety
- Patient Choice

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- Cost effective
- Financially viable

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What are the challenges now?

- Insufficient levels of staffing at all grades
- 2 departments (physical space) that we have grown out of
- An IT system that requires up-graded
- The patient flow out of the Emergency Department

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What are the challanges in the future?

- We will be dealing with an older population with increasing multiple medical problems
- Increasing number attendances
- Increasing cost of present medical therapy with a reducing budget
- Increase in new procedures and treatments with increasing demand on staff, time and budget

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- Increasing supervision of junior medical staff (GMC)
- Inadequate national recruitment to Emergency Medicine training

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Thank You

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Reviewing Emergency Care
Organisational Perspective 1 - Local Perspective

Dr Kevin Eardley
Consultant Physician in Renal Medicine and Clinical Champion for Unscheduled Care, The Shrewsbury and Telford Hospital NHS Trust

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What does good look like? An organisational perspective

17 October 2012

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What does good look like? Key factors

Key factors

A service that is safe of itself and safe in the context of the wider hospital service

Patient outcomes, clinical quality, safety

Clinical sustainability issues

Clinical linkages/interdependencies

Safe and sustainable staffing

A service that meets the standards and expectations from commissioners and regulators and is affordable

Commissioning and contracting expectations

Performance and Compliance

Productivity, efficiency, cost effectiveness

Financial sustainability, I&E, capital

A service that meets the needs and expectations of our patients and communities

Whole system approach for urgent care (Self care, 1ry care, NHS111, WIC/MIU/UCC, A&E, Trauma Network, Tertiary, Ambulance)

Right care, right place, right person, right time

A service that changes, adapts and improves

Current demand

Future demand

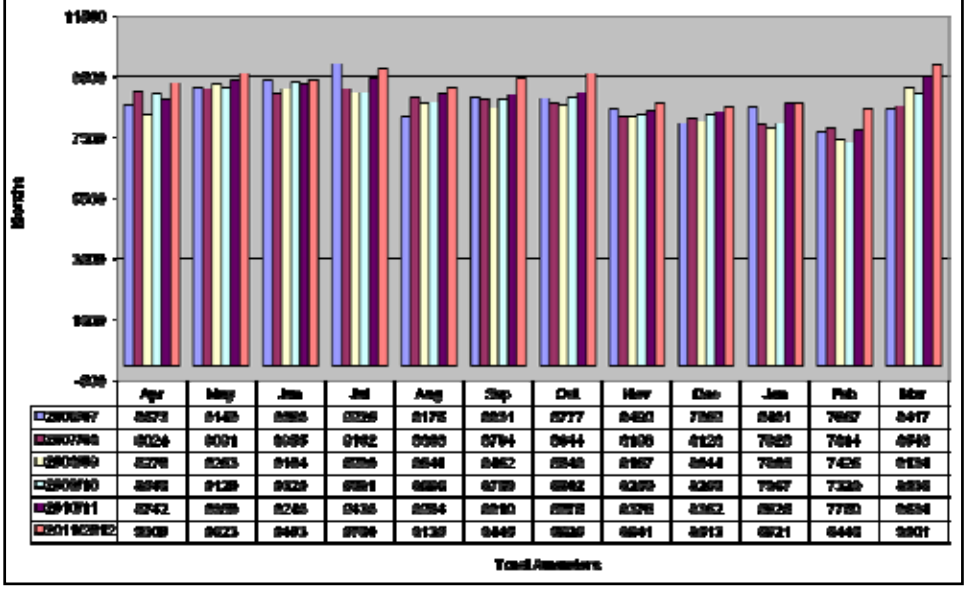
Demographics, market trends

Changing environment, technology etc.

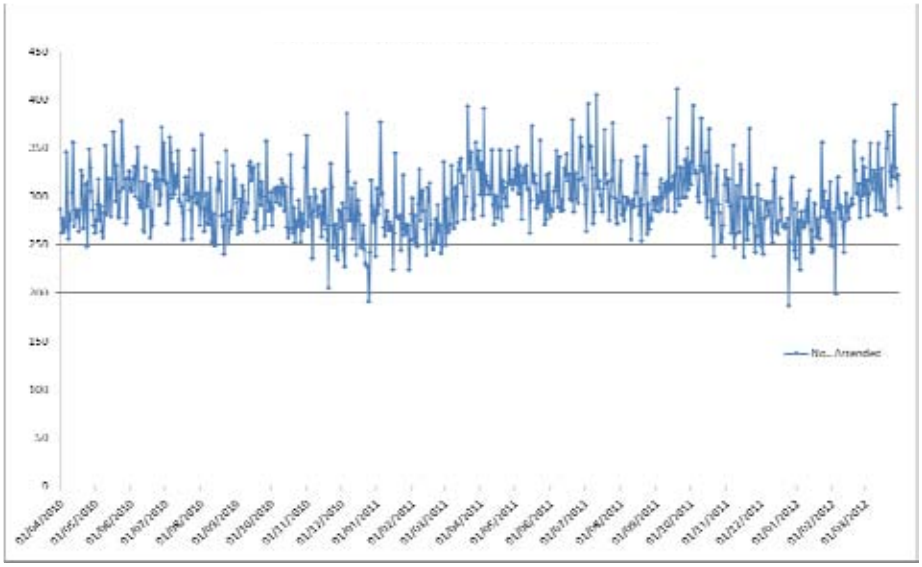
What does good look like? Key factors

National recruitment challenges / challenges in sustainable and safe staffing for two A&E departments Ensuring safe services, improving patient flow, BED Bundle and reducing long stays in acute hospital	Inconsistent delivery against 95% target Sustaining A&E service within tariff income
Trauma Unit status Role of A&E in new urgent care system / navigation / patient access Day vs. night / weekday vs. weekend Local vs. specialist Impact of NHS111 and wider urgent care reforms	Growing elderly population, dementia, chronic conditions Benefits of rapid transfer to specialist care Access and demography

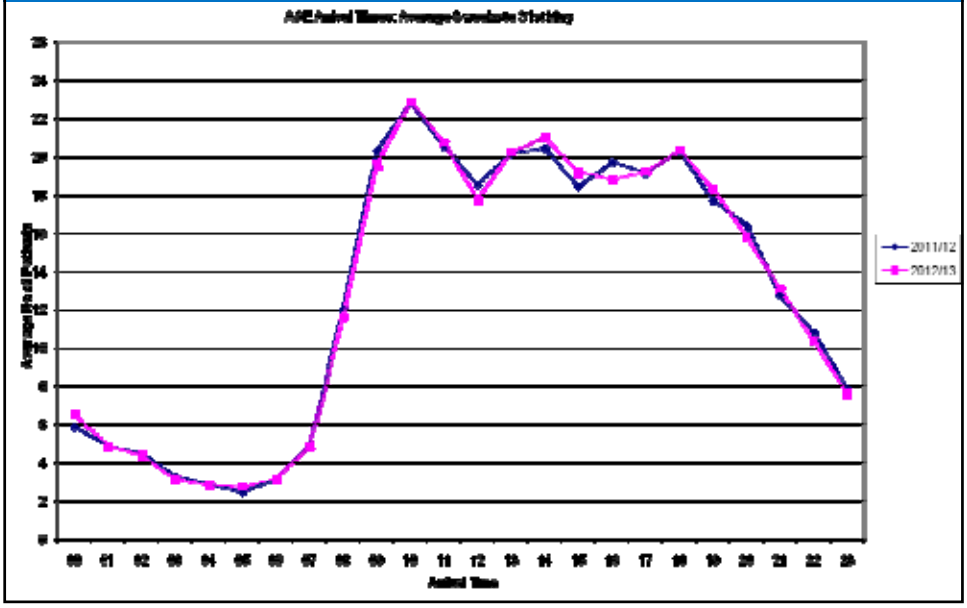
Emergency Department Activity



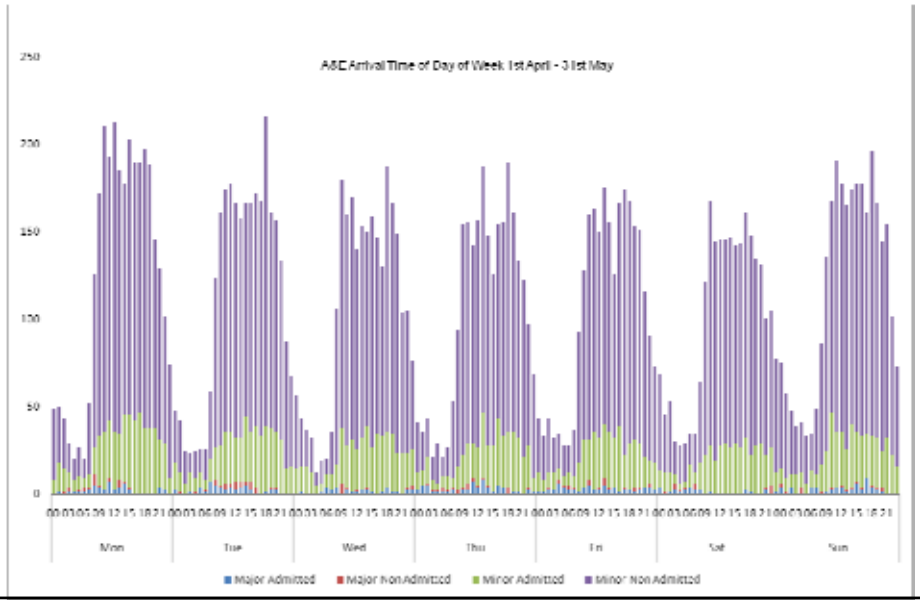
Emergency Department Attendance



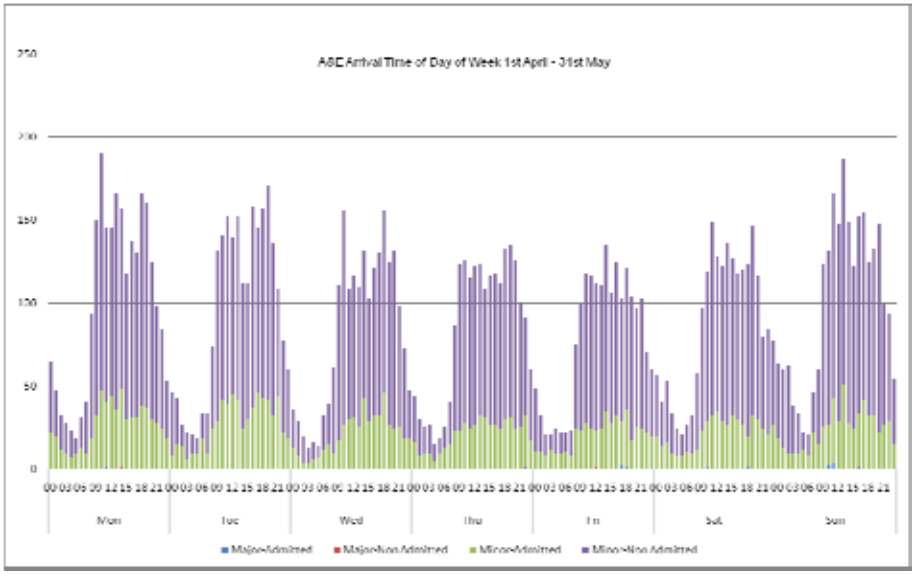
Emergency Department Arrival Times



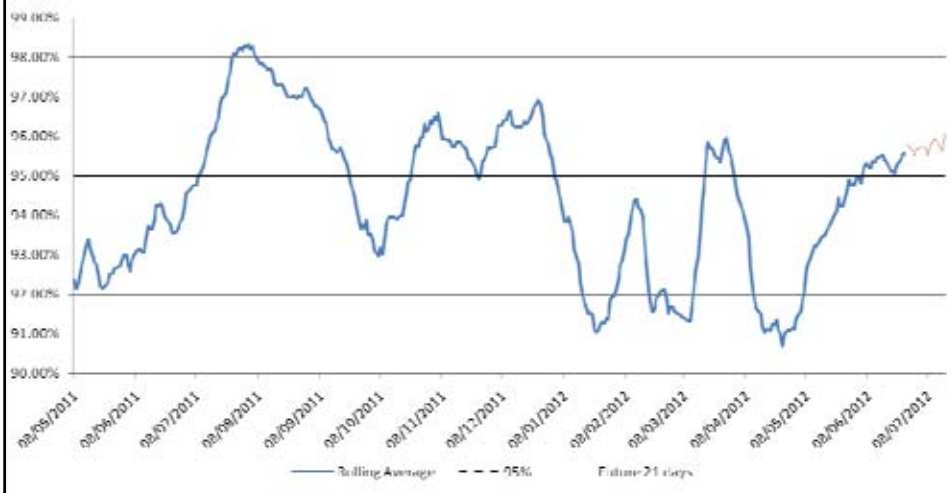
ED Arrival Times by day of the week - PRH



ED Arrival Times by day of the week - RSH



A&E 4-hour wait performance



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Reviewing Emergency Care
Organisational Perspective 2 - National Perspective

Diane Fuller
Emergency Care Intensive Support Team

What does good look like?
A national perspective

Diane Fuller
Emergency Care Intensive Support Team
17th October 2012

What is the role of the Emergency Care IST?

To encourage and support the systematic adoption of known good practice along the whole urgent and emergency care pathway

What are our goals?

- Improve patient safety and outcomes
- Improve staff and patient satisfaction
- Reduce waste and inefficiency
- Support delivery of the A&E Clinical Quality Indicators and national standards

National Context

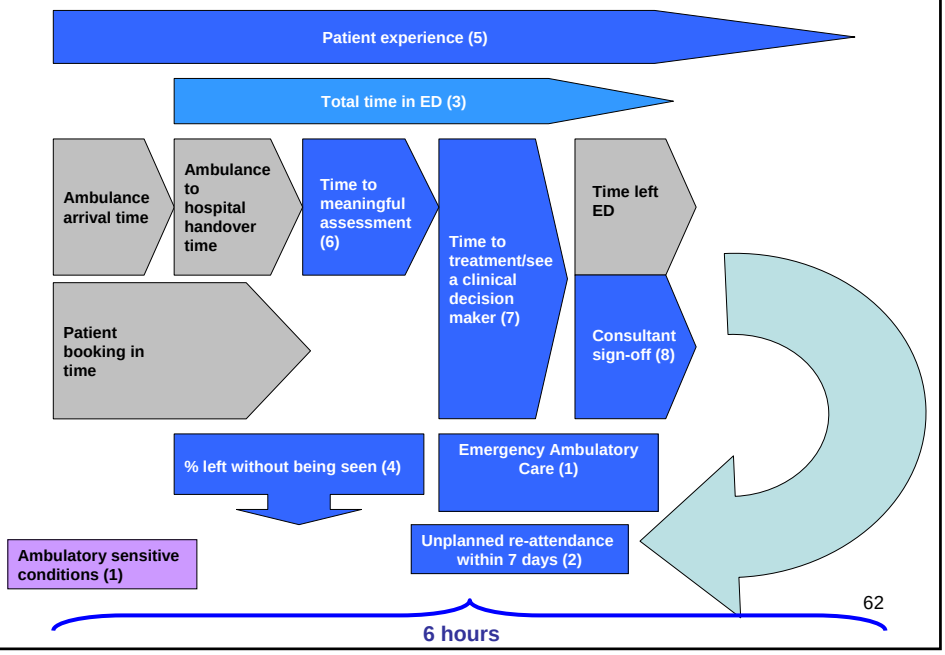
- Emergency attendances increase on 2011/12
- Emergency admissions increase on 2011/12
- Yet National A&E 4 hour performance year to date 96.8% against 95% standard
- Shrewsbury & Telford performance year to date 92.8%

- National Challenges
  - meeting all the A&E Clinical Quality Indicators
  - recruiting to Emergency Dept. medical vacancies
  - developing new roles in emergency care
  - financial pressures
  - delivering safe and sustainable services

Overview of A&E Clinical Indicators

- Headline indicators represent *minimum* standards
- Failure to achieve the minimums may indicate an 'unsafe' service – increasing evidence that waits in ED >4 hours for a bed increases length of stay and mortality levels
- Apply to all Emergency Departments
- Apply to minor illness and injury units (WICs, UCCs)
- Medical/surgical/paediatric *assessment units* should adopt the Clinical Quality Indicators if they are able to do so

The A&E Clinical Quality Indicator Landscape



62

Contractual requirements

The Provider shall satisfy at least one of the following Patient Impact Indicators, and at least one of the following Timeliness Indicators:

Patient Impact Indicators:
1. Unplanned re-attendance rate

2. Left department without being seen [rate]

Timeliness Indicators:

1. Total time spent in A&E department

2. Time to initial assessment (95th percentile)

3. Time to treatment in department (median)"

The standard NHS contract (2012/13) also includes a requirement to deliver the other ED indicators, with standards and sanctions to be locally agreed.

63

A&E Clinical Indicators August 2012	RSH performance	PRH performance	Threshold for intervention	Notes
Left without being seen	1.35%	1.79%	≥5%	
Unplanned re-attendance	1.72%	2.26%	>5%	
Time to initial assessment	95th percentile = 30mins	95th percentile = 23mins	95th percentile >15mins	
Time to treatment	Median = 25mins	Median = 49mins	Median >60 minutes	
Total time in ED (admitted pts)	95th percentile = 542mins	95th percentile = 436mins	95th percentile >240mins	Maximum time in August = 861 and 1153mins
Total time in ED (non-admits)	95th percentile = 280mins	95th percentile = 238mins	95th percentile >240mins	Maximum time In August = 793mins

National Good Practice

- Understand the reasons behind long waits and breaches
- Reduce variation in practice
  - - use known tools e.g. MEWS to monitor vital signs
- Review processes to deliver:
  - - early assessment and senior clinical decision making
  - - early specialty intervention
  - - prompt access to diagnostics
  - - pre-emptive general, HDU and ITU bed capacity
- Apply good practice "See and Treat" and "Rapid Assessment and Treatment" (RAT) models

National Good Practice

- Support delivery through clear operational frameworks
  - - live monitoring
  - - timely exposure of delays
- Model capacity based on arrivals hour by hour
  - - workforce configuration and deployment
  - - cubicle capacity
  - - escalation and contingency plans
- Ensure appropriate IT infrastructure

National Key Finding

- Emergency Department and hospital overcrowding is sometimes accepted
- Overcrowding is the responsibility of the Whole System
- Overcrowding is a symptom of pathway failure

Approaches favoured by many (that often don't work)

- More beds
- Accelerate discharges when A&E becomes full
- Divert ambulances
- Cancel elective admissions and reschedule
- Hold admits in the emergency department until an inpatient bed is available
- Admission avoidance schemes*

Good practice to improve patient flow

- *Early* senior review
- *Daily* senior review* – every patient in every bed every day
- Focus on discharge*
- Continuity of care*
- Match capacity to demand & tackle variation
- Establish, standardise and manage time/response standards (internal professional standards)
- Maximise ambulatory emergency care
- Place patients in appropriate flow streams

Focus on discharge

- *Consistently* prioritising discharge activities can significantly reduce length of stay in elective or emergency clinical care pathways.
- Prioritising discharge activities only when beds are full may have little impact on patient throughput or average length of stay.
- Increasing beds may increase length of stay with no benefit to patient throughput.

Simulation of patient flows in A&E and elective surgery Discharge Priority: reducing length of stay and bed occupancy
Michael Allen, Mathew Cooke & Steve Thornton, Clinical Systems Improvement 2010

Continuity of care and regular reviews

- Hospitals with two or more AMU ward rounds per day on weekdays AND admitting consultants working blocks of more than one day had a lower adjusted case fatality rate.
- Where the admitting consultant was present for more than four hours, seven days per week they had a lower 28 day readmission rate

RCP Taskforce 2007

Admission avoidance & early discharge

Stronger evidence

- Admission prevention from nursing homes
- Ambulatory emergency care
- Improve urgent access to primary care
- Intermediate care *in-reach* to ED and assessment units
- Assertive case management of frail patients with dementia
- Continuity of care with a GP
- Hospital at home as an alternative to admission
- Assertive case management in mental health
- Early senior review in A&E
- Multidisciplinary interventions and tele-monitoring in heart failure
- Integration of primary and secondary care

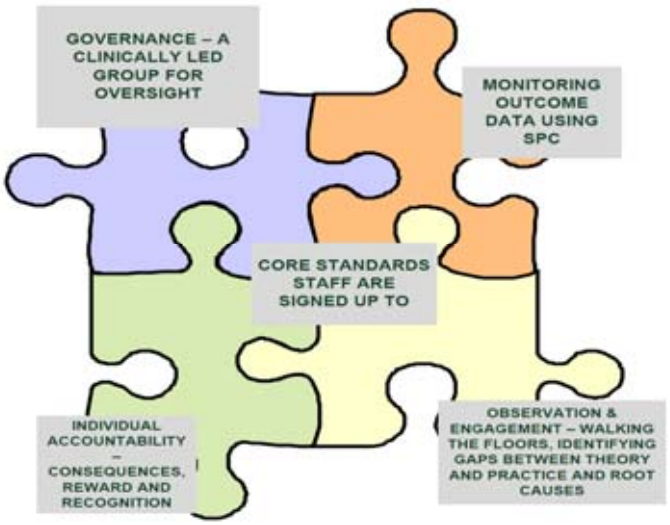
Weaker evidence

- GPs in ED
- WICs and UCCs (unless co-located with EDs with integrated governance)
- Public education
- Pharmacist home-based medication review
- (Unfocussed) intermediate care
- Community-based case management (generic conditions)
- Early discharge to hospital at home on readmissions
- Nurse-led interventions pre- and post-discharge for patients with chronic obstructive pulmonary disease (COPD)
- Telemedicine (except for heart failure)

The 5 Golden Rules!!

- Capacity is decision makers not cubicles, beds, trolleys, chairs etc.
- Match demand with capacity
- Reduce variation
- Reduce handovers
- Collaboration NOT Competition- (Clinical conversations are crucial!)

Standards are a core part of what needs to happen



Overview of ED Medical Workforce

- Acute on chronic challenge
- Modernising Medical Careers programme - 46% of 180 junior doctor posts on emergency medical training programme filled in 2011
- General Medical Council – survey highlighted concerns about junior doctor workloads in EDs
- Department of Health – initial survey of medical staffing levels as part of Winter Planning process
- College of Emergency Medicine "Crisis Summit" - 50% too few ED consultants to achieve Emergency Departments with 10wte, reports of 14-hour days, "acting down" & high levels of variable quality locums

National Good Practice

- Minimum standard of Middle Grade ST4 or above 24/7
- Increased consultant presence- long days/weekend cover
- Develop local recruitment strategy – local, national and international
- Implement good practice models: RAT/SIFT
- Increase focus on essential consultant delivered services
- Develop new roles
  - Consultant Nurse
  - Emergency Nurse Practitioner
  - Advanced Nurse Practitioner
  - Extended Therapist roles
  - Physicians Assistant
  - Extended Health Care Assistants
  - Many others…

Delivering Safe and Sustainable Services

New approaches seen across the country:

- Same model of care with extended workforce
- New model of care provided planned/reactive basis
  - unplanned temporary closures
  - unplanned temporary night time closures
  - planned new model of care e.g.
  * Urgent Care Centre
  * Primary Care out of hours support to Emergency Departments
  * Integration of Acute Medicine and Emergency Departments
  * Many other examples

Thanks

- Diane Fuller
- Diane.fuller@southwest.nhs.uk

The Shrewsbury and Telford Hospital NHS
NHS Trust

Introducing the Group Work

Adrian Osborne
Communications Director, The Shrewsbury and Telford Hospital NHS Trust

The Shrewsbury and Telford Hospital NHS
NHS Trust

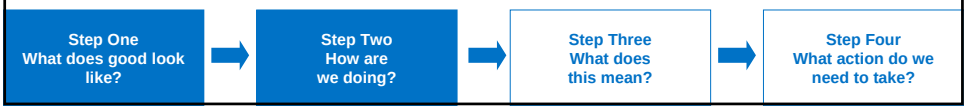
Group Work

Steps 1 and 2

What's missing? What else do we need to do to develop our picture of:

- **"what does good look like"?**
- **"how are we doing?"?**

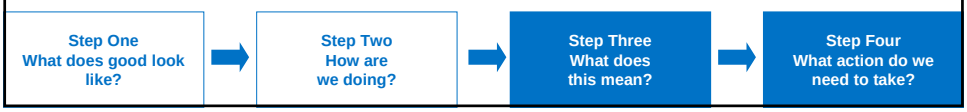
What practical steps do we need to take to build a fuller picture?



Steps 3 and 4

Based on what you have heard, what does this mean for us in Shropshire, Telford & Wrekin and mid Wales?

What steps might we need to take?



The Shrewsbury and Telford Hospital NHS
NHS Trust

Next Steps

Overview of Pan Shropshire Unscheduled Care Strategy Development 2012/13

1. Background

1..1. Further to a review of urgent care provision across the Health Economy it has been identified that there is a need for a whole system commitment to early and sustainable improvement across urgent care.

1..2. To enable timely, clinically appropriate and cost effective urgent care to be delivered, there was a recognition that the whole health and social care system is require to work together in partnership. Consequently, a Pan Shropshire approach has been adopted.

2. Strategy Development

2..1. The emerging urgent care strategy has been developed under the leadership of Dr Bill Gowans. This process has been guided by the principal that in order to achieve transformational, large scale and cultural change, it is necessary to first identify the attitudes, behaviours and relationships in ourselves and others (including patients, providers and commissioners) to succeed. Only then can the necessary structural and organisational changes be made.

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2..2. To date, six stakeholder events have been held. The first stakeholder meeting established agreement on the need for change and generated a wealth of ideas on service developments. The second meeting provided a forum for discussion and prompted members of this group to sign up to a 'framework for change'. The third stakeholder meeting included presentations from each provider detailing their aspirations, plans and commitment to changes they had identified to improve the delivery of urgent care across the Health Economy. The fourth meeting focused upon the need to move from an aspirational to an operational phase and introduced a project management framework which had been developed to oversee this process. The fifth and sixth event allowed the opportunity for project sponsors and leads to present their individual project developments to date.

2..3. Patient representatives have attended all six stakeholder events and the collation of the views expressed in patient focus groups has been an integral part of the strategy development.

2..4. Provider and commissioner views were convergent with the views expressed by the patient representatives and have been easily aligned to form the basis of an urgent care strategy which can then be articulated from these three perspectives.

2..5. A final version of the Pan Shropshire Unscheduled Care Strategy 2011-2014 has been produced and has been ratified by/presented to all local health and social care partners.

3. Implementation

3..1. The priority areas for service improvement have been identified within the strategy and have consequently been used to develop individual projects.

3..2. Clinical programme sponsors and supporting project managers have been identified for each of the identified projects. Project plans including aims, objectives and metrics, working

groups, timescale mapping and resource planning has been undertaken for each of the projects listed.

4. Strategic Themes

4..1. Further to the work undertaken to develop the individual project groups, these workstreams have been aligned with one of five strategic themes. These are:

- The development of a service specifically for frail and complex patients
- The development of a demand and capacity hub
- Improving patient 'flow' through the unscheduled care system
- Access to unscheduled care services
- Improving mental health liaison

4..2. Each of the 19 project groups has been aligned with one of these central themes (Appendix 1).

Appendix 1: Project list and Strategic Themes

No.	Project Description	Whole system strategic development
2	Demand and Capacity Management (Winter 9)	Demand & Capacity Communications Hub
3	111 – Local Implementation	Demand & Capacity Communications Hub
4	DOS including NHS Pathways	Demand & Capacity Communications Hub
1	Education & Publicity	Access
5	Walk in Centres/MIUs Reconfiguration	Access
6	GP Surgery Urgent Care Audit-> Primary Care Access	Access
13	Paramedics&MIU's co-location->Ambulance destinations	Access
16	A&E	Access
8	Mental Health Liaison	Mental Health Liaison
14	Emergency Ambulatory Care	Flow
9	Pathways for Urgent Care Diagnostics	Flow
15	Case Management & Discharge Planning	Flow
17	Delayed Transfer of Care (DTOC)	Flow
18	Re-ablement	Frail & Complex Service
7	Acute Frail & Vulnerable Pathways	Frail & Complex Service
10	Virtual and Community Hospitals	Frail & Complex Service
19	Active Case Management	Frail & Complex Service
11	End of Life Care	Frail & Complex Service
12	Clinical Support to Care Homes	Frail & Complex Service

NHS Midlands and East

Overview and Scrutiny Committees/ July 2012 / For Information and Comment

Stroke Review: achieving a step change improvement in stroke care.

Sally Standley, Stroke Review Programme Lead

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1 Purpose of the paper

1.1 The purpose of this paper is:

- to summarise the arrangements for reviewing stroke services across NHS Midlands and East (NHS M&E) in 2012/13;
- to draw attention to the opportunity over the summer in shaping options for how the service can deliver a step change improvement in stroke care
- to seek comment on the high level criteria against which recommendations will be made about delivery of a step change improvement in stroke care..

2 Background

2.1 Stroke is acknowledged as a major cause of mortality and morbidity, accounting for in excess of 40,000 deaths a year in England of which over 12,000 are in Midlands and East.

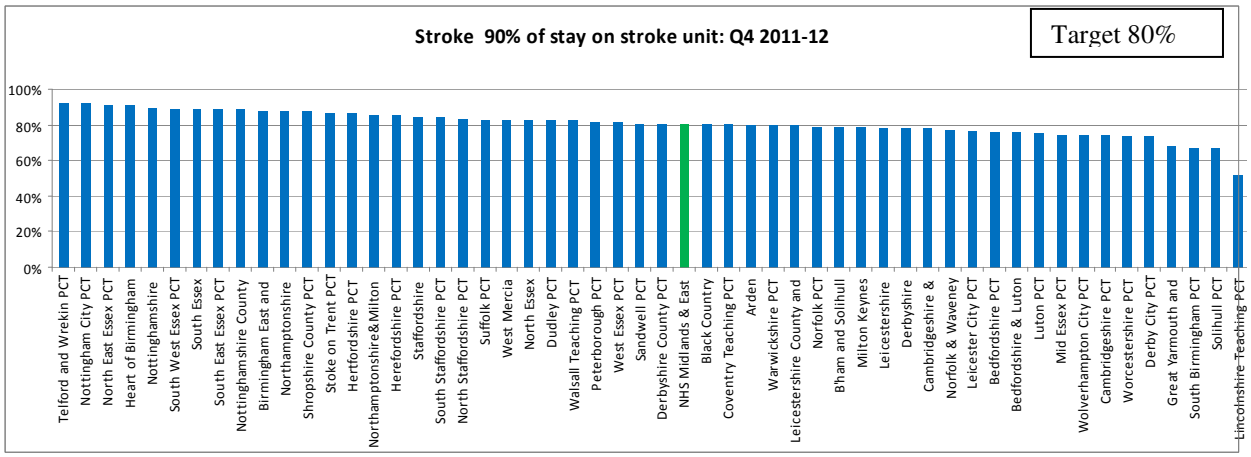
2.2 The UK does not compare favourably with international performance in the management of stroke:

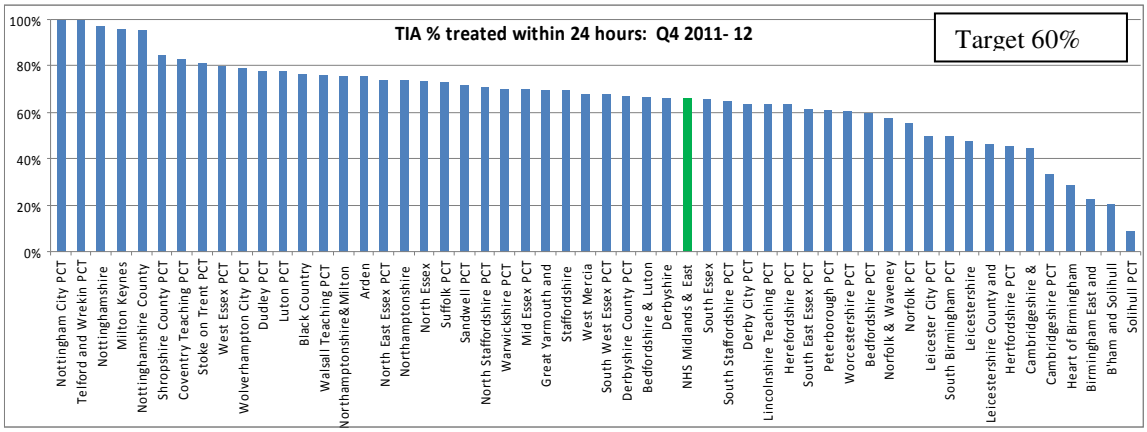
- league tables rank Britain's survival rates for the most common type of stroke as the worst in the developed world;
- OECD statistics comparing 30 developed Western countries, rank UK's death rates after hospital admission for an ischaemic stroke as twice the OECD average, and three times worse than those in Denmark.

2.3 At its meeting in January 2012, the Regional Cluster Board noted the shortfall in performance compared to national standards of best practice, articulated as long ago as 2008 in the National Stroke Strategy e.g. only 30% of patients receiving a brain scan in under 1 hour (SINAP 2011); only 17% of patients admitted to a stroke unit in under 4 hours of arrival (NAO 2010).

2.4 The Board also noted that although there had been improvements in stroke care relating to the two national vital signs for acute care (figure 1), there remained a variation in practice across the cluster, and considerable shortfall in performance in relation to the whole stroke pathway.

Figure 1:





2.5 The Board noted the significant improvement in stroke outcomes achieved in London, following its review of acute stroke services; albeit with recognition that the geography and configuration of Midlands and East differs considerably to that of London.

e.g. Stroke mortality, adjusted for case mix and other factors, was 25% lower in London in 2010/11 than the national average;

e.g. Performance against the two national stroke/TIA vital signs (see figures 2 and 3). Figure 2:

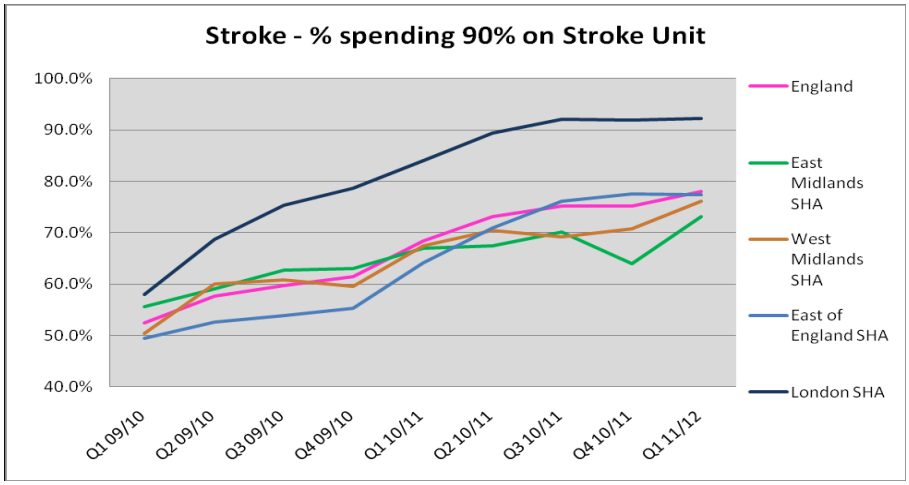
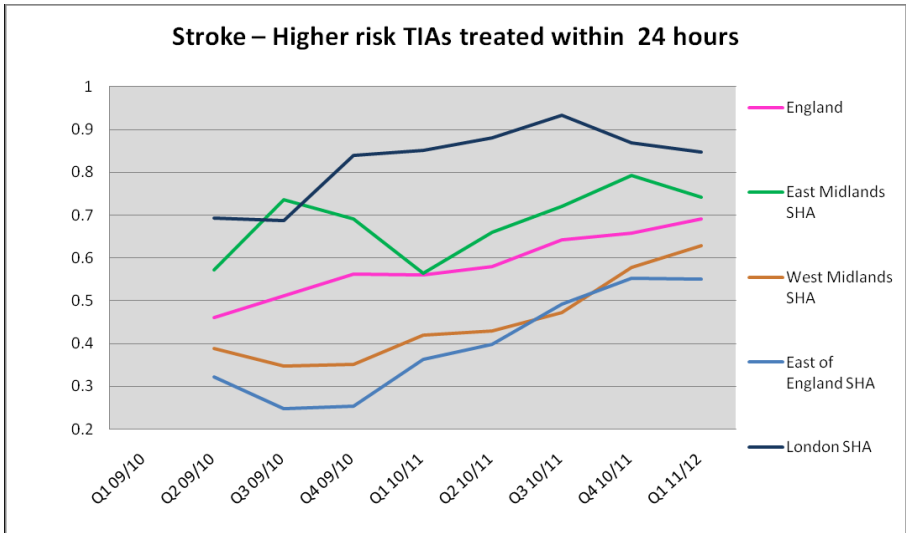
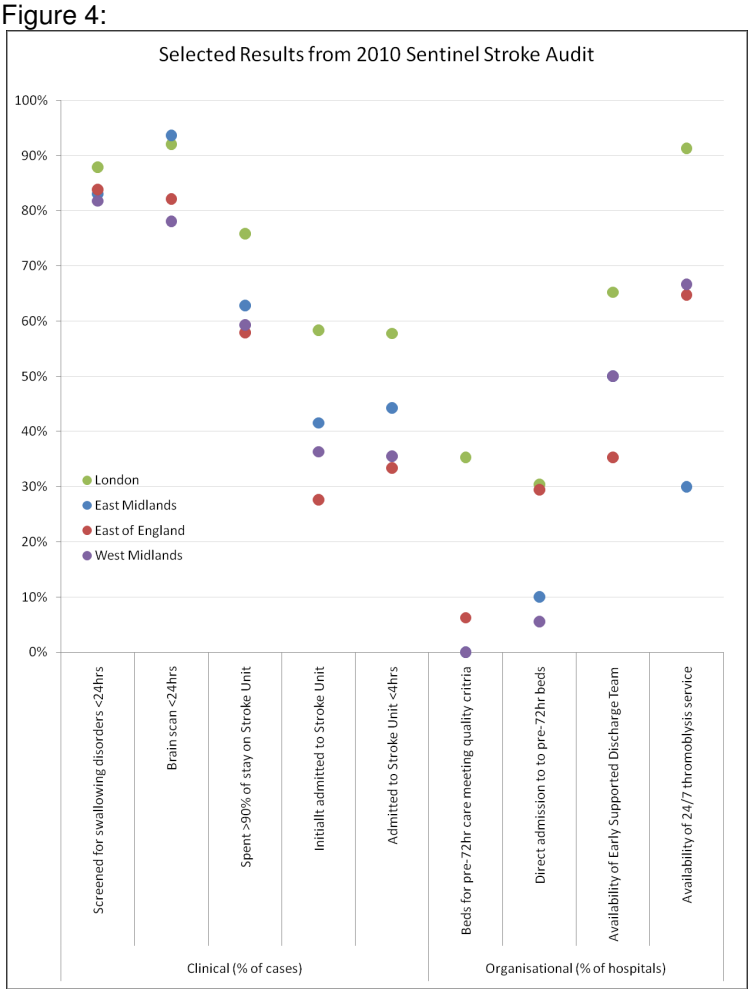


Figure 3:



e.g. Performance against the 2010 National Stroke Sentinel Audit. Although the data is now outdated, it shows that even during the period of transition, the London service compared favourably with the SHAs in the NHS Midlands and East.

Figure 4:



2.6 It was agreed that a major review of stroke services should be undertaken in NHS M&E, to establish the means to make a step change improvement in stroke care across the Cluster; making clear recommendations before the SHA's abolition in March 2013. There is a significant challenge in the timescale, even before taking account of the structural change in many of the key stakeholder organisations, i.e. the abolition of the SHA and PCTs; emergence of Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards; and the in year changes to Stroke Networks and Observatories, the details of which are both not yet clear. None the less, partners have agreed to work together to deliver this in the expected timescale, in the interests of improving patient care.

3 Structure and Process of the Review.

3.1 The Review has been commissioned by NHS Midlands and East. It will establish a clear strategic vision and implementation plan, and make an explicit recommendation, as a 'strategic steer', to CCGs to guide their commissioning in 2013/14 and beyond. In commissioning stroke services,

and working to achieve best practice and an improved return on investment, the CCGs will be performance managed by the National Commissioning Board (NCB)

3.2 The Review is being led by Cambridge University Health Partners (CUHP); one of the five academic health science partnerships (AHSC) in the country, and the only one in NHS Midlands and East. It is being undertaken with local leadership of the nine clinically managed Stroke Networks across NHS M&E. Deloitte have been commissioned to undertaken elements of the Review which the NHS partners do not have capacity for in the timescale, in particular the modelling associated with the Review, and supporting documentation of a best practice specification, against which the review is being undertaken.#

3.3 To supplement the NHS M&E Board's recommendation to CCGs, commissioners will receive a Commissioning Toolkit which will include the health economics for investment; guidance for inclusion in contracts to optimise delivery and outcome; and guidance on splitting tariffs where necessary.

Project Board

3.4 A Project Board has been established, chaired by Professor Tony Rudd, Royal College of Physicians Stroke Lead, and stroke physician at Guys and St Thomas' NHS Foundation Trust. Membership reflects representation of key stakeholders, and provides governance to the Review. Membership is set out at Annex A.

3.5 There are three sub groups working to the Project Board:

- **Data and modelling:** this includes establishing a baseline and evaluation of the outcome of the review; modelling to identify the optimum configuration of services, and to ensure that the impact of any proposals have been identified and taken into account'. The group is chaired by Matt Ward, West Midlands Ambulance Service;
- **Service User and Carer Forum:** this helps shape and provide comment on emerging proposals for the review overall, and supplements local service user and carer engagement at a network level;
- **Education, Training and Workforce:** this includes production of toolkits to support providers in responding to the outcome of the review; and a commissioner toolkit to support CCG's in commissioning its implementation.

External Expert Advisory Group

3.6 An External Expert Advisory Group (EEAG) has been established; chaired by Dr Damian Jenkinson, the DH's Interim Director for Stroke; and NHS Improvement Lead for Stroke. The Group has produced an evidence based best practice specification for the whole stroke pathway, to guide the service in being clear about what needs to be provided to achieve a step change improvement in outcomes. Deloitte has worked with the EEAG to help document this vision.

3.7 EAAG has a strong membership, with a combination of national expertise, and experience in the major review and implementation of improvement to stroke services, in both urban and rural areas. Membership is set out at Annex B.

Clinical Leads within NHS M&E

3.8 The 9 Stroke NHS M&E Networks have each identified a medical, nursing, and therapy clinical lead, to lead engagement at a local level. They are supported by the Network Director and other network team members. The Networks in each region (ie. E Midlands, W Midland and East of England) have identified a medical, nursing and therapy lead, drawn from the nine, who can represent the region at the Project Board, and in discussions with the EEAG and other fora.

Communication and engagement

3.9 Professional communication and engagement expertise is provided from the Strategic Health Authority, working closely with local stroke networks. A Review Bulletin is produced; and 'flash reports' from Project Board meetings setting out key decision and actions. All papers (Project Initiation Document (PID), terms of reference, minutes etc), and the source documents which have informed the EEAGs best practice specifications are available on the SHA's public facing web site: https://www.eoe.nhs.uk/page.php?page_id=2266 .

3.10 Local engagement is being driven by the 9 Stroke Networks, each of which has refreshed the membership of its Stroke Advisory Group to ensure representation from all relevant stakeholders; and developing a locally appropriate set of arrangements to maximise engagement to contribute to the review. We are working to make the review as open and transparent as possible.

3.11 If as part of the review it is necessary to undertake a period of formal consultation on the emerging recommendations, this will take place for the area concerned, rather than be part of a regional cluster wide consultation process. This will maximise local opportunity to engage in issues relevant and pertinent to the area, and avoid an unnecessary process being undertaken for the remainder of the region.

The focus of the review.

3.12 The Review is being undertaken with the following guiding 'principles':

- It will cover the whole stroke pathway from primary prevention to end of life. To achieve gains in health outcome, and productivity, it is essential that the whole pathway of care is reviewed, not just the provision or configuration of acute services;
- It will work to build on existing work, rather than duplicate or start work again. This is particularly pertinent to E Midland and W Midlands, and around Hincingbrooke Hospital in the East of England where considerable work has recently been undertaken to review acute stroke care;

- The work will be driven and undertaken where ever possible through the auspices of the 9 Stroke Networks. They already have strong clinical leadership for stroke; established relationships with local providers and commissioners (albeit with the latter changing from PCT to CCG in 2012/13); and a clear understanding of the strengths and weaknesses of current provision;
- The solutions for the three regions within the Cluster may differ considerably; one size will not be expected to fit all, not least because of urban and rural differences;
- It will draw learning from existing work undertake in the regional cluster, and from other parts of the county which have recently undertaken effective review and improvement to stroke care.

The process of the review

3.13 The EEAG has developed an evidence based Best Practice Specification covering the whole stroke pathway, divided into 8 phases:

a) Primary prevention

b) Pre hospital

c) Acute: i) hyper acute, ii) acute, iii)TIA, iv) tertiary care (neuro surgery)

d) In hospital rehabilitation

e) Community rehabilitation (inc Early Supported discharge)

f) Long term care and support

g) Secondary prevention

h) End of life

This sets out the expected features of care provided at each point on the pathway, workforce requirements, metrics for monitoring performance etc.

3.14 Before being completed, Networks have had opportunity to ensure that its content is clear, and to comment on any areas of query or omission. This has also had the advantage of extending the period of the networks being familiar with its content, which is otherwise very challenging.

3.15 The Specification was being presented to local system at the end of June to encourage their local proposals of how they can achieve the required step change improvement in outcome. Local systems will have a six week period over the summer to consider this. They will also be given a framework for the response, and the high level criteria against which EEAG will make a recommendation.

3.16 The timescale is challenging, particularly as it is over the summer months, but extending beyond this is not possible if the Review is to conclude with a formal recommendation by March 2013. Networks are coordinating and supporting this process as a local level, and are responsible for maximising local engagement. Responses are being presented back to the EEAG for consideration, along side other scenarios that emerge from the modelling.

3.17 In making its recommendations, EAAG will link with the Network clusters' clinical leads (i.e. 3 x 3) for clarification of proposals where necessary. Where issues relate specifically to an individual network's area, and EEAG

requires clarification, or where consensus hasn't been reached at a local level, EAAG may want to meet with the relevant network's clinical leads themselves rather than the network cluster clinical leads (s).

3.18 EEAG will make a formal recommendation to the Project Board, which will consider whether the proposals constitute major change for any part of the NHS M&E. The SHA will consider this conclusion, and if necessary require a period of formal consultation; after which it will consider the formal response to consultation and make a decision about the outcome of the review. The SHA's decision will take the form of a 'strategic steer' to the CCGs which will take on responsibility for commissioning Stroke services from April 2013.

Timeline for the Review

3.19 Key points in the time line include:

- June 2012 EEAG develops the evidence base best practice specification; distributed to local systems by the end of June
- June to August 2012, **6 weeks period during which local systems respond to the Specification**
- August 2012 EEAG develops its recommendations
- Sept 2012 Project Board considers the recommendation and identifies the need for a period of formal consultation
- Oct-Dec 2012 period of formal consultation (3 months)
- January 2013 response to consultation, and further work if necessary to refine proposals
- March 2013, SHA Board meeting to consider the outcome of the Review, and make recommendation to CCGs.

3.20 The full Review timetable is presented as a Gant chart in Annex C.

Criteria against which EEAG will make its recommendations

3.21 A set of high level criteria have been proposed, to inform EEAG's recommendations. Comment is welcomed on these criteria before they are finalised.

a) Service configurations meet best practice, and can demonstrably improve:
   - clinical outcomes *e.g. 30 day mortality*
   - quality of life outcomes *e.g. Level of disability at 30 days*
   - patient experience of stroke services *e.g. Patient satisfaction of rehabilitation services*

b) Services are cost effective and financially sustainable

c) Service provision is geographically and socio-economically equitable, reaching the whole area population

d) Service provision effectively handles and manages population flows into, and out-of, area

e) Services support the whole stroke pathway, end-to-end, from prevention to long term care or end of life care

f) Services are coordinated by local stroke networks demonstrating collaboration between providers along the whole stroke pathway

g) Stroke service configurations support the delivery of other, in particular acute, services

h) Service provision is clinically sustainable.

3.22 Comment is sought by 1 August 2012 on whether these are the right criteria.

4 Engagement of Health and Well Being Boards, and Overview and Scrutiny Committees

4.1 Directors of Public Health are acting as the key conduit to health and wellbeing boards, in particular to support effective primary prevention activities and interventions. The Stroke Networks will be briefing their regional Overview and Scrutiny Committees (OSCs) where they exist; and supporting local commissioners (PCTs and CCGs) in engaging with their local OSC.

4.2 OSCs, amongst other stakeholders, will be invited to comment on the high level criteria against which the EAAG will make a recommendation for NHS M&E achieving a step change improvement in stroke outcome. This will need to take place before EEAG's deliberations in late August/early September 2012.

5 Evaluation

5.1 Over the summer the Review will establish the region's baseline to support evaluation of the Review's impact on improving clinical outcomes and return on investment. Discussions are underway to use the same parameters as the reviews of London, Manchester and other areas recently reviewing their stroke services.

6 Recommendation

6.1 Overview and Scrutiny Committees are asked to:

i) be aware the arrangements for the Stroke Review;

ii) note that their primary points of contact are their local commissioners, supported by their local Stroke Network;

iii) note that if consultation is required this will be determined in September/October 2012; proposals will be subject to a period of formal consultation; it is proposed that consultation be undertaken in the affected areas, rather than a region wide consultation;

iv) comment on the high level criteria which will inform EEAG's recommendations.

Sally Standley
Programme Lead, Stroke Review, NHS Midlands and East
Director, Cambridge University Health Partners
30 June 2012

Annex A: Stroke Review Project Board Members:

Prof Tony Rudd, (Chair), Royal College of Physicians Stroke lead; Consultant Guy's and St Thomas' London

Barbara Zutshi, National Stroke Improvement Team

Chris Larkin, Stroke Association

Rebecca Larder, Network Link Director – East Midlands

Prof Tom Robinson, Clinical lead – East Midlands

Dawn Good, Nursing lead – East Midlands

Therapy lead – East Midlands

CCG rep – East Midlands

Jonathan Webb, Service User & carer rep, East Mids

Genevieve Dalton, Network Link Director – EoE

Dr Anthony O'Brien (interim), Clinical lead – EoE

Suzanne Helliwell, Therapy lead – EoE

Moira Keating, Nursing lead – EoE

Dr Brian Houston, CCG rep – EoE

Katrina Power Luton CCG

Jim Barker, NHS Norfolk and Waveney

Rob Wilson, Network Link Director – West Midlands

Dr David Sandler, Clinical lead – West Midlands

Dr Tony Kenton, Shared Clinical lead – West Midlands

Dr Indira Natarajan, Shared Clinical lead – West Midlands

Jacqui Winter, Therapy lead – West Midlands

Paula Bourke, Nursing lead – West Midlands

Dr Liz Pope, CCG rep – West Midlands

Janette Adams, Service User & carer rep, Herefords& Worcs

Norman Phillips Service User and Carer rep, Coventry and Warwickshire

Elaine Yardley, Social care, Nottingham

Matt Ward (Chair of data, modelling and information group) WM Ambulance Service

Prof Robert Harris, Director, NHS M&E

Jon Cook, Head of Reconfiguration, NHS M&E

Sally Standley, Stroke Review Programme Lead, NHS M&E; Cambridge University Health Partners

Alida Farmer, Project Manager NHS M&E

Helen Jackson, Communications Lead NHS M&E

Dr Anne McConville, Acting Regional Dir Public Health

Clare Hilitt ,North Trent Stroke Strategy Project (corresponding)

Chris Larkin, NW Stroke Association

ANNEX B: External Expert Advisory Group members:

Dr Damian Jenkinson, Interim Director, Stroke, NHS Improvement.
Prof Tony Rudd, Director of the Royal College of Physicians Stroke Programme Consultant Stroke Physician Guy's and St Thomas' NHS Foundation Trust
Peter Moore, Stroke Association
Dr Jane Williams, Consultant Nurse in Stroke Care at Portsmouth Hospitals NHS Trust
Prof Caroline Watkins, Professor of Stroke and Older People's Care and Director of Research. University of Central Lancashire
Dr Charlie Davey, Consultant Neurologist (with special interest in stroke), Royal Free Hospital
Adrian South, Deputy Medical Director, South Western Ambulance Service NHS Foundation Trust
Sarah Gillham, Stroke lead, NHS Improvement
Mirek Skrypak, Occupational Therapist, and Chair North Central London Stroke and Cardiovascular Network, Life after Stroke Group.
Claire Fulbrook-Scanlon, Joint Clinical Stroke lead, Avon, Gloucestershire, Wiltshire and Somerset Cardiac and Stroke Network
Barbara Zutshi, Stroke Lead, NHS Improvement
David Roberts, Director of Adult Social Services, London Borough of Bromley
Prof Helen Rodgers, Clinical Professor of Stroke Care, Newcastle University

SHROPSHIRE AND TELFORD & WREKIN COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 28th NOVEMBER 2012

JOINT HOSC WORK PROGRAMME

REPORT OF SCRUTINY GROUP SPECIALIST

1.0 PURPOSE

1.1 To update Members on the work programme for the Committee and enable members to review the work programme for 2012 – 14.

2.0 RECOMMENDATIONS

2.1 The Committee receives the update on work programme for the Joint HOSC set out in Appendix 1.

2.2 The Committee agrees any changes to the work programme.

3.0 PREVIOUS MINUTES

3.1 JHOSC -20

4.0 BACKGROUND INFORMATION

4.1 None

5.0 JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE WORK PROGRAMME

5.1 The work of the Joint HOSC has focussed largely on the reconfiguration of services and the subsequent business case. As set out in the response to the consultation held in 2010/11 the Committee will continue to monitor the issues identified and these have been reported to the Committee as part of the assurance grid. However as the service changes are made and other issues are identified for the joint HOSC to consider it is appropriate to update the assurance grid and incorporate additional issues.

5.2 Appendix 1 sets out a draft work programme for the Joint HOSC identifying issues to come to the Committee over the next 18 months. Members are asked to consider the draft work programme and agree any amendments. The following items in the Assurance Grid do not currently have a timescale for an update. Members are asked to consider how this work will be incorporated in the work programme:

- 1.9 Further work with Commissioners to develop hospital at home service for children to avoid unnecessary hospital admissions
- 3.3 Wider changes in NHS e.g. changes in commissioning resulting in services going out of County
- 3.4 Service changes not meeting planned timescales putting patients at risk and impacting on the project as a whole

5.3 In addition to the items sets out on Appendix 1 which relate to the planning and provision of services by the Royal Shrewsbury Hospitals NHS Trust Members may also want to include further work on:

- The modernisation of mental health services
- Community Health Trust updates and Foundation Trust application

6.0 EQUAL OPPORTUNITIES

6.1 There are no specific equal opportunity impacts arising from this report. Equal Opportunity issues will be considered as part of the work of the JOINT HOSC.

7.0 ENVIRONMENTAL IMPACT

7.1 There are no environmental implications resulting from this report. Environmental impacts will be considered as appropriate to the topics in the work programme.

8.0. LEGAL COMMENT

8.1 Each Scrutiny Committee may agree its own work programme in accordance with Part 4 Section 5 of the Council's Constitution.

9.0 LINKS WITH CORPORATE PRIORITIES

9.1 The work of the Joint HOSC links with Telford and Wrekin Council's

corporate priority to improve the health and wellbeing of our communities and address health inequalities.

10. OPPORTUNITIES AND RISKS

10.1 The Joint HOSC will consider the risks and opportunities of the issues included in the work programme.

11. FINANCIAL IMPLICATIONS

11.1 The work programme will need to be managed within existing resources and adjustments made accordingly to ensure that this is the case. Any financial implications arising from recommendations will be considered as part of the relevant reports and any variances will be reported through financial monitoring as appropriate.

12. WARD IMPLICATIONS

12.1 There are no specific ward implications arising from this report.

13. BACKGROUND PAPERS

13.1 None.

Report prepared by Fiona Bottrill, Scrutiny Group Specialist 01952 383113

Joint HOSC Assurance Grid

	Service / Issue identified In Joint HOSC Response to Reconfiguration Consultation	Information Requested	Related Items on work Programme
1	**Paediatric Services**		
1.3	Additional travel time to PRH for some children transported by car and ambulance		Spring 2013 Update on Make Ready Spring 2014 Closing report on move of Women's and Children's Services
1.4	Development of clinical pathways and mitigation of risks when transferring children between hospital sites		Spring 2013 Update on Make Ready Summer 2013 Update on Women's and Children's Services (including workforce development issues) Spring 2014 Closing report on move of Women's and Children's Services
1.9	Further work with Commissioners to develop hospital at home service for children to avoid unnecessary hospital admissions		
1.10	Evidence of work force planning and availability to support the proposals	Are the workforce plans subject to external assurance e.g. by Royal Colleges?	Spring 2013 Update on Make Ready Summer 2013

	Service / Issue identified In Joint HOSC Response to Reconfiguration Consultation	Information Requested	Related Items on work Programme
			Update on Women's and Children's Services (including workforce development issues) Summer 2013 Completion of move of Head and Neck services (including workforce development issues) Spring 2014 Closing report on move of Women's and Children's Services
2	**Maternity Services**		
2.1	Development of clinical pathways to mitigate risks for mothers who will have to travel further to services at PRH	– Assurance about robustness of clinical pathways. – More information about the enhancement of skills and techniques being used by clinicians delivering services to the rural population. – Information about Skills Drills in MLUs.	Spring 2013 Update on Make Ready Summer 2013 Update on Women's and Children's Services (including workforce development issues) Spring 2014 Closing report on move of Women's and Children's Services
2.2	Further work with GPs and midwives to assess those considered at risk and action taken to ensure the safety of mothers and their unborn children.		Summer 2013 Update on Women's and Children's Services (including workforce development issues) Spring 2014

	Service / Issue identified In Joint HOSC Response to Reconfiguration Consultation	Information Requested	Related Items on work Programme
			Closing report on move of Women's and Children's Services
2.3	Continued engagement of the WMAS in the development of clinical pathways	Request response from WMAS.Update provided to July Joint HOSC	Update on Make Ready
2.4	Potential loss of midwives who do not want to move to PRH	A loss of midwives was not envisaged – is this still the case?	Summer 2013 Update on Women's and Children's Services (including workforce development issues) Spring 2014 Closing report on move of Women's and Children's Services
3	**Acute Surgery**		
3.2	Maintaining existing services in the County and SaTH becoming a Centre of Excellence		Summer 2013 Update of SaTH FT Application
3.3	Wider changes in NHS e.g. changes in commissioning resulting in services going out of County		
3.4	Service changes not meeting planned timescales putting patients at risk and impacting on the project as a whole	On-going monitoring of progress against Implementation Plan in FBC What are the key risks in the Risk Register	
3.5	Detailed workforce planning		Summer 2013 Completion of move of Head and Neck services (including workforce development issues)

	Service / Issue identified In Joint HOSC Response to Reconfiguration Consultation	**Information Requested**	**Related Items on work Programme**
			Sumer 2013 Update on Women's and Children's Services (including workforce development issues) Spring 2014 Closing report on move of Women's and Children's Services
4	**Stroke Services / Urology**		
4.2	Evaluation of current provision against the National Stroke Strategy with indication from SaTH and Commissioners on how gaps will be met		November 2012 Stroke Review
4.3	Provision of angioplasty procedures		
5	**Public & Staff Engagement**		
5.1	Further discussions with patients, public and parents to listen to them and discuss their concerns and give further reassurance	Continue to monitor Communication and Engagement Strategy	Spring 2013 Patient and public engagement – ongoing involvement and engagement as part of service reconfiguration Spring 2013 Quality and Performance Measures – Patient Experience and patient experience survey. Overview and further information on low scoring areas.

	Service / Issue identified In Joint HOSC Response to Reconfiguration Consultation	**Information Requested**	**Related Items on work Programme**
5.2	SaTH does all it can to alleviate the concerns of those who have been opposed to the proposals	Continue to monitor Communication and Engagement Strategy	Spring 2013 Patient and public engagement – ongoing involvement and engagement as part of service reconfiguration Spring 2013 Quality and Performance Measures – Patient Experience and patient experience survey. Overview and further information on low scoring areas.
5.3	Address concerns of Welsh colleagues who will be affected by the changes		Spring 2013 Patient and public engagement – ongoing involvement and engagement as part of service reconfiguration
5.4	Public are kept informed and patients informed of the implications for changes before they take place	Continue to monitor Communication and Engagement Strategy	Spring 2013 Patient and public engagement – ongoing involvement and engagement as part of service reconfiguration
6	**Work force planning**		
6.1	Planning to ensure that once the process of transferring services begins patient safety is not compromised		Summer 2013 Completion of move of Head and Neck services (including workforce development issues) Summer 2013

	Service / Issue identified In Joint HOSC Response to Reconfiguration Consultation	**Information Requested**	**Related Items on work Programme**
			Update on Women's and Children's Services (including workforce development issues)
6.2	Recruitment and training of paramedics by WMAS to support transport between sites		Spring 2013 Update on Make Ready
6.3	Report in press of reduction in staff numbers to make savings	Bed capacity modelling in FBC. Work force development plans / Transformational Change Programme to future meeting. Monitoring of BED bundles and bed capacity modelling	
7	**Finance and Estates**		
7.1	Robust plans for all aspects of financial planning to ensure financial sustainability	– What is the assurance process for the finances in the FBC? – Final assurance from SaTH that the scheme is affordable? Link to FT application.	Summer 2013 Update of SaTH FT Application
7.3	Adequate parking at both sites	Addressed in estates plan at last meeting.	November 2012 Travel and Transport Plan update
8	**Transport**		
8.1	Good transport to both sites		November 2012 Travel and Transport Plan update

	Service / Issue identified In Joint HOSC Response to Reconfiguration Consultation	**Information Requested**	**Related Items on work Programme**
8.2	Arrangements are made so staff, patients and visitors can move between sites as soon as services are relocated		November 2012 Travel and Transport Plan update
9	**Implementation**		
9.1	Joint HOSC request details of any changes prior to implementation		