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TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNTY COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Monday, 10 November 2008 at 3.00 pm at the AFC Telford Learning Centre, Wellington, Telford

PRESENT – Councillor D R W White (TWC Health Scrutiny Chair) (Chairman), Ms D Davis (TWC), Councillor V A Fletcher (TWC), Councillor D Gaskill (SCC), Councillor Y Holyoak (SCC Health Scrutiny Chair), Mrs V Lindley (TWC), Councillor A McClements (TWC), Councillor V Parry (SCC), Councillor E Parsons (SCC), Mr D Saunders (TWC)

Also Present –S Conolly (Chief Executive, Telford & Wrekin Primary Care Trust), J MacDonald (Chair of the Clinical Leaders Forum / Programme Director: Strategy for Developing Health & Health Care), J Povey (Medical Director, Shropshire County Primary Care Trust) T Taylor (Chief Executive, Shrewsbury & Telford Hospitals NHS Trust) and P Tulley (Director of Strategic Planning and Commissioning, Shropshire PCT),

D Beechey (Shropshire County Council Health Overview and Scrutiny Panel co-optee); G Hossell (Telford & Wrekin Council Health Scrutiny Commission); C West (Shropshire County Council Health Overview and Scrutiny Panel co-optee); and H Williams (Telford & Wrekin Council Health Scrutiny Commission);

Officers – K Clarke (Head of Audit & Democracy, TWC); T Dodds (Lead Officer – Scrutiny & Modernisation, SCC); M Evans (Senior Committee Officer, SCC); S Kenton (Director of Joint Commissioning, SCC/Shropshire PCT); L Nicholson (Interim Corporate Director, Community Services, SCC); A Smith (Scrutiny Manager, TWC) and D Moseley (Assistant Democratic Services Officer, TWC)

JHOSC-1 APOLOGIES FOR ABSENCE

Councillor S West (SCC) and Councillor M Winckler (SCC)

JHOSC-2 DECLARATIONS OF INTEREST/PARTY WHIP

None

JHOSC-3 MINUTES OF THE MEETING HELD ON 11 JULY 2008

The notes of the meeting held on 11 July 2008 were agreed as an accurate record of the meeting.

JHOSC-4 SHROPSHIRE, TELFORD & WREKIN HEALTH ECONOMY

The Chairman welcomed everyone to the meeting and invited all parties to introduce themselves before explaining that the purpose of the meeting was to receive an update on progress on the development of an over-arcing Health and Health Care Strategy for Shropshire, Telford and Wrekin.

The Joint Committee received a summary of the clinical vision for the Health and Health Care Strategy and a presentation on the progress that had been made in

developing the Strategy, identifying challenged services, future options for acute surgery and the further steps required to reach a conclusion on the way forward.

The Chair of the Clinical Leaders Forum reminded the Committee members of the key strategic issues and objectives and the processes that had been undertaken to inform and shape the Strategy. A number of the models of care that had been examined were suggesting increasing outpatients and emergency care provision as an alterantive to hospital admission by 2012/13. This had a number of implications, and further discussions would need to be held about how long it would take to build up capacity in Primary Care and move activity to a community/primary care setting. For acute hospital services, it was being suggested that there should be a single service across two sites by 2012/13 and in the longer term, a single site for the acutely ill and injured by 2020.

The interim report from the Clinical Leaders Forum had concluded that there was a need to address the sub specialisation in acute surgery and the implications for emergency care, particularly around breast and vascular surgeons, that a better paediatric model of care was required to provide more and better care Closer to Home with paediatric assessment at both hospitals and an inpatient paediatric unit on one site but that any transition to a new model of paediatric care should be taken over time. The interim report highlighted that solutions to the key challenges could not wait until 2020.

The Chair of the Clinical Leaders Forum then went on to explain the four options for clinically viable models for acute surgery: no change; emergencies on two sites; emergencies on one site with elective and diagnostic clinics on both sites; and emergencies and elective in-patient on one site and diagnostic clinics on both sites. He further discussed the implications and clinical risks for each option, particularly paediatrics, before outlining the characteristics of the existing sites at Princess Royal Hospital (PRH) and Royal Shrewsbury Hospital (RSH) in relation to size, population, rurality, deprivation and estate.

The Chair of the Clinical Leaders Forum concluded by describing the steps which would be taken to reach conclusions and findings for presentation to the PCT Boards on 25 November 2008. There would then be an assurance process including a review of the proposals by the Office of Government and Commerce.

The Chairman thanked the Chair of the Clinical Leaders Forum for the report on progress and opened the meeting to questions and comments.

With regard to the option to keep emergencies on two sites, it was understood that eight surgeons would have to be appointed to resolve the sub-specialist problem but that this was not viable due to the volume of work. Did the opportunity exist for surgeons to engage in additional private practice or a share scheme with Robert Jones and Agnes Hunt Orthopaedic and District Hospital (RJ&AH)?
Response: The process had considered the possibility of private medicine but had concluded that there would not be the level of work to justify eight appointments since the demand to provide a private service was falling as a result of shorter NHS waiting lists.

The RSH already had an arrangement whereby it bought-in RJ&AH consultant time and the orthopaedic staff at PRH were linked to the RSH unit. Clear links between the three hospitals already existed and any notice to terminate the arrangement would be a 12 month period.

Who would be consulted as part of the Office of Government & Commerce (OGC) Review?
Response: Consultees would consist of stakeholders which would include Local Authorities and the Voluntary Sector. The Clinical Leaders Forum would recommend that the consultation should be as broad as possible and similar advice would be applied to the National Clinical Advisory Team (NCAT) visit.

It was noted from the briefing paper supplied with the agenda that the external assessment of the work had asked what critical time points by which the likes of the workforce issues (eg European Working Time Regulations or resource issues) would make change unavoidable but no clear answers had been available. Were answers now available?
Response: It was anticipated that a further six junior doctors would need to be appointed to meet the requirements of the European Working Time Directive. The Directive was due to come into force in August 2009 but there were not enough numbers currently available to fill posts. It was considered that changes did not have to be in place by that time as long as a clear timetable was in place to implement the requirements to which the Deanery could give its support. .

It was clear that there were significant issues regarding manpower and training for "Hospital at Home" particularly with regard to paediatrics.
Response: The training needs across both sites were very different and further work would need to take place to accurately assess requirements.

Clarification was sought as to whether the objectives were looking at two sites, or a single new site.
Response: The Chair of the Clinical Leaders Forum advised that with regard to the location, there were two timescales involved. Since it was impossible to build a new hospital by 2012/13, in the short-term the report had to consider how best to maintain two sites. In the longer-term (2020) it was considered that a single-site would provide the best model for acute care. There were however three options for a single site: the existing Telford or Shrewsbury sites or a new site built at a central point between the two. Full appraisals including access, management and funding would need to take place before a recommendation could be made on this aspect. It should be noted that one hospital at the mid-way point would not only require significant investment but would also be much smaller than the combined size of the current two estates and would, therefore, result in a loss of work requiring care at home to make it more viable.

Who would pay for any reconfiguration of services?
Response: There were various funding options. It was clear, however, that it would be most economical and beneficial to patients if services were provided on a single site in the long-term. There was lots of evidence to support this view relating to the duplication of services and the population in each catchment area which had thus far hindered the development of services. However, in the medium term it was important to reduce clinical risks and the Clinical Leaders Forum might feel it more prudent to wait to make a decision on the future as some options were more capital intensive.

The Chief Executive, Shrewsbury & Telford Hospitals NHS Trust (SATH) added that it was important to look holistically at the options with regard to "Hospital at Home" and reducing in-patient admissions rathe than focussing on 2012/13 or 2020. Prior assessment centres at both sites together with a Hospital at Home Service was a viable option to reduce paediatric overnight hospital stays which currently averaged

at 1.4 nights. Day care rates were currently at 80% compared to 62% three years prior and it was important to keep this rate high.

When would the Equalities Impact Assessment (EIA) take place and what would it entail?
Response: The EIA would be a required part of the next phase of work and would consider the impact on all vulnerable or minority elements of the populations once the options were known.

What is the position on Urology?
Response: The current configuration following the SSP decision had not been questioned by the report and there had been no changes proposed. If it was felt there was a need to revisit the decision for capacity issues, there would need to be a clinical argument. It was advised that day patients would continue to be seen at both sites.

Concerns were raised on the implementation of Hospital at Home, particularly relating to the support, staffing and financing of the initiative and any new building. What consultation with the Local Authorities had or would take place?
Response: The 2020 Option Appraisal would review the current sites' capacity and the possibility of new buildings. This process would involve a wide range of stakeholders including both Local Authorities, who were represented on the Clinical Leaders Forum. It was clear that if a new hospital was to be built, 5 to 7 years was too short a timescale and Hospital at Home would need to be implemented first making the best use of current resources. Some figures of between £12m and £35m had been mentioned which did not accurately reflect the costs of a new build.

Concerns were expressed over public perception of the proposals and it was suggested that public consultation and engagement should take place as soon as possible.
Response: The report was due to be presented to the PCT Boards on 25 November 2008 when a decision would be taken as to whether additional work needed to take place before any consultation process could begin. The NHS operated a new process of checks and balances which meant that it was a requirement that an NCAT Visit and OGC Review take place before a commitment to public consultation be made. However, those processes did not preclude discussions with the Local Authorities on the proposed future options although, during that time, it would need to be borne in mind that those discussions would not be based around a definite agreed outcome.

Concerns were raised on the issue of workforce training.
Response: It was anticipated that there would be a transfer of skills from acute surgery although the required development of the workforce had already begun, for example with the increase in nursing care for 'end of life' services. Workforce issues would dictate the pace of change for "Hospital at Home" services and would necessitate some recruitment of new staff.

Where will workers to the initiative be recruited from?
Response: It was envisaged that there would be a mix of new recruits, transfer from acute surgery and retraining of skills. This would be achieved through a process of continuing development, working with GPs and acute services to address the issues. Implementation would not be rushed if there was not a supporting workforce.

What capacity was there for theatre and supporting infrastructure?

Response: The options appraisal would need to consider whether theatre services were in the right place to support future models. Some options would be more capital intensive than others. A clear direction of travel for 2020 would be required before decisions were made.

It was considered that the operation of three individual sites would be extremely problematic and assurance was sought that this was not planned.
Response: There was no intention to operate from three sites, with the exception of day care surgery which allowed the service to operate within a wide variety of settings. In fact, evidence suggested that it did not make sense to carry out major surgery on more than one site. The Committee were reminded that the drivers for change had been set out in the briefing paper and suggested a new building as an option for the future to replace the current two sites rather than run alongside them.

What role was foreseen for community hospitals?
Response: The role of community hospitals was seen to be an area of growth which had implications related to the 'Closer to Home' initiative which was highlighted by the maternity model which demonstrated that 25% of care was given from midwifery units.

The Committee were particularly concerned about Closer to Home arrangements for the very young and in relation to mental health care.
Response: It was important that workforce development provided the best model for paediatric care. It was acknowledged that the new initiatives would require a culture change but it would be linked to meeting the needs of and providing better services to patients in Shropshire.

With regard to Mental Health, provision for primary carers was a principle concern and it was acknowledged that a better model of care was required to offer increased and improved support, specifically targeted at dementia since there was a critical rise in the numbers of elderly people. Such a model of care would need to be managed and planned jointly with the health service and Local Authorities.

Clinical protocols would be developed to highlight risks to vulnerable patients. It was acknowledged that "Hospital at Home" was not appropriate for all patients and, for some children, it would not be the right option.

Is there an agreed position statement for clinical linkages? Where is this published?
Response: There was no single statement and the lists were based on the Royal College Guidance. The management of clinical linkages and how risk should be minimised and managed would form part of the future debate.

The Strategy would consider what was essential and what was desirable, considering how services could be set up and managed to meet local needs. The strategy would address issues such as what were the risks to services not on the same site, what were the risks to patients if operations ran from separate sites and how those risks could be mitigated. If the Royal College Guidance was followed then all services would operate from a single site.

What considerations were being made for personalisation of care, for example around patient choice and safeguarding the vulnerable.
Response: It was difficult to ascertain exactly how to take this agenda forward. It relied upon flexible services and needed associated patient rights to be clear, for example could they choose their own nurse? It was hoped that the Closer to Home initiatives would help to get these choices right, particularly for the vulnerable.

Members noted that difficulties had been encountered in marrying the NHS timescales with Cabinet processes and clearer information on the timescales involved was welcomed. It was considered that appropriate Cabinet Members should be invited to future meetings as it was likely that difficulties would always arise in co-ordinating both processes and it was imperative that the next meeting took place as soon after 25 November 2008 as possible.

RESOLVED – that a further meeting of the Joint Health Overview and Scrutiny Committee be arranged for a date as soon after 25 November 2008 as possible to consider the findings presented to the PCT Boards.

The meeting closed at 4.37pm

Chairman……

Date……

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

SHROPSHIRE, AND TELFORD EXECUTIVE GROUP'S REPORT TO SHROPSHIRE COUNTY AND TELFORD AND WREKIN PRIMARY CARE TRUST BOARDS

25th November 2008

BACKGROUND

In November 2007 the Chief Executives of the four NHS organisations in Shropshire, Telford and Wrekin (Shropshire and Telford Executive Group) commissioned the Clinical Leaders Forum (CLF)[1] to lead the development of the eight 'Darzi' clinical pathways and to carry out an assessment of challenged services where there were clinical viability issues or concerns about sustainability of services. Specifically the CLF were asked:

"To review the evidence in respect of the options and to make recommendations for the future pattern of clinically safe general hospital services, serving the populations of Shropshire, Telford & Wrekin, and the catchments of the provider organisations.

To consider options and make recommendations to Shrewsbury and Telford Executive Group (STEG) of an overall picture of the future shape of hospital services, within the context of a modern NHS. To give early consideration to A&E services, services for children and also to cover maternity and neonatal services, emergency surgery and urology services.

In doing so the CLF will need to liaise with the clinical pathway groups meeting at a West Midlands-wide level (associated with the 'Our NHS, Our Future' exercise), to give information and also to receive and consider information from these clinical pathway groups.

To conduct the work of the CLF in a structured manner and to describe a clear process of dialogue and consideration which leads to your recommendations which are evidence based.

The CLF will need to take into account future patterns of demography. Also to consider the issues around sustainability within the context of the European Working Time Directive (EWTD) and Medical Manpower Careers (MMC).

The CLF will make recommendations which meet the following principles: that recommendations will be clinically safe and also make sense to the communities we serve.

Financial saving is not a driver for this work. However, recommendations would need to be affordable within available resources, and be clinically sound and viable for the future."

[1] The Clinical Leaders Forum includes the senior clinical staff and directors of commissioning and strategy from the two Primary Care Trusts and the two acute trusts, and representatives of the two local authorities.

In May 2008 the two PCT Boards received an Interim Report from the Clinical Leaders Forum. The CLF has now completed its work and submitted two reports to STEG. The findings and conclusions have been discussed by STEG and with the West Midlands Strategic Health Authority.

The two reports from the CLF set out a clinical vision for health services in Shropshire, Telford and Wrekin which is informed by clinical considerations and the needs of the population. The process has involved a wide range of stakeholders and has looked at good practice elsewhere in the NHS and national and regional health policy.

CONCLUSIONS FROM STEG

Strategic Direction

1. STEG welcomes the three strategic recommendations of the CLF and in particular the emphasis on the prevention of ill health and the promotion of good health together with the clear vision of providing care closer to where people live. Whilst much of the public debate has focussed attention on hospital services, the wider context within which the strategy has been developed, as set out in the three strategic objectives, must be taken forward:

    - The prevention of disease and the promotion of healthy lifestyles and independent living;
    - Provision of services at home or as close to home as possible;
    - Provision of sustainable and accessible acute hospital services.

Patient and Public Involvement

2. STEG has recognised the considerable involvement of a wide range of stakeholders in the process including representatives of the two local authorities who were members of the CLF, a number of public engagement events and patients and other key stakeholders being members of the groups developing the models of care. The process for developing the clinical service options for children's services has also been reviewed by an external team comprising a senior clinician and a chief executive with considerable experience of children's services.

3. STEG recognised the importance of continuing to engage the public and other key stakeholders in the next stages of the work. It is recommended that a workshop be held in December or early January with key stakeholders to map out the engagement process to the point when formal consultation starts. This should be facilitated by Professor Bob Sang who has supported the process and who has considerable expertise in involving patients and the public in health service planning. In addition an expert in the recent legislation on public involvement[2] should be asked to participate.

Models of Care

4. The eight Models of Care that have been developed provide an overarching plan within which services for the people of Shropshire, Telford and Wrekin can be developed and improved. These models of care have been built into the two PCTs' Strategic Plans together with the projects and initiatives that have been identified by the Pathway Development Groups who have developed the models of care.

[2] Section 242 (1B) of the NHS Act, 2006 and Sections 17A, 24A, 24B and 242 A of the S Act 2006.

5. The further assessment and development of the strategy for challenged services (as outlined in conclusion 7) should not delay implementation of those aspects of the models of care for challenged services which can be taken forward in the short term, including:

    - Development of acute medicine and hospital at home;
    - Development of hospital at home for children and paediatric assessment units at both hospitals.

6. STEG recognises the importance of continuing to develop the capacity in primary and community care to support care closer to home and make this a reality.

Challenged Services

7. The final report from the CLF sets out the clinical service options for the challenged service strategies. This is the first and critical stage of developing options which are sustainable, clinically viable and financially robust and which provide the people of Shropshire, Telford and Wrekin with high quality, accessible hospital services.

    The process that STEG propose for the development of options to meet the sustainability and viability issues facing the challenged strategies of acute surgery, accident and emergency, paediatrics, obstetrics and urology is summarised in the diagram attached to this report. In summary there are four stages in identifying and agreeing options for formal consultation:

    - Stage One: Define the issues and challenges to be addressed. The Interim Report described these and set out the basis on which these issues should be addressed (CLF Interim Report, May 2008).
    - Stage Two: Develop clinical service options which **make sense clinically** and **make sense to the communities we serve** (these are set out in the CLF's Final Report, November 2008)[3].
    - Stage Three: Further develop the clinical service options including an Equality and Diversity Impact Assessment, a financial assessment and external assessment by the National Clinical Advisory Team and the Office of Government Commerce. It is anticipated that this work will be completed by the end of February.
    - Stage Four: Based on the above work agree the options that would go to formal consultation. It is proposed that this decision is made in March 2009.

    Alongside this process the option appraisal of options for a single site for the seriously ill and injured for 2020 and beyond should be taken forward. Work on this has begun.

8. The CLF identified the major challenge facing hospital services in the immediate future was the need to ensure sustainable and safe services. The CLF concluded that the clinical options must ensure that:

    - the challenges facing emergency general and vascular surgery and inpatient paediatric were met in a timely manner and at the latest by 2012/13;
    - any option should not pre-empt the appraisal of options for hospital services in the longer term and, in particular, the recommendation that services for the seriously ill and injured should be provided from a single site as we look to 2020 and beyond.

[3] Report One: Care Pathways and Models of Care, November 2008 and Report Two: Challenged Service Strategies, November 2008.

9. The CLF has recommended that four clinical service options should be taken forward for financial assessment and scrutiny. The four options are summarised in the table below.

   There was not a consensus in relation to option 2 and a number of members of the CLF felt that this option would potentially pre-empt the appraisal of options for hospital services in the future. The CLF agreed that since there was not a unanimous view on this option that it would be included at Stage Three.

Clinical Service Option	PRH	RSH
1	Level 3 A and E[4], urology	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates
2	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates	Level 3 A and E, urology
3	Level 3 A and E with inpatient paediatrics, urology	Level 2 A and E with acute surgery, obstetrics and neonates
4	Level 2 A and E with acute surgery, and inpatient paediatrics	Level 3 A and E, obstetrics and neonates, urology

   There was considerable discussion within STEG about the inclusion of Option 2. It was however agreed that, in the absence of an agreement at STEG, this option should be included in the list of options to go forward for review at Stage Three.

[4] A Level 2 Acute Emergency Service deals with most medical, surgical and trauma (including multiple trauma) emergencies but not those requiring specialised services such as neurosurgery (which are taken to regional Level 1 Emergency Services). A Level 3 Acute Emergency Service dealing with most medical emergencies and significant trauma such as fractured neck of femur but not multiple trauma.

Recommendations

The following recommendations should be presented to Trust Boards:

1. **To RECEIVE the reports from the Clinical Leaders Forum and to support the three strategic recommendations of the CLF, in particular the emphasis on the prevention of ill health and the promotion of good health together with the clear vision of providing care closer to where people live.**

2. **To AGREE that the engagement and consultation process should be further developed through a joint workshop as outlined in conclusion 3 above, to be held no later than 16th January.**

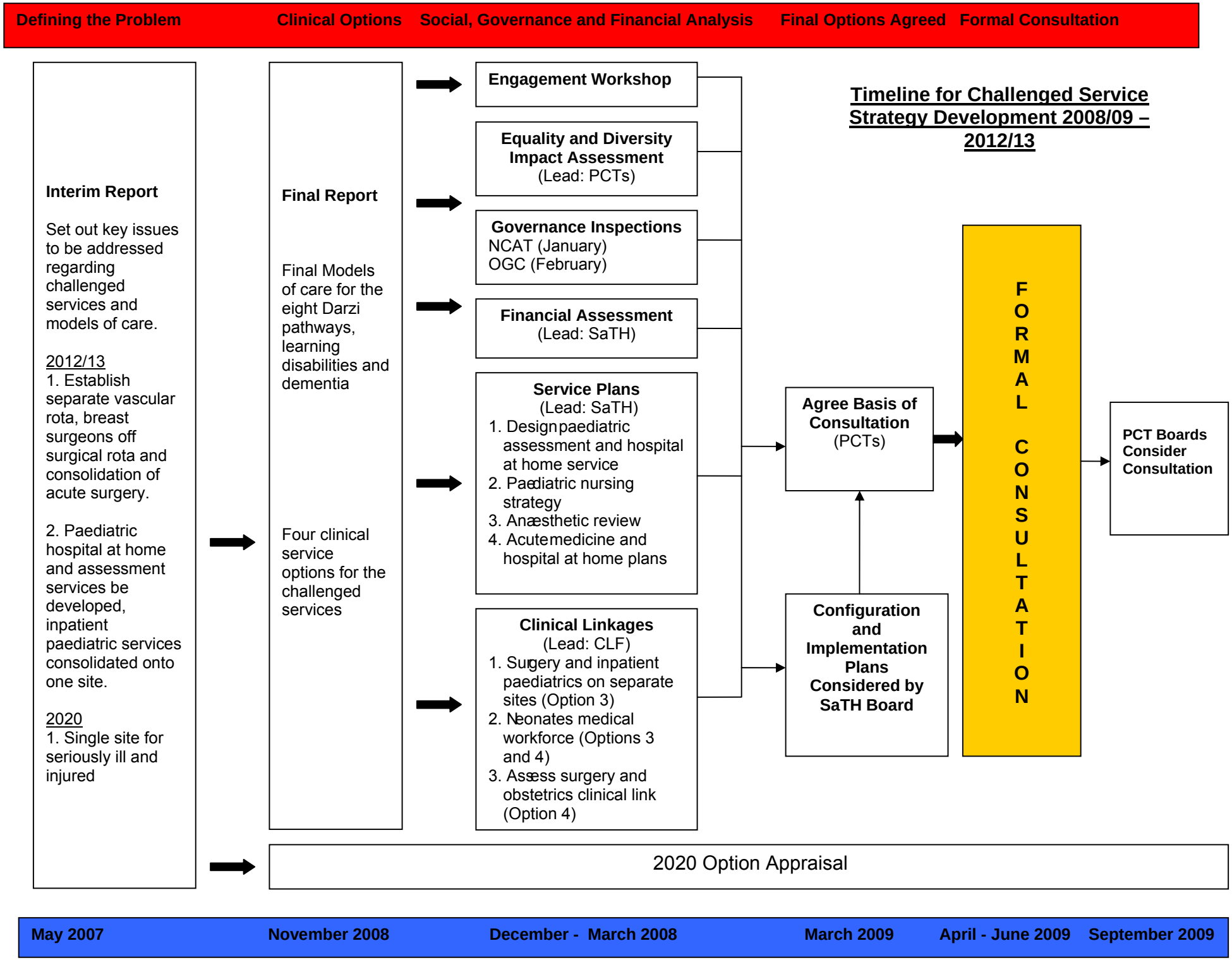
3. **To APPROVE the implementation of the Models of Care as developed by the Pathway Development Groups (conclusions 4 and 5).**

4. **To APPROVE the development of detailed plans to improve the capacity in primary and community care to support care closer to home (conclusion 6).**

5. **To APPROVE the outline process for taking forward the development of options to address the challenged service strategies set out in conclusion 7 above and shown in the attached diagram. Lead organisations have been identified to take forward this work. It is vitally important that this work is done with the full engagement of key stakeholders and will be subject to external scrutiny by the National Clinical Advisory Team and the Office of Government Commerce.**

6. **To AGREE that the four options set out in Table One above should be taken forward for further review in Stage Three of the options development process.**

7. **To NOTE that a further report will be received from STEG early in the new year setting out proposals for taking forward the work on the longer term options for the future of acute hospital services in Shropshire, Telford and Wrekin.**


Defining the Problem
Clinical Options
Social, Governance and Financial Analysis
Final Options Agreed
Formal Consultation
Timeline for Challenged Service Strategy Development 2008/09 – 2012/13
Interim Report
Set out key issues to be addressed regarding challenged services and models of care.
2012/13
1. Establish separate vascular rota, breast surgeons off surgical rota and consolidation of acute surgery.
2. Paediatric hospital at home and assessment services be developed, inpatient paediatric services consolidated onto one site.
2020
1. Single site for seriously ill and injured
Final Report
Final Models of care for the eight Darzi pathways, learning disabilities and dementia
Four clinical service options for the challenged services
Engagement Workshop
Equality and Diversity Impact Assessment
(Lead: PCTs)
Governance Inspections
NCAT (January)
OGC (February)
Financial Assessment
(Lead: SaTH)
Service Plans
(Lead: SaTH)
1. Design paediatric assessment and hospital at home service
2. Paediatric nursing strategy
3. Anæsthetic review
4. Acute medicine and hospital at home plans
Clinical Linkages
(Lead: CLF)
1. Surgery and inpatient paediatrics on separate sites (Option 3)
2. Neonates medical workforce (Options 3 and 4)
3. Assess surgery and obstetrics clinical link (Option 4)
Agree Basis of Consultation
(PCTs)
Configuration and Implementation Plans Considered by SaTH Board
FORMAL CONSULTATION
PCT Boards Consider Consultation
2020 Option Appraisal
May 2007
November 2008
December - March 2008
March 2009
April - June 2009
September 2009

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

REPORT FROM THE CLINICAL LEADERS FORUM

Report One

Overarching Plan for Health and Healthcare in Shropshire, Telford and Wrekin: Care Pathways and Models of Care

November 2008

EXECUTIVE SUMMARY

In October 2007, the Clinical Leaders Forum, comprising the senior clinicians from the local Primary Care Trusts and acute trusts and representatives of the local authorities, was charged with developing an overarching plan for Health and Healthcare in Shropshire, Telford and Wrekin. The final report consists of two reports:

1. Report One: Care Pathways and Models of Care. This sets out the vision for health and healthcare across primary, secondary and social care;
2. Report Two: Challenged Service Strategies. This sets out clinical service options for the hospital services in Shrewsbury and Telford.

In carrying out this work, the project plan was revised to bring it, as far as possible, in line with the timetable for the Strategic Plan and World Class Commissioning. This has ensured that that the Strategic Plan is informed by the overarching plan and that the commissioning intentions are consistent with the overarching plan.

The Health and Health Care Strategy for Shropshire, Telford and Wrekin provides a framework for the provision of health services to local people. The strategy focuses on health and healthcare and the interfaces with social care and local government. It has been developed by the NHS organisations working with local government, patients and partner organisations.

The strategy builds on the strengths of the NHS in providing health services to the people of Shropshire, Telford and Wrekin. It also incorporates the conclusions and recommendations from the national review of the NHS led by Lord Darzi, "*Our NHS, our future*" and the NHS West Midlands' *Investing for Health* strategy.

As part of the process of developing an overarching strategy for Health and Health Care in Shropshire, Telford and Wrekin a set of guiding principles was developed and agreed with stakeholders. Two key principles have guided the development of the strategy:

- Proposals must make sense clinically; and
- Proposals must make sense to the communities we serve.

The Strategy was developed through eight Pathway Development Groups, each led by a senior clinician with membership from key stakeholders and organisations. The process of developing the overall plan was designed to ensure that there was active and effective engagement with key stakeholders through the development of the strategy. In addition to membership of the Pathway Development Groups, nine public and staff engagement events were held which were attended by some 700 people. Regular reports were also made

to key stakeholders including the joint Overview and Scrutiny Committees of Shropshire County and Telford and Wrekin Councils.

The Clinical Leaders Forum identified six strategic considerations which informed the strategy:

- Health, Wellbeing and Equity (including analysis of demographic trends and public health factors and deprivation)
- Quality, Safety and Effectiveness
- Supporting the Workforce
- Involving People in Making Decisions About Their Future Health Services
- Affordable, Sustainable and Fit For Purpose (including clinical and financial viability of services)
- Personalised Services and Access to Care Closer to Home.

The Clinical Leaders Forum identified three main objectives for the development of health and healthcare In Shropshire, Telford and Wrekin:

- The prevention of disease and the promotion of healthy lifestyles and independent living;
- Provision of services at home or as close to home as possible;
- Provision of sustainable and accessible acute hospital services.

The implementation of the overarching plan will be through the Models of Care which have been developed for eight pathways. These are:

- Maternity and New Born;
- Children's Health;
- Planned Care;
- Mental Health;
- Getting Health, Staying Healthy;
- Long Term Conditions;
- Acute Care;
- End of Life Care.

Each of these pathways sets out a future vision for how the services should be developed and the three strategic objectives realised. They have significant implications for the way in which health and healthcare is provided across health and social care as well as the independent and voluntary sector. Delivering the improvements will requires the development of primary and community care as well as a reshaping of the way in which hospital services are delivered.

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SUPPORTING PAPERS AND REPORTS

A. Pathway Development Group Reports
- Maternity and Newborn Care
- Children's Health
- Planned Care
- Mental Health
- Getting Healthy, Staying Healthy
- Long Term Conditions
- Acute Care
- End of Life Care

B. Technical Papers
- Access
- Clinical Linkages
- Sustaining Services
- Children and Young People
- External Review of Paediatrics

C. Building Capacity in Primary Care
- Summary Report
- Care Coordination
- Diagnostics
- Workforce

D. Engagement Plan and Evidence of Engagement

1. INTRODUCTION

This report is the final report of the Clinical Leaders Forum (CLF) on Developing Health and Healthcare: A Strategy for Shropshire, Telford and Wrekin. Following a request from the West Midlands Strategic Health Authority for each local health economy to develop an overarching strategy for health and healthcare by October 2008, the Clinical Leaders Forum (CLF) was charged with developing the overarching plan. Specifically the CLF was asked:

"To review the evidence in respect of the options and to make recommendations for the future pattern of clinically safe general hospital services, serving the populations of Shropshire, Telford & Wrekin, and the catchments of the provider organisations.

To consider options and make recommendations to Shrewsbury and Telford Executive Group (STEG) of an overall picture of the future shape of hospital services, within the context of a modern NHS. To give early consideration to A&E services, services for children and also to cover maternity and neonatal services, emergency surgery and urology services.

In doing so the CLF will need to liaise with the clinical pathway groups meeting at a West Midlands-wide level (associated with the 'Our NHS, Our Future' exercise), to give information and also to receive and consider information from these clinical pathway groups.

To conduct the work of the CLF in a structured manner and to describe a clear process of dialogue and consideration which leads to your recommendations which are evidence based.

The CLF will need to take in to account future patterns of demography. Also to consider the issues around sustainability within the context of the European Working Time Directive (EWTD) and Medical Manpower Careers (MMC).

The CLF will make recommendations which meet the following principles: that recommendations will be clinically safe and also make sense to the communities we serve.

Financial saving is not a driver for this work. However, recommendations would need to be affordable within available resources, and be clinically sound and viable for the future."

The Clinical Leaders Forum comprised the leading clinicians in the health organisations in Shropshire, Telford and Wrekin and senior officers from Shropshire County Council and Telford and Wrekin Council.

An Interim Report was considered by Shropshire County and Telford and Wrekin Primary Care Trusts in May 2008[1]. The main focus of work during the second phase (July – November) has been on:

- refining the models of care where the model developed during Phase 1 was well developed and agreed. These included Maternity and the New Born; Planned Care; Mental Health; End of Life; Getting Healthy, Staying Healthy;
- further development of the models of care for long term conditions, acute care and children's services. This work included further appraisal of 'challenged' strategies, particularly children's health and acute care;
- development of models of care for the areas of learning disabilities and dementia.

Considerable attention has also been paid to assessing the capacity in primary care and the ability of primary and community care to support activity as care moves closer to home. Five areas were identified as important in this regard: workforce and integrated community teams, diagnostics, information technology, the estate and care coordination and information for patients and professionals.

In carrying out this work, the project plan was revised to bring it, as far as possible, in line with the timetable for the Strategic Plan and World Class Commissioning. This has ensured that that the Strategic Plan is informed by the overarching plan and that the commissioning intentions are consistent with the overarching plan.

The Health and Health Care Strategy for Shropshire, Telford and Wrekin provides a framework for the provision of health services to local people. The strategy focuses on health and healthcare and the interfaces with social care and local government. It has been developed by the NHS organisations working with local government, patients and partner organisations.

The strategy builds on the strengths of the NHS in providing health services to the people of Shropshire, Telford and Wrekin. It also incorporates the conclusions and recommendations from the national review of the NHS led by Lord Darzi, "*Our NHS, our future*" and the NHS West Midlands' *Investing for Health* strategy.

This report presents the conclusions and findings of the CLF and in particular the Models of Care that have been developed by the Pathway Development Groups. A second report presents the conclusions and findings of the CLF regarding the challenged strategies.

[1] Interim Report from Clinical Leaders Forum to Shropshire County Primary Care Trust Board and Telford and Wrekin Primary Care Trust Board, 13th May 2008

2 THE PROCESS

2.1 Principles

As part of the process of developing an overarching strategy for Health and Health Care in Shropshire, Telford and Wrekin a set of guiding principles was developed and agreed with stakeholders. Two key principles have guided the development of the strategy:

- Proposals must make sense clinically; and
- Proposals must make sense to the communities we serve.

Formal and informal feedback on the principles was sought directly from stakeholders, through the Pathway Development Groups and at workshops with stakeholders. Feedback on the principles was generally supportive with the main written feedback from Shropshire County Council and Telford & Wrekin Council in a position paper which outlined the role of local government in relation to the health of the population; as a joint commissioner and provider of integrated services with the NHS; and in light of the "community leadership" role which is vested in local authorities.

The final principles and criteria are given in Figure 1. The principles were used by the pathway development groups to assess their services and identify key issues to be addressed. The principles were also used to assess options in those pathway development groups where choices had to be made about alternative models of care and/or configuration of services. Finally the principles were used to assess the strategic options for the 'challenged' services where there were particular issues about future configuration of services.

2.2 The Pathway Development Groups

The Strategy was developed through eight Pathway Development Groups, each led by a senior clinician. The eight groups and their leads were:

Pathway Development Group	Clinical Lead
Maternity and Newborn Care	Mr. Andrew Tapp, Clinical Director (SaTH)
Children's Health	Dr. Richard Brough, Consultant Paediatrician (SaTH)
Planned Care	Jo Banks, Head of Workforce Development (T & W PCT)
Mental Health	Dr. Martin Deahl, Consultant Psychiatrist, (SSS NHSFT)
Getting Healthy, Staying Healthy	Dr. Catherine Woodward, Director of Public Health (T&W PCT)

(continued on page nine)

Figure 1: Principles

	Themes	Criteria
Making Sense Clinically	***Health, Wellbeing and Equity***	▪ To offer equitable access to health and healthcare services according to need across the populations we serve, taking personal circumstances and diversity into account. ▪ To develop and commission all health care based on locally agreed care pathways. ▪ To maximise the opportunity to avoid preventable disease including through primary prevention and clinical pathway redesign. ▪ To meet the current, forecast and changing needs of the populations of Shropshire and Telford & Wrekin.
	Quality, Safety and Effectiveness	▪ To deliver care and dignity in patient services which are safe, of good quality and clinically effective. ▪ To ensure that care is responsive to emerging policy, evidence and technology, including that clinical teams are appropriately configured to deliver safe and effective care. ▪ To deliver evidence-based care within patient care pathways (from prevention to tertiary care) which minimise gaps, duplication and delay.
	Supporting and Developing the Workforce	▪ To ensure the Shropshire and Telford & Wrekin local health economy is an attractive and effective place for the training of clinical staff. ▪ To deliver organisational sustainability and accredited clinical services through carefully planned change, while recognising that the role of individual clinicians may need to change. ▪ To ensure that NHS workforce planning becomes a robust exercise conducted in close partnership across the organisations.

	Themes	Criteria
Making Sense to the Communities We Serve	***Involving People in making decisions about their future Health Services***	▪ To improve opportunities for people to be fully engaged in their own personal health and lifestyle choices. ▪ To increase personalisation and choice in health services. ▪ To ensure that all stakeholders are involved and influential in the development of options for services from an early stage. ▪ To help people navigate their way through the health and care system.
	Affordable, Sustainable and Fit for Purpose	▪ To be affordable within available resources. ▪ To take into account forecast changes in demographics and to be robust in the short term (2009) and in the medium term (2020). ▪ To take advantage of opportunities to work together across the public sector and with the community, voluntary and independent sectors to improve health and wellbeing, provide integrated services and improve our collective contribution to the communities we serve. ▪ To ensure that process leads to the right framework of health services for people in Shropshire and Telford & Wrekin that supports equity in health status and health services
	Personalised Services and Access to Care, Closer to Home	▪ To assure the public that in formulating and assessing options for safe and appropriate services, the Pathway Development Groups will have demonstrated that balanced consideration has been given to both the Princess Royal and Royal Shrewsbury Hospital ▪ To promote independence by providing equitable health at home or as close to home as possible, whenever this is clinically safe, clinically effective and affordable ▪ To continue to develop clinically appropriate alternatives to hospital admission, so that patients are only admitted when their needs cannot be met outside hospital ▪ To deliver enhanced access to diagnostic services, without the need for hospital-based out-patient or in-patient assessment ▪ Where hospital-based services must, by necessity, be provided further away, patient travel plans will be developed to ensure appropriate access according to clinical need, including emergencies ▪ To develop clinical pathways and discharge arrangements which facilitate early yet safe hospital discharge

Long Term Conditions	Dr Lindsay Ward, General Practitioner (T & W PCT, Phase 1) Dr. Jane Povey, Medical Director (SCPCT, Phase 2)
Acute Care	Dr. Kieran McCormack, General Practitioner (SC PCT)
End of Life Care	Dr. Wendy Jane Walton, General Practitioner (SC PCT)

During the second phase of the work the proposals for emergency and urgent care were taken forward by the Urgent Care Network. In addition the strategy has specifically incorporated dementia and learning disabilities.

The Pathway Development Groups included other healthcare professionals and commissioning staff, and worked closely with patient groups and other stakeholders. Their main tasks for the Pathway Development Groups included:

- mapping out the current service models for their pathway, and the main issues facing local services;
- understanding the challenges in greater detail, and identifying options for addressing these challenges;
- working with stakeholders to develop the options and to determine the future models of care and strategic direction;
- developing the preferred option(s) and detail activity, workforce and financial implications and key milestones.

A number of cross cutting themes were identified by the pathway development groups. These were seen as particularly important in developing the capacity in primary and community care to enable care to be provided closer to home. The key aspects of this were care co-ordination and navigation, diagnostics, workforce and integrated primary care teams, information technology and the estate.

As part of the development of the strategy, service strategies have been developed for four 'challenged' services as identified by the West Midlands Strategic Health Authority. In additional the strategy for Urology was added as this service area was highlighted in last year's Strategic Service Plan as needing review.[2]

2.3 Working With Patients and Stakeholders

The process of developing the overall plan was designed to ensure that there was active and effective engagement with key stakeholders through the development of the strategy. To support and advise on the engagement

[2] The challenged service strategies are discussed further in the Report from Clinical Leaders Forum: Challenged Service Strategies, November 2008

activities the Clinical Leaders Forum was advised by Professor Bob Sang, an expert on engaging with the public. A team of communications specialists drawn from across the local health economy supported the process. Each of the Pathway Development Groups was supported by a communications specialist who advised the PDG and supported their engagement and communications activities.

The aims of the Engagement and Communications Plan were to:

- ensure that "Developing Health and Health Care: A Strategy for Shropshire, Telford and Wrekin" leads to a vision that reflects the needs and aspirations of all local stakeholders through the fullest possible engagement in developing and owning the vision for future healthcare in Telford and Shropshire;
- understand our stakeholders' information needs, and address these through clear and timely communications;
- ensure that the NHS in Shropshire, Telford and Wrekin delivers clear and consistent messages to our stakeholders;
- work together as a community of NHS engagement and communications leads to support our organisations to develop a strategy for Health and Health Care in Shropshire, Telford and Wrekin.

The Engagement Plan identified five phases:

- Phase 1: Initial Engagement and Preparation during which key stakeholders were briefed on the process. This culminated in a workshop for some 70 people on 1st February;
- Phase 2 (February – May): Engagement and Development when options and models were developed and alternatives assessed. Much of this work was through the Pathway Development Groups. A number of workshops was held in February and March for particular PDGs and a further workshop on cross cutting themes (Table 1);
- Phase 3 (May – June): Submission of Outline Plans including a workshop on 7th May at which the conclusions of the work to the end of April were presented;
- Phase 4 July – November): Developing the Models of Care and options for the challenged service strategies;
- Phase 5 (2009): Implementation including the potential for formal consultation.

The key stakeholders included the four NHS organisations, NHS staff, local government, the voluntary sector and patients and carers. Stakeholders have been involved in the pathway development groups and the workshops. They have been involved in developing pathways and as pathways are developed and implemented they will play an increasing role. The work in involving stakeholders

must be built on and developed in the future to ensure that stakeholders play a key role in shaping the delivery of health care.

Table 1: Staff and Stakeholder Events

Date	Event	Location	Purpose	Attendance
19th November 2007	Staff Workshop	Albrighton Hall Hotel	Outline process and purpose	Over 100 NHS staff
1st February 2008	Public and Stakeholder Event	Telford, Park Inn	Share preliminary findings and progress to date	86 members of public and staff
20th March	Public and Stakeholder Event	Shrewsbury Football Club	Detailed discussion on planned care, end of life and long term conditions	58 members of the public and staff
14th April 2008	Public and Stakeholder Event	Whitehouse Hotel, Wellington	Children's services	25 members of the public and staff
7th May 2008	Public and Stakeholder Event	Albrighton Hall Hotel	Discussion of PDG Models of Care	78 members of the public and staff
9th July 2008	Staff Event	Mercure Hotel, Albrighton	Leadership and Engagement	Around 70 members of staff
15th and 16th July 2008	Public and Stakeholder Events	Telford and Shrewsbury	Discussion of interim report and next steps	Over 100 members of the public and staff
11th September 2008	Staff Event	Telford, Park Inn	Workforce issues	Over 65 members of staff
9th and 10th October 2008	Public and Stakeholder Events	Telford and Shrewsbury	Focus on children's and Emergency Care	Around 120 members of the public and staff

In addition to the Staff and Stakeholder Events, a wide range of media and briefings with key stakeholders have been used. Activities include:

- briefing papers giving updates on progress and inviting feedback. Seven briefings have been issued to a wide audience of staff, public, and stakeholders - available both electronically and in print;
- a website with information, news, reports, documentation from the events and links to regional and national websites;

- regular meetings with MPs and Council members and officers including joint Overview and Scrutiny meetings;
- regular briefings to staff and staff representatives;
- regular communication with the press
- posters and summary briefings produced explaining pathways and key issues in detail
- presentations and meetings with groups when requested.

Feedback and views of the public have also been sought from individuals and groups and through participation in the Shropshire and Telford and Wrekin Citizens Panels.

2.4 Governance of the Process

A key element in developing the strategy is that it should engage with patients, partner organisations and others and that the strategy should be based on rational information where possible and to have fully considered all the options. In order to assure the public in Shropshire, Telford and Wrekin that this has been done:

- advice was sought from Professor Bob Sang, an expert on engagement;
- meetings were held early with the chairs of the two scrutiny committees to brief them on the process. The purpose of these meetings was to brief the scrutiny committees and it was recognized that these briefings in no way removed the role of local government in reviewing the proposals;
- the scrutiny committees were briefed individually as well as at joint meeting during the process;
- councillors and senior staff of the two Councils were involved in workshops and in wider discussions;
- senior staff from the Councils were on the Clinical Leaders Forum;
- a Shared Governance Committee was established comprising representatives form the Councils, patient representatives and representatives from the voluntary sector. This Group met four times.

Councillors and officers from the two top-tier Councils have been particularly focused on the “making sense to communities” and the NHS and local government interface aspects of this review. Their involvement and contributions have been extremely important but do not indicate sign-up from their respective organisations to the recommendations set out in this and related reports. Nor does it preclude thorough and rigorous scrutiny by the relevant Health Scrutiny Committees.

Finally, the Boards of the four organisations were regularly briefed as were the Professional Executive Committees of the two PCTS.

3. BACKGROUND

3.1 The National and Regional Context

3.1.1 National Context

In July 2007 the NHS launched a national review of the NHS. Led by a practising surgeon and Health Minister Lord Darzi, Our NHS, our Future focused on three themes:

- Quality and safety;
- Access;
- Reducing inequalities.

The review focused on eight care pathways which reflect the main health themes for the population of England:

- Maternity and Newborn Care
- Children's Health
- Planned Care
- Mental Health
- Getting Healthy, Staying Healthy
- Long Term Conditions
- Acute Care
- End of Life Care.

The Our NHS, our future report (titled "High Quality Care for All") and reports from each of the eight Strategic Health Authorities in England were published in the summer of 2008. Our NHS, our future builds on the progress made in delivering the vision set out in the NHS Plan and the Government's reform agenda, to identify the way forward for a 21st Century NHS which is clinically-driven, patient-centred and responsive to local communities.

During the summer of 2008 each PCT developed their strategy for World Class Commissioning. In developing the overarching plan, the work programme was revised to bring it, as far as possible, in line with the timetable for the Strategic Plan. This has ensured that the Strategic Plan is informed by the overarching plan and that the commissioning intentions and activity projections and the overarching plan are consistent.

3.1.2 The Regional Context

NHS West Midlands is one of 10 Strategic Health Authorities. The area covers, some 5,000 square miles, and is home to more than 5.3 million people. The area contains the Coventry-Birmingham-Black Country conurbation and stretches from Leek in Staffordshire in the north to Ross-on-Wye in Herefordshire in the south,

from Bishop's Castle in Shropshire in the west to Rugby in Warwickshire in the east.

Investing for Health is the strategic framework for health services in the West Midlands. The regional plan sets the direction for Primary Care Trusts to determine their local plans that make sense for local circumstances. The framework starts from the understanding that there have been dramatic improvements in many areas, but that the system as a whole is not working as well as it could.

The framework acknowledges that we have to recognise and confront some important challenges if we are to create a health service that meets the needs and rising expectations of local people. It therefore identifies seven 'big challenges' that must be addressed through the framework:

Outcomes and Quality	Challenge 1: Inequalities Widening
	Challenge 2: Variable Quality & Safety
Patient Focus	Challenge 3: Complex Services Difficult to Navigate
	Challenge 4: Lack of Public Confidence in Services
Investment and Cost Focus	Challenge 5: Lack of Upstream Investment
	Challenge 6: Buying things that don't work
	Challenge 7: Costs Increasing Faster than Income

As well as these 'big challenges', the framework also highlights five themes – strategic priorities – that must guide health services in the future:

- Full Engagement;
- Improving Quality and Safety;
- Care Closer to Home;
- Sustainability;
- Organisations Fit for Purpose.

3.2 Health and Demographics[3]

3.2.1 Shropshire County

Shropshire is a predominantly rural county of 289,300 people with a varied landscape covering an area of 3,197 square kilometres. In 2006, the population density of Shropshire was 90 people per square kilometre. This is much lower than the average for England as a whole (389 people per square kilometre) and Shropshire is one of the most sparsely populated counties in England.

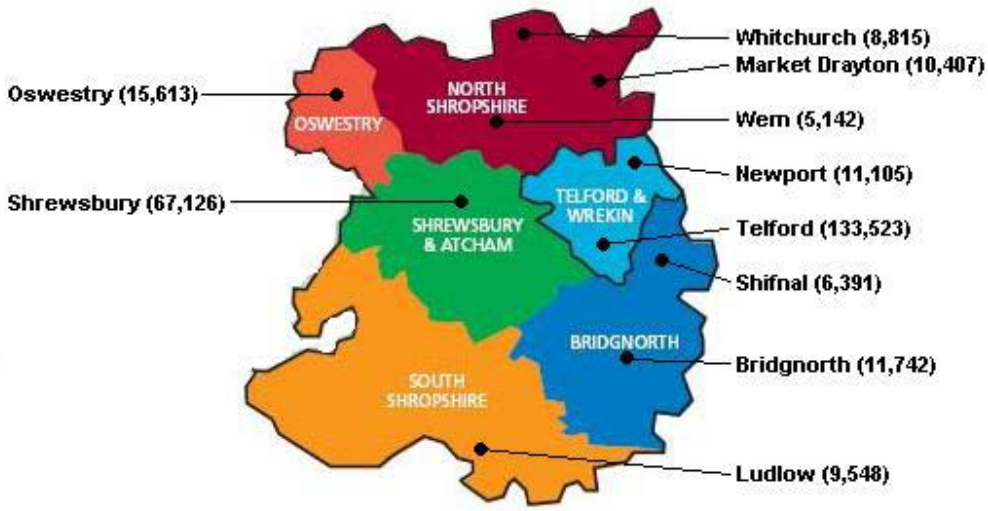
[3] This section draws heavily on information from the Directors of Public Health in the two PCTs and the draft Integrated Business Plan for FT status, SaTH.

The main population centres are Shrewsbury (67,126), Oswestry (16,660), Bridgnorth (11,891), Market Drayton (10,407), Ludlow (9,250), Whitchurch (8,067), Shifnal (6,391) and Wem (5,142).

There are few motorways and dual carriageway roads in the county, which means that most journeys take place on a network of A roads. There are also few rail links within the county, making travel around the county difficult for non-car users – 18% of households do not own a car compared with the England average of 27%.

It is currently a two-tier authority area comprising Shropshire County Council and five county districts (Bridgnorth, North Shropshire, Oswestry, Shrewsbury and Atcham, South Shropshire). Following consultation the Government has supported a proposal to establish a unitary authority in Shropshire which will replace these six local authorities. The new authority will be established by April 2009.

Figure 2: Main Centres of Population in Shropshire, Telford and Wrekin



3.2.2 Telford and Wrekin

The Borough of Telford & Wrekin covers around 112 square miles and has a population of approximately 167,000. At the heart of the Borough is the new town of Telford, so designated in the 1960s and now the local focus for both population and economic growth. The Borough is also home to several small towns - Wellington, Dawley, Donnington, Madeley and Oakengates. To the north of Telford is the market town of Newport and to the south on the bank of the River Severn is historic Ironbridge. The Borough also has a significant rural area which is located to the north and west of Telford and covers approximately 72% of the Borough's total area.

The area is dominated by the large new town of Telford (population 133, 523) and nearby borough towns. The other area of population concentration is Newport (11,015). Transport links are generally better than in rural Shropshire, including the direct M54 link to Birmingham and central England. However, there are still access difficulties for people without access to car transport in the more rural and more deprived parts of the borough – 22% of households do not own a car compared with the England average of 27% and 18% in Shropshire.

3.2.3 Out of Area Patients

In addition to the people of Shropshire, Telford and Wrekin, the local NHS also provides services to the people in the northern portion of the county of Powys, which includes a population of about 62,000 people. The county of Powys has a population of 126,000 people in area of 5,196 square kilometres.

3.2.4 Population Projections and Deprivation

Table 2 gives population by age and population projections over the next 15 years for Shropshire, Telford & Wrekin. The population under 15 is proportionately higher in Telford and Wrekin than Shropshire County (21% and 18% respectively) whilst the proportion over 65 is higher in Shropshire County (20% compared to 14%).

Table 2: Current and Projected Population

	Shropshire County			Telford and Wrekin		
	Population 2007	**Growth 2007-12**	**Growth 2007 - 22**	Population 2007	**Growth 2007-12**	**Growth 2007 - 22**
0-15	51,800	-5%	-7%	33,900	0%	9%
16-64	182,600	0%	-1%	109,300	5%	12%
65-84	49,900	17%	44%	19,900	18%	53%
Over 84	7,300	18%	64%	2,500	12%	48%
	291,600	2%	7%	165,600	**5%**	**17%**

Source: Shropshire County Council and Telford and Wrekin Council

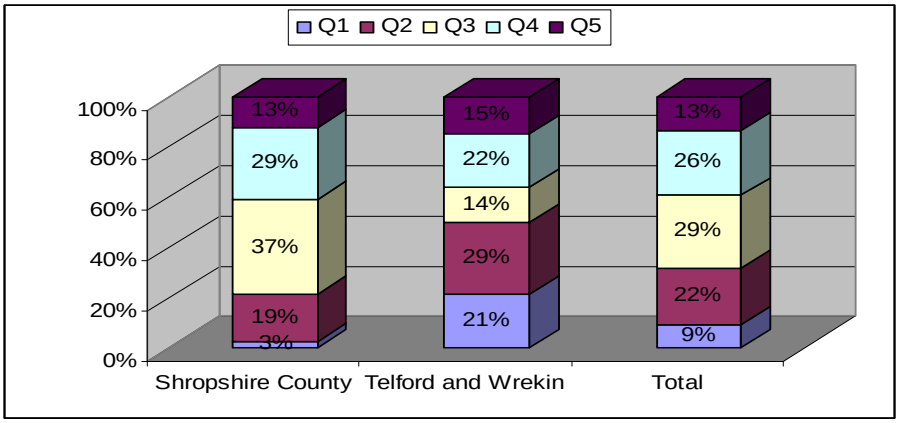
The population is projected to grow by just over 7% over the next 15 years in Shropshire County and by 17% in Telford and Wrekin with the largest growth in the older age groups (the over 65 population is projected to grow 47% in Shropshire County and 52% in Telford and Wrekin). In addition further inward migration into Telford and Wrekin and a significant expansion in house building (it is projected that at least 26,500 additional houses will be needed by 2026), is projected to increase the growth in the working population by 12%, compared to a 1% fall in Shropshire.

There has been a substantial inward migration of people from eastern Europe into Telford & Wrekin in recent years. Approximately 5% of the community are from black and minority ethnic groups. By 2026, it is estimated that the proportion of the population from black and minority ethnic groups will have grown to 6.5%, around 12,900 people.

Figure 3 summarises the levels of socio-economic deprivation in Telford & Wrekin and Shropshire County[4], as measured by the quintiles of the Index of Multiple Deprivation. Nearly half of the Telford & Wrekin population live in the two most deprived national quintiles. Overall, the Index of Multiple Deprivation (IMD) 2007 ranks the Borough as falling within the top third most deprived local authorities in England. This compares to 22% of the Shropshire County population who live in the two most deprived national quintiles.

In Telford & Wrekin 21.4% of the population (nearly 36,000 people) live in areas classified within the most deprived fifth of areas in England. In Shropshire County, 3% of the population (586 people) live in the most deprived 20% of areas in England.

Figure 3 Proportion of Population in National Deprivation Quintiles



The deprivation and health of the children varies across Shropshire, Telford and Wrekin. In Telford & Wrekin 24.5% of children aged 0-15 years live in deprivation, which is statistically significantly higher than the English average (22.4%). In Shropshire County 13.2% of 0-15 year olds live in deprivation, which is statistically significantly lower than the English average (22.4%). As a result there are more children living in deprived circumstances in Telford & Wrekin than

[4] This is a summative measure, based on 37 measures of socio-economic status. Scores are published at "super-output area" level (which exist below ward level and are defined by the 2001 census) and have an average population of around 1,500 people. For comparative purposes, super-output areas are often aggregated into the 20% bandings (quintiles) of the overall score.

in Shropshire County (8,318 in Telford and Wrekin and 6,820 in Shropshire County).[5]

3.2.5 Overview of the Health of the Population

Figure 4 summarises trends in life expectancy. Life expectancy at birth in both men and women is lower in Telford & Wrekin than in Shropshire County. Over the past decade, male life expectancy has improved in both PCTs. Projections indicate that the gap in male life expectancy between Telford & Wrekin and Shropshire County may narrow up to the 2008/10 position. In women, smaller improvements in life expectancy are predicted over the next few years. It is estimated that the gap in female life expectancy between Telford & Wrekin and Shropshire County will persist up to 2008/10.

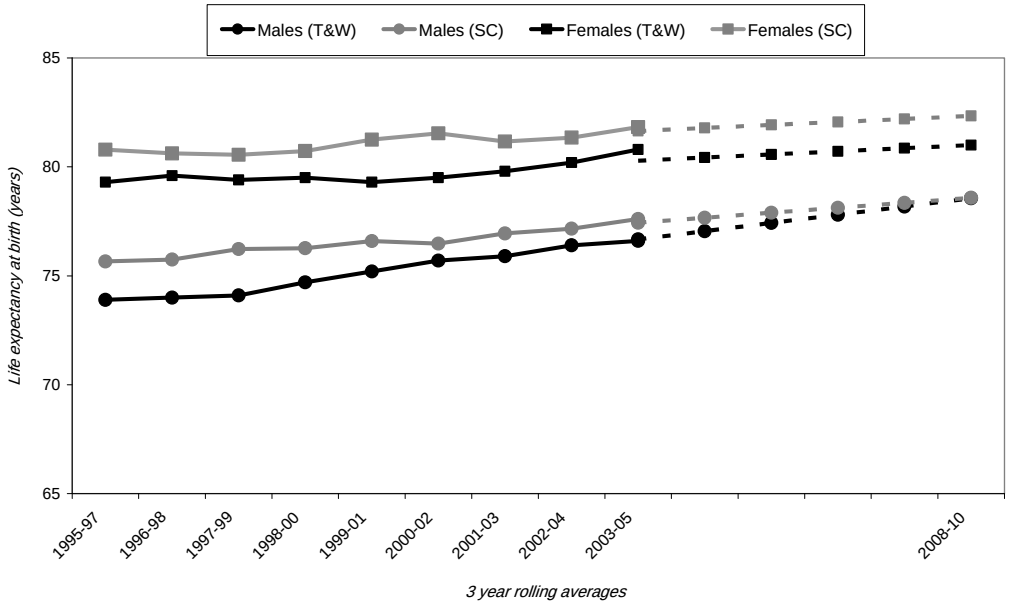
In line with trends elsewhere in England and Wales all age all cause mortality, infant mortality (AAACM) and deaths from circulatory diseases and cancers have been falling since the early 1990s. Comparisons of the health of the population in Telford and Wrekin and Shropshire show that:

- all age all causes mortality are similar to the national average in Telford and Wrekin for men and significantly higher for women than the national average. Those in Shropshire were significantly lower than the national average;
- infant mortality rates in both Shropshire County and Telford & Wrekin are similar to the national average;
- premature death rates from circulatory diseases were statistically significantly higher than the national average in Telford & Wrekin but significantly lower in Shropshire;
- premature death rates from all cancer were statistically similar to the national average in both Shropshire and Telford and Wrekin other than for women which is lower in Shropshire;
- suicide rates for men, women and persons in Telford & Wrekin and Shropshire County were similar to the national average but rising.

The Association of Public Health Observatories provides epidemiological models showing the prevalence of disease on local areas. These are summarised for some of the more common long term conditions in Table 3.

[5] Further detail of deprivation and demographics of children in Shropshire, Telford and Wrekin is given in Technical Paper 4: Children and Young People.

Figure 4: Trends in Life Expectancy, Telford & Wrekin and Shropshire County



Source: Office for National Statistics, Compendium of Clinical and Health Indicators www.nchod.nhs.uk

Table 3: Prevalences for Selected Long Term Conditions

	Modelled Prevalence			Estimated Number of Patients		
	T & W	Shropshire	England	T & W	Shropshire	Total
Diabetes	3.8%	4.2%	4.4%	6,306	12,377	18,682
Coronary Heart Disease	3.8%	5.1%	4.3%	6,283	14,841	21,214
Hypertension	22.3%	27.1%	23.8%	36,888	79,243	116,131
COPD	2.2%	1.8%	2.3%	3,658	5,510	8,808
Atrial Fibrillation			1.1%	1,821	3,219	4,040
Heart Failure			1 – 2%	3,310	5,852	9,162
Stroke			1.5%	2,483	4,389	6,872

Sourced: Department of Public Health, Telford and Wrekin PCT

Other indicators (Figure 5) point to a greater public health agenda in Telford and Wrekin than in Shropshire, where the indicators are generally more favourable. For instance:

- the proportion of babies breastfed at birth in Telford & Wrekin remains significantly lower than in Shropshire County;
- the proportion of mothers still smoking at delivery in Telford & Wrekin is significantly higher than in Shropshire County;
- there has been no improvement in smoking in pregnancy rates in Telford & Wrekin or Shropshire County in the past five years;
- whilst teenage conception rates have fallen, the under 18 conception rates remain significantly higher than the national average in Telford and Wrekin but are in the lowest quartile in Shropshire;
- obesity levels are high compared to the rest of England and rising.

3.2.6 Conclusions

The analysis of demographic trends and public health factors has significant implications of the health and healthcare strategy. When compared to national figures, Shropshire County is generally less deprived, with a low violent crime rate and a lower rate of teenage pregnancies. However there are significant areas of localized deprivation within Shropshire County such as Oswestry and parts of Shrewsbury and Atcham. There is also higher prevalence of long term conditions compared to England. Whilst there is a high level of obesity, there are fewer deaths from smoking, cancer and fewer early deaths from heart disease and stroke.

Conversely, Telford and Wrekin has higher projected growth in population, and a younger and more deprived population. The borough is also in the lowest 20% of areas based on income and employment levels. There are higher rates of early mortality from smoking and circulatory diseases than the average in England. Telford and Wrekin also has relatively high rates of teenage pregnancy and obesity and higher numbers of children living in deprivation.

Figure 5: Indicators of Health

Indicator	Telford and Wrekin	Shropshire County				
		Bridgnorth	North Shropshire	Oswestry	Shrewsbury & Atcham	South Shropshire
Income Deprivation						
Homelessness						
Children in Poverty						
Teenage Pregnancy						
Smoking (adults)						
Binge Drinking (adults)						
Healthy Eating (adults)						
Physical Activity (adults)						
Obese (adults)						
Life expectancy male						
Life expectancy female						
Deaths from smoking						
Early deaths: heart disease & stroke						
Early deaths: cancer						
Infant deaths						
Road injuries and deaths						
Mental health						
Hospital stays due to alcohol						
Drug misuse						
People with diabetes						
Children with tooth decay						
Older people: hip fracture						

Source: APHO and Department of Health

	Significantly worse than England average
	Not significantly different from England average
	Significantly better than England average

3.3 Commissioning Healthcare

Services for the people of Shropshire, Telford and Wrekin are commissioned through the two PCTs as summarised in Table 4.

Table 4: Commissioning Arrangements*

PCT	Population	County Districts	Practice Based Commissioners	PBC Coverage	
				GP Practices	Population (list size) as at 01.01.08
Shropshire County PCT	289,000	Bridgnorth South Shropshire Shrewsbury & Atcham Oswestry North Shropshire	South East South West Shrewsbury Other North West North East	8 8 11 2 7 8	55,371 43,793 83,432 10,189 49,732 51,914
Telford & Wrekin PCT	162,000		Wrekin Small Practices Others	4 5 11	45,831 18,562 104,250
	451,000			64	463,074

* In addition Telford and Wrekin are planning to establish two more practices, one in the town centre and one alongside the Princess Royal Hospital.

Practice Based Commissioning (PBC) is developing in a number of ways within both PCTs. Within Shropshire County PCT, there are four locality commissioning groups covering the North East, Shrewsbury and Atcham, the South West and South East. The other practices are taking PBC forward as individual practices. In the North West, the individual practices work together as and when appropriate. The commissioning plans all support the strategic direction of care closer to home, improved access and vibrant community hospitals.

Service improvement is focused on redesigning traditional out-patients and avoiding preventable admissions using the Advanced Primary Care Services model and other community services. Consultant involvement in these new models of care is seen as a priority and joint working between secondary and primary care clinicians and managers is now well under way.

In Telford and Wrekin PCT there are currently two consortia, the Wrekin Commissioning Group and the Small Practices Consortia. The rest of the practices in Telford and Wrekin are working individually on PBC .

Commissioning of mental health, learning disability, substance misuse, physical disability and older people's service are undertaken on a joint basis with Shropshire County and Telford and Wrekin Councils. In addition, the development of personal budgets and direct payments in social care services

and lead budget-holding in children's services, means that many citizens are beginning to "micro-commission" their own services.

Both PCTs have recently developed strategic plans for World Class Commissioning. The competencies of the commissioners are a key factor in the delivery of a 'World Class' service to the population of Shropshire, Telford and Wrekin. PCTs should not commission services in isolation and in addition to the commissioning of health care services, the PCTs are committed to the consideration of the wider determinants of health and the role of partners, such as local government and the voluntary sector in improving the health. The development of the Health and Healthcare Strategy has engaged with all partners, including patient groups and the strength of that partnership is integral to the success of all of the planned redesign.

The process of developing the World Class Commissioning strategy has shown:

- the local leadership of the NHS;
- effective working with community partners;
- engagement with public and patients;
- strong clinical leadership;
- a understanding of the demographics to assess need;
- prioritisation of investment;
- promotion of improvement and innovation; and,
- sound financial planning.

In developing the strategy and taking forward world class commissioning, the local health economy will build on these principles to ensure that services are fit for purpose and that the right planning and procurement skills are developed to ensure that commissioning of services is an involving, open and transparent process.

3.4 Healthcare in 2008

The provision of healthcare in Shropshire, Telford and Wrekin is summarised in Figure 6 (see page 25) and discussed in this section.

3.4.1 Self Help and Prevention

The NHS works closely with local government and voluntary agencies improve health and quality of life. Examples of Programmes include:

- Help to Quit (H2Q) programmes to encourage and support people to give up smoking;
- programmes to encourage and enable people to exercise;
- adv ice, education, support and specific schemes to reduce dependence on alcohol;

- an active breastfeeding promotion and support programme;
- programme to reduce the level of teenage pregnancy.

Despite these programmes the population of Shropshire, Telford and Wrekin have relatively low levels of health compared to the population of West Midlands. For example:

- high teenage pregnancy rates in Telford and Wrekin
- high alcohol related admissions to hospital;
- prevalence of adult obesity and diabetes, relatively high levels of death from smoking, heart disease and stroke for some sections of the communities.

In common with the rest of the NHS, investment in health prevention is relatively low (Wanless Review) and increased investment could have significant benefits for the population and reduce dependence on the NHS[6].

3.4.2 Primary Medical and Community Services

Primary Care

Primary and community services are currently managed by local PCTs. There are 20 GP practices in Telford and Wrekin and 44 in Shropshire County. Out of hours services are provided by Shropdoc, a not-for-profit company formed by Local Shropshire Doctors to manage their out-of-hours responsibilities. ShropDoc covers the whole of Shropshire, Telford & Wrekin, Powys & Wrexham, a population of some 750,000 people. Improving access to primary care services is a key PCT target.

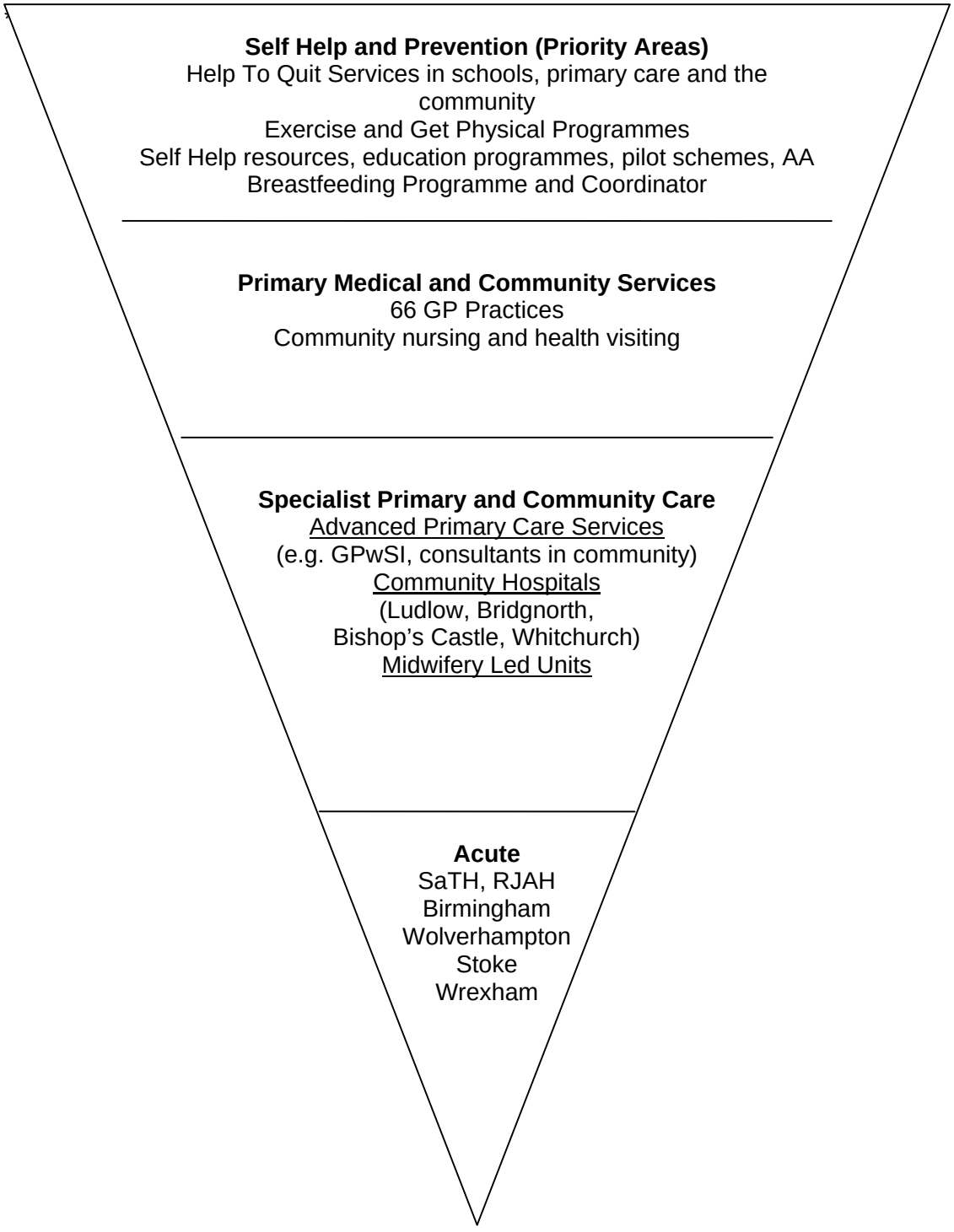
Within Shropshire County, all practices have open lists and all practices report that patients can book routine GP appointments two or more days ahead.[7] The latest survey on availability of appointments shows that:

- over 90% of practices were able to offer a third bookable appointment;
- at 90% of practices, patients could see a primary care professional within 24 hours.

In order to ensure patients can have access to a GP appointment the PCT funds a network of 'buddy appointments' where each week a number of practices across the county reserve appointments which can be offered to any patient where their own practice is unable to meet the 24hr/48hr access target. Patient

[6] Securing Good Health for the Population as a Whole, 2004.
[7] In 2007/08 all 44 GP practices in Shropshire County were signed up to the Access Directed Enhanced Service and to participating in the quarterly Primary Care Access Survey (PCAS). In January 2007 the Department of Health surveyed patients about their experiences of access to primary care services. In Shropshire 42 out of the 44 practices took part in the survey.

Figure 6: Schematic Overview of Healthcare System in Shropshire, Telford and Wrekin



note summaries can be transmitted to the buddy practice if a patient accepts an appointment elsewhere.

The table below shows the results of the Patient Experience for Shropshire and Telford and Wrekin compared with the West Midlands and national performance.

Table 5: Patient Experience in Shropshire County and Telford and Wrekin PCT

	Satisfaction Telephone Access	Access to GP in 2 days	Advanced Bookings	Appointment with specific GP	Satisfaction with opening hours
Shropshire County	92%	87%	87%	94%	85%
Telford and Wrekin	84%	85%	71%	85%	85%
West Midlands	85%	86%	75%	87%	85%
England	86%	86%	75%	88%	84%

In summary people in Shropshire reported better telephone access, better opportunity to book appointments ahead and better access to a GP of their choice, compared to other areas across the West Midlands and in England. In Telford and Wrekin these were slightly lower satisfaction levels. In those practices where satisfaction was below levels elsewhere plans were agreed to improve access through investing in staff or facilities.

NHS Dentistry

Shropshire County and Telford & Wrekin PCT share dental and other independent contractor primary care service arrangements. Dental Public Health and the Salaried Primary Care Dental Service is hosted by Shropshire County. There is also joint working with other PCTs in Staffordshire and throughout the West Midlands through a well-established Dental Public Health network

The objective of a modernised NHS dental service for 21st Century Shropshire are to improve oral health and provide accessible services focused on prevention and high quality, effective treatment. Central to this is the need for children to learn the essential skills to secure and maintain good oral health.

Substantial improvements have been made over the last 3 years to increase access to NHS dentistry and improve oral health inequalities. Within the local population, there are groups who require special attention – hard to reach groups and groups with special needs, rural communities, and people requiring domiciliary care, the homeless, and families of the armed services. The PCTs are developing a flexible service to cater for these groups. For example if a practice sets up in an area of particularly poor oral health contracts can be “stepped” to reflect the initially higher treatment needs of the new patients taken on.

NHS dentistry services will be improved and developed over the next five years through:

- prioritising oral health to ensure that it is an integral to the health improvement agenda establishing a comprehensive preventive care system for children and young people which include enhanced services for those in most need; ensuring that oral health is seen as an integral part of health improvement actions in particular in children and young people with programmes such as Sure Start, health promoting schools programme and community based health improvement programmes; giving responsibility to Community Health Partnerships to achieve a more co-ordinated approach across community based services, to assess needs and respond through multi-professional and multi-agency action and ensuring that dental teams are responsive to the needs of children and that all dental services are child friendly;
- establishing new practices to improve access in rural areas;
- increasing capacity in domiciliary services and specialist contracts for dentists with special interests;
- increasing dental workforce through increased placements, dental nurse training programme and a dental foundation programme;
- reducing waiting times for orthodontic assessment and treatment and develop managed clinical network to reduce admissions to secondary care through improving the capacity in primary care;
- developing plans to improve access for vulnerable groups.

3.4.3 Specialist Primary and Community Care

The focus of specialist and primary care is to support care closer to home through:

- the development of advanced primary care services (APCS) including specialist primary care staff, for example GPs with a special interest (GPwSI), specialist nurses and consultants working in the community;
- a hub and spoke midwifery model;
- joint commissioning of services with the local authorities;
- providing services at the community hospitals in the rural areas of Shropshire.

The way in which the APCS service can work in reducing reliance on the acute sector in is the respiratory service in Shropshire County. This service has three elements: a consultant led APCS; respiratory specialist nurses; and pulmonary rehabilitation. These services work together to empower the patient to manage their condition. With support from the specialist nurses and proactive case management, patients have a self-care plan. This plan includes medication for use when the patient has an exacerbation. Known and new patients are also seen in the APCS and there are strong working relationships with secondary care

clinicians. Patients can also receive informal support as a member of the 'Breathe Easy' club. Discussions are underway with a voluntary group who will visit house-bound patients and offer appropriate support.

In Telford and Wrekin, a Nurse Consultant in primary care is leading the community teams to develop further skills in IV therapies, blood transfusions and community care of more complex patients such as those who require ventilation in order to facilitate early discharge and avoid admission. Care pathways are being carefully process mapped to ensure that GPs and Consultants work together with the community staff to provide safe and sustainable community care.

In other areas there is the potential to give greater support to patients in the community – for instance those with diabetes. Whilst the view is that this should be a primary care led and managed service for all patients except those with complex needs, the reality is that many patients are still reviewed on an annual basis in secondary care with no planned discharge to primary care. Also, for many patients insulin is initiated within secondary care, despite capacity to provide this service in primary care with appropriate support from secondary care.

The proportion of patients treated in the community in 2006/07 was:

- 16% of A and E attendances;
- 25% of births in midwifery led units;
- 7% of new outpatients and 3 % of follow up appointments;
- 3.5% of X-rays.

Services that are available to support the provision of care closer to home and away from an acute hospital are listed below. Services are provided by the NHS, voluntary and charitable organisations, the independent sector and families and other informal carers especially at the end of life:

- Mental Health: beds for short-term crises admissions, rehabilitation and recovery, residential care home, independent living for people with mental health problems drop in services and crises resolution home treatment services. A number of these services including beds for the elderly mentally ill and drop in services are provided by the voluntary/charitable sector e.g. MIND or the independent sector e.g. Coverage Care and Accord Housing, Bennett House;
- Emergency Care: out of hours (Shropdoc), care coordination centre (in hours) a partner organisation of Shropdoc, transfer of non urgent patients between providers predominantly through 'Patients First';
- Long Term Conditions: community nurses, diabetes nurse specialists, services provided by voluntary agencies e.g. brain injury and support groups e.g. stroke, arthritis Ludlow Group, Copt Horne Cardiology Group;

- Children's Services: CAHMS, out-patients at community hospitals and Monomer campus, respite and palliative care, Hope House, CYP Services;
- Planned Care: advanced primary care services (APCS) in dermatology, ENT, gynaecology, minor surgery, respiratory, orthopaedics, outpatients;
- End of Life: Macmillan outreach teams, Marie Curie nursing, hospices (Severn), pilot GPwSI pilot in Telford, SE and NE Shropshire, nurse specialists in the community and consultants domiciliary visits.

Shropshire is well served by community hospitals with community hospitals in Bishop's Castle, Bridgnorth, Ludlow and Whitchurch. The community hospital services are summarised in Table 6.

There are no NHS community hospitals in Telford and Wrekin, although there is a private community facility in Newport – Newport Cottage Care. There are a number of towns with significant populations which have primary care and are a distance from Telford or the nearest acute hospital and where there is a need to develop services closer to home.

Shropshire County PCT has an ongoing programme to improve and develop the community hospitals. Recent refurbishments have included Bridgnorth and there are plans to refurbish Bishop's Castle. A major project to develop a new healthcare campus in Ludlow will provide:

- outpatient, diagnostic and therapies;
- minor surgery and endoscopies;
- a minor injuries unit
- intermediate care beds;
- midwifery and children's centre;
- base for mental health services;
- healthy living centre;
- GP services;
- dental, pharmacy and optician services.

The proposal to develop Ludlow Hospital focuses the on integration between hospital and community services and to support the care of people closer to home. It is anticipated that the campus will provide for some 500 admissions a year, 18,800 outpatients (up to 70% of outpatient activity), 6,200 minor injuries together with associated diagnostic procedures and therapy support and 100 births a year. The proposals will also improve access to primary care. The model of care is shown in Figure 7.

Figure 7: Ludlow Community Hospital Advanced Primary Care Service

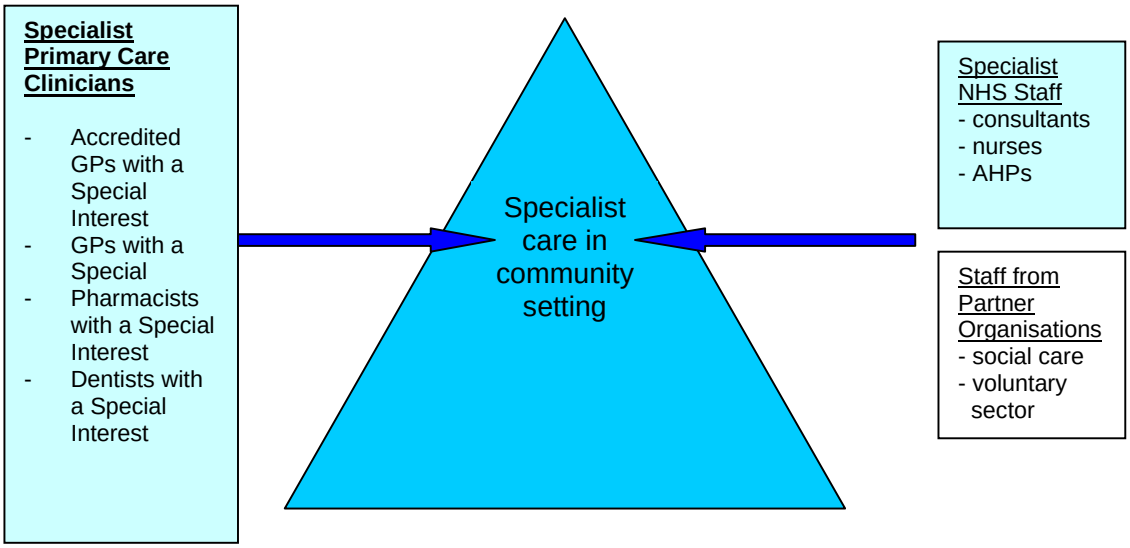


Table 6: Community Hospitals and Hospital Based Services*

Hospital	Population	Facilities	Services
Bishop's Castle	1,630	18 beds MIU Physiotherapy	Rehabilitation and inpatient beds for the elderly Visiting services – audiology, podiatry, speech therapy.
Bridgnorth	11,742	25 beds 4 Theatre Beds MIU/DAART Outpatient facilities Midwifery led unit (2 labour rooms, 4 postnatal beds) Day Surgery Ultrasound X-Ray Physiotherapy Surgical Podiatry	Rehabilitation and inpatient beds for the elderly Midwife-led maternity unit Consultant outreach services (Dermatology, Cardiology, General Surgery, Paediatrics, ENT, Orthopaedics, Neurology, Respiratory, Gastroenterology) APCS in ENT Range of Voluntary Support Groups Visiting services – audiology, podiatry, speech therapy.
Ludlow	9,548	40 beds MIU Outpatient facilities Midwifery led unit (2 labour rooms, 7 post natal beds) X-Ray	Rehabilitation and inpatient beds for the elderly Midwife-led maternity unit Consultants outreach services (General Surgery, Paediatrics, Respiratory, Obstetrics and Gynaecology) Range of Voluntary Support Group
Whitchurch	8,815	32 Beds 16 older adults Mental Health beds MIU Outpatient facilities Physiotherapy Occupational therapy Social Care Day Centre X-Ray	Rehabilitation and inpatient beds for the elderly Nursing for MH beds provided by South Staffs NHS Trust Consultant outreach services (Cardiology, General Surgery, Paediatrics, ENT, Gastroenterology, Obstetrics, Orthopaedics, Respiratory, Gynaecology) Range of voluntary Organisation support groups

* There are also midwifery units at Robert Jones and Agnes Hunt Hospital (6 post natal beds), The Royal Shrewsbury (13 beds) and The Princess Royal in Telford (14 beds).

3.4.4 Acute Services

Acute Hospital services are mainly provided by The Shrewsbury and Telford Hospital NHS Trust and the Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust as well as other hospitals in Stoke, Wolverhampton, Birmingham and Wrexham.

The Shrewsbury and Telford Hospital NHS Trust is the main provider of acute hospital services for Shropshire, Telford and Wrekin and also mid Wales. The Trust runs the Princess Royal Hospital in Telford, the Royal Shrewsbury Hospital, midwife-led units in Ludlow, Bridgnorth and Oswestry as well as other outreach services (e.g. specialist nursing).

The Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust is a specialist hospital providing elective orthopaedic surgery and musculoskeletal medical services as well as some local hospital services for communities in and around Oswestry.

Together these Trusts treat 83% of the patients from Shropshire County (77% of acute expenditure) and 96% of the patients from Telford and Wrekin (92% of acute expenditure). The two PCTs are therefore very dependent on the two local Trusts (Table 7).

Table 7: Activity and Expenditure by Acute Provider for Shropshire County PCT and Telford and Wrekin PCT

	% Patients Treated		% Acute Expenditure	
	Shropshire PCT	T & W PCT	Shropshire PCT	T & W PCT
The Shrewsbury and Telford Hospital NHS Trust	68%	94%	65%	89%
Robert Jones and Agnes Hunt Orthopaedic and District Hospital	15%	2%	12%	3%
Other	17%	4%	23%	8%
	100%	100%	100%	100%

There is limited choice for people in the west of Shropshire with the main alternative provider being the Nuffield Hospital Shrewsbury. The choice is much greater for people in the east of Shropshire County PCT and in Telford and Wrekin PCT. The population of Market Drayton or Bridgnorth have up to ten alternative providers available within 25 miles – including major NHS and private providers in Birmingham, Wolverhampton and Stoke.

3.4.5 Local Authority Services

Shropshire County Council and Telford and Wrekin Council provide a broad range of 24 hour and community based services. These include:

- Joint Commissioning with the NHS including mental health, learning disability, substance misuse, physical disability and older people's service;
- Services for Children and Young People including school and community cluster teams, integrated with the NHS, Police and other partner agencies; education services; specialist social work; Children's Centres / Sure Start programmes; residential care; educational psychology and support for young people with severe emotional and behavioural needs; specialist services for children with disabilities; youth offending services; and adoption, fostering and family placement;
- Adult Social Services including specialist assessment, care management and social work services as part of older people's services, physical disability and sensory loss services; joint intermediate care services; joint mental health services; learning disability services and substance misuse services; occupational therapy services; direct payments services; advocacy services; carers services; and The Supporting People programme.

In addition, Telford and Wrekin Council and the five district councils in Shropshire (and the new, unitary Shropshire Council from 2009) provide, or commission, other key services which impact on health and health care. These include housing and homelessness services; disabled adaptations and equipment services; home improvement and repair services; affordable warmth / fuel poverty services; benefits advice; Environmental Health and Food Safety Services; and Leisure Services.

4. STRATEGIC CONSIDERATIONS

4.1 Health, Wellbeing and Equity

As described in Section 3, the population of Shropshire, Telford and Wrekin will change dramatically over the next 15 years. Of particular importance is the increase in the number of people over 65 of 17% in Telford and Wrekin by 2012 (52% by 2022) and 17% in Shropshire (47% by 2022). There are also concerns about the rising obesity levels, levels of smoking, alcohol and substance abuse and high teenage pregnancy rates. The health and healthcare strategy proposes an increase in the investment in health promotion to:

- enable an increasingly elderly population to live independent lives;
- focus on the areas of particular concern including reducing smoking, alcohol and substance abuse and reducing teenage pregnancy rates;
- promote an increase in activity levels and other lifestyle changes to reverse the rising levels of obesity.

Failure to invest in health promotion and work with local government and other agencies will lead to increasing demands on the health services and an increasing dependency on hospital services. There will also be significant increases in demand on other services such as social services.

Some sectors of the population have poorer access to services where earlier access would significantly improve the outcome for patients and/or avoid the need for more costly treatment and care. For example this is an issue in maternity services for disadvantaged groups such as those with mental health problems, those experiencing domestic violence and migrants.

4.2 Quality, Safety and Effectiveness

There are national standards and policies which this strategy needs to ensure are delivered. These include:

- the Darzi Review of the NHS
- the West Midlands SHA Investing For Health;
- ensuring timely access to both primary and secondary care services;
- giving patients a choice about where they get their treatment and care;
- National Service Frameworks and strategies;
- national standards on clinical services;
- guidance from the Royal Colleges, the National Institute for Health and Clinical Excellence (NICE) and the Healthcare Commission.

This guidance has been incorporated into the work of the Pathway Development Groups and is referred to in the PDG reports.

4.3 Supporting and Developing the Workforce

Section 4.5 details significant challenges facing the medical workforce and the ability to continue to provide some services within the present configuration of services in the hospitals. A key element of this is the ability of the NHS to offer attractive jobs to highly trained clinical staff and to successfully recruit and retain high quality clinical staff

The Darzi review has identified the importance to patients of providing high quality care closer to where people live and to enabling them to lead independent lives with the support of healthcare professionals. This has significant implications for the clinical workforce, for instance:

- developing specialist skills in the community;
- enabling those with specialist skills in the hospitals to take a more active role in community and primary care settings;
- supporting the more dispersed provision of care with information technology and access to information and advice.

Providing care closer to home will require the further development of primary care and community teams and close working across the health and social care sectors, with voluntary agencies and other services. The strategy will need to ensure that there are programmes and initiatives in place to ensure that the current working relationships are strengthened and developed and to support the workforce in collaborating across different agencies.

4.4 Involving People in Making Decisions About Their Future Health Services

The development of this strategy has been clinically led and has involved patients, the voluntary sector and partner organisations including local government. The further development of the strategy must build on this and actively involve stakeholders in the development of plans for the future of health care services.

The strong message that has come from the patient and patient groups involved in the strategy is that patients want to be more actively involved in decisions about their own care and, wherever possible, to take responsibility for managing their condition. This happens in many instances. But in many others it will require changes in the approach in both secondary and primary care. Patients will need to have greater information to make choices about their care and healthcare professionals will need access to information about the care that has been provided by other healthcare professionals.

The way that clinical teams work and the need to provide information and signposting to help patients ‘navigate the health care system will be central to enabling patients and carers to take more control over their care and their lives.

4.5 Affordable, Sustainable and Fit For Purpose

4.5.1 Clinical Viability of Hospital Services

Over the next 10 years a number of trends that have been seen in the configuration and nature of services traditionally provided in district general hospitals. These are anticipated to accelerate. Specifically:

- an increasing range and complexity of work can now be carried out in primary and community care settings and closer to where people live;
- some specialist services will be concentrated in fewer major centres;

The two hospitals in Shrewsbury and Telford are similar sized hospital for emergency admissions and A and E attendances There are significant challenges to continuing to provide emergency services from two sites and continue to provide 24 hour a day out of hours cover by senior medical staff to both hospitals. This has become increasingly difficult over the last ten years as a result of:

- sub specialisation with medical staff becoming more specialist;
- out of hours arrangements – in some specialties there are consultants covering a number of services and/or sites at the same time;;
- European Working Time Directive (EWTD);
- training of medical where trainees support the delivery of training and there are conflicts between the service and the training needs;
- difficulties in recruitment.

The current provision of services has also limited the ability to develop more specialised services that could be provided in Shropshire, Telford and Wrekin, for instance vascular surgery and paediatrics.

These issues are discussed in more detail in the CLF's report on challenged service strategies.[8] In summary, continuing to provide services for the seriously ill and injured from two sites for the population of Shropshire, Telford and Wrekin and Powys is increasingly difficult and carries with it risks to patients, pressure on medical staff and limits the ability to develop more specialist services. At the same time, the urban population concentrations in Shrewsbury and Telford combined with the rurality of the population in Shropshire County and the deprivation levels in Telford and Wrekin provide major challenges for access to health care services. The strategy will need to ensure that both these issues are taken into account.

[8] Challenged Service Strategies, Report from Clinical Leaders Forum, November 2008.

4.5.2 Financial Viability

During the last decade the NHS has received unprecedented increases in funding. Growth is projected to increase by 4% in real terms over the next three years. Within this financial outlook there are pressures on resources and demands to meet the increasing needs of the population and to finance new developments. Many of these pressures are no different to pressures faced elsewhere in the NHS.

There are however some specific issues affecting the financial viability of services which need to be incorporated within the strategy in addition to those felt throughout the NHS. These include:

- the current configuration of services result in duplication of hospital services across three sites and particularly across the Royal Shrewsbury and Princess Royal Hospitals;
- Telford and Wrekin PCT are currently subsidising access to paediatric inpatient services by paying SaTH an additional £200,000 per year over the amount paid per patient to enable them to recruit additional staff. This is likely to increase further with the European Working Time Directive to around £400,000;
- the need to invest in medical staff to support emergency services across two sites. It is estimated that this would be between £1 million and £2 millions depending on the precise configuration.

The Robert Jones and Agnes Hunt NHS Trust in Oswestry is facing significant financial challenges and a review is currently underway, supported by external financial consultants. This work is being taken forward as a parallel but separate exercise.

4.6 Personalised Services and Access to Care Closer to Home

4.6.1 Care Closer to Home

An increasing range of healthcare can be effectively provided closer to home so avoiding a visit to or stay in an acute hospital is one of the strategic principles. Table 8, summarises the current situation and best practice from elsewhere in the country for selected services. It is clear that there is considerable scope to move care closer to home which the strategy will need to accommodate and support.

Table 8: Potential to Treat Patients Closer to Home

	Clinical Service – Best Practice	Best Practice[9]	Current Practice
Acute Care	Urgent Care and Minor Injuries		19% A & E Attendances
Planned Care	Dermatology - community services to manage skin conditions	80 % plus avoidable admissions	11%
	Neurology		0%
	General Surgery – direct access minor surgery clinics, nurse led clinics	35% reduction in outpatient attendances	<5%
	Urology – specialist nurses, nurse led clinics, GPwSI flexible crystoscopy examinations and endscopy lists	40% reduction in outpatient attendances	0%
	Urology – improve drug therapies, diagnostics and community management of kidney and urinary tract infections	50%-80% kidney/urinary tract infections admissions avoidance	0%
	Musculo-skeletal – triage team, extended scope for physiotherapists, GPwSI, multi professional clinics	40% reduction in outpatient attendances	10%
	ENT - GpwSI developments for range of conditions	40% reduction in outpatient	<5%
	Ophthalmology – protocols for cataracts, rapid access clinics to community optometric clinics, nurse led pre assessment and follow up	35% reduction in outpatient attendances	0%
	Other Medical Outpatients		<5%
Long Term Conditions	Cardiac – management of ongoing cardiac conditions	Heart failure 30% - 50% Chest Pain 50%	<5%
	Diabetes	25% plus avoidable admissions	0%
	Respiratory – specialist services in the community to manage COPD and asthma	Asthma 33% to 50% avoidable admissions COPD 20% - 50% avoidable admission	<5%
Maternity	Births in midwifery led units, at home		25%
Mental Health	Hospital at home and community nursing Improved assessment and triage at A & E		
Staying Healthy	Smoking, obesity, alcohol abuse		n/a
End of Life	Increased choice to die at home		23% of people wanting to die at home do so

[9] West Midlands SHA Local Health Economy Overarching Plans Analysis, February 2008, Team Work Management Services.

4.6.2 Access to Hospital Services

A detailed assessment of access to hospital have been undertaken using drive time data provided by Dr Foster, adjusted to reflect market share. This has provided an estimate of the 'effective' catchment population (Table 8).

Table 9: Effective Catchment Populations of the RSH and PRH[10]

	PRH	RSH	Total	Other Trusts
Shropshire County	74,456	154,448	228,904	60,696
Telford and Wrekin	150,382	0	150,382	11,218
Montgomeryshire	0	36,819	36,819	22,931
	224,838	119,267	416,105	94,845

The conclusions of the drive time analysis are:

- over 80% of the population of Shropshire, Telford and Wrekin live within a 40 minute drive of the RSH or PRH;
- some 5% of the 'effective' catchment population have a drive time of over one hour. The areas affected are parts of Shropshire County (2% of the population) and Montgomeryshire (41% of the population);

The analysis is based on drive times. The greater deprivation and lower car ownership levels in Telford and Wrekin would further impact on the population without a car and/or require greater use of public transport or the ambulance service to access services. The health of the population and deprivation levels are discussed in Section 3.2.

The views of patients when choosing a hospital for planned care were obtained through participation in the two Council's Citizen Questionnaire. In summary:

- 60% of the population in Shropshire County and 68% of the population put quality of care, reputation of the hospital and expertise of the surgeon ad the most important factor;
- 11% of people in Shropshire County and 15% of people in Telford and Wrekin felt that speed of treatment was the most important factor;
- Proximity of the hospital was the most important factor for 11% of people in Shropshire County and 13% of people in Telford and Wrekin;
- 10% of people thought cleanliness was the most important factor.

Whilst proximity of care is likely to be of greater importance when considering emergency care, it is clear that safe and effective services are critical issues for the people of Shropshire, Telford and Wrekin.

[10] Technical Paper 1: Access. The 'effective' catchment population is based on an analysis of drive times to hospitals and non elective market share.

4.7 Issues Identified by Pathway Development Groups

In addition to the issues regarding the challenged strategies discussed above, the Pathway Development Groups through the assessment of their services, discussions and workshops with stakeholders identified a number of issues facing the services and areas where services could be improved. These are detailed in the reports from the PDGs and summarised in Table 10.

Table 10: Overview of Issues Identified by Pathway Development Groups

	Principle	**Staying Healthy**	**Maternity & New Born**	**Children's Services**	**Acute Care**	**Planned Care**	**Long Term Conditions**	**Mental Health**	**End of Life**
M A K I N G S E N S E C L I N I C A L L Y	Health, Well Being and Equity	Ageing population. Increasing obesity levels. Alcohol and substance misuse. Teenage pregnancy rates in Telford and Wrekin	Inadequate support for mental health and substance abuse patients, domestic violence victims and migrants. Outcomes worse in poor areas. High teenage pregnancy rates, Telford.	Strengthen early intervention & prevention - obesity, oral health, sexual health, and alcohol abuse, all rising or above England average in some areas. Increasing prevalence of children with LTC/disabilities.	Ageing population. Access for those with mental health problems need improving.	Increasing obesity levels. Ageing population	Increasing demand with ageing population. Poor access for mental health and people with learning disabilities. Higher prevalence in lower paid & unemployed.	Ageing population and increasing dementia.	Ageing population. Focus almost entirely on cancer, need to consider other long term conditions.
	Quality, Safety and Effectiveness		Ante natal care access. Ante natal screening. Midwives not always available through established labour. Labour ward cons cover. NICU only recognized as level 2.	Clinical viability of inpatient services on two sites. Need earlier intervention and shorter waiting times for CAHMS. Nursing capacity at PRH. EWTD.	Clinical viability - workforce issues in A and E, surgery, anaesthesia and critical care. A and E targets. Stroke care standards not met. EWTD.	18 week target. Need to improve access to diagnostics. Cancer strategy.	Inadequate early detection. Proactive care not risk stratified. Variable standards e.g. those with co morbidities, stroke services. Limited shared information between professionals	Care too secondary care biased. Support to GPs too specialized. Need more emphasis on recovery, not long hospital stays.	Variable, dependent on voluntary sector. Support for those dying in hospital needs improving.
	Supporting & Developing the Workforce	Limited knowledge of staff re services.			Primary care capacity if care moves from acute.	Primary care capacity if care move to community.	Need to improve capacity and training.		Need to improve awareness and skills.

	Principle	Staying Healthy	Maternity & New Born	Children's Services	Acute Care	Planned Care	Long Term Conditions	Mental Health	End of Life
MAKING SENSE TO COMMUNITIES	Involving People in Making Decisions about Their Future Health Services		MSLC not fully established.	Voluntary sector involvement	Lack of information for people to make choices.	Lack of information for people to make choices.	Limited involvement of voluntary sector and patients/carers in planning future health services.	Good involvement	Scope to strengthen links with voluntary sector
	Affordable, Sustainable and Fit for Purpose	Higher priority needs to be accorded to prevention.	Facilities at RSH not fit for purpose. Ludlow MLU needs updating.	Inadequate therapy capacity. Lack of adolescent beds. High acute admissions to hospital.	Delayed discharge. Ludlow Hospital facilities need improving. Separate elective from emergency	Are RSH facilities suitable for 21st century. Ludlow Hospital facilities.	Scope to reduce admissions and length of stay.	Skelton Hospital facilities need rationalising and improving.	Reliant on charitable sector.
	Personalised Services and Access to Care Closer to Home		Need better ante/post natal care in community settings. Midwifery led units support more births. Community support for breastfeeding needs strengthening.	CAHMS and disabilities - transition of care from child not well managed. Social care/health care systems not fully coordinated. Too hospital based.	No single 'portal of entry'. Need to strengthen urgent care services outside of A and E.	Do patients have real choice. High cancellation rates for out & in patients. Scope to increase care outside acute setting. Limited role of 'ACPS'	Reactive, not proactive. Care fragmented. Limited self management. Need more information & education for patients. Transition to adult care not well managed.	Transition between children and adults inadequately managed. System is not well enough coordinated.	23% people die at home compared to 50% who say they would prefer to die at home. Care fragmented. Lack of information re support.

5. STRATEGIC OBJECTIVES

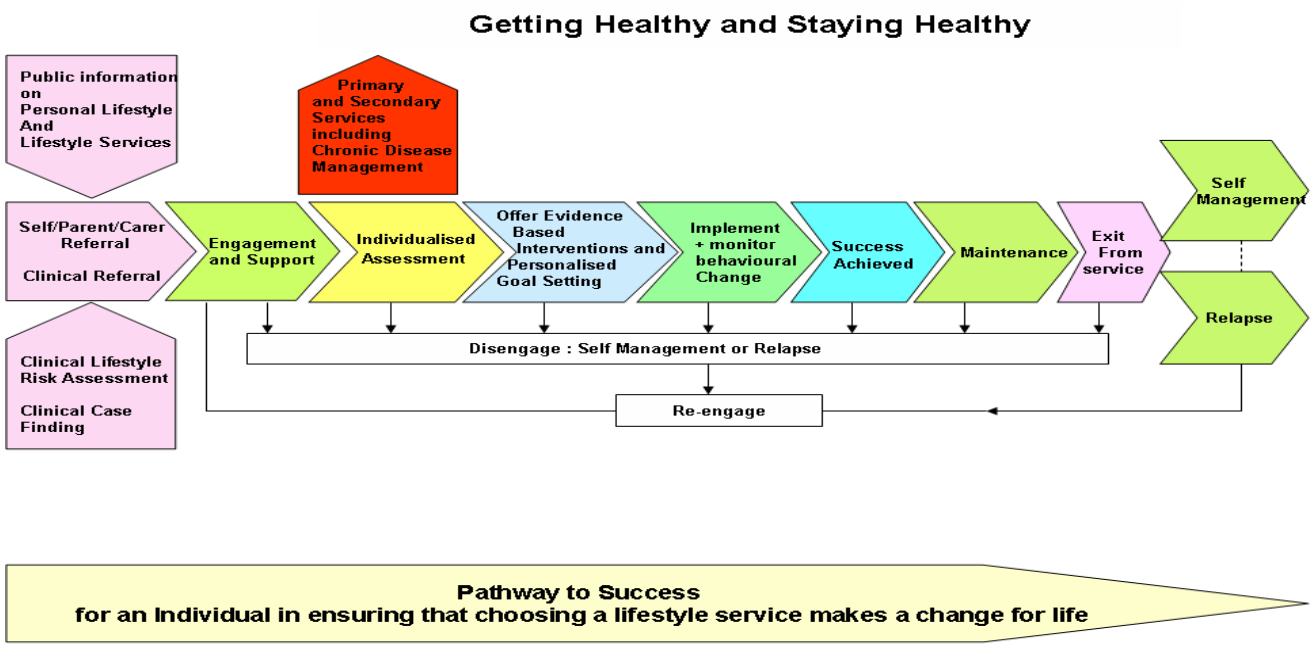
The Vision for Heath and Healthcare Services in Shropshire, Telford and Wrekin has three main objectives:

- The prevention of disease and the promotion of healthy lifestyles and independent living;
- Provision of services at home or as close to home as possible;
- Provision of sustainable and accessible acute hospital services.

5.1 Prevention of Disease and Promotion of Healthy Lifestyles

The 2020 Vision is one where people are encouraged and helped to lead a healthy lifestyle and, for those with long term conditions, individuals manage their disease and are supported to lead as independent a life as possible. The 2020 for Getting Healthy, Staying Healthy is the Wanless[11] fully engaged scenario where the lifestyle change model is fully developed and geared up to respond to maximum demand for lifestyle change services. The Model of Care for this is shown below.

Figure 8: 2020 Vision for Model of Care for Getting Healthy, Staying Healthy



[11] The Wanless Review: Securing Good Health for the Whole Population: Final Report, Department of Health February 2004.

5.2 Care Closer to Home

The prevalence of long term conditions[12] and those living with the effects of a disease such as cancer will increase by 25% over the next 20 years due to an ageing population and the earlier treatment of patients earlier so enabling them to live longer with their disease. For this group of people, living an independent life will not only improve their quality of life over an increasing number of years but also reduce the demands on the health service. For those people nearing the end of their life, they will be supported in their choice of where they want to die through voluntary, health and social care services and the independent sector working together to provide a range of integrated and coordinated services.

The proposed strategy aims to provide personalised services and access to care closer to home through:

- patients managing their care and exercising choice about how and where they receive their care;
- strengthening and development of the Advanced Primary Care Services model;
- continued developments of pathways across primary and secondary care;
- better information and sign posting for patients;
- developing specialist community services including community hospitals, midwifery led units and integrated working across primary and health and social care teams, strengthening community nursing and diagnostics in the community;
- involvement of the voluntary sector and local authorities in planning and delivering services;
- increased specialist skills in the community and advice to primary care including specialist GPs, consultants and specialist nurses working in the community and making use of technologies to provide information and advice to health care professionals;
- development of facilities in the community including community hospitals and primary care premises.
- a network of health facilities linked electronically to provide information to professionals, patients and carers.

5.3 Sustainable and Accessible Hospital Services

The third strategic objective is to ensure that hospital services across Shropshire, Telford and Wrekin are sustainable and that there is a network of community and acute hospitals within Shropshire, Telford and Wrekin. Specifically:

[12] Long Term conditions are those that cannot at present be cured but can be controlled by medication and/or other therapies. LTCs include diabetes, coronary heart disease, respiratory diseases and those with complex morbidities. Mental health which has many of the same characteristics as a LTC was considered by the Mental health PDG.

- A single acute service will be provided across two sites for the next ten years with the immediate challenges to emergency care and paediatrics addressed;
- By 2020 all emergency services for the seriously ill and injured should be concentrated onto a single site. The way in which this should be done will be assessed through a detailed options appraisal.

6. MODELS OF CARE

The following pages provide two-page summaries of the models of care developed by the eight Pathway Development Groups:

- Maternity and Newborn Care
- Children's Health
- Planned Care
- Mental Health
- Getting Healthy, Staying Healthy
- Long Term Conditions
- Acute Care
- End of Life Care

Maternity and Newborn Care

Summary of our local clinical vision for a world class service

Here we summarise ideas from local clinicians for improving maternity and newborn care throughout Shropshire, Telford and Wrekin over the next five years in order to provide 'world class' care.

In developing these proposals, clinicians from Shropshire County and Telford and Wrekin have worked together with local communities, NHS and social care staff and other key partners. In addition, they have drawn on the regional framework for maternity and neonatal care recently published by NHS West Midlands.

What has emerged from this is a suggested vision for delivering the highest possible quality of services for mothers and babies.

We welcome your views and comments so that we can publish a local framework for health and health care in Shropshire, Telford and Wrekin in October 2008.

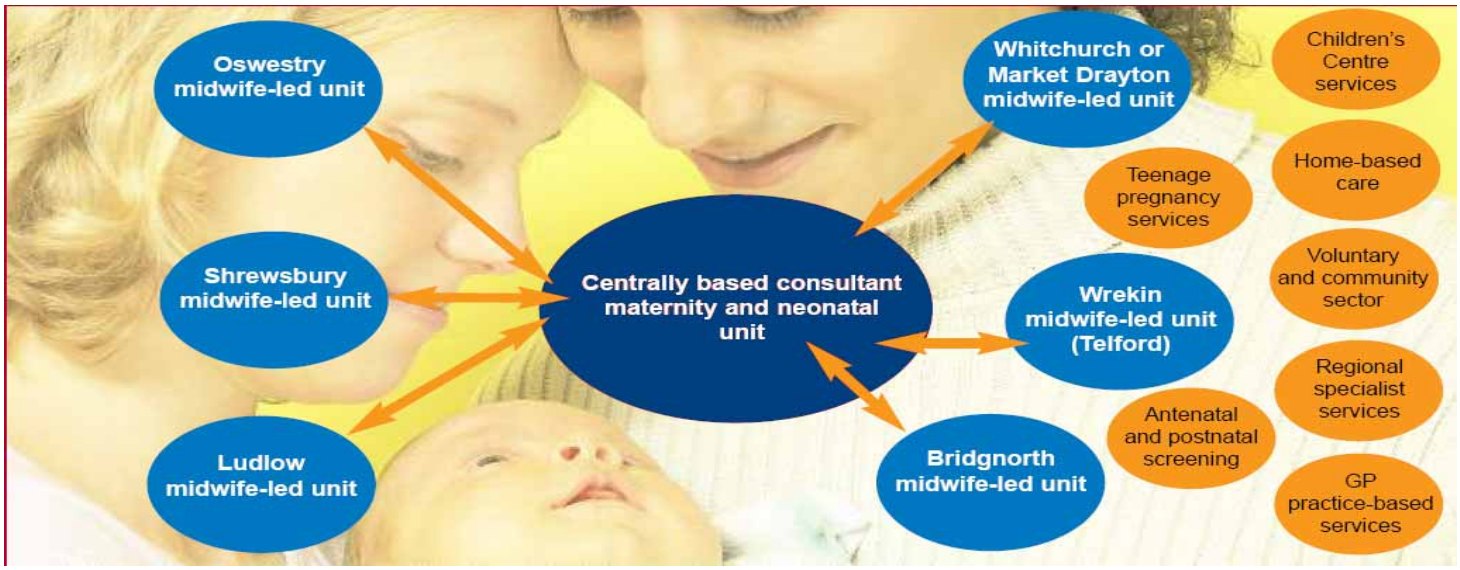
Key elements of our proposed pathway

In drawing up our proposed pathway, we have been mindful of several key factors:

- Projected increases in the birth rate in Shropshire, Telford and Wrekin
- The current absence of a midwife-led unit in the north east of Shropshire, which results in 25% of births taking place outside the county
- Midwifery staffing levels falling below levels recommended in the Maternity Matters strategy
- The need for medical staffing rotas to comply with EU working time directives and the Safer Childbirth review
- The need for further investment to improve facilities at the consultant-led unit and at the midwife-led units in Ludlow and Shrewsbury

Our proposed maternity care pathway is set out in the diagram on this page. As it shows, no major changes to the current model of care for Shropshire, Telford and Wrekin are proposed, other than the development of a midwife-led unit in Whitchurch or Market Drayton and delivery of more antenatal and post-natal care in children's centres and midwife-led units in the county.

We will continue to have a centrally located, consultant-led maternity and neonatal unit as the hub of the network, together with local midwife-led units. Out of around 5,000 births a year in Shropshire, 1,400 of those considered to be 'low risk' currently take place in five midwife-led units based in Shrewsbury, Oswestry, Ludlow, Telford and Bridgnorth or at home. We will support more women in giving birth to their babies at one of these units or in their own home. We will also take a fresh look at the configuration of neonatal units that has been developed by the Shropshire, Staffordshire and Black Country Newborn Network.



Implementing our 2020 vision

Key Performance Indicators

1. Early Booking
Target: 80% in first trimester

2. Continuity of Care
Target: 75% of visits with the same maternity health care professional in community settings

3. Detection of fetal growth restriction
Target: 60% of growth restricted babies detected antenatally

4. Smoking in Pregnancy
Target: Reduced to a prevalence of 15% by 2010 or 1% reduction per year

5a. Breastfeeding
Target: Increase in breastfeeding initiation rates by 2% per year

5b. Breastfeeding
Target: To establish breastfeeding prevalence at 6-8 weeks from birth

Improved maternity facilities

Under our proposals, hospital-based inpatient and outpatient maternity and neonatal facilities will be significantly enhanced.

A second operating theatre and recovery facilities are required to meet current requirements and the additional demand arising from the projected rise in the birth rate.

We believe that these developments are best undertaken at the main consultant-led unit, although its location will need to be reviewed in the context of the broader scenarios for the future of health services in Shropshire, Telford and Wrekin.

In addition, the existing midwife-led units in Shrewsbury and Ludlow will be enhanced.

Medical and midwifery staffing

To deliver the highlighted KPI's and the recommendations of 'Maternity Matters', the Maternity workforce will be expanded. Midwifery and Support Worker staffing levels will be increased to levels recommended by Birth Rate Plus and Safer Childbirth.

The increase in Midwives and Support Workers will enable one to one care in labour, women to see the same midwife for at least 75% of her community visits and achieve improved breastfeeding rates and Baby Friendly status.

Additional senior and middle tier obstetricians will be required to meet NHSLA standards, Safer Childbirth recommendations and EWTD requests, let alone to deliver high quality medical care.

Additional anaesthetists and theatre staff are required to support 24 hour dedicated Consultant labour ward cover.

Recommended action

To move these proposals forward, it is recommended that:

- A business case be prepared for a midwife-led unit at Whitchurch or Market Drayton
- Enhancement of the midwife-led unit at Ludlow, together with plans for expanded children's centre services, be included in the business case for the development of the site as a social enterprise
- A business case be developed for improvements to maternity and neonatal facilities at the Royal Shrewsbury Hospital
- A workforce development plan be completed for midwifery, obstetrics and neonatal nurses

In addition, it is recommended that plans for the Re-designation of neonatal units in Shropshire, Staffordshire and the Black Country be reviewed to take account of our concerns about the impact on the current service at the Royal Shrewsbury Hospital.

*Find out more and have your say… t***o ensure that this strategy *makes sense clinically* and *makes sense to the communities we serve*. You can find out more from our website at www.ournhsinshropshireandtelford.nhs.uk Or by writing to: Developing Health and Healthcare, c/o Communications Team, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ. Or you can email communications@sath.nhs.uk**

Children's Health

Summary of our local clinical vision for a world class service

Here we summarise ideas for improving children's health in Shropshire, Telford and Wrekin over the next five years. The aim is to ensure that sick children receive world class services to restore and maintain their health, and that all children have opportunities to 'be healthy', in line with *Every Child Matters.*
In developing these ideas, local clinicians from Shropshire County and Telford and Wrekin have worked together with parents, carers, NHS, social care staff and other key partners.

In addition, they have drawn on the regional framework for children's health recently published by NHS West Midlands.
What has emerged is a suggested vision for delivering the highest possible quality of care. For the minority of children who require treatment in hospital, options are presented for further local investigation and debate.
We welcome your views, which will help us to continue to develop a local framework for health and health care in Shropshire, Telford and Wrekin.

Service improvement

To develop and improve our children's service, we are proposing the following, to make the healthcare we provide sustainable and of the highest quality possible.

- **Hospital at Home**

Hospital at home would be a nurse-led service with two main aims: avoiding admission to hospital and discharging children earlier. It would initially cater for children passing through the assessment services and the inpatient units. It would not replace existing inpatient facilities but will compliment them.

- **Outpatient services**

Outpatient facilities at the Royal Shrewsbury in particular need major improvement

- **The Assessment service**

We aim to provide a high quality assessment service that meets the diverse needs that are provided in the current service: routine work and emergency work,

- **Inpatient services**

Currently our high-dependency facilities only meet minimum requirements and there are no facilities for adolescent care. Also our paediatric surgery is currently split between two sites and consolidation of these services would allow us to concentrate all our expertise on one site. We also aim to improve our facilities for children with special needs and other specialist care services.

- **Transport**

If site reconfiguration occurs then transport requirements for patients, staff, and carers would need to be taken into consideration

Clinical Linkages

The most important factor in deciding the location of a single paediatric outpatient site is its relationship to the other clinical services that it uses.
The following services have been identified as having strong links with children's healthcare service.

General Paediatric and Emergency Surgery
Trauma
Anaesthetics
Ear, Nose and Throat (ENT)
Neonatology

Our aim is:

'To provide high quality children's healthcare that focuses on the needs of the child and is delivered at home, or as close to home as possible."

Pathways of Improvement in Children's health

Reasons for change

Changing clinical safety and sustainability
We face a real challenge in our recruitment and training requirements. Our consultants agree that our service is clinically safe but could be safer. There are concerns that if nothing changed there would be a serious risk to how we provide services, and in the cases of high quality specialist services with small patient numbers, e.g.neonatal units, there is a danger that these could be moved elsewhere.

Changing Service Development
We are committed to improving all our healthcare services for children. Centralisation of our services can help us to do this. The consolidation of our children's oncology service from two sites to a single site, for example, has allowed it to work closer with a specialist cancer unit at Birmingham Children's Hospital, reducing the need for many patients to travel to Birmingham for their treatment.

Changing needs
The nature of illness in children is changing. There is now much less in the way of acute infection in children's wards and survival rates are increasing for chronic diseases and conditions. More children are also being sent home for nursing treatment such as tube feeding or ventilation. This all means that our service levels have changed drastically over the last few decades allowing us to rethink our services.

Changing European Working Time Directive (EWTD)
Previously, junior doctors worked an average of 74 hours a week, but EWTD means that from August 2009 they should not exceed 48 hours. Therefore we need to employ more doctors to provide 24 hour cover and support medical training. Most junior grade doctors are recruited in training posts but since the number of training posts is also being reduced, recruitment becomes harder.

Pathway of Improvement

Here, we set out the four options for service configuration in detail. It is important to remember, however, that the service is not just about what happens in hospital. Many sick children can now be cared for in their own homes. It is therefore vital that we strengthen the community-based services that support children and their families in this way, which is why we are advocating the development of a new 'hospital at home' initiative to be provided by an expanded community nursing service.

After consultation with staff and public, a common theme has emerged regarding the options below, in that they can be viewed as a pathway of improvement for children's health care rather than standalone options - ***Option One*** *being where we are now, with* ***Option Four*** *representing our possible vision for 2020.*

Option One	Option Two	Option Three	Option Four
TWO Assessment Services & TWO Inpatient Units	**TWO Assessment Services & TWO Inpatient Units & Hospital At Home**	**TWO Assessment Services & ONE Inpatient Unit & Hospital At Home**	**ONE Assessment Service & ONE Inpatient Unit & Hospital At Home**
		Sub Options: **PRH RSH**	***Sub Options:*** **PRH RSH 'New Site'**

Find out more and have your say … to ensure that this strategy ***makes sense clinically*** and ***makes sense to the communities we serve***. You can find out more from our website at **www.ournhsinshropshireandtelford.nhs.uk** or by writing to **Developing Health and Healthcare, c/o Communications Team, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**. Or you can email **communications@sath.nhs.uk**

Planned Care

Summary of our clinical vision for a world class service

Here we summarise ideas for improving planned care in Shropshire, Telford and Wrekin over the next five years. The aim is to ensure that patients receive a world class service.

In developing these ideas, local clinicians from Shropshire County and Telford and Wrekin have worked together with service users, carers, NHS and social care staff and other key partners. In addition, they have drawn on the regional framework for planned care recently published by NHS West Midlands.

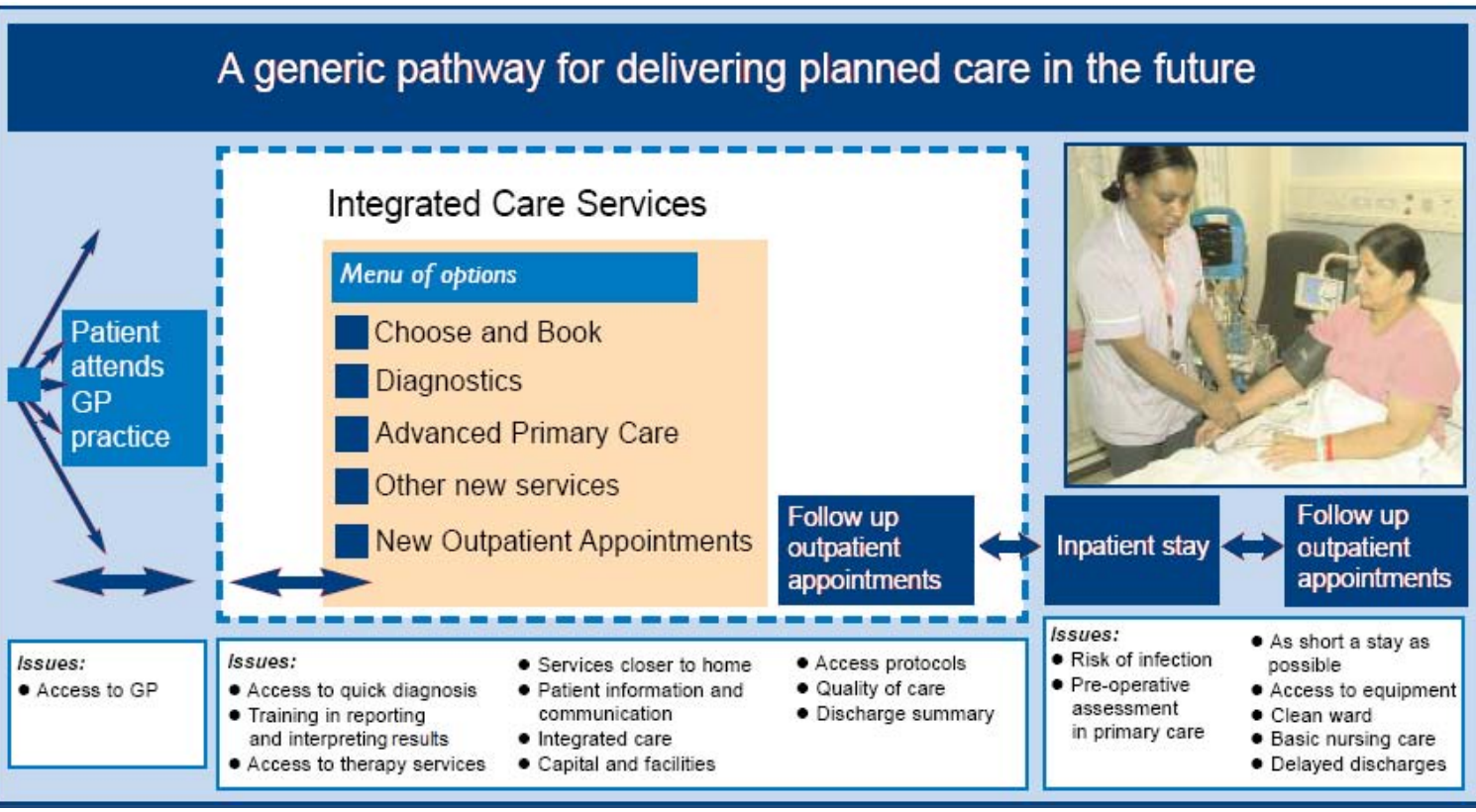
What has emerged is a suggested vision for delivering the highest possible quality of care, with emphasis on moving services from secondary to primary care so that most patients have less far to travel and do not have to attend hospital for what they need. We have also given specific examples of how this would work in a number of key specialties. These ideas draw heavily on our interim work earlier this year. We welcome your views, which will help us to continue to develop a local framework for health and healthcare in Shropshire, Telford & Wrekin.

Key elements of our proposed pathway

A fundamental aim of these proposals is that, wherever possible, there should be a shift away from providing planned care in hospital and a shift towards providing it in primary care.
In addition, we want to bring about a closer integration of services. That means hospital and primary care services working more closely together to ensure that patients receive diagnosis and treatment at the right time, in the right place from the right person.
In changing the model of planned care in this way, we aim to:

- make it easier for patients to navigate their way through the services they need;
- reduce travelling distances and times for diagnosis and treatment by providing more conveniently located services closer to where patients live and work;
- provide faster, more efficient services, with shorter waiting times at each stage in the pathway;
- develop new clinical roles to enable staff to provide a better service and enhance their career opportunities;
- use available clinical and other resources more effectively, reduce reliance on acute hospital care and increase the range of non-acute settings where care is provided.

A generic pathway for delivering planned care in the future



Action needed to apply our proposed model in four key specialties and medical outpatients

Integrated dermatology care services

This would entail open access to dermatology services in primary care and community settings across Shropshire, Telford and Wrekin, with specialist advice being provided online and the use of digital camera imaging to aid diagnostics.

To deliver the new model, it would be necessary to appoint an additional dermatology consultant and GP with a special interest in this field. Investment in equipment would also be required.

Planned shift in proportions of dermatology work undertaken in secondary and primary care:

	2008	2012/13	2020
Primary care	10%	50%	90%
Secondary care	90%	50%	10%

Integrated urology care services

This would entail open access to urology services in primary care and community settings across Shropshire, Telford and Wrekin, with specialist advice accessible online and specialists also available at the point of care. The new model could be implemented through enhanced training of existing nurse specialists and the appointment of a GP with a special interest in this field.

Planned shift in proportions of urology work undertaken in secondary and primary care:

	2008	2012/13	2020
Primary care	0%	40%	70%
Secondary care	100%	60%	30%

Integrated musculoskeletal care services

This would entail open access to musculoskeletal services in primary care and community settings across the county, with specialist advice available online and patients attending a 'one stop shop' designed to meet as many of their needs as possible.

To deliver this new model, investment is required in additional musculoskeletal specialists, a specialist in rehabilitation medicine and a rheumatology specialist.

Planned shift in proportions of musculoskeletal work undertaken in secondary and primary care:

	2008	2012/13	2020
Primary care	10%	30%	50%
Secondary care	90%	70%	50%

Integrated neurology care services

This would entail open access via a 'one stop shop' to neurology services in primary care and community settings across the county, with specialist advice available online and specialists also available at the point of care. The new model could be implemented through enhanced training of existing nurse specialists and the appointment of a GP with a special interest.

Planned shift in proportions of neurology work undertaken in secondary and primary care:

	2008	2012/13	2020
Primary care	0%	30%	95%
Secondary care	100%	70%	5%

Medical Outpatients

Part of our proposed strategy involves moving as much medical outpatient work as possible from secondary to primary care. This, we believe, can be achieved by a combination of workforce training, specialist nurses working in the community and timely access to specialist advice.

To deliver this new model, investment is required in facilities, diagnostics (EEG and CT scanning), information technology and the appointment of a GP with a special interest in this field.

Planned shift in proportions of medical outpatient work undertaken in secondary and primary care:

	2008	2012/13	2020
Primary care	0%	70%	90%
Secondary care	100%	30%	10%

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Mental Health

Summary of our local clinical vision for a world class service

Here we summarise ideas for improving mental health services throughout Shropshire, Telford and Wrekin over the next five years, as well as setting out a longer-term vision for what needs to be done between now and 2020 to ensure that local residents are receiving 'world class' care. In developing these ideas, local clinicians from Shropshire County and Telford and Wrekin have worked together with service users, carers, NHS and social care staff and other key partners. In addition, they have drawn on the regional framework for mental health recently published by NHS West Midlands. What has emerged is a suggested vision for promoting good mental health in our communities, and for how we can deliver the highest possible quality of mental health care and support to those who need it. We welcome your views, which will help us to continue to develop a local framework for health and healthcare in Shropshire, Telford and Wrekin.

Key elements of our 2020 Vision

Our 2020 vision is based on the principle that **'there is no health without mental health'**. In other words, mental well-being is an integral part of general well-being – so much so that it should be a concern of all health and public services.
To ensure good mental health, we believe there should be:

- greater emphasis on health promotion and prevention;
- a shift towards providing more mental health services in primary care and reducing hospital admissions;
- early identification of signs that an individual is suffering from mental distress;
- easier and more equal access to services for people throughout Shropshire;
- greater consistency in the way services are provided across the county;
- a strong focus on the recovery model of care and on getting people back into education, training, work and living fulfilling lives in their communities;
- effective management of mental illness coupled with a focus on the 'positive' that ensures people have the right life and communication skills coupled with a sense of self-esteem and worth;
- a single point of access into specialist mental health services;
- better co-ordination of mental health care and better liaison between GPs, primary care teams and specialist services;
- a step by step pathway for ensuring access to psychological therapies.

As the diagram shows, our aim is to increase people's awareness and understanding of mental health and mental illness. This, we hope, will lead to reduced stigma associated with mental health problems at the same time as promoting greater social inclusion.
Using this vision as our guide, we have developed a mental health clinical pathway for the effective management of illness.
The pathway is based on person-centred, individualised assessment of needs leading to evidence-based treatment and care. People presenting with mental health needs may be referred, as appropriate, to support services in the community or to specialist services. Those recovering from an acute episode of mental illness need the right level and type of ongoing support to enable them to resume their lives as fully as possible. The idea is that they should recover sufficiently to be able eventually to sustain that recovery without the need for specialist support.

Implementing our 2020 vision

Adult Mental Health Inpatient Services

Our aim: To reduce the number of admissions to inpatient services by one third and develop a range of alternatives to hospital. This could be achieved by making best use of units such as Castle Lodge in Telford and Oak Paddock in Shropshire County, and by community teams supporting more people in their own homes.

Expected outcomes: If this strategy is pursued, it would mean the number of acute adult inpatient beds at Shelton Hospital being reduced from 69 to 46. At the same time, there would be a significant increase in the number of contacts that people with mental health problems have with community-based services.

Benefits: Greater choice for service users, with care provided 'closer to home' in the least restrictive environment consistent with their needs. Improved clinical outcomes and fewer people requiring long-term care in an inpatient setting. Increased support for staff working in the community.

Primary Care

Our aim: To deliver more mental health services in primary care settings and to ensure that those services are integrated with other health services, so that patients benefit from a more holistic approach to meeting their needs.

Expected outcomes: A 75% expansion of mental health services provided in primary care, with the voluntary sector playing a key part. An increase in the number of people receiving psychological therapies.

Benefits: A wider range of treatments and support available to patients through primary care, including nursing, counselling, cognitive behavioural therapy, social support and housing. Fewer people being referred to secondary services. A reduction in the stigma associated with mental illness. Improved chances for service users seeking to get back into work.

Older People - Dementia Services

Our aim: To meet the mental health needs of older people during a period when it is estimated that the numbers potentially requiring care and treatment for dementia will rise by 45%. This will require alternative forms of support to be developed outside hospital.

Expected outcomes: A reduction by one third in the number of older people admitted to inpatient services for dementia care.

Benefits: Greater choice for service users, with care provided closer to their homes and increased support for the families and carers of older people.

Psychological Therapies

Our aim: To develop a stepped model of services so that individuals experiencing mental distress can access the psychological therapies best suited to their individual needs.

Expected outcomes: More service users, including older people, being able to access psychological therapies.

Benefits: Reduced waiting times. Improved clinical outcomes. Fewer inappropriate admissions to hospital.

Emerging Diagnoses

Our aim: To meet the specific needs of people diagnosed with personality disorder, autistic spectrum disorder and alcohol or drug dependency.

Expected outcomes: Development of new services that will more effectively meet the needs of individuals and their families. Support provided in future by a network of professionals rather than by a single member of a team

Benefits: Care provided closer to people's homes. Fewer inappropriate and 'out of area' admissions. Reduced dependency over time on mental health services.

Find out more and have your say … to ensure that this strategy ***makes sense clinically*** and ***makes sense to the communities we serve***. You can find out more from our website at **www.ournhsinshropshireandtelford.nhs.uk** or by writing to **Developing Health and Healthcare, c/o Communications Team, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**. Or you can email **communications@sath.nhs.uk**

Getting Healthy, Staying Healthy

Summary of our clinical vision for a world class service

Here we summarise ideas for helping people of all ages in Shropshire, Telford and Wrekin to get healthy and stay healthy.
In developing these ideas, local clinicians from Shropshire County and Telford and Wrekin have worked together with service users, carers, NHS and social care staff and other key partners. In addition, they have drawn on the regional framework for staying healthy recently published by NHS West Midlands.

What has emerged is a suggested vision for the best ways of preventing disease and promoting health over the next five years and beyond.

We welcome your views and comments, especially on the options for future hospital care, to help us to continue to develop a local framework for health and health care in Shropshire, Telford and Wrekin.

Key elements of our proposed pathway

By 2020, we want people in Shropshire, Telford and Wrekin to be 'fully engaged' in promoting and maintaining their own health. To achieve this, we aim to ensure that:

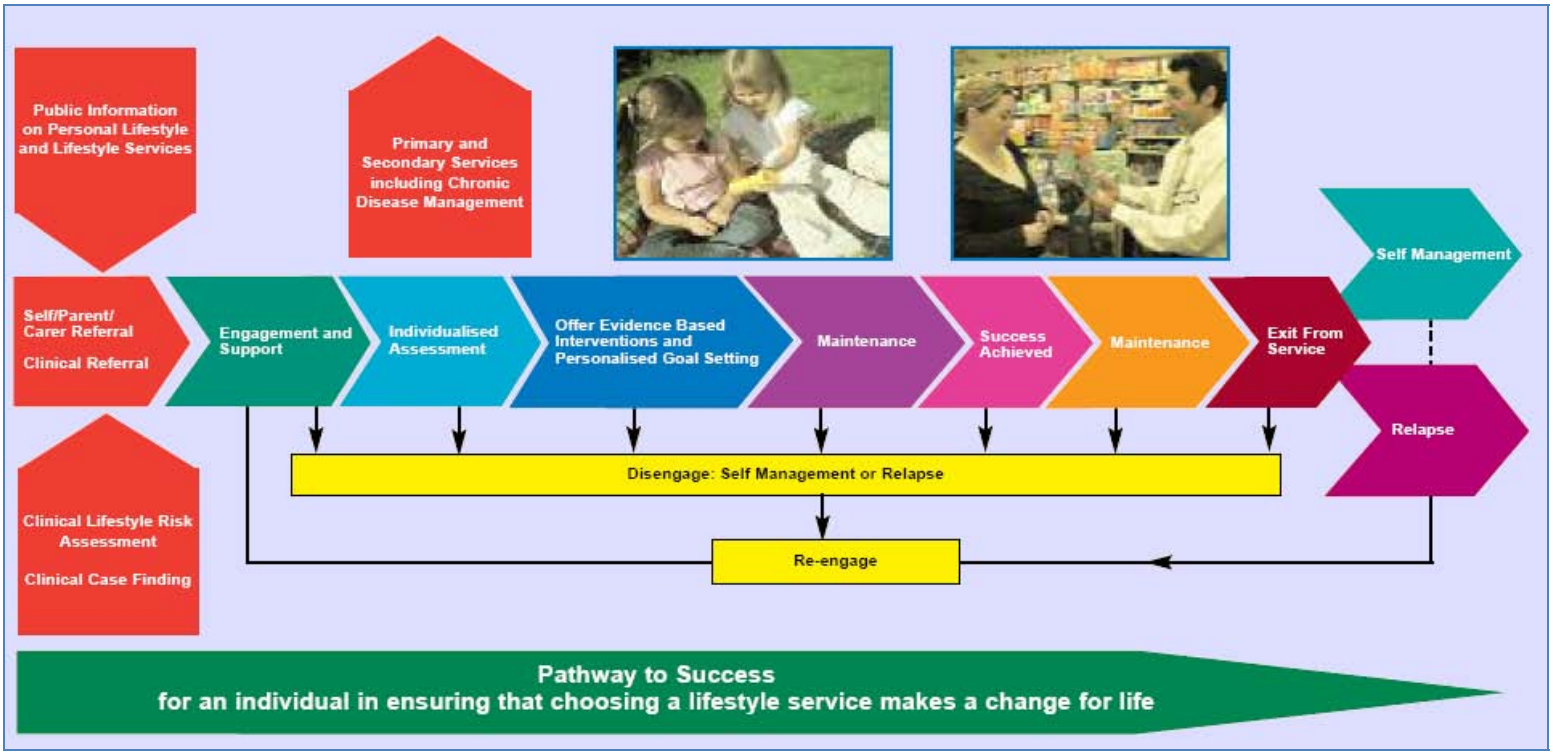
- more people are actively seeking to change their behaviour in ways that will improve their quality of life, prevent disease and help them live longer;
- health professionals and the public have become truly'equal partners' in promoting health

Our approach recognises that personal lifestyles are responsible for many people's health problems and that there is enormous scope for reducing the risks of disease by helping people to change their lifestyles.

To bring about significant health improvements, we believe that there must be effective partnerships between the NHS and the other organisations whose activities also have a major influence, including housing services, education and employers. Our model for 'getting healthy and staying healthy' is based on:

- improving public information on the importance of lifestyle changes to health and how to access the necessary help, advice and support in making those changes;

- developing personalised services that address the specific needs of individuals



Proposed action to tackle our four 'priority areas'

Smoking Cessation

Smoking remains the biggest single cause of death and illness. Yet 70% of smokers say they want to quit and 80% wish they had never started. To build on the success of the county-wide *Help 2 Quit* service, we propose to:

- increase availability of stop smoking services by providing them in a wider range of accessible venues, including pharmacies and workplaces;
- train all frontline health and allied professionals in stop smoking interventions;
- appoint stop-smoking support workers to help 'high risk' groups to stop;
- create opportunities for former smokers to act as 'champions' of the stop smoking service and provide volunteer support to others who are trying to stop;
- appoint specialist co-ordinators to target young people and pregnant women;
- expand the role of hospital-based stop smoking nurses to help reduce the risks of complications among smokers who require surgery.

Weight Management

Obesity is rising, bringing with it increased risks of heart disease, cancer and type 2 diabetes. To help tackle the problem in Shropshire, Telford and Wrekin, we propose to:

- train our frontline workforce to promote greater awareness of the health consequences of obesity and to provide weight management services for children, young people and adults;
- launch initiatives to address the fact that a significant proportion of excess weight in children is gained before they reach school age;
- develop the role of school nurses in preventing obesity in children;
- provide weight management services in a variety of convenient locations, including schools, workplaces and pharmacies;
- target people from disadvantaged backgrounds, possibly through the use of 'community weight management champions' to get key messages across, raise awareness and encourage individuals to seek help and support

Addressing Alcohol Misuse

An increasing number of people are drinking above recommended safe limits, with a consequent rise in alcohol-related health problems. Alcohol consumption by young people in Telford and Wrekin is relatively high compared with national figures. To reduce the risks associated with alcohol misuse, we propose to:

- increase public awareness about the risks of drinking too much too often;
- undertake training of NHS staff to improve early identification of alcohol misuse;
- develop the role of the school nursing workforce to help deliver alcohol education to children and young people;
- provide information and help in a wide range of accessible venues in the community;
- work with hospital A&E departments to signpost individuals attending with alcohol-related problems to services that can help them;
- develop services for 'dependent drinkers', including specialist help to support home detoxification.

Breastfeeding

To encourage mothers to breastfeed, we will:

- encourage hospitals and community health services to adopt UNICEF *Baby Friendly Standards*; develop peer support services so that mothers can receive encouragement from others who have tried and succeeded;
- undertake public campaigns to promote breastfeeding and increase awareness of the benefits;
- provide training to health professionals so that they can support mothers in trying to breastfeed their babies and in sustaining their efforts once they have started;
- further develop local schemes to encourage the owners and managers of premises to become 'breastfeeding friendly'.

Find out more and have your say … to ensure that this strategy ***makes sense clinically*** and ***makes sense to the communities we serve***. You can find out more from our website at **www.ournhsinshropshireandtelford.nhs.uk** or by writing to **Developing Health and Healthcare, c/o Communications Team, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**. Or you can email **communications@sath.nhs.uk**

Long Term Conditions

Summary of our clinical vision for a world class service

Here we summarise ideas for helping people of all ages in Shropshire, Telford and Wrekin to get healthy and stay healthy.
In developing these ideas, local clinicians from Shropshire County and Telford and Wrekin have worked together with service users, carers, NHS and social care staff and other key partners. In addition, they have drawn on the regional framework for staying healthy recently published by NHS West Midlands.

What has emerged is a suggested vision for the best ways of preventing disease and promoting health over the next five years and beyond.
We welcome your views and comments, especially on the options for future hospital care, which will help us to continue to develop a local framework for health and health care in Shropshire, Telford and Wrekin.

Key elements of our proposed pathway

In line with the feedback we received from patients, as well as the recommendations of the regional clinical group on long term conditions, we want to:

- develop a system where people are willing and able to take responsibility for their own health
- help and support people in understanding how to use the best information and advice to manage their condition
- ensure that people are cared for closer to their own homes by the right professional with the right skills
- provide integrated health and social care that is adaptable to patients' needs ensure that the care provided in the acute sector is more versatile, and that much of it is delivered in future in community settings rather than in hospital.

Patients told us that they want to be seen and treated as a whole person, not as a disease. They want better information about their diagnosis and the options available to them. They also want better co-ordination of services. Our model seeks to respond to these hopes and aspirations.

There are many benefits for patients from our proposed pathway, including easier access to care, greater choice, improved continuity and, importantly, shared decision making between patients and the staff who support them.

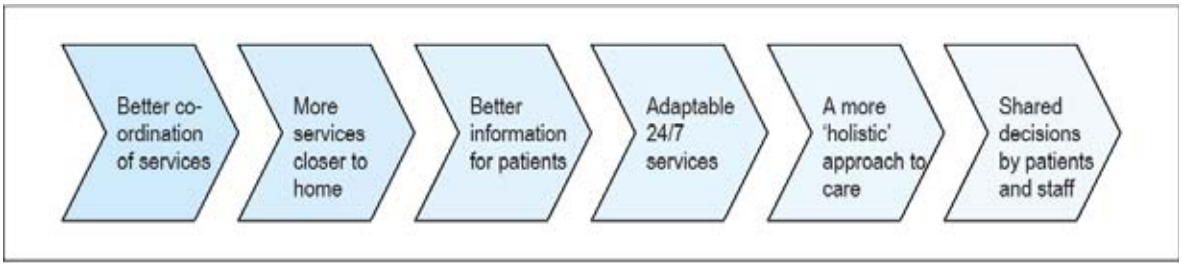
Other aims include an increased emphasis on prevention, earlier diagnosis of conditions and more individualised treatment plans once a diagnosis has been confirmed.

Care will also be more holistic, addressing not only patients' physical needs but also their emotional and cultural needs.

We recognise the importance of equipping and supporting staff to play their full part in delivering the care pathway we propose. This involves:

- strengthening partnership working to enable the safe delivery of care closer to patients' homes
- ensuring that 'gold standards' are used by all members of the multidisciplinary team, particularly in addressing the most complex cases
- training staff to deliver services in primary care and in a range of community settings
- improving communication between health and social care staff
- developing a flexible workforce that is available to support patients 24 hours a day.

On the reverse side of this summary, we highlight some proposed actions in six priority areas between 2008 and 2012.



Proposed action to tackle our four 'priority areas'

Six Priorities for Long Term Conditions

Diabetes

We propose to develop specialist diabetes disease teams aimed at providing integrated care.

The 24/7 service would seek to:

- detect and diagnose diabetes quickly in primary care to ensure that the condition becomes controlled as soon as possible
- prevent hospital admissions and length of stay in hospital caused by a loss of blood glucose control and/or complications arising from it
- speed up discharge from hospital where admission had proved unavoidable.

Heart Failure

We propose a model of community-based diagnosis and management of heart failure that enables more patients to receive care and support closer to where they live rather than in hospital. Provided by nurses with input from doctors and diagnostic technicians.

The service would aim to:

- improve co-ordination between primary and secondary care
- reduce avoidable hospital admissions and recurrent hospital stays

Respiratory Disease

We propose a 24/7 community-based respiratory disease service that provides screening, investigations pulmonary rehabilitation, oxygen assessment, nebuliser services and support to patients who need advice and help to stop smoking.

The service would aim to:

- enhance patients' independence and ability to function as normally as possible
- provide more accessible care and reduce hospital admissions.

Stroke

We propose a model of early supported discharge for people following acute stroke. Provided by teams of nurses, therapists and doctors.

The service would seek to:

- enable patients to undergo rehabilitation in community settings rather than in hospital
- help patients to regain their independence and remain in their own homes.

Dementia

We propose to develop a service that supports people with dementia and their carers through early identification and intervention.

The service would aim to:

- Increase public and professional awareness of dementia and reduce the stigma attached to it
- Provide good quality early diagnosis and intervention
- Improve the quality of care provided in a primary and secondary environment

Alcohol Misuse

We propose to develop a service that provides early identification and intervention of alcohol misuse and works to actively reduce alcohol consumption and the number of people who become alcohol dependent.

The service would aim to:

- Reduce unscheduled hospital admissions
- Reduce repeat presentations at accident and emergency departments

Find out more and have your say … to ensure that this strategy ***makes sense clinically*** and ***makes sense to the communities we serve***. You can find out more from our website at **www.ournhsinshropshireandtelford.nhs.uk** or by writing to **Developing Health and Healthcare, c/o Communications Team, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**. Or you can email **communications@sath.nhs.uk**

Acute Care

Summary of our local clinical vision for a world class service

Here we summarise ideas for improving acute care in Shropshire, Telford and Wrekin over the next five years. The aim is to ensure that patients receive world class services and that they are treated in the right place and by the right clinicians for their particular condition and needs.
In developing these ideas, local clinicians from Shropshire County and Telford and Wrekin have worked together with patients, NHS and social care staff and other key partners. In addition, they have drawn on the regional framework for acute care recently published by

What has emerged is a suggested vision for delivering the highest possible quality of care.
This vision emphasises easy access to conveniently located services within a well integrated system that avoids unnecessary delays. It also focuses on preventing patients' health problems from becoming 'emergencies' wherever possible.
We welcome your views, which will help us to continue to develop a local framework for health and health care in Shropshire, Telford and Wrekin.

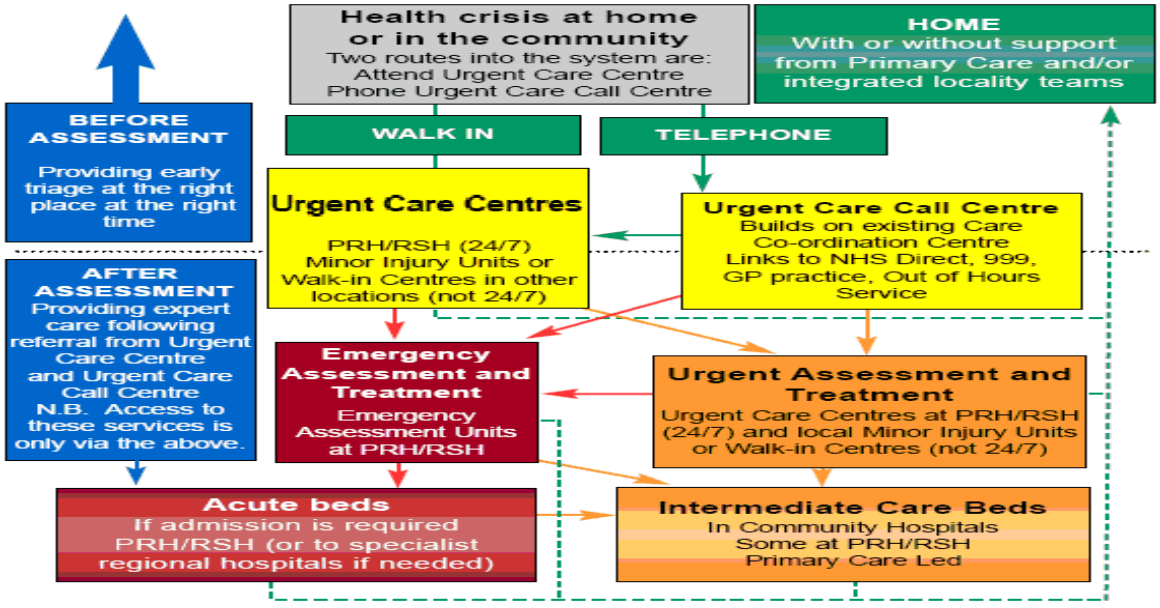
Key elements of our propose pathway

Patients with urgent or 'acute' care needs say they want reassurance, prompt attention, and effective and timely care. They also want to avoid being passed from one service to another and would like their GP to be kept informed.
Many people find the current system confusing. If they are not sure where to go for help, or if a service they need is not immediately available, they go to an accident and emergency department (A&E) or ring 999 by default. We are proposing a model that both satisfies the needs and expectations of patients and reduces inappropriate use of hospital A&E departments and unnecessary admissions.
Our aim is to enable patients to be seen in a primary care or community setting wherever possible, so that only those who
require high level specialist care come to hospital.
The new model will operate 24 hours a day, 365 days a year.
It will be both simple and seamless for patients, with urgent and emergency care based on clinical need.

Importantly, the service will be very much a partnership between acute hospitals, GPs, primary and community care, the ambulance service and local authorities.
In future, there will be a 'triage service' at every point of access to emergency and urgent care in Shropshire, Telford and Wrekin.
Delivering the 'triage' will be our proposed Urgent Care Centres (UCCs), which will be integrated with access to more acute hospital-based services. The UCCs will fall into two categories:

- 24/7 services integrated with the two A&E departments at the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital

- Daytime UCCs with limited opening hours. In Shropshire PCT, these will form part of the current Minor Injury/Illness Units at Ludlow, Bridgnorth, Whitchurch, Bishop's Castle and Oswestry. In Telford and Wrekin, a UCC will be located in a new health centre being developed in Telford, which will have walk in facilities.



Implementing our 2020 vision

Establish Urgent Care Centres at Princess Royal Hospital and Royal Shrewsbury Hospital plus Urgent Care Call Centre

This would involve developing two new Urgent Care Centres (UCCs) integrated with the A and E service at Royal Shrewsbury and Princess Royal Hospitals to direct patients to the most appropriate service for treatment.
Assessment of patients' needs at UCCs will be undertaken by an appropriate healthcare professional, who will give advice and, if required, refer patients on to A&E, their GP out of hours service or their GP for a routine appointment.
The UCCs will bridge the gap between primary and secondary care, reduce A&E waiting times, advise patients on self care and ensure a more consistent approach to meeting urgent care needs. This model will also help to ensure that clinical expertise is used in a better way to meet the needs of patients.

Develop rapid turn-around Acute Assessment Units at Princess Royal Hospital and Royal Shrewsbury Hospital

This would involve enhancing both hospitals' existing acute assessment units (AAUs). Within 24 hours of patients being referred to the AAUs, they will either be admitted to a specialist ward in the hospital, referred to another care facility or discharged home.
Essential features of the AAUs will include their ability to take patients at very short notice, access to improved radiology services, ability to refer to specialty ward beds, and a mix of medical staffing to meet the variety of acute health needs of patients using these services.
Benefits for patients include:

- early diagnosis leading to a safe management plan;
- improved care by more senior medical staff; and
- reduced time in hospital

Establish an integrated team at the hospital 'front door' and in the Acute Assessment Unit to follow patients through the pathway

This would involve establishing a team comprising nurses, therapists, social workers, consultants in elderly care and drug and alcohol workers who will:

- be available 24 hours a day and liaise closely with the Care Co-ordination Centre, out of hours services in the community and the hospital discharge team;
- follow up patients who need to be admitted to hospital to ensure that they are supported to return home or are referred to another facility as soon as clinically appropriate.

Develop care pathways for all common conditions so that patients move through the system smoothly and appropriately

This would start with a review of the existing clinical pathways for the conditions that currently account for the highest levels of A&E attendances and admissions to acute hospital services.
The project would look specifically at the staffing and skills needed to meet patients' needs in the safest, most effective and efficient way.

Other Key Tasks

- Examine the financial and other implications of shorter lengths of stay in hospital for patients with less complex conditions, balanced by a greater inpatient focus on patients with the highest levels of clinical need who are more costly to treat than average.
- Also examine the financial and other implications of establishing the new Urgent Care Centres at the Princess Royal Hospital and Royal Shrewsbury Hospital.
- Develop and expand the Care Co-ordination Centre to create a single point of access to the system.
- Examine the implications of the new model for staffing, information, IT and diagnostic equipment.
- Take account of service reconfiguration possibilities at the Royal Shrewsbury Hospital and Princess Royal Hospital sites.
- Link up with other projects for the redevelopment of Ludlow Hospital and the development of new GP surgeries.

Find out more and have your say … to ensure that this strategy ***makes sense clinically*** and ***makes sense to the communities we serve***. You can find out more from our website at **www.ournhsinshropshireandtelford.nhs.uk** or by writing to **Developing Health and Healthcare, c/o Communications Team, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**. Or you can email **communications@sath.nhs.uk**

End of Life Care

Summary of our clinical vision for a world class service

Here we summarise ideas for improving care at the end of life in Shropshire, Telford and Wrekin over the next five years. The aim is to ensure that people receive the highest quality care during the final stages of their life. In developing these ideas local clinicians have worked together with service users, carers, NHS and social care staff and key partners including the Severn Hospice and other voluntary organisations. They have drawn on the regional framework for End of Life Care published by NHS West Midlands and the National End of Life Care Strategy published by the Department of Health in July 2008. What has emerged is a suggested vision for delivering the high quality care and support that patients and their carers need when they are nearing the end of their life, at the time of death and afterwards, whatever their diagnosis and in whatever setting they may be.

Key elements of our proposed pathway

In line with the feedback we received from patients, as well as the recommendations of the regional clinical group on end of life care, our priorities are to:

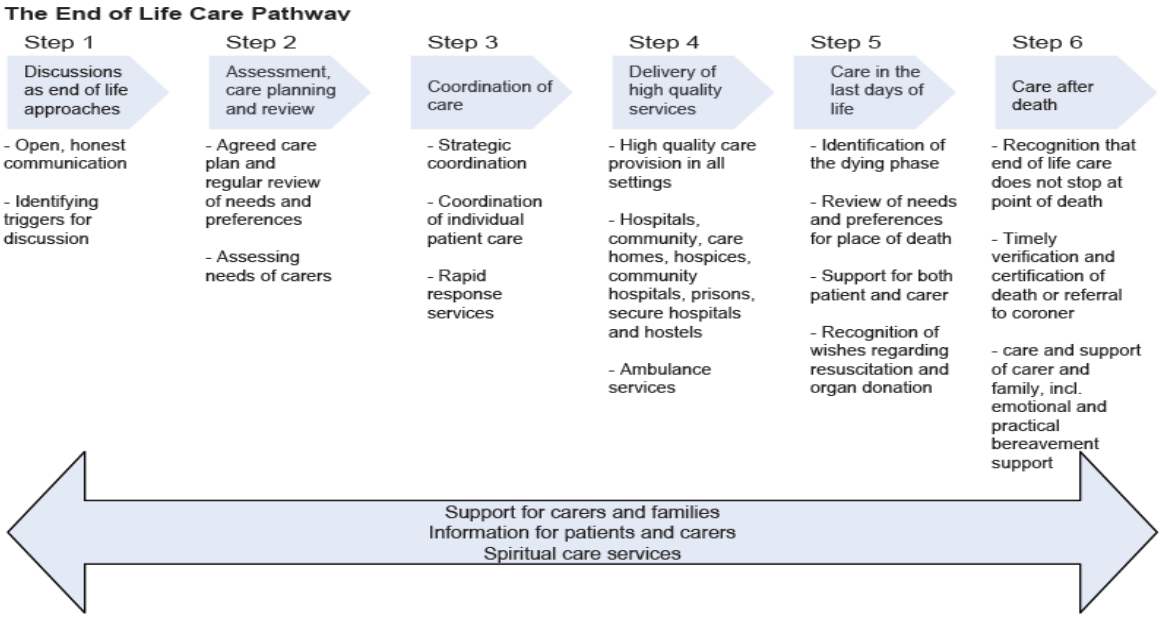
- ensure that patients are treated with dignity and respect at all times
- ensure they have appropriate treatment to control their pain and other symptoms, so that they are as comfortable as possible.
- offer patients information and choice over their care and where they die
- ensure that patients are cared for in supportive environments and are in the company of close family and/or friends at the time of their death wherever possible

Our aim is to extend best practice to ensure high quality care is available to all patients, whatever their diagnosis, wherever they may be and according to need. We hope to redress the fact that currently most people die in hospital although the majority would prefer to die at home. To achieve this we need to address a number of key challenges.

These include

- the perception of dying as a medical failure, making it difficult for clinicians to have open and honest discussions with patients who are approaching the end of life.
- lack of information for patients and poor communication between care sectors
- lack of 24 hour coordinated care services in the community
- variable levels of knowledge and skills among health and care professionals involved in caring for people at the end of life
- the projected rise in the numbers of elderly over the next 25 years, coupled with a lack of availability of carers, both informal and paid.

Progress has already been made in implementing the Gold Standards Framework in GP practices, the Liverpool Care Pathway across all care settings and both of these initiatives in some care homes. But much more remains to be done to achieve a fully coordinated service. The reverse of this summary highlights key actions for 2008 till 2012.



Proposed action to tackle our four 'priority areas'

Ensure that our commissioning strategy meets the needs of the population

We propose:

To revise the existing Shropshire, Telford and Wrekin palliative care strategy to take account of the National End of Life Care Strategy (July 2008), The NHS West Midlands report 'Investing for Health' (May 2008) and the Shropshire, Telford and Wrekin End of Life Care baseline review (January 2008).

To include the needs of young adults in transition from children's palliative care services and other vulnerable adults in commissioning services.

To consider options and develop a model for a 24 hour coordinated approach to care through joint commissioning of health and social care services and involving all relevant care providers including the voluntary and independent sectors.

- Optimise the use of existing services for example Integrated Palliative Care Scheme (Hospice at Home and Marie Curie)
- Consider central coordination of services to ensure better access and seamless care for patients
- Emphasis on the development of the key worker role for individual patients
- Ensure availability of 24 hour care and support in community settings
- Ensure adequate medical support out of hours either through quality assured service specifications for GP out of hours care or a specialist on call GP rota through the OOH provider.

To establish a consistent approach to education and standards in end of life care across the whole health economy including primary care, the acute sector, care homes and the voluntary sector, and to include standards for social care provision through agency staff.

- Expand the GPwSI role to develop close clinical links between the hospice-based specialist service, primary care, acute trusts, community hospitals and the independent care home sector.
- Develop quality standards within service specifications for all end of life care services

To use the results of clinical audit and service user feedback to inform future service development

Extend use of the End of Life Care Tools in Shropshire, Telford and Wrekin

A team of end of life care co-ordinators are working alongside health professionals across all settings. Together, they will maintain and increase the momentum of recent service improvements resulting from the introduction of the Gold Standards Framework, Liverpool Care Pathway and other key tools.

Through this initiative we are looking for four key outcomes:

- Increasing the numbers of patients achieving choice in treatment options and place of death
- Increasing deaths in community settings by at least 14% by 2012/13
- Reducing the number of admissions to hospital for end of life care
- Improving the quality of end of life care experience for patients and carers

Patients in all settings will be offered information about the options available to them and will be given the opportunity to state their preferences for end of life care by using the *Preferred Priorities for Care* document.

Overall, this will give patients and their families greater responsibility for and control over the process of dying and death. NHS staff will develop their skills and confidence in identifying and intervening appropriately with end of life care patients.

Find out more and have your say … to ensure that this strategy ***makes sense clinically*** and ***makes sense to the communities we serve***. You can find out more from our website at **www.ournhsinshropshireandtelford.nhs.uk** or by writing to **Developing Health and Healthcare, c/o Communications Team, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ**. Or you can email **communications@sath.nhs.uk**

7. BUILDING CAPACITY IN PRIMARY CARE

The Models of Care developed by the Pathway Development Groups project a considerable shift into community and primary care settings. This change will require a significant development of capacity in primary and community care as well as closer collaboration with social care and the voluntary and independent sectors. The change will also have implications for the acute sector in terms of transfer of skills, changing roles of the specialist and financial challenges.

The CLF has identified five key areas where primary and community care needs to be strengthened in order to support the models of Care. These are:

- care coordination and navigation;
- diagnostics
- the workforce;
- information technology; and
- the estate.

7.1 Care Coordination and Navigation

A key issue that was common to many of the Pathway Development Groups was the need to address navigation and care coordination for patients across the healthcare system. At an early stage of the discussions, it was agreed to link this approach for adults with the 'Putting People First' projects in both Social Care Systems. In Adult Social Care, World Class Commissioning is matched by an equivalent initiative called Putting People First which as a central theme around personalisation of services that will enable people to exercise choice and control over the way that care is provided, where possible within the person's own home. New concepts such as brokerage, enablement and provider development are part of this agenda.

The development seeks to benefit health and social care professionals as well as patients, carers the voluntary and independent sector. The overall goal of the project is to provide a **Single Point of Access** for information, advice and navigation to what, where, how and which services are appropriate in health and social care

"Nobody drops the care of the caller until they pass the baton of care"

A project team will be established to take the project forward and will include representatives from the NHS organisations, social care, the voluntary sector and patient and carer representatives.

7.2 Integrated Diagnostics

Across the health economy there is a lack of consistency with regard to what services patients receive and where. For example, many patients can have blood taken within the practice, whilst others have to travel to the Royal Shrewsbury or Princess Royal Hospitals. Some patients can have a plain film x-ray Monday to Friday at one community hospital but not at another. There are also inconsistencies in the level of direct access that GPs have to certain imaging services. For example, some GPs have direct access to MRI (i.e. not having to refer via a consultant) whilst the majority do not. This lack of consistency and gaps in service provision present a major constraint on moving care closer to home.

The principles that have been adopted in developing the plans for diagnostic services are:

- to promote independence by providing equitable health at home or as close to home as possible, whenever this is clinically safe , clinically effective and affordable;
- to continue to develop clinically appropriate alternatives to hospital admission, so that patients are only admitted when their needs cannot be met outside hospital;
- to deliver enhanced access to diagnostic services, without the need for hospital-based out-patient or in-patient assessment;
- to develop clinical pathways and discharge arrangements which facilitate early yet safe hospital discharge.

Diagnostic provision within the health economy spans primary, community and secondary care and for ease of description is broken down into two areas. These are:

- access to diagnostics, that is the generation of a request (for a blood test, x-ray, scan etc);
- intervention or procedure (actual phlebotomy or patient undergoing a ultrasound scan).

Table 11 below identifies the current and future diagnostic service in terms of access and intervention.

A Steering Group has been established to take this work forward. The Group includes membership from the four statutory NHS organisations. Consideration is also being given to the inclusion of non-statutory involvement such as Shropdoc and local independent providers.

Table 11: Present and Proposed Pattern of Diagnostic Service Delivery

	GP/primary care		GP led health centre		Community hosp/team		Secondary care	
Imaging	**Access**	**Intervention**	**Access**	**Intervention**	**Access**	**Intervention**	**Access**	**Intervention**
Audiology								
Barium enema								
Echocardiography								
Electrophysiology								
Colonoscopy								
CT								
DEXA								
Flexi sigmoidoscopy								
Gastroscopy								
MRI								
Neurophysiology								
Non-obstetric ultrasound								
Resp - sleep studies								
Urodynamics								
Plain film x-rays								
PET scan								
Pathology								
Blood gases								
FBC, U&E, LFTs								
INR								
Near patient testing								

Present and Future Service

Present Service

Future Service

7.3 Workforce

Developing and implementing the Models of Care developed by the PDGs requires a coordinated approach to workforce planning and development. A framework to enable and support the workforce planning and implementation of the Local Health Economy Review has been developed based on an assessment of the PDG proposals. As a result of this work the following are being developed:

- a coordinated approach to the development of an integrated workforce and the workforce aspirations identified by each PDG;
- new roles and service requirements to support the workforce aspirations of the PDG work plans;
- the development, education and learning needs to support new roles and service delivery;
- initial financial scoping in relation to controls and workforce activity.

The workforce aspirations include a vision to 2013 and outline the main workforce developments and improvements that will be needed over the next five years.

The key influences on the workforce strategy include:

- developing a flexible, adaptable workforce that is capable of sustaining continuous service improvement in order to deliver effective and efficient healthcare;
- modernising healthcare careers to maximise benefits for patients, staff and employers of a competence-based workforce;
- providing quality healthcare, while maximising value and productivity;
- extending and enhance skills of existing staff and teams at all levels on the career framework and develop new roles enabling healthcare to be provided in different settings;
- realising the benefits of Agenda for Change, the KSF and the consultant contracts;
- developing capable leaders, both clinical and non-clinical, at all levels within the NHS as a key priority for future health care.

Each PDG considered future skills needs, opportunities for joint/multi-agency working, new/changed roles, perceived skill gaps and training required. For each of these factors, a view was taken at each stage of the patient journey. These included prevention and early detection, primary and community care, secondary/specialist care and continued supportive care. The future needs for each PDG were assessed[13]. In summary the main cross-cutting learning and development implications identified by the PDGs are:

[13] These are detailed in the Workforce Project Report and summarised in the report on 'Building Capacity in Primary Care'

- there is a need to identify and assess psychological and mental health needs of patients in the different pathways;
- the workforce requires skills for the early detection of individuals at risk of developing conditions;
- the workforce needs to engage with individuals in personal health and lifestyle choices and personal health and influencing behavior;
- the workforce needs additional specialist and generalist skills and roles in primary and community settings;
- effective triage needs to be further implemented within the pathway;
- the workforce needs to engage with social care and voluntary sector staff in common and integrated training programmes;
- PCT funding needs to be identified to further increase workforce volume and capacity.

The development and learning requirements will be further analysed and confirmed by the future work forming part of a West Midlands SHA Project 9 to develop a full workforce transformation plan. It is planned that the findings within this report will be taken forward and developed into an integrated workforce transformation plan for the Local Health Economy, within the framework of Investing for Health Project 9.

7.4 Information Technology

Taking care closer to home has implications for information technology as a result of the wider range and volume of services being provided in community settings, and the increased number of locations. The following areas have been identified as key to supporting care closer to home:

- Order Communications – the systems in place and being developed should enable tests to be ordered and results to be reported;
- PACS – currently PACS is available in three of the four community hospitals. It is proposed to roll this out to all community hospitals;
- GP systems – there is a need to improve data capture in some practices. This is largely a cultural and working practices issue and PCTs need to have in place actions to ensure that there is appropriate data capture;
- different clinical systems (Lorenzo, Semahelix (SaTH) and HMS (GP Out of Hours) makes it very difficult to share electronic medical notes. A common system or at least systems which have excellent interfaces need to be adopted;
- linking of social care to enable information to be shared in key areas such as long term conditions;
- technologies to support mobile working as clinical staff increasingly work in a wider range and number of locations.

The Information Strategy for both PCTs and the acute trusts incorporate many of the issues above. The Information and IT strategies of the NHS organisations should be reviewed t o ensure that the key issues identified above are incorporated in future work programmes. Discussions should also be held with social care about the information implications of moving services closer to home.

7.5 Primary Care Estate

The draft Estates Strategy for Shropshire County and Telford and Wrekin PCTs outline the development programme for primary care premises and the community hospitals. Developments for primary care premises total £8 millions over the next five years across both PCTs. In addition there are planned developments in all four the community hospitals and the development of the Oswestry Primary Care Centre Phase 1 to provide GP premises, DART facilities, MIU and consulting rooms.

Whilst the estates strategy will provide capacity for treating more patients in community settings, the strategy needs to be reviewed once the overarching plan and strategic plans have been finalised and the extent of shifting care closer to home agreed. Specifically the developments at the community hospitals should be reviewed to assess whether they will provide the capacity to support care closer to home.

8. TAKING THE OVERARCHING PLAN FORWARD

This section summarises the implications for activity, the workforce and finance of the models of care developed by the PDGs.

8.1 Care Closer to Home

The models of care for each of the PDGs were assessed to determine the potential for moving care into primary and community care settings. These projections were then reviewed through:

- comparisons with projections in other health economies in the West Midlands;
- discussions with NHS organisations in Shropshire, Telford and Wrekin;
- assessment of the capacity in primary care and the time it would take to develop.

The conclusions of this work are shown in Table 12. Further analysis is needed to ensure that the pace of change is consistent with the capacity in primary and community care.

8.2 Project and Initiatives

A number of projects and initiatives have been identified by the Pathways development Groups. Many of these are summarised in the Models of Care (section 6) and have also been built into the Strategic Plans of the two PCTs.

8.3 Financial Implications

The shifts in activity from acute to primary and community settings have significant implications for the acute sector and for PCTs financial plans, commissioning intentions and the PCT Strategic Plans. The NHS in Shropshire, Telford and Wrekin needs to manage the financial risk to the health economy as a whole and agree:

- the pace of change of the shift to primary care;
- the extent to which changes in income can be set against staff working in primary care and community settings rather than in acute settings;
- the role that SaTH will play in delivering care outside of the RSH and PRH.

Table 12: Care Closer to Home

PDG Group	Initiative	Description	Total Activity Shift	09/10	10/11	11/12	12/13
Maternity & New Born	Develop Midwife led Unit capacity	Increase use of existing units and consider development of NE unit	Increase in midwife led births from 25% to 30%	1%	1%	1%	2%
Paediatrics	Hospital At Home	Develop hospital at home service to enable more children to be cared for at home	Reduction in emergency admissions by 20% 5% shift in new and follow-up outpatients	0% 0%	5% 1%	7% 2%	8% 2%
Planned Care	Integrated dermatology services	Open access to dermatology services within primary and community settings	40% of outpatient activity shift	10%	10%	10%	10%
Planned Care	Integrated musculoskeletal services	Open access to musculoskeletal services within primary and community settings	30 % of outpatient activity shift	0%	5%	10%	15%
Planned Care	Integrated urology services	Open access to urology services within primary and community settings	40% of outpatient activity shift	10%	10%	10%	10%
Planned Care	Integrated neurology services	Open access to neurology services within primary and community settings	30% of outpatient activity shift	5%	5%	10%	10%
Acute Care	Urgent Care Centres	Develop UCC at RSH and PRH to direct people to most appropriate care	30% shift in A&E 15% reduction in certain HRG emergency admissions	5% 3%	5% 4%	10% 4%	10% 4%

PDG Group	Initiative	Description	Total Activity Shift	09/10	10/11	11/12	12/13
LTC	Pathway for Respiratory Services	Reduce admissions and enable early discharge	10% shift in COPD emergency admissions 10% shift in new and follow-up outpatients	2% 2%	5% 5%	3% 3%	0% 0%
LTC	Shropshire Heart Failure Service	Reduce admissions through care closer to home and identification and active management of people at risk	10% in Heart Failure related admissions 10% reduction in NOP and corresponding FU's in Cardiology	2% 2%	5% 5%	3% 3%	0% 0%
LTC	Diabetes	Establish a multidisciplinary service in the community, integrated with primary care	10% in Diabetes related admissions	2%	5%	3%	0%
LTC	Early Supported Discharge (Stroke)	Develop rehabilitation and care in community settings to enable at least 40% patients to have rehabilitation outside hospital	Reduce Occupied bed days by 1600 by12/13	10%	20%	10%	0%
LTC	Stroke	To commission acute care in line with national standards (incl thrombolysis available 24/7)	80% of those admitted spend 90% of their stay on an acute stroke unit	To be determined			
LTC	Dementia (Older people)	Improve support for dementia patients and carers in the community	Reduce admissions to older peoples mental health wards by 30%	Dependant on Shelton re-build			
LTC	Alcohol misuse /reducing alcohol related admissions	To promote early identification and treatment of alcohol misuse and to reduce alcohol related A&E attendances and inpatient admissions	Baseline activity not available for A&E – first stage of project to undertake a needs assessment and identify activity baseline. To reduce the rate of admissions for alcohol related harm per 100,000 people	1653	1768	tbd	tbd
End of Life	GP with Special Interest (GPwSI) in Palliative and Supportive Care	Expand the existing GPwSI role in order to provide close clinical links and education between the Hospice based specialist service, primary care, acute trusts, community hospitals, the independent sector	See below– unable to split overall assumption by initiative				
End of Life	End of Life Care Pathway Project	Improving four key stages of the EOLC Pathway for all patients creating a team, which will work alongside existing CNS in Palliative Care in the acute, community and care home settings	Increase % of people able to die at home by at least 14% by 2012/13	3%	3%	4%	4%
End of Life	End of Life Care Commissioning Strategy	Review commissioning strategy for Shropshire, Telford and Wrekin	See above – unable to split overall assumption by initiative				

PDG Group	Initiative	Description	Total Activity Shift	09/10	10/11	11/12	12/13
Mental Health	Emerging Diagnosis	Improve diagnosis of personality disorder, autism spectrum disorder or ADHD	Reduction in A and E attendances (to be quantified once the baseline has been identified) and admissions (by 25% of total T code admission numbers)	2%	6%	7%	10%
Mental Health	Primary care	Further expand role of primary care mental health teams into mental health and wellbeing services	Reduction in A and E attendances(to be quantified once the baseline has been identified); improvement of early detection; and reduce therapy waiting lists to 18 weeks	tbd	tbd	tbd	tbd
Mental Health	In patient Services	Reduce beds at Shelton Hospital by a third and provide alternatives to admission by making better use of existing facilities	Reduce number of admissions (Shelton) by 25% adult ward and increase support in community settings	Dependant on Shelton re-build			

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

REPORT FROM THE CLINICAL LEADERS FORUM

Report Two

Challenged Service Strategies

November 2008

SUMMARY AND CONCLUSIONS

This section presents the findings and conclusions of the Clinical Leaders Forum with regard to the challenged services of accident and emergency, acute surgery, paediatrics, obstetrics and urology.

The Interim Report considered by Shropshire County and Telford and Wrekin Primary Care Trusts in May 2008 set out three strategic objectives:[1]

- The prevention of disease and the promotion of healthy lifestyles and independent living;
- Provision of services at home or as close to home as possible;
- Provision of sustainable and accessible acute hospital services.

The last of these three strategic objectives was particularly relevant to the challenged services. Specifically the Interim Report concluded that:

<u>by 2012/13</u>

- accident and emergency services should be maintained at both the Princess Royal and Royal Shrewsbury hospitals;
- acute medicine should be developed to underpin emergency medicine;
- general surgery should be reshaped to provide a service for the seriously ill and injured at one site with planned care (elective in patients and day cases) on both sites;
- urgent care centres should be developed;
- assessment services should be strengthened at both site for children and adults;
- hospital at home services should be developed for children and the smaller children's inpatient service should be concentrated onto one site.

<u>by 2020</u>

- emergency services should be concentrated onto a single site for the seriously ill and injured within a network of community and specialist community hospitals;
- an option appraisal should be carried out to determine the location of the single site for the seriously ill and injured and the nature of the network of hospitals providing urgent care and minor injuries units.

[1] Clinical Leaders Forum Interim Report to Shropshire County Primary Care Trust and Telford and Wrekin Primary Care Trust, May 2008.

The CLF and the respective Pathway Development Groups have developed options and assessed options against the two criteria of:

- Making sense clinically; and
- Making sense to the communities we serve.

In assessing the options, the CLF were also aware of the need to resolve the issues in a timely manner and to ensue that any solutions and approaches that needed to be put in place in the immediate future did not compromise the 2020 Option Appraisal.

Benefits to Patients

There are significant benefits to the people of Shropshire, Telford and Wrekin from taking forward the changes identified in the Interim Report over the next five years.

- Developing a specialist service to ensure that patients requiring an emergency vascular operation, such as a life threatening aortic aneurysm, would be carried out by a specialist vascular surgeon at any time of the day or week.

- Allowing the specialist breast surgeons to concentrate on breast surgery.

- Ensuring that emergency general surgery would be done by colorectal and upper gastrointestinal surgeons with expertise in the types of operation which comprise most emergency surgery.

- Having sustainable accident and emergency departments at both hospitals whilst providing a focus for the most seriously ill and injured.

- Continuing to provide planned day case, low risk elective inpatient general surgical/vascular operations and outpatients on both sites so that some 80% of patients will not have to travel to a different site for their planned care.

- Reducing the number of children who need to come into hospital and the time they spend in hospital by providing specialist advice and support closer to home and at the front door of the hospitals.

- Continuing to provide day case operations and outpatient services for children on both sites.

- Providing a working environment for medical staff which allows them to use their specialist expertise to best effect and to ensure that they keep up to date and at the leading edge of clinical care.

- Making the most efficient use of current facilities on both sites.

The Clinical Leaders Forum recognises that the proposals and options in this report have implications for the time it will take for some people to get to hospital. Considerable thought has been given to seeking to minimise the impact on getting to hospital. Both hospitals would retain their accident and emergency services and in addition all outpatient and day case surgery as well as low risk elective inpatient surgery would continue to be done on both sites. In addition, care closer to home is one of the strategic objective underpinning all the models of care developed by the Pathway Development Groups.

CHALLENGED SERVICES 2012/13

General Surgery

1. Continuing to provide emergency surgery services on both the PRH and the RSH Powys is increasingly difficult and carries with it risks to patients, pressure on medical staff and limits the ability to develop more specialist services.[2]

2. The breast surgeons should cease to participate in the acute surgery rota as soon as is practically possible.

3. A separate vascular rota should be established as soon as is practically possible.

4. Emergency general surgery should be consolidated onto one site since maintaining acute surgery across two sites is not clinically or financially viable once the breast and vascular surgeons withdraw from the acute rota.

5. Arrangements for the transfer of patients between sites where necessary should be reviewed and strengthened. Protocols should also be put in place with the ambulance service regarding consolidation of acute surgery on one site.[3]

[2] These pressures on and challenges to the current provision of emergency surgery are described in Section 2.

[3] The CLF considered emergency operations for patients who need an emergency operation but can wait until the next day being done on both sites. However it was felt this would be inefficient, would require duplication of some clinical support services and would have implications an increase in level of out of hours so negating many of the benefits and advantages of consolidating emergency surgery.

6. Out of hours surgical cover should be provided across both sites to ensure that acute medicine and other clinical services have the support of surgical advice and cover. The CLF believe this can be done at a relatively small cost and with minimal clinical risk with, for example, cooperation from the vascular surgeons in providing back up cover for the general surgeons.

7. Major vascular and colorectal elective surgery should be done on the site with acute surgery.

8. All day case surgery (some two thirds of general surgery) and outpatient services should continue to be done on both sites. In addition consideration should be given to establishing a five day ward for short stay elective general surgery on the site without acute surgery.

Accident and Emergency Services

1. Accident and Emergency services should be retained on both sites.[4]

2. A Level 2 Emergency service should be provided on one site. This would mean a 24 hour A and E department with acute surgery, acute medicine, trauma, critical care, interventional radiology and clinical support services and diagnostics on site.

3. A Level 3 Emergency service should be provided on the site without acute surgery. The service should be 24 hour a day with acute medicine, trauma (major trauma would need to go to a Level 2 A and E but significant levels of trauma could continue to be provide e.g. fractured neck of femur), critical care, clinical support services and diagnostics on site. Arrangements would also need to be put in place to ensure acute surgery support including the ability to transfer patients and to properly cope with medical patients who need urgent surgical intervention, for instance in the case of a GI bleed.

4. Acute medicine and hospital at night should be developed with the priority focussed on the site with the Level 3 A and E.

Paediatrics

1. The model of care proposed by the Children's PDG should be implemented including hospital at home, paediatric assessment units at both sites and consolidation of paediatric inpatients onto one site. This

[4] A Level 2 Acute Emergency Service deals with most medical, surgical and trauma (including multiple trauma) emergencies including unselected patients. A Level 3 Acute Emergency Service dealing with most medical emergencies and most trauma including fractured neck of femur but not multiple trauma.

should be implemented over a three year period with consolidation of inpatient paediatric services only after the hospital at home and the assessment services have been established.

2. Paediatric anaesthetic competencies must be available on the site with in patient paediatrics. In addition there must be anaesthetic cover for the paediatric assessment units. Co-location of in patient paediatrics with ENT surgery, whilst desirable, is not essential.

   With regard to the other critical clinical linkages (acute surgery and neonates), the CLF did not feel that the challenges on any of these by themselves were insurmountable. This was the same as the view of the external review of the Children's Pathway Development Group process:

   "Our overall conclusion on clinical linkages was that whilst they were an important consideration, and should be optimised wherever possible, no linkages were so imperative per se as to dictate a specific solution in terms of the future configuration of children's services. This means that there is room to consider fully the range of other issues (e.g. facilities, population access)."[5]

   There was however concern that the cumulative effect of neonates and surgery on a different site to inpatient paediatrics presented considerable risks and challenges that would require careful management. Further the system would be more complex than with the services co-located. A majority of the clinicians on the CLF felt that splitting paediatrics from acute surgery and neonates was not appropriate in light of these issues. However this was not a unanimous view.

3. If acute surgery and in patient paediatrics were not on the same site then consideration would need to be given to:

   - ceasing to carry out general surgical emergency operations on children at night and at the weekends to avoid transfer of very sick children post operatively. Instead these children would need to be transferred to an appropriate children's unit in Stoke, Wolverhampton or Birmingham (this would affect very few children, approximately one at month at each site);
   - arrangements to perform emergency but not immediate operations on children on the site with inpatient paediatrics would need to be put in place to avoid pre and post operative transfers;
   - the out of hours arrangements for general surgery on the non acute site would need to be strengthened to support children whose

[5] Technical Paper 5: External Review of Paediatrics PDG Process, October 2008

medical condition deteriorated and who might need the support of a general surgeon;
- paediatric out of hours cover would need to be available on the acute surgical site.

4. The consolidation of acute surgery and paediatrics would provide some flexibility for the anaesthetic service to review its arrangements and ensure that anaesthetists with paediatric expertise are, as far as is practical, concentrated onto the site with inpatient paediatrics.

Obstetrics

1. The CLF recognised the importance of the location of the obstetric hub within the maternity network; the clinical linkages and the poorer clinical outcome with regard to deprived populations.

2. It is essential that obstetrics and neonates are co-located.

3. The facilities for the obstetric unit require considerable investment to bring it up to 21st century standards. However investment in the unit should be limited to what is essential until the completion of the 2020 Option Appraisal.

Urology

1. The CLF found no clinical or strategic argument to alter the conclusion of the Strategic Service Plan that urology should transfer to PRH.

2. Should the implications of moving other surgical services result in unused bed and theatre capacity at either site then consideration should be given to basing urology on the site with surplus capacity.

CONFIGURATION OF CHALLENGED SERVICES

The CLF identified a number of options for the configuration of services on the RSH and PRH. These were assessed against the two key objectives of:

1. consolidating acute surgery and in patient paediatrics in a timely manner;
2. not compromising the 2020 Option Appraisal.

As a result of this, four options were identified for further assessment. The location of the challenged services under each option is shown in the table below. In all cases, day case and outpatient paediatrics & general surgery will be carried out on both sites.

Option	PRH	RSH
1	Level 3 A and E, urology	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates
2	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates	Level 3 A and E, urology
3	Level 3 A and E with inpatient paediatrics, urology	Level 2 A and E with acute surgery, obstetrics and neonates
4	Level 2 A and E with acute surgery, and inpatient paediatrics	Level 3 A and E, obstetrics and neonates, urology

Each of these options was assessed against the following questions:

1. Did the options meet the two key objectives of resolving the surgery and paediatric issues in a timely manner without compromising the 2020 Option Appraisal?
2. Did the options satisfy the clinical linkage requirement and/or had measures to manage any risks as a result of co-location been identified?
3. What would be the implications for patients in terms of access?
4. Would the options have a significant beneficial or detrimental impact on those living in rural areas?
5. Would the options have a significant beneficial or detrimental impact on deprived sections of the population?
6. How affordable were the options from the point of effective use of capacity, medical workforce and capital implications?

The Clinical Leaders Forum concluded that:

- Option 1 (acute surgery, in patient paediatrics, obstetrics and neonates on the RSH) would provide clinically appropriate co-location of services, make good use of existing capacity and so minimising any capital costs and investment in the medical workforce. Option 1 would maintain access for the rural populations but would have a detrimental effect on the

more deprived populations and have the largest increase in the time taken to get to hospital for most people.

- Option 2 (acute surgery, in patient paediatrics, obstetrics and neonates on the PRH) would provide clinically appropriate co-location of services and minimise the required investment in the medical workforce. Option 2 would require additional beds and theatre capacity to be provided at PRH whilst not fully using the existing capacity at RSH.[6] The option would worsen access for the rural populations but would locate services closer to the most deprived people as well as to people in the east of Shropshire County. The option would have the smallest impact on the time taken to get to hospital for most people.

- Option 3 (acute surgery, obstetrics and neonates on the RSH and inpatient paediatrics on the PRH) would mean some clinical compromises in the clinically appropriate co-location of services with acute surgery and neonates on a different site to inpatient paediatrics. Option 3 would make good use of existing capacity and require the least capital investment but would require additional investment in the medical workforce. The option would worsen access for the rural populations to inpatient paediatrics but would locate inpatient paediatrics closer to the most deprived people as well as to the people in the east of Shropshire County.

- Option 4 (obstetrics and neonates at the RSH and acute surgery and inpatient paediatrics at the PRH) would mean some compromise in the clinically appropriate co-location of services with acute surgery and paediatrics on the PRH and obstetrics and neonates on the RSH. Option 2 would require additional beds and theatre capacity to be provided at PRH whilst not fully using the existing capacity at RSH. The option would worsen access for the rural populations to acute surgery and inpatient paediatrics but would locate these services closer to the most deprived people as well as to the people in the east of Shropshire County.

[6] Option 2 would potentially compromise the 2020 Option Appraisal with the relocation of the obstetric unit. However as the detailed costing of the options had not yet been done, it was agreed to leave this option in for further assessment.

2020 VISION

The CLF concluded that in the medium term there should be a single site for the seriously ill and injured. An option appraisal has been started to consider the optimal location.

All the options assume a network of vibrant community hospitals with a range of specialist community and community services providing services closer to home, as identified in the Overarching Plan.

The following options have been identified.

Baseline Option	This will be the configuration of hospital services agreed on the basis of this report for implementation by 2012/13
Option 2	Under Option 2 the main A and E is based at Shrewsbury together with acute surgery and medicine, trauma, inpatient paediatrics, obstetrics and neonates, Outpatient, day case surgery, minor injuries, midwife unit and specialist community services would be provided in Telford.
Option 3	Under Option 3 the main A and E is based at Telford together with acute surgery and medicine, trauma, inpatient paediatrics, obstetrics and neonates, Outpatient, day case surgery, minor injuries, midwife unit and specialist community services would be provided in Shrewsbury.
Option 4	There will be a new acute hospital between Shrewsbury and Telford dealing with all seriously ill and injured patients. The sub options identify a number of possibilities for the two existing hospitals.

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SUPPORTING PAPERS AND REPORTS

A. Pathway Development Group Reports

- Maternity and newborn care
- Getting Healthy, Staying healthy
- Children's services
- Planned care
- Acute care
- Mental health
- Long term conditions
- End of life care

B. Technical Papers

- Access
- Clinical Linkages
- Sustaining Services
- Children and Young People
- External Review of Paediatrics

C. Building Capacity in Primary Care

- Summary Report
- Care Coordination
- Diagnostics
- Workforce

D. Engagement Plan and Evidence of Engagement

1. INTRODUCTION

1.1 Background

This report is the second report of the Clinical Leaders Forum (CLF) on Developing Health and Healthcare: A Strategy for Shropshire, Telford and Wrekin and focuses on the 'challenged' service strategies[7]. These were identified by the West Midlands Strategic Health Authority as accident and emergency, acute surgery, paediatrics and obstetrics. In addition the local health economy agreed that urology should also be included as a challenged strategy.

The CLF was asked by the Chief Executives of the four NHS organisations in Shropshire, Telford and Wrekin:

"To review the evidence in respect of the options and to make recommendations for the future pattern of clinically safe general hospital services, serving the populations of Shropshire, Telford & Wrekin, and the catchments of the provider organisations.

To consider options and make recommendations to Shrewsbury and Telford Executive Group (STEG) of an overall picture of the future shape of hospital services, within the context of a modern NHS. To give early consideration to A&E services, services for children and also to cover maternity and neonatal services, emergency surgery and urology services.

In doing so the CLF will need to liaise with the clinical pathway groups meeting at a West Midlands-wide level (associated with the 'Our NHS, Our Future' exercise), to give information and also to receive and consider information from these clinical pathway groups.

To conduct the work of the CLF in a structured manner and to describe a clear process of dialogue and consideration which leads to your recommendations which are evidence based.

The CLF will need to take in to account future patterns of demography. Also to consider the issues around sustainability within the context of the European Working Time Directive (EWTD) and Medical Manpower Careers (MMC).

The CLF will make recommendations which meet the following principles: that recommendations will be clinically safe and also make sense to the communities we serve.

[7] In October 2007, The West Midlands Strategic Health Authority asked each local health economy to develop an overarching plan for health and healthcare by October 2008, the Clinical Leaders Forum (CLF) was charged with developing the overarching plan.

Financial saving is not a driver for this work. However, recommendations would need to be affordable within available resources, and be clinically sound and viable for the future."

The CLF comprised the leading clinicians in the health organisations in Shropshire, Telford and Wrekin and senior officers from Shropshire County Council and Telford and Wrekin Council.

1.2 Conclusions of the Interim Report

The CLF's Interim Report was considered by Shropshire County and Telford and Wrekin Primary Care Trusts in May 2008[8]. The Interim Report set out three strategic objectives:

- The prevention of disease and the promotion of healthy lifestyles and independent living;
- Provision of services at home or as close to home as possible;
- Provision of sustainable and accessible acute hospital services.

Regarding the last of these three strategic objectives the Interim Report concluded that:

by 2012/13[9]

- accident and emergency services should be maintained at both the Princess Royal and Royal Shrewsbury hospitals;
- acute medicine should be developed to underpin emergency medicine;
- general surgery should be reshaped to provide a service for the seriously ill and injured at one site with planned care (elective in patients and day cases on both sites);
- urgent care centres should be developed;
- assessment services should be strengthened at both site for children and adults;
- hospital at home services should be developed for children and the smaller children's inpatient service should be concentrated onto one site.

by 2020

- emergency services should be concentrated onto a single site for the seriously ill and injured within a network of community and specialist community hospitals;

[8] Interim Report from Clinical Leaders Forum to Shropshire County Primary Care Trust Board and Telford and Wrekin Primary Care Trust Board, 13th May 2008
[9] Pages 15 and 16 Interim Report to Shropshire County and Telford and Wrekin PCT Boards, 13th May 2008

- an option appraisal should be carried out to determine the location of the single site for the seriously ill and injured and the nature of the network of hospitals providing urgent care and minor injuries units.

During the second phase of the work, the options for the 2012/13 configuration of services have been assessed further. This work has been led by the CLF with the detailed work carried out by:

- the Urgent Care Network which has taken over the role of the Acute Pathway Development Group;
- the Children's Pathway Development Group;
- senior clinicians and managers with The Shrewsbury and Telford Hospital NHS Trust. This work was led by the Medical Director.

The work has been carried out within the approach and principles described in the first report from the CLF.[10]

1.3 Demographics and Health of the Population

1.3.1 The Catchment Area of PRH and RSH

Shropshire County is a predominantly rural area of 289,300 people with a varied landscape covering an area of 3,197 square kilometres. In 2006, the population density of Shropshire was 90 people per square kilometre. This is much lower than the average for England as a whole (389 people per square kilometre). Shropshire is one of the most sparsely populated counties in England.

The main population centres are Shrewsbury (67,126), Oswestry (16,660), Bridgnorth (11,891), Market Drayton (10,407), Ludlow (9,250), Whitchurch (8,067), Shifnal (6,391) and Wem (5,142).

There are few motorways and dual carriageway roads in the county, which means that most journeys take place on a network of A roads and smaller B road and lanes. There are also few rail links within the county, making travel around the county difficult for non-car users – 18% of households do not own a car compared with the England average of 27%.

The Borough of Telford & Wrekin covers around 112 square miles and has a population of approximately 167,000. At the heart of the Borough is the new town of Telford, so designated in the 1960s and now the local focus for both population and economic growth. The Borough is also home to several small towns - Wellington, Dawley, Donnington, Madeley and Oakengates. To the north of Telford is the market town of Newport and to the south Ironbridge. The

[10] Health and Healthcare in 2012/13: Care Pathways and Models of Care, Report from the Clinical Leaders Forum, November 2008, Section 2.

Borough also has a significant rural area which is located to the north and west of Telford and covers approximately 72% of the Borough's total area.

The area is dominated by the large new town of Telford (population 133, 523) and nearby borough towns. The other area of population concentration is Newport (11,015).

Transport links are generally better than in rural Shropshire, including the direct M54 link to Birmingham and central England. However, there are still access difficulties for people without access to car transport in the more rural and more deprived parts of the borough – 22% of households do not own a car compared with the England average of 27% and 18% in Shropshire.

In addition to the people of Shropshire, Telford and Wrekin, the local NHS also provides services to the people in the northern portion of the county of Powys, which includes a population of about 62,000 people. The county of Powys has a population of 126,000 people in area of 5,196 square kilometres.

1.3.2 Population Projections and Deprivation

Table 1 gives population by age and population projections over the next 15 years for Shropshire, Telford & Wrekin. The population under 15 is proportionately higher in Telford and Wrekin than Shropshire County (21% and 18% respectively) whilst the proportion over 65 is higher in Shropshire County (20% compared to 14%).

Table 1: Current and Projected Population

	Shropshire County			Telford and Wrekin		
	Population 2007	**Growth 2007-12**	**Growth 2007 - 22**	Population 2007	**Growth 2007-12**	**Growth 2007 - 22**
0-15	51,800	-5%	-7%	33,900	0%	9%
16-64	182,600	0%	-1%	109,300	5%	12%
65-84	49,900	17%	44%	19,900	18%	53%
Over 84	7,300	18%	64%	2,500	12%	48%
	291,600	2%	7%	165,600	**5%**	**17%**

Source: Shropshire County Council and Telford and Wrekin Council

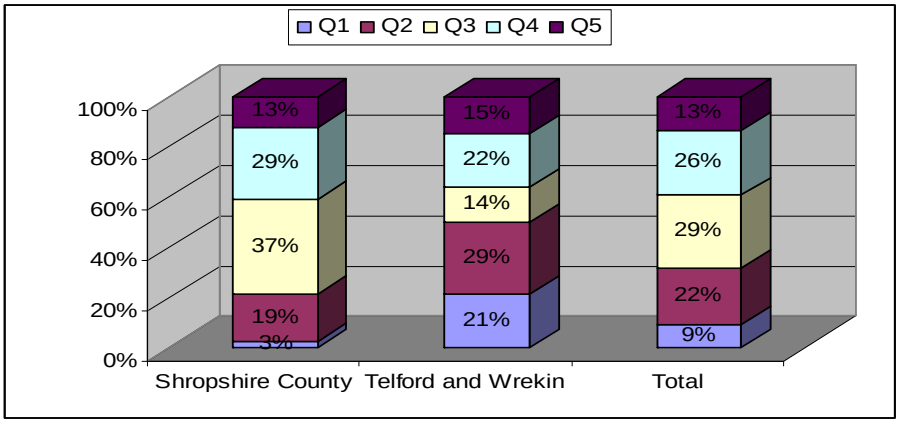
The population is projected to grow by just over 7% over the next 15 years in Shropshire County and by 17% in Telford and Wrekin with the largest growth in the older age groups (the over 65 population is projected to grow 47% in Shropshire County and 52% in Telford and Wrekin). In addition further inward migration into Telford and Wrekin and a significant expansion in house building (it is projected that at least 26,500 additional houses will be needed by 2026), is projected to increase the growth in the working population by 12%, compared to a 1% fall in Shropshire.

There has been a substantial inward migration of people from eastern Europe into Telford & Wrekin in recent years. Approximately 5% of the community are from black and minority ethnic groups. By 2026, it is estimated that the proportion of the population from black and minority ethnic groups will have grown to 6.5%, around 12,900 people.

Figure 1 summarises the levels of socio-economic deprivation in Telford & Wrekin and Shropshire County[11], as measured by the quintiles of the Index of Multiple Deprivation. Nearly half of the Telford & Wrekin population live in the two most deprived national quintiles. Overall, the Index of Multiple Deprivation (IMD) 2007 ranks the Borough as falling within the top third most deprived local authorities in England. This compares to 22% of the Shropshire County population who live in the two most deprived national quintiles.

In Telford & Wrekin 21.4% of the population (nearly 36,000 people) live in areas classified within the most deprived fifth of areas in England. In Shropshire County, 3% of the population (586 people) live in the most deprived 20% of areas in England.

Figure 1 Proportion of Population in National Deprivation Quintiles



The deprivation and health of the children varies across Shropshire, Telford and Wrekin. In Telford & Wrekin 24.5% of children aged 0-15 years live in deprivation, which is statistically significantly higher than the English average (22.4%). In Shropshire County 13.2% of 0-15 year olds live in deprivation, which is statistically significantly lower than the English average (22.4%). As a result there are more children living in deprived circumstances in Telford & Wrekin than

[11] This is a summative measure, based on 37 measures of socio-economic status. Scores are published at "super-output area" level (which exist below ward level and are defined by the 2001 census) and have an average population of around 1,500 people. For comparative purposes, super-output areas are often aggregated into the 20% bandings (quintiles) of the overall score.

in Shropshire County (8,318 in Telford and Wrekin and 6,820 in Shropshire County).[12]

1.3.3 The Health of the Population

Life expectancy at birth in both men and women is lower in Telford & Wrekin than in Shropshire County. Over the past decade, male life expectancy has improved in both PCTs. Projections indicate that the gap in male life expectancy between Telford & Wrekin and Shropshire County may narrow up to the 2008/10 position. In women, smaller improvements in life expectancy are predicted over the next few years. It is estimated that the gap in female life expectancy between Telford & Wrekin and Shropshire County will persist up to 2008/10.

In line with trends elsewhere in England and Wales all age all cause mortality, infant mortality (AAACM) and deaths from circulatory diseases and cancers have been falling since the early 1990s. Comparisons of the health of the population in Telford and Wrekin and Shropshire show that:

- all age all causes mortality are similar to the national average in Telford and Wrekin for men and significantly higher for women than the national average. Those in Shropshire were significantly lower than the national average;
- infant mortality rates in both Shropshire County and Telford & Wrekin are similar to the national average;
- premature death rates from circulatory diseases were statistically significantly higher than the national average in Telford & Wrekin but significantly lower in Shropshire;
- premature death rates from all cancer were statistically similar to the national average in both Shropshire and Telford and Wrekin other than for women which is lower in Shropshire;
- suicide rates for men, women and persons in Telford & Wrekin and Shropshire County were similar to the national average but rising.

Other indicators point to a greater public health agenda in Telford and Wrekin than in Shropshire, where the indicators are generally more favourable. For instance:

- the proportion of babies breastfed at birth in Telford & Wrekin remains significantly lower than in Shropshire County;
- the proportion of mothers still smoking at delivery in Telford & Wrekin is significantly higher than in Shropshire County;

[12] Further detail of deprivation and demographics of children in Shropshire, Telford and Wrekin is given in Technical Paper 4: Children and Young People.

- there has been no improvement in smoking in pregnancy rates in Telford & Wrekin or Shropshire County in the past five years;
- whilst teenage conception rates have fallen, the under 18 conception rates remain significantly higher than the national average in Telford and Wrekin but are in the lowest quartile in Shropshire;
- obesity levels are high compared to the rest of England and rising.

1.4 Strategic Considerations

The CLF identified six key strategic considerations. These are:

- Health, Wellbeing and Equity;
- Quality, Safety and Effectiveness;
- Supporting and Developing the Workforce;
- Involving People about Making Decisions about their Future Health Services;
- Affordable, Sustainable and Fit For Purpose;
- Personalised Services and Access to Care, Closer to Home.

In addition a number of specific issues were identified by the Pathway Development Groups. These issues are discussed in the report by the CLF on Care Pathways and Models of Care, November 2008. The issues concerning clinical viability and access to hospital services are discussed in more detail in the next section.

2. CHALLENGED SERVICES IN SHROPSHIRE, TELFORD AND WREKIN

2.1 Clinical Viability

Over the next 10 years a number of trends that have been seen in the configuration and nature of services traditionally provided in district general hospitals are anticipated to accelerate. Specifically:

- am increasing range and complexity of work can now be carried out in primary and community care settings and closer to where people live;
- some specialist services will be concentrated in fewer major centres. For example:
    - major trauma - at present about one percent of major trauma is taken directly or transferred to major centres with tertiary services such as neurosciences. It is projected that the proportion of patients who will be treated at specialist centres will increase to between 5 and 10%;
    - stroke services when the first 48 hours is critical in improving outcomes. Patients will be taken to centres which can guarantee a CT scan within an hour and have on site specialist neurology and neurosurgery services. Patients will then be transferred back to hospitals closer to where they live for rehabilitation;
    - vascular, paediatric and some cancer surgery;
    - Intensive care for the most complex cases.

This will require local acute hospitals to focus on what they can do best, working within a network of specialist and community hospitals. Local acute hospitals are likely to become smaller with the clinical staff playing a wider role outside of the acute hospital.

Experience from around the country and the view of the Royal Colleges is that a 24 hour acute hospital emergency service should be planned on the basis of a minimum population of around 500,000. The two accident and emergency services (at the Princess Royal and the Royal Shrewsbury) currently have an 'effective' catchment population of 416,000 as shown in Table 2 below.

Table 2: SaTH's Effective Catchment Population[13]

	PRH	RSH	Total	Other Trusts
Shropshire County	74,456	154,448	228,904	60,696
Telford and Wrekin	150,382	0	150,382	11,218
Montgomeryshire	0	36,819	36,819	22,931
	224,838	191,267	416,105	94,845

[13] Technical Paper 1: Access. The 'effective' catchment population is based on an analysis of drive times to hospitals and non elective market share.

The emergency activity of the two hospitals in Telford and Shrewsbury is shown in the Table 3. The figures show very similar sized hospital for emergency admissions and A and E attendances, particularly when one takes into account the configuration of surgical services (which would result in more emergency surgery being done at the Royal Shrewsbury Hospital) and the minor injuries units in Shropshire which provide a local service to people and avoid a trip to the A and E in Shrewsbury.

Table 3: Non Elective Inpatients and A and E Attendances 2007/08

	Medical	Surgical	Trauma	Gynaecology and Paediatrics	Total	A and E Attendances
Royal Shrewsbury	9,937	4,093	2,028	4,049	20,107	49,778
Princess Royal	9,609	3,066	1,544	2,423	16,642	53,282
Total	19,006	7,159	3,572	6,742	36,749	103,060

Source: Shrewsbury and Telford Hospitals NHS Trust

There are significant challenges to continuing to provide emergency services from two sites. The main services where clinical viability is an issue are A and E, emergency surgical services, anaesthetics and critical care and paediatrics. The key challenge facing the hospitals is the ability to provide 24 hour a day out of hours cover by senior medical staff to both hospitals. This has become increasingly difficult over the last ten years as a result of:

- Sub specialisation - medical staff becoming more specialist. Whilst this gives greater expertise and a higher quality of service in those areas where there has been sub specialisation, there are fewer consultants to provide a general emergency service. This is a particular problem in general surgery;
- Out of Hours arrangements – in some specialties there are consultants covering a number of services and/or sites at the same time. Services where this is an issue include inpatient paediatrics and anaesthetics/critical care. These arrangements have been put in place over the years to help sustain services on two sites but carry with them risks to patients and unrealistic pressure on medical staff;
- European Working Time Directive (EWTD) – since 1998 the EWTD has resulted in a reduction in the average working time per week that staff including medical staff should work. These requirements have become increasingly stringent and form August 2009 average working time should not exceed 48 hours per week (from 56 hours since August 2007);
- Training of Medical Staff – the decision on where junior doctors should be based is the responsibility of the Postgraduate Dean, taking into account

the number of doctors in training and the quality of the training that is available. A key factor in the assessment of the quality of the training is that junior doctors should be able to see an appropriate number of patients with a variety of illnesses and injuries. Whilst there are few official figures for the number of patients that a junior doctor should see, small units or services which are provided across a number of locations provide fewer opportunities to see the number of patients or the range of conditions. The loss of training recognition significantly reduces the ability of a service to continue and may, in some instances, force the service to close;

- Recruitment - services where there are concerns about risks to patients, pressure on medical staff and continued recognition of training posts have considerable difficulty in recruiting high quality senior medical staff and in particular consultants.

The current provision of services has also limited the ability to develop more specialized services that could be provided in Shropshire, Telford and Wrekin. For instance:

- vascular surgery has moved to being mainly provided at the Royal Shrewsbury. However this had occurred earlier in many other places. The development of techniques, in particular interventional radiology, can only be fully realized if the service is on one site;
- the national cancer strategy seeks to concentrate operations on fewer sites;
- the development of a children's oncology service has only been possible because of it being consolidated on the Royal Shrewsbury Hospital. Other service developments such as renal dialysis are hindered by the current provision of services.

In summary, continuing to provide services for the seriously ill and injured from two sites for the population of Shropshire, Telford, Wrekin and Powys is increasingly difficult and carries with it risks to patients, pressure on medical staff and limits the ability to develop more specialist services. At the same time, the urban population concentrations in Shrewsbury and Telford combined with the rurality of the population in Shropshire County and the deprivation levels in Telford and Wrekin provide major challenges for access to health care services. The strategy will need to ensure that both these issues are taken into account.

2.2 Accident and Emergency

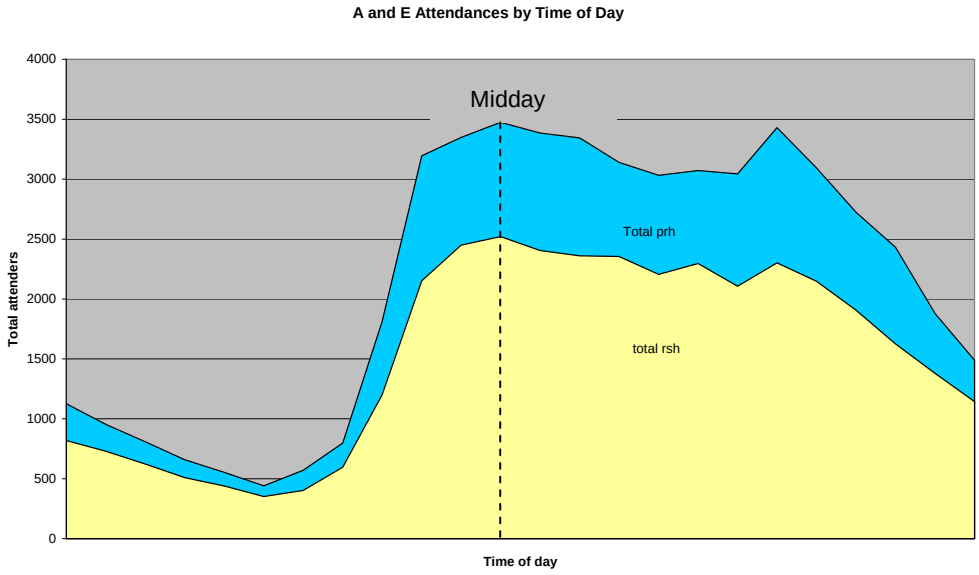
The Accident and Emergency Department (A and E) should be the hub of an emergency service within a coordinated network of primary and community services, community hospitals, and urgent care centres The Accident and Emergency Department must also have strong links with major trauma centres providing specialist tertiary services such as neurosurgery and cardiac surgery.

Currently A and E is provided at both the Princess Royal and Royal Shrewsbury hospitals. As shown in Table 2, above the two hospitals have very similar activity levels.

The pattern of A and E attendances by day of week and time of the day are very predictable as shown in Figure 1. Attendances drop significantly between 11 pm and 8 am on both sites.

Currently there are four A and E consultants and six associate specialists across both sites. The departments are staffed overnight by a single handed trainee doctor with back up from senior staff on call at home. The current staffing levels do not provide adequate senior medical cover at night. Ideally there should be 24 hour cover at consultant level. Continuing to provide services on both sites would require a sustained investment in A and E consultants to at least double the number of consultants.

Figure 2: A and E Activity by Time of Day



2.3 Emergency Surgery

Currently services are provided from Telford and Shrewsbury. Out of hours cover for general surgery is provided by all the surgeons. However sub-specialisation with new consultants having less or no general experience for the acute take and a changing skill mix in junior trainees is now limiting the ability to provide safe cover. Examples of where the implications of these issues are impacting include:

- Breast surgery is already highly sub-specialised and in many places breast surgeons do not participate in the acute take. Although the breast

surgeons currently perform acute general surgery this is not sustainable in the medium term as there is a need to maintain skills. Furthermore the replacement of surgeons when they retire will be by specialist breast surgeons with limited experience of acute surgery;

- Vascular surgery. National recommendations are to provide access to treatment by consultant vascular surgeon, which necessitates a separate vascular surgery emergency rota. This practice has been adopted in most places and the evidence base supports better outcomes. The need for a vascular surgery rota together with the demands that vascular surgery places on surgical anaesthetic and radiology resources argues strongly for emergency vascular and major elective surgery to be located on one site. New techniques, including endovascular and palliative care, are currently only on offer on one site. The establishment of a separate vascular rota would result in the loss of five surgeons to the acute surgery rota;
- Colorectal surgery where the need to attract good trainees and the requirements of the Greater Midlands Colorectal Cancer Network to consolidate colorectal cancer work means that most elective operative activity is now centralized on RSH site with out-reach clinics performed in the community and at PRH.

The withdrawal of sub specialty surgeons from the acute take would make the maintenance of two sites admitting emergency surgical patients non-viable without a significant increase in the number of surgeons. Even if the finances were to be made available, it is unlikely that the Trust would be able to recruit as the posts would not be attractive enough top attract high calibre surgical consultants because of the dilution of the elective workload across a larger number of surgeons.

2.4 Urology

Urology services are currently provided at both RSH and PRH with three quarters of the beds and activity undertaken at RSH. Following public consultation under The Strategic Service Plan it was agreed to transfer urology to the PRH with outpatient and day case services provided on both Royal Shrewsbury and Princess Royal hospital sites.

2.5 Paediatrics

Hospital paediatric services in Shropshire, Telford and Wrekin are provided in both Shrewsbury and Telford. Paediatric activity at the two sites is summarised in Table 4.

Table 4: Emergency and Outpatient Paediatric Activity 2007/08

	Emergencies	New Out Patients
Royal Shrewsbury	2,736	3,506
Princess Royal	2,422	3,944
	5,158	7,450

Source: Shrewsbury and Telford Hospitals NHS Trust

Services in the community are less well supported and as a result children are treated in hospital who could be more appropriately treated at home. The national trend is for children to be supported in community settings resulting in fewer hospital admissions and shorter lengths of stay.

The two paediatric units are currently staffed on separate rotas. Rotas at PRH are managed using staff grades. At the RSH the rota includes consultants covering the neonatal unit and a community paediatrician. Neither of these situations is ideal and present additional clinical risks. The Telford and Wrekin PCT has agreed to fund the implications of the European Working Time Directive in order to sustain in patient paediatric services on both sites. The current cost of this is £200,000 a year above the tariff paid for the paediatric services and is projected to increase to £400,000 a year. However it is proving increasingly difficult to recruit to these posts.

Currently there is recognition for training posts at the Royal Shrewsbury. If the concerns about the configuration of services and training opportunities are not resolved then there is a risk that recognition of training posts will be withdrawn. This would threaten the future viability of the inpatient service on both sites.

There are clear national and regional standards which the local services will need to meet by 2009. These include the West Midlands standards in 'The Care of the Critically Ill or Injured Child' and the European Working Time Directive. A regional review of paediatric services[14] has concluded that the Princess Royal service does not meet minimum staffing requirements and raises concerns about the maintenance of skills within the current configuration. There are also significant risks to the continued recognition of training posts under the current configuration of services.

2.6 Anaesthetics and Critical Care

Anaesthetists provide out of hours cover for critical care, on outreach wards for critically ill patients, emergency resuscitation, emergency surgery and obstetrics.

[14] West Midlands Children's, Young People and Maternity Services Configuration Group, April 2008

They also are involved in the transfer of acutely ill patients between sites or to tertiary centres such as the neurosurgery unit in Stoke. There are two major constraints on the anaesthetic services providing effective out of hours cover on both sites:

- there is not a separate rota for critical care ;
- the implications of the more stringent European Working Time Directive. The anaesthetic rotas will not be compliant without additional staffing and further expansion and development of the intensive care service will be very difficult if the service remains across two sites.

In addition, the infrastructure of the ICU at RSH is inadequate and needs rebuilding rather than refurbishing. Both are very high cost options. Currently the unit is poorly equipped to deal with infection risks such as MRSA and C. difficile.

The precise requirements of the critical care facilities and the anaesthetics workforce depend on the final configuration of services. However maintaining emergency admissions on both sites will require additional anaesthetic staff and an investment in the facilities. In the medium/longer term continuing to provide ICU services across both sites will limit the ability of the critical care unit to develop and provide appropriate services for the seriously ill and injured.

2.7 Maternity Services

The Darzi West Midlands Clinical Pathway Group in conjunction with other regional groups believe the model of care for maternity and the newborn should consider pregnancy to be a normal event and care should be midwifery led. Care should be holistic with a greater emphasis on social elements. There should be equity of access especially for the most vulnerable groups. There should be choice for the site of care and delivery with an emphasis on keeping that care local. Obstetric and neonatal services should be, when clinically appropriate, designed around the majority with access to these specialised services when required.

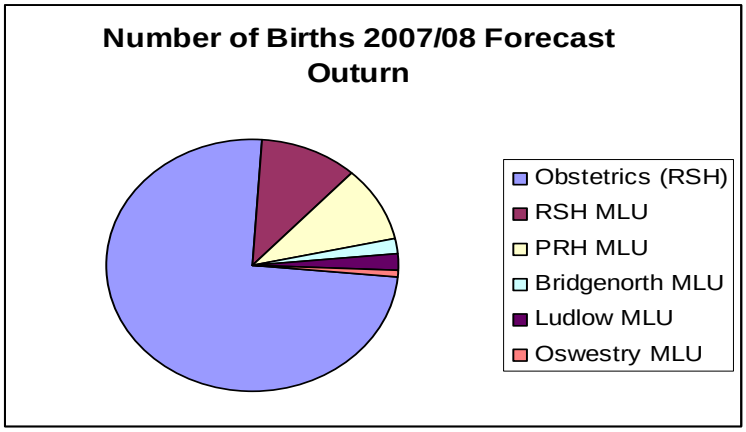
The model of care in Shropshire since 1972 has been that of a Hub and Spoke with the Consultant Unit based at the Royal Shrewsbury Hospital acting as the Hub and the midwifery led units in Oswestry, Telford, Bridgnorth, Shrewsbury, Ludlow, Newtown and Welshpool. In 2007/08 there were just over 5,000 births with just over a quarter of these in the midwifery led units. The proportion of births at each unit is shown in Figure 3.

A regional review of maternity services[15] has identified the need for dedicated anaesthetic support and an increase in consultant presence on the labour ward.

[15] West Midlands Children's, Young People and Maternity Services Configuration Group, April 2008.

This model of care enables the maternity service to deliver the aspiration of the regional Darzi group and records a peri-natal mortality rate which is lower than the rate for the West Midlands (CEMACH). In addition, compared with other units in the West Midlands, the service delivers a lower surgical intervention rate (caesarean section); a lower rate of antenatal admission (CBSA: maternity services paper); a lower number of antenatal visits and an increased number of contacts with community midwives. The Trust was assessed by the Healthcare Commission Maternity Services Review 2007 as a "best performing" Trust and achieved CNST level 3 in 2007, as well as being recognised nationally by the award of the 2004 "All Parliamentary Award for the highest normal delivery rate" and the 2005 "All Parliamentary Award for increasing home births". All this is delivered with an average cost per birth that is well below the mean for the West Midlands (CBSA).

Figure 3: Births by Location



* Oswestry and Bridgnorth units were closed for part of the year.

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3. CHALLENGED SERVICE STRATEGIES: MAKING SENSE CLINICALLY

The CLF has considered the future provision of services which are facing particular challenges as discussed in Section 4. This has been done within the framework provided by the Models of Care and taking into account:

a. access[16];
b. clinical linkages[17];
c. clinical viability and sustainability issues[18];
d. children and young people[19] .

The options have also been assessed for affordability based on an assessment of making use of available theatre and bed capacity to minimise additional capital costs and medical workforce costs. A detailed assessment of capital costs has not been done Some of the options do not require significant changes in capacity or capital investment. Where significant capital investment is required, a final decision should be taken in light of the conclusions of the 2020 Option Appraisal.

The Maternity and New Born model of care is leading edge and development should seek to enhance and build on the current model of care. There is however a need to invest significantly in the infrastructure of the obstetrics unit. The implications of access and service issues have been looked at in this review of challenged strategies but any major investment in the obstetrics unit whether at RSH or at a different location should be consistent with the 2020 option appraisal.

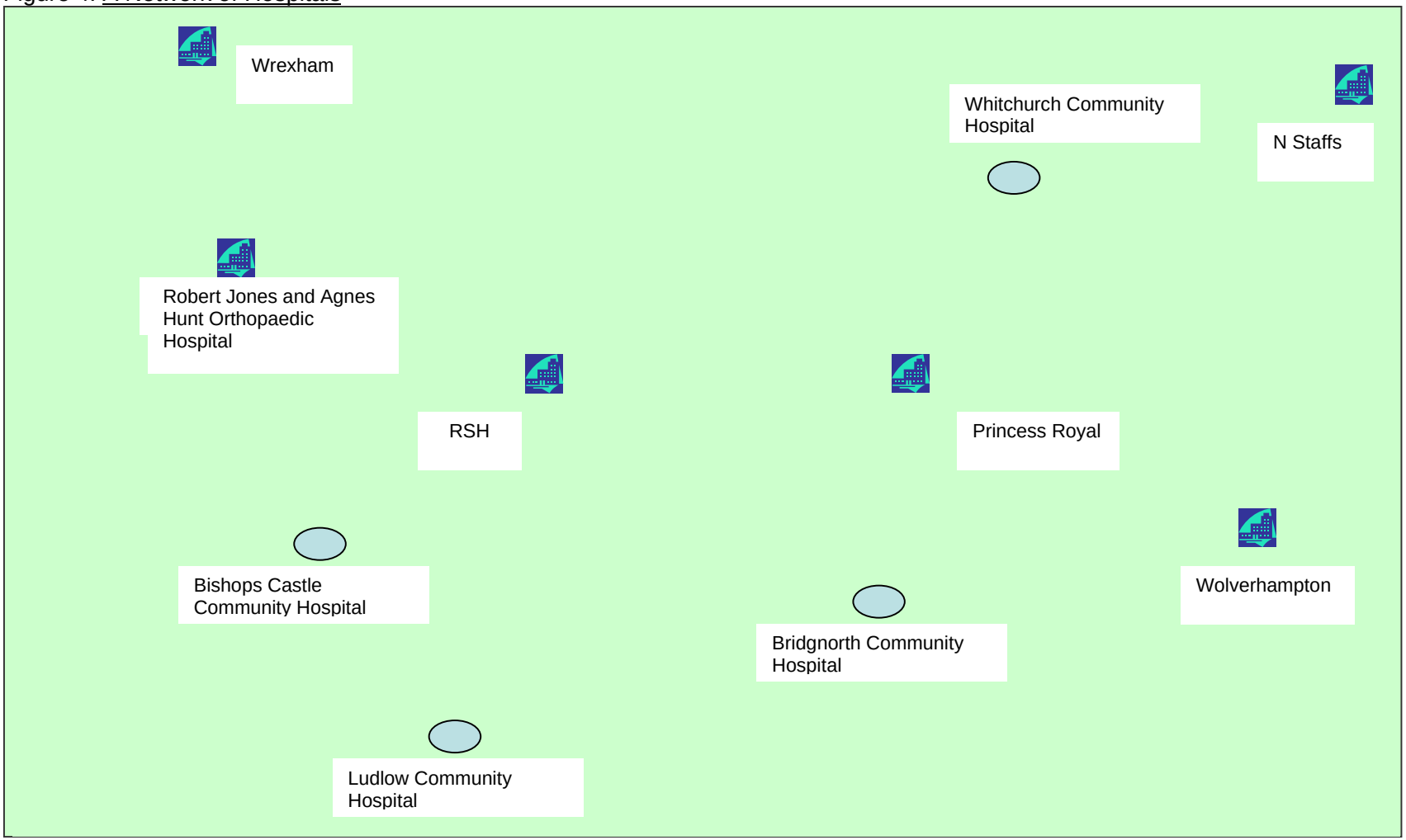
3.1 A Network of Hospitals

In identifying the options for the challenged services four levels of hospital emergency care were defined. These would be provided from a network of hospital as shown in Figure 4.

- Level 1 Acute Emergency Service dealing with all emergencies including immediate life threatening and major trauma including those requiring specialist tertiary care;
- Level 2 Acute Emergency Service dealing with most medical, surgical and trauma emergencies including unselected patients;
- Level 3 Acute Emergency Service dealing with most medical emergencies and significant trauma;
- Urgent Care Centre and Minor Injuries Units.

[16] Technical Paper 1: Access, November 2008
[17] Technical Paper 2: Clinical Linkages, November 2008
[18] Technical Paper 3: Sustaining Clinical Services, November 2008
[19] Technical Paper 4: Children and Yong People, November 2008

Figure 4: A Network of Hospitals



A and E Level 1 requires neurosurgery and other specialist services and is provided in Birmingham or Stoke.

A Level 2 Emergency service requires a 24 hour A and E department acute surgery, acute medicine, trauma, critical care, interventional radiology, clinical support services and diagnostics on site.

A Level 3 Emergency service needs to have a 24 hour A and E department[20] trauma (major trauma would need to go to a Level 2 A and E but significant levels of trauma could continue to be provide e.g. fractured neck and femur), critical care, clinical support services and diagnostics on site. Arrangements would also need to be put in place to ensure acute surgery support including the ability to transfer patients and to properly cope with medical patients who need urgent surgical intervention, for instance in the case of a GI bleed. The report by the Academy of Royal Colleges[21] recommends that a hospital dealing with acute medical emergencies should not be seen as a permanent configuration but may be implemented as a step towards a more permanent configuration of services.

3.2 Emergency Hospital Care

3.2.1 Accident and Emergency Services

The two A and E departments are currently covered on a joint consultant rota with middle grade doctors at each site. Whilst this is not ideal, it does not constitute a major clinical risk. As such the major determinates on A and E services in the 2012/13 model of care are the issues facing acute surgery.

Whatever the emergency model of care for 2012/13, there are a number of potential developments which could help address the issues facing A and E over the next five years. These include:

- development of acute medicine which could enable a more senior doctor at the front end (either in A and E or the admissions unit);
- hospital at night which could take some of the pressures off the junior doctors by having routine tasks done by a multidisciplinary team;
- development of a paediatrics assessment unit on each site.

3.2.2 General Surgery

Four options are considered for the future of acute surgery. These are:

- no change i.e. continuing to provide elective and emergency surgery at both sites with all surgeons participating in the acute take;

[20] Or one which was open for the majority of the 24 hours with arrangements for patients to be transferred at times of low activity
[21] Report of Acute Services Working Party, Academy of Royal Colleges, 2007

- continuing to provide acute surgery on both site whilst recognising the sub specialisation issues – two sub options are considered, one with no separate vascular rota (Option A1) and one with a separate vascular rota (Option A2). In both A1 and A2 the breast surgeons would not be part of the acute take. In patient elective and day case surgery would continue to be provided on both sites;
- moving all emergency general/vascular surgery to one site but maintaining inpatient elective and day case surgery on both sites (Option B);
- moving all inpatient general/vascular surgery to one site with day case surgery at both sites (Option C).

The options for general surgery have been assessed against the implications for patients, clinical viability and safety, clinical linkages and medical workforce and costs.[22] In summary:

- continuing with the current arrangements would mean that emergency surgical services in Shropshire, Telford and Wrekin continue to be provided by all surgeons including the breast surgeons and without a separate vascular rota. This means that patients requiring an emergency vascular operation such as an aortic aneurysm are not guaranteed a vascular surgeon. This is not the practice in most hospitals and is against what is regarded as best practice;

- maintaining acute and elective surgery on both sites whilst removing breast surgeons for the acute take (Option A1) and establishing a separate vascular rota (Option A2) will require these consultants to be replaced on the rota at a cost of £360,000 and £600,000 respectively. Further investment in middle grade staff will also be needed. Out of hours cover would continue to be provided at both sites. There are a number of problems associated with this option including:
    - colorectal surgery remaining split across two sites. The development of cancer services requires colorectal cancer surgery to be centralised;
    - there is not sufficient elective colorectal, upper GI or vascular work to justify the appointment of significant additional consultants or to offer sufficiently attractive jobs to recruit suitably qualified applicants;
    - continuing to sustain the acuity of care on both sites would make it more difficult to resolve the challenges facing anaesthetics including the ability to have a second middle grade rota at the RSH in light of the out of hours workload (theatres, critical care, obstetrics unit);

[22] Technical Paper 3: Medical Staffing, Sub Specialisation and the Out of Hours Challenge, November 2008

- concentrating acute surgery on one site whilst maintaining elective inpatient and day case surgery on both sites (Option B). The implications of this option are:
    - day surgery will be provided on both sites. This means that two thirds of general surgical planned operations will be provided at the same hospital as at present;
    - major elective inpatient vascular and colorectal surgery would be consolidated on the site with emergency medicine. Other elective in patient surgery will be done on both sites, possibly within a 5 day ward;
    - some 7-8 patients requiring emergency surgery will need to go the other site or be transferred each day;[23]
    - there will need to be an investment in medical workforce. The extent of this depends on what out of hours arrangements are made as summarised in Table 5;
    - there would be implications for paediatric services as discussed in Section 3.4.

Table 5: Implications of Consolidating Emergency Surgery

Out of hours arrangements	**Additional Medical Manpower Costs**	**Implications for Patients**
Rota on each site with general and vascular surgeons participating (1 in 7 on acute site, 1 in 6 on non acute site) Option B1	£240,000 but may be possible to reduce middle level staff (net cost £60,000)	7-8 patients a day need to go to acute site or be transferred. May be able to reduce by operating on emergency, non immediate patients the next day
Acute surgery rota on acute site also covers non acute site with backup from separate vascular rota on acute site Option B2	£120,000	7-8 patients a day need to go to acute site or be transferred

- concentrating all emergency and inpatient surgery on one site (Option C) with day case surgery (two thirds of general surgery elective surgery) on both sites. There would need to be surgical out of hours cover for medical patients on the non acute site as there would be clinical risks for medical patients e.g. GI bleeds and, if inpatient paediatrics is on a different site, for children. One additional GI consultant would be required.

[23] The CLF considered emergency operations for patients who need an emergency operation but can wait until the next day being done on both sites. However it was felt this would be inefficient, would require duplication of some clinical support services and would have implications for out of hours so negating many of the benefits and advantages of consolidating emergency surgery.

3.3 Other Surgical and Critical Care Services

3.3.1 Anaesthetics

The anaesthetic service provides services for theatres, obstetrics and critical care. Currently the out of hours rotas are 1 in 11 at Telford and 1 in 13 at Shrewsbury. The rotas are run as separate rotas. There are a number of challenges facing the anaesthetic service:

- at both sites the out of hours rotas cover theatres, critical care and, in the case of the RSH, the obstetric unit;
- there is no dedicated obstetric anaesthetist;
- there is no weekend trauma list leading to delays for patients;

Rationalisation of acute surgery across the two sites under options B and C will provide some flexibility within anaesthetics to address the above issues. However more integrated working across the two sites would also give additional flexibility within the anaesthetic service. Whilst rationalisation of acute surgery and cross site working will provide part of the solution to the challenges facing anaesthetics, investment in anaesthetics is likely to be needed in the future.

3.3.2 Other Surgical Services

Urology

Currently urology services are provided at both RSH and PRH with three quarters of the beds and activity undertaken at RSH. Following public consultation under The Strategic Service Plan it was agreed to transfer urology to the PRH. The arguments on locating urology on either of the two existing sites are:

> Shrewsbury: the RSH services an older population and there are clinical linkages with gynaecology but these are not essential.
>
> Telford: development and retention of the urological cancer work will be reliant on strategic alliance with Wolverhampton which would be better provided from Telford.

Other factors to consider are

- making the best use of capacity;
- the clinical linkage with paediatrics (desirable but not essential);
- the low proportion of urological emergency work;
- potential to develop hospital at night enabling some of the tasks done by junior doctors to be done by a multidisciplinary team. This is particularly advantageous on sites with less acute surgery and lower acuity levels and OOH demands.

Head and Neck

The head and neck services are currently all provided at RSH. If emergency surgery transfers to one site, some services will need to be on the other site to make the best use of current capacity. A number of the clinicians at SaTH have suggested that head and neck could be based on the non acute site. The main reason for this is that the head and neck services have a low emergency workload. Other factors to consider are:

- making the best use of capacity;
- the clinical links to paediatrics;
- potential to develop hospital at night enabling some of the tasks done by junior doctors to be done by a multidisciplinary team. This is particularly advantageous on sites with less acute surgery, lower acuity levels and out of hours requirements.

3.4 Paediatrics

The options for in patient paediatrics must be looked at in light of the overall model of care for children's services and in particular the proposed development of hospital at home and assessment units. The Interim Report identified four scenarios for paediatrics. These were:

Scenario 1	Scenario 2	Scenario 3	Scenario 4
TWO Assessment Units & TWO Inpatient Units	TWO Assessment Units & TWO Inpatient Units & Hospital at Home	TWO Assessment Units & ONE Inpatient Unit & Hospital at Home	ONE Assessment Unit & ONE Inpatient Unit & Hospital at Home
		Sub Options RSH PRH	Sub Options RSH PRH New Site

The second phase of the work focussed on the clinical linkages. Four key clinical links were identified by the PDG as being particularly important for paediatric services. These are:

- Acute surgery;
- ENT;
- Anaesthetics;
- Neonates.[24]

[24] These are discussed in more detail in the Children's PDG report.

As part of the development of the strategy, an external review of the process and work of the Children's PDG was commissioned.[25] The conclusion of this review regarding clinical linkages was that:

> *"Our overall conclusion on clinical linkages was that whilst they were an important consideration, and should be optimised wherever possible, no linkages were so imperative per se as to dictate a specific solution in terms of the future configuration of children's services. This means that there is room to consider fully the range of other issues (e.g. facilities, population access)."*

Neonates

Concerning neonates, the external review stated that:

"Classically neonatal services and paediatric services are co-located and at first glance it is easy to assume that they must be co-located. But typically this is for issues of workforce and not because of intersecting clinical pathways other than on infrequent occasions."

In considering the issue, the CLF also took into account the increasing specialisation distinction between paediatrics and neonatal care, and the policy that babies under 28 days who require readmissions are not re admitted to the neonatal unit, mainly to minimise the possibility of infection.

The Children's PDG has assessed the medical workforce implications as proposed by the Children's PDG of different configurations. These are summarised in Table 6. The PDG's analysis concluded that:

- retaining two inpatient units will require further investment in middle grade and consultant staff;
- having a single in patient paediatrics unit on the same site as neonatal care will enable the middle grade tier to be rationalised and a smaller expansion in consultant staff. In addition there could be a reduction in the number of junior doctors;
- having a single site for in patient paediatrics but on a different site to neonates would require a significant expansion in consultant staff with the potential for some reduction in the middle grade tier. In addition there would need to be a separate on call rota for neonatal intensive care. The main increase in staffing is the establishment of a separate NICU rota and assumes a 1 in 8/10.

[25] The review was carried out by Dr Steve Ryan, Medical Director, Alder Hey Children's Hospital and John Adler, formerly Chief Executive, Sheffield Children's Hospital.

Whilst recognising that separating inpatient paediatrics and neonates would require some investment, the CLF were concerned that the proposed medical workforce model was more appropriate to a tertiary centre. For this to be an option a more flexible and cost effective medical workforce model would be required.

Table 6: Medical Workforce Implications of the Different Options for Paediatrics

	Consultants	Middle Grade	Comments
Current Situation	12	18	Combined NICU/Paeds OOH at RSH Separate Paed OOH at PRH
2 IP Units full workforce	15	22	Combined NICU/Paeds OOH at RSH Separate Paed OOH at PRH
Paediatrics and NICU on same site	14	14	Combined NICU/Paeds OOH at RSH Separate Paed OOH at PRH
Paediatrics and NICU on different sites	18	14	4 cons run NICU in day, need 8-10 to have NICU OOH rota

Paediatric Surgery

Paediatric surgery is currently provided at both RSH and PRH. General paediatric surgery is carried out by general surgeons (of whom three do most of the elective work). Emergency in patient paediatric surgery levels in 2007/08 are given in Table 7. As discussed in the Children's PDG report there are problems with the data and in particular what is counted as an emergency and the fact that children are admitted under a paediatrician, not a surgeon. The level of activity is likely to be underestimated.

An assessment was carried out of children who had had an emergency operation at night at PRH over a 12 month period (procedures which started after 6 pm). Of the 54 operations, 46 were trauma patients and 8 were general surgical emergencies. This equated to less than one general surgical operation a month. An assessment was not carried out at RSH but given the similar level of emergency paediatrics, the number operated on at night is low.

With acute surgery and paediatrics on both sites, paediatricians are available to support children having operations and surgeons are available on site to operate on children who need emergency surgery.

Table 7: Paediatric Surgery

	RSH	PRH	Total
General Surgery	45	78	123

Urology	7		7
ENT	102		102
Ophthalmology	12		12
Oral Surgery	25		25
Gynaecology	17		17
	208	78	286

Where acute surgery and inpatient paediatrics are on separate sites the clinical linkages need to be addressed. It is clear from the PDG report and national guidance that having in patient and children's services on a site without acute surgery carries with it risks. In particular:

- children arriving at the non acute site and needing an emergency operation would need to be transferred to the acute surgery site for their operation and then transferred back again.[26] Alternatively they would need to be transferred to another paediatric unit for their operation;
- children arriving at the acute site and needing an emergency operation would need transferring to the in patient ward post operatively;
- paediatricians and surgeons would need to be available for out of hours advice and support to each other on both sites.

Whilst none of the challenges are insurmountable, there are significant implications for children and professionals which would require careful management and investment in, for instance, transport capacity.

ENT

If ENT and the inpatient paediatric unit are on different sites there would be issues regarding emergency tracheotomies and support to children on the ENT ward from a paediatrician. Addressing these issues would require ENT clinicians to cover the site with inpatient paediatrics and paediatricians able to visit the ENT ward when required.

The CLF did not feel that ENT and in patient paediatrics on the same whilst desirable was essential.

Anaesthetics

[26] The CLF considered emergency operations for children who need an emergency operation but can wait until the next day being done on both sites as is presently the case. However it was felt this would be inefficient in that theatre capacity would need to be available on every day for a small number of children. It would also require duplication of some clinical support services and would increase in level of out of hours surgical cover so negating many of the benefits and advantages of consolidating emergency surgery.

Under the options for acute surgery, it is proposed to have acute medicine on both sites. This will require anaesthetic cover out of hours, so providing support to in patient paediatrics.

Conclusion

The CLF did not feel that the individual clinical linkages issues that arise if surgery and inpatient paediatrics are not co-located were insurmountable. There was however concern that the combined effects of neonates and surgery on a different site to in patient paediatrics presented considerable risks and challenges that would require careful management. Further the system would be more complex than with the services collocated. A majority of the clinicians on the CLF felt that splitting paediatrics, surgery and neonates was not appropriate in light of these issues. However this was not a unanimous view.

4.5 2020 Vision

The CLF concluded that in the medium term there should be a single site for the seriously ill and injured and an option appraisal be carried out.. All the options assume a network of vibrant community hospitals. The following options have been identified.

Baseline Option	This will be the configuration of hospital services agreed on the basis of this report for implementation by 2012/13
Option 2	Under Option 2 the main A and E is based at Shrewsbury with outpatient, day case surgery, minor injuries, midwife unit and specialist community services in Telford.
Option 3	Under Option 3 the main A and E is based at Princess Royal Hospital with outpatient, day case surgery, minor injuries, midwife unit and specialist community services in Shrewsbury.
Option 4	There will be a new acute hospital between Shrewsbury and Telford dealing with all seriously ill and injured patients. The sub options identify a number of possibilities for the two existing hospitals.

4. CHALLENGED SERVICE STRATEGIES: MAKING SENSE TO COMMUNITIES

4.1 Access to Hospital Services

4.1.1 Drive Time Analysis

A detailed assessment of access to hospital has been undertaken using drive time data provided by Dr Foster. Adjustments have been made to reflect market share. This has provided an estimate of the 'effective' catchment population for each hospital as discussed in Section 2.[27]

All the options considered propose that a considerable level of planned care including all day case activity would continue to be provided at both sites. The impact of relocating services will therefore be on general surgical emergency care and major elective surgery, not outpatients or at least 80% of planned operations.

The conclusions of the drive time analysis are:

- over 80% of the population of Shropshire, Telford and Wrekin live within a 40 minute drive of the RSH or PRH;
- some 5% of the 'effective' catchment population have a drive time of over one hour. The areas affected are parts of Shropshire County (2% of the population) and Montgomeryshire (41% of the population);
- consolidation of any service or services to PRH would have less impact on average drive times than consolidating them on the RSH (average drive times would increase by 20% compared to 29%);
- consolidation of any service or services onto the RSH would adversely impact on the more deprived sections of the population in Telford and Wrekin;
- consolidation onto RSH would have no impact on the population living over one hour away. Consolidation onto the PRH would double the proportion of the population living over one hour away to nearly 10% with the greatest impact on western Shropshire and Montgomeryshire.

The analysis is based on drive times. The greater deprivation and lower car ownership levels in Telford and Wrekin would further impact on the population without a car and/or require greater use of public transport or the ambulance service to access services.[28]

[27] Details are provided in Technical Paper 1: Access.

[28] The drive time analysis was also carried out for Site 'X' between Telford and Shrewsbury. This is one of the options for the longer term as discussed in Section 5.2. The conclusions of this are:

- moving services to Site 'X' has the lowest impact on drive times with an estimated 17% increase ion average drive times;

The analysis also looked at the impact on the 'effective' catchment population of consolidation all services onto one site. The conclusion are summarised in Table 8.

Table 8: 'Effective' Catchment Population of Single Site Options

	Current (RSH & PRH)	PRH only	RSH only	Site 'X'
Shropshire County	228,904	198,923	153,615	187,306
Telford and Wrekin	150,382	161,600	71,851	161.600
Montgomeryshire	36,819	6,000	36,819	32,119
	416,105	366,522	262,284	381,025
Change from Current	---	-49,583	-153,821	-35,080

The importance of taking access in account when considering configuration of hospital services has recently been emphasised by the decision of the Independent Reconfiguration Panel to reject the proposals of the Oxford Radcliffe Hospitals NHS Trust to reconfigure services in Banbury and stated that:

> *'The ORH must do more to develop clinically integrated practice across the Horton, the John Radcliffe and Churchill sites as well as developing wider clinical networks with other hospitals, primary care and the independent sector.'*
>
> and
>
> *'The IRP is concerned that the changes to paediatric, maternity, special care and gynaecology services at Horton Hospital are being driven by future medical staffing constraints, not by providing a better service for local people.'*[29]

4.1.2 Deprivation

- the proportion of the population living over an hour away increase for Site X but the increase is less that that for services moving to the PRH.

[29] Independent Reconfiguration Panel ADVICE ON CHANGES PROPOSED BY THE OXFORD RADCLIFFE HOSPITALS NHS TRUST TO PAEDIATRIC SERVICES, OBSTETRICS, GYNAECOLOGY AND THE SPECIAL CARE BABY UNIT AT THE HORTON GENERAL HOSPITAL IN BANBURY Submitted to the Secretary of State for Health 18 February 2008

The assessment of the deprivation of the populations in the local authorities has been detailed in the report on Models of Care from the CLF.[30] The conclusion from this are:

> *'The analysis of demographic trends and public health factors has significant implications of the health and healthcare strategy. When compared to national figures, Shropshire County is generally less deprived, with a low violent crime rate and a lower rate of teenage pregnancies. However there are significant areas of localized deprivation within Shropshire County. Whilst there is a high level of obesity, there are fewer deaths from smoking, cancer and fewer early deaths from heart disease and stroke.*
>
> *Conversely, Telford and Wrekin has a higher projected growth in population, significantly higher levels of deprivation both in Telford and Wrekin as well as Shrewsbury and Atcham parts of which are served by the Princess Royal. Telford and Wrekin also have higher rates of early mortality from smoking and circulatory diseases. Telford and Wrekin also have relatively high rates of teenage pregnancy and obesity and higher numbers of children living in deprivation.'*

The implications of the health and deprivation levels of children and young people have also been looked at[31]. The conclusions of these studies show that:

- social deprivation correlated strongly with neonatal morbidity and the need for a neonatal unit admission [32];
- there is a clear relationship between A&E attendance and deprivation against all triage categories[33];
- deprivation was found to be significantly associated with childhood admission rates for respiratory infection, particularly in the under 5 age group[34];
- the rate of hospital admissions for infectious intestinal diseases is double in children from the most deprived areas compared to those from the most affluent[35].

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[30] Report from the Clinical Leaders Forum: Health and Healthcare 2012/13: Care Pathways and Models of Care, November 2008

[31] Technical Paper 4: Children and Young People, November 2008.

[32] *Archives of Disease in Childhood Fetal and Neonatal Edition* 2005;90:F337-FF338 D Manning**,** B Brewster**,** P Bundred. Social deprivation and admission for neonatal care

[33] *Archives of Disease in Childhood Fetal and Neonatal Edition 2005;90:F337-FF338* T F Beattie**,** D R Gorman**,** J J Walker. The association between deprivation levels, attendance rate and triage category of children attending a children's accident and emergency department.

34 *Respiratory Medicine* 2003 Nov;97(11):1219-24 Hawker JI, Olowokure B, Sufi F, Weinberg J, Gill N, Wilson RC. Social deprivation and hospital admission for respiratory infection: an ecological study.

35 *The Lancet* , Volume 353 , Issue 9155 , Pages 807 - 808 B . Olowokure , J . Hawker , J . Weinberg , N . Gill , F. Sufi. Deprivation and hospital admission for infectious intestinal diseases.

The level of non-elective paediatric admission activity in Telford & Wrekin has been higher than the England average. In terms of rates, most of this activity is accounted for by admissions from the most deprived population quintile in Telford & Wrekin, supporting the research that higher levels of deprivation are associated with higher admissions.

4.1.3 Patient's Views on Choosing Hospitals

The views of patients when choosing a hospital for planned care was obtained through participation in the two Council's Citizen Questionnaire. In summary:

- 60% of the population in Shropshire County and 68% of the population put quality of care, reputation of the hospital and expertise of the surgeon as the most important factors;
- 11% of people in Shropshire County and 15% of people in Telford and Wrekin felt that speed of treatment was the most important factor;
- Proximity of the hospital was the most important factor for 11% of people in Shropshire County and 13% of people in Telford and Wrekin;
- 10% of people thought cleanliness was the most important factor.

Whilst proximity of care is likely to be of greater importance when considering emergency care, it is clear that safe and effective services are critical issues for the people of Shropshire, Telford and Wrekin.

4.2 Affordability

Capacity

The current bed and theatre configuration (and the configuration for Option A) is shown in Table 9 together with the number of beds and theatre sessions required under Options B and C[36].

If the RSH is Site 1 then the number of beds required for general/vascular surgery would be 90 under Option B and 105 under Option C at the RSH (an increase of 34 and 49 respectively). The number of beds for general surgery at PRH would fall from 49 to 15 and 0. This could be accommodated to a larger degree by moving other surgical services from RSH to PRH e.g. urology or head and neck so using current capacity.

If the PRH is Site 1 then there would need to be an increase in beds at PRH from 49 to 90 (Option B) and 105 (Option C). This would need to be additional

[36] The following assumptions have been made:
(i) Site 1 is the emergency surgery site;
(ii) no adjustments have been made for increased day case rates or more efficient use of beds.

capacity as there is limited scope to move other surgical services to RSH. There would be a corresponding decrease in requirements at RSH.

A similar picture emerges with theatre capacity where relocating other surgical services from PRH would enable services to be broadly accommodated within current capacity if RSH was Site 1. Additional investment would be needed if PRH was Site 1.

Table 9: Bed Configuration and Future Requirements[37]

	Current & Option A			Option B			Option C		
	RSH	PRH	SaTH	Site 1	Site 2	SaTH	Site 1	Site 2	SaTH
	----------Number of Beds----------								
General/Vascular Surgery	56	49	105	90	15	105	105	0	105
Possible locations of other surgical services to make best use of capacity									
Urology	18	6	24						
Head and Neck	40	0	40						
	114	55	169						
	----------Number of Inpatient Theatre Lists----------								
General/Vascular Surgery, elective	728	884	1,612	728	884	1,612	1,612	0	1,612
General/Vascular Surgery, CEPOD	520	260	780	780	0	780	780	0	780
	1,248	1,144	2,392	1,508	884	2,392	2,392	0	2,392
Possible locations of other surgical									
Urology	312	104	416						
Head and Neck	884	0	884						
	2,444	1,248	3,692						

Source: Shrewsbury and Telford Hospitals NHS Trust

Medical Workforce

The projected medical workforce costs of the options general surgical options are given in Tables 10 and 11 and details are given in Technical Paper 3: Sustaining Services.

[37] Patients requiring emergency but not immediate operations and can be operated on the non acute site the following day could mean some adjustment in the bed numbers. The implication of this is that the required bed numbers will move closer to the current bed numbers under Options B and C but the relative differences between the options will not be significantly affected.

Table 10: Cost of Changes to Surgical Medical Workforce (£'000s)

	A1	A2	B1	B2	C
General Surgery	600	1,200	60	120	0*

* potential for middle grade savings dependent on location of other services.

The medical staffing implications of different configurations for paediatrics were discussed in Section 3. Table 11 summarises the cost implications. From this analysis the main issue is the cost of inpatient paediatrics and neonates being on different sites. The assessment by the Children's PDG assumes a separate rota for NICU (Section 3). If separate sites for neonates and paediatrics are to remain an affordable option, alternative out of hours arrangements will need to be found. Further work on this is needed regarding:

- the level of on call for NICU;
- a more integrated rota across NICU and paediatrics to avoid deskilling of consultants whilst retaining cover on both sites.

Table 11: Changes in Costs of Paediatric Workforce[38]

	£'000s
Current Situation	2,400
2 IP Units full workforce	2,940
Paediatrics and NICU on same site (combined PICU and NICU rotas)	2,460
Paediatrics and NICU on different sites (separate NICU rota)	3,240

[38] Consultant and middle grade salary costs

5. FUTURE CONFIGURATION OF CHALLENGED SERVICES

5.1 Configuration of Challenged Services in 2012/13

The CLF identified a number of options for the configuration of services on the RSH and PRH. These were assessed against the two key objectives of:

3. consolidating acute surgery and in patient paediatrics in a timely manner;
4. not compromising the 2020 Option Appraisal.

Each of these options was assessed against the following questions:

1. Did the options meet the two key objectives of resolving the surgery and paediatric issues without compromising the 2020 Option Appraisal?
2. Did the options satisfy the clinical linkage requirement and/or had measures to manage any risks as a result of collocation been identified?
3. What would be the implications for patients in terms of access?
4. Would the options have a significant beneficial or detrimental impact on those living in rural areas?
5. Would the options have a significant beneficial or detrimental impact on deprived sections of the population?
6. How affordable were the options from the point of effective use of capacity, medical workforce and capital implications?

The conclusions of the Clinical Leaders Forum are summarised in Table 13 and further details given in the Technical Papers. Four options were identified for further assessment as shown in Table 12.[39] In all cases day case and outpatient general surgery and paediatrics will be carried out on both sites.

Table 12: Options for Configuration of Challenged Services

Option	PRH	RSH
1	Level 3 A and E, urology	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates
2	Level 2 A and E with acute surgery, inpatient paediatrics, obstetrics and neonates	Level 3 A and E, urology
3	Level 3 A and E with inpatient paediatrics, urology	Level 2 A and E with acute surgery, obstetrics and neonates
4	Level 2 A and E with acute surgery, and inpatient paediatrics	Level 3 A and E, obstetrics and neonates, urology

[39] There was concern expressed by some members of the Clinical Leaders Forum that Option 2 could potentially compromise the 2020 Option Appraisal. However it was agreed to leave this Option 2 in for further assessment, recognising that any potential problem must be managed to ensure that 2020 option appraisal was not compromised.

Table 13: Assessment of Options for Future Configuration of Challenged Services

Option	Key Objectives	Clinical Linkages	Access	Rurality	Deprivation	Affordability
1	Yes	All critical clinical linkages be satisfied	Average drive times increase by 29%	No change	Move emergency services and inpatient paediatrics away from most deprived people	Makes good use of existing capacity with low medical workforce costs and capital implications
2	No unless delay any decision on relocation of obstetrics until 2020 decision made	All critical clinical linkages be satisfied	Average drive times increase by 20%	Double the number of people over an hour away double	Locate services with most deprived section of the population	Increase beds by 84% and theatres by 30% at PRH. 20% beds and 60% theatres capacity not be needed at RSH. Medical manpower costs low. Significant capital to relocate obstetrics
3	Yes	Paediatrics be on different site to surgery and neonates	Increase in average travel time for emergency surgery (29%) and inpatient paediatrics (20%)	In crease in travel time for those in rural areas for inpatient paediatrics	Locate inpatient paediatrics close to most deprived population	Makes good use of existing capacity with minimal capital requirements. Medical manpower costs increase in neonates and paediatrics and acute surgery
4.	Yes	Paediatrics and acute surgery be on different site to obstetrics and neonates	Increase average travel time by 20%	Double the number of people over an hour away double	Locate inpatient paediatrics/acute surgery close to most deprived population	Increase beds by 84% and theatres by 30% at PRH. 20% beds and 60% theatres capacity not be needed at RSH. Medical manpower costs rise with neonates inpatient paediatrics on different sites

5.2 2020 Vision

The CLF concluded that in the medium term there should be a single site for the seriously ill and injured. An option appraisal has been started to look at the options for where the optimal location for such a facility.

All the options assume a network of vibrant community hospitals with a range of specialist community and community services providing services closer to home, as identified in the Overarching Plan.

The following options have been identified.

Baseline Option	This will be the configuration of hospital services agreed on the basis of this report for implementation by 2012/13
Option 2	Under Option 2 the main A and E is based at Shrewsbury with outpatient, day case surgery, minor injuries, midwife unit and specialist community services in Telford.
Option 3	Under Option 3 the main A and E is based at Princess Royal Hospital with outpatient, day case surgery, minor injuries, midwife unit and specialist community services in Shrewsbury.
Option 4	There will be a new acute hospital between Shrewsbury and Telford dealing with all seriously ill and injured patients. The sub options identify a number of possibilities for the two existing hospitals.

The options are outlined in more detail in the Appendix.

Appendix
2020 Options

OPTION 2		
Option	**Royal Shrewsbury Hospital**	**Princess Royal Hospital**
Option 2A	A and E level 2 dealing with all Emergency Services including acute medicine, acute surgery, trauma and paediatrics and critical care Obstetrics and midwife-led unit Outpatients, day case surgery, all inpatient elective surgery Community services Diagnostic and Clinical Support Services	Urgent Care Centre Paediatric Assessment Uni9t Minor Injuries Unit Midwife-led unit Outpatients, day case surgery Specialised Community Services Diagnostic and Clinical Support Services
Option 2B	A and E level 2 dealing with all Emergency Services including acute medicine, acute surgery, trauma and paediatrics and critical care Obstetrics and midwife led unit Outpatients, day case surgery, inpatient elective surgery Community services Diagnostic and Clinical Support Services	Urgent Care Centre Paediatric Assessment Unit Minor Injuries Unit Midwife-led unit Outpatients, day case surgery and elective surgery not requiring critical care Specialised Community Services Diagnostic and Clinical Support Services
Option 2C	A and E level 2 dealing with all Emergency Services including acute medicine, acute surgery, trauma and paediatrics and critical care Obstetrics and midwife led unit Outpatients, day case surgery, all inpatient elective surgery Community services Diagnostic and Clinical Support Services	Minor Injuries Unit Midwife-led unit Outpatients, day case surgery Specialised Community Services Diagnostic and Clinical Support Services

Option 3		
Option	**Royal Shrewsbury Hospital**	**Princess Royal Hospital**
Option 3A	Urgent Care Centre Paediatric Assessment Unit Minor Injuries Unit Midwife-led unit Outpatients, day case surgery Specialised Community Services Diagnostic and Clinical Support Services	A and E level 2 dealing with all Emergency Services including acute medicine, acute surgery, trauma and paediatrics and critical care Obstetrics and midwife led unit Outpatients, day case surgery, all inpatient elective surgery Community services Diagnostic and Clinical Support Services
Option 3B	Urgent care Centre Paediatric Assessment Unit Minor Injuries Unit Midwife-led unit Outpatients, day case surgery and elective inpatients not requiring critical care Specialised Community Services Diagnostic and Clinical Support Services	A and E level 2 dealing with all Emergency Services including acute medicine, acute surgery, trauma and paediatrics and critical care Obstetrics and midwife led unit Outpatients, day case surgery, inpatient elective surgery Community services Diagnostic and Clinical Support Services
Option 3C	Minor Injuries Unit Midwife-led unit Outpatients, day case surgery Specialised Community Services Diagnostic and Clinical Support Services	A and E level 2 dealing with all Emergency Services including acute medicine, acute surgery, trauma and paediatrics and critical care Obstetrics and midwife led unit Outpatients, day case surgery, all inpatient elective surgery Community services Diagnostic and Clinical Support Services

Option 4			
Option	**New Hospital for Seriously Ill and Injured**	**Royal Shrewsbury Hospital**	**Princess Royal Hospital**
Option 4A	All acute services	RSH closes	PRH closes
Option 4B	A and E level 2 dealing with all Emergency Services including acute medicine, acute surgery, trauma and paediatrics and critical care	Minor Injuries Unit	Minor Injuries Unit
	Outpatients, day case surgery, all inpatient elective surgery	Midwife-led unit	Midwife-led unit
	Obstetrics and midwife led unit	Outpatients, day case surgery	Outpatients, day case surgery
		Specialised Community Services	Specialised Community Services
	Diagnostic and Clinical Support Services	Diagnostic and Clinical Support Services	Diagnostic and Clinical Support Services