Committee and Date	Item	Paper
Joint Health Overview and Scrutiny Committee 3 April 2009 11.30am	3 Public	A

MINUTES OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING HELD ON 11 DECEMBER 2008 AT THE SHIREHALL, SHREWSBURY 9.30AM – 11.25AM

Responsible Officer Michelle Evans
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Present

Members of the Joint Committee

Shropshire County Council:
Yvonne Holyoak (Chairman), Viv Parry, Stuart West, Margaret Winckler

Borough of Telford and Wrekin Council:
Val Lindley (co-optee), Angela McClements, Dag Saunders (co-optee), Derek White (Chairman)

Also Present

Barbara Craig, Portfolio Holder for Community Services
David Beechey, Shropshire County Council Health Overview and Scrutiny Panel (co-optee)
Madge Shineton, Shropshire County Council Health Overview and Scrutiny Panel (co-optee)

John MacDonald, Chair of the Clinical Leaders Forum & Programme Director
Jo Chambers, Chief Executive, Shropshire County Primary Care Trust (SCPCT)
Jane Povey, Medical Director, SCPCT
Paul Tulley, Director of Strategic Planning and Commissioning, SCPCT
Simon Conolly, Chief Executive, Telford & Wrekin Primary Care Trust (TWPCT)
Tom Taylor, Chief Executive, Shrewsbury & Telford Hospital NHS Trust (SATH)

Ruth Houghton, Interim Assistant Director, Community Services, SCC
Tom Dodds, Lead Officer Performance, Scrutiny and Innovation, SCC
Ken Clarke, Head of Audit and Democracy, TWC
Alison Smith, Scrutiny Manager, TWC
Deborah Moseley, Assistant Democratic Services Officer, TWC
Michelle Evans, Senior Committee Officer, SCC

1. Apologies for Absence

1.1 Apologies for absence were received from Dilys Davis (TWC), Veronica Fletcher (TWC), Dilys Gaskill (SCC) and Liz Parsons (SCC).

1.2 Although not a member of the Joint Committee, apologies were received from James Gibson (Shropshire County Council Health Overview and Scrutiny Panel)

1.3 Apologies were also received from Val Beint, Director of Community Services.

2. Declarations of Interest

2.1 Although not a member of the Joint Committee, Madge Shineton (SALC) declared a personal interest as an Independent Health Care Councillor.

3. Minutes

3.1 The minutes of the meeting held on 10 November 2008 were confirmed as a correct record.

4. Shropshire, Telford & Wrekin Health Economy

4.1 The Committee considered the report of Shropshire and Telford Executive Group which had been presented to the Boards of Shropshire County Primary Care Trust and Telford & Wrekin Primary Care Trust together with two reports from the Clinical Leaders Forum setting out a clinical vision for health services in Shropshire, Telford & Wrekin (copies attached to the signed minutes). Members also received a presentation from the Chair of the Clinical Leaders Forum (copy attached to the signed minutes).

4.2 The Chair of the Clinical Leaders Forum reminded members of the key principles of making sense clinically and making sense to the communities they served, and recapped on the three strategic objectives of prevention of ill health, promotion of good health and providing care closer to home. He informed members that there had been much debate around the provision of sustainable and accessible acute hospital services and the importance of developing capacity in primary and community care.

4.3 The Chair of the Clinical Leaders Forum gave examples of how the Models of Care identified by the Pathway Development Groups would lead to improved services. The Clinical Leaders Forum had concluded that there needed to be a single site for the seriously ill and injured because providing the service on both sites was not sustainable. More work was to be done to look at the impact of population catchment and growth, rurality and travel times and deprivation issues.

4.4 The Chair of the Clinical Leaders Forum explained to members the different options available. A timetable was given for assessing and developing the options however it was recognised that there could be slippage. He then described the outstanding work to be completed including a detailed social impact assessment and external assessment by the National Clinical Advisory Team. Engagement activities were currently being planned to feed into the formal consultation process.

4.5 It was felt that the Joint HOSC should not be involved in the workshop to map out the engagement process as it needed to maintain its independence and autonomy to enable it to effectively scrutinise future services. It was therefore requested that Professor Bob Sang be invited to a future meeting of the Joint HOSC to present the draft Engagement Plan. The Chair of the Clinical Leaders Forum would take this request back to the PCT who would decide on the best way forward.

4.6 In response to a query the Chair of the Clinical Leaders Forum explained that travel and deprivation issues had been looked at in the long term. Services would still be provided on both sites but it would be critical for services to be provided on a single site for the seriously ill and injured by 2020.

4.7 The Chief Executive, SaTH explained that the decision about where to site services would need to be agreed by the SaTH Board as they were the accountable body with responsibility for providing services. Their decision would then go back to the PCT and possibly the Department of Health for a final decision. The Chief Executive TWPCT added that the recommendation needed to be an agreed position between

the two PCTs and SaTH. It was inconceivable to get to the stage of recommendations without agreement between the 3 parties.

4.8 It was confirmed that protocols would be agreed with the Ambulance Service showing which hospital would provide which services. These protocols were used all over the country to avoid patients being taken to the wrong hospital. The PCT were urged to clearly define what services would be provided where, to ensure that time was not wasted going to eg a Community Hospital, if this was not appropriate.

4.9 In response to a query, the Chief Executive, SaTH explained that a full range of training facilities were available for junior doctors. However the deanery did not treat the Trust as one site so training opportunities were spread over the two sites. SaTH would need to look at how services were configured in the future to ensure it would not lose its training accreditation.

4.10 The Chair of the Clinical Leaders Forum explained that there would be implications for the workforce however it was more mobile than in the past with better IT links. Further work needed to be done on workforce issues. The shift to primary care would be phased in to ensure that support was available to properly deliver services.

4.11 The Chief Executive, SaTH explained that many processes needed to be streamlined and made more efficient, for example, blood samples taken by a GP were collected at a certain time eg 2000 samples collected at 5pm but there were not enough machines to process the samples even though they had been empty for most of the day.

4.12 The Portfolio Holder for Community Services hoped that SaTH and the PCT would work closely together. She welcomed a national review of primary care capacity which was long overdue.

4.13 In response to a query the Chief Executive, SCPCT explained that most services were provided by primary care however more could be done with support from community services. The Director of Strategic Planning and Commissioning, SCPCT added that the role of community hospitals in end of life care needed to be developed.

4.14 It was felt that members of the Joint HOSC may disagree and have different views on certain points however they would strive to do their best to work together. The Joint Committee now wished to look in depth at what was being proposed to ensure that it was workable. It was important to get this right to ensure a strong and healthy economy for the benefit of the communities served. It was proposed that a small working group be set up as it was a huge piece of work for the Committee to consider as a whole.

4.15 In response to a query the Chair of the Clinical Leaders Forum advised that the population and catchment figures had been provided by the Local Authorities and that population growth would be taken into account. A lot of work had already been undertaken looking at drive times but more work was needed to look at this in the longer term.

4.16 The Chair of the Clinical Leaders Forum advised members not to lose sight of the fact that the four options for the shorter term would be a stepping stone to a long term solution. He reiterated that there would be no change for the vast majority of services across both sites. However, there was a clear message that complex work eg for the critically ill, should take place in the best place for the patient, with the best opportunities for a surgeon and therefore the best chance of survival. The issues for

further development were broader than just where services would be provided and were more about improving services for patients.

4.17 The Chief Executive, SaTH reported that the Trust also provided services to patients in Powys. The Joint HOSC were only concerned with the health economy of Shropshire, Telford and Wrekin and did not wish to take Powys into account. However the Chief Executive of SaTH explained that it would lead to problems for this health economy if SaTH were to lose funding from Powys which funds staff in both Shrewsbury and Telford.

4.18 The Medical Director, SCPCT explained that they welcomed working together and the opportunity to significantly improve the quality of care for patients.

4.19 In response to a comment that the environmental impact of treating people at home needed to be addressed, the Chair of the Clinical Leaders Forum explained that this would be looked at but another issue would be the appropriateness of care at home.

4.20 The Chair of the Clinical Leaders Forum explained that some staff would need to become more mobile however some services would only be provided at one hospital, for example, all surgeons would be based on one site.

4.21 The Portfolio Holder for Community Services was confident that improvements would be made by working together and taking difficult decisions that not everyone would agree with.

4.22 The Scrutiny Manager, TWC requested a steer as to how Joint HOSC were to be involved. She requested that meetings take place when conclusions from individual work streams were reached so that members could ask detailed questions on each of the work streams.

4.23 The Chief Executive, TWPCT explained that the current proposals were different to what had happened in the past. They were clinically led and not financially led and he was confident that they could deliver the quality expected by patients.

4.24 The Chief Executive, SaTH concluded that it would not be an easy process but it was important that they took their time in order to make the right decisions.

4.25 The Chairman thanked the officers for attending and noted the timescales. She urged the Chair of the Clinical Leaders Forum to take back members' comments.

4.26 It was agreed for the Chairmen of SCC and TWC Health Scrutiny to meet to look at the issues and come back with a programme for Joint HOSC to consider.

Chairman: _____

Date: _____

AGENDA ITEM 4
APPENDIX A

National Clinical Advisory Team

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

NCAT Visitors:

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

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

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

Visit by NCAT Team 13 January 2009

Agenda for the Day and Attendees

09.00 – Briefing

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

10.00 - Telford & Wrekin PCT

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

11.00 - Shropshire County PCT

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

13.00 - Emergency & Urgent Care

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

14.00 - Shrewsbury & Telford Hospital NHS Trust

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

15.00 - Children's Pathway Development Group

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

15.45 - Maternity and New Born PDG

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

17.00 - Feedback

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

Reports Received and reviewed

1. Shropshire & Telford Executive Group report to Shropshire County and Telford & Wrekin PCT Boards 25-11-08

2. Children's Pathway Development Group Report for the Clinical Leaders Forum – 18-4-08

3. Children's Pathway Development Group Second Report for the Clinical Leaders Forum 31-10-08

4. Report from Clinical Leaders Forum; Report Two Challenged Services Strategies, November 2008

5. External Review feedback to Mr John MacDonald 30-10-08

6. Report from Clinical Leaders Forum; Report One – Overarching Plan for Healthcare in Shropshire, Telford and Wrekin – Care Pathways and Models of Care November 2008

7. Maternity and New Born Pathway Development Group – Maternity Matters in Shropshire, Telford & Wrekin, October 2008

8. Emergency and Urgent Care in Shropshire, Telford & Wrekin – Final Report from the Acute Pathway Development Group, October 2008

Background

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

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

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

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

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

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

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

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

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

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

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

The role of NCAT

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

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

Views heard by NCAT

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

We heard that:

- In advance of moving to a single site, there were safety issues regarding the delivery of acute inpatient services in paediatrics, acute paediatrics needed to be co-located with acute surgical services for safety reasons for those children admitted with acute abdominal surgical problems, and also to enhance critical care delivery to children.

- Inpatient paediatrics should be co-located with neonatology (which always has to lie alongside obstetric services) but the main reason to do this would be for workforce issues to help consultants and trainees meet the requirements of EWTD for out of hours cover.

- There was a need to develop adolescent services.

- There were inadequate high dependency unit (HDU) facilities on both acute sites (adult and paediatric) and a need to improve these as soon as possible.

- There were good plans to improve Hospital at Home care for children, and that these should proceed whatever interim arrangements are made.

- Local ambulance services had been consulted, but there was a lack of clarity from the PCTs and health service providers about the strategic plans for development of ambulance services, in particular regarding pre-hospital care. Welsh ambulance services have not been contacted.

- The population of Telford & Wrekin is more deprived than that of Shropshire County with significant health inequalities. Some wards in Telford & Wrekin are significantly more deprived than the national average position

- Making progress with interim plans had proved difficult because of historic stances from PCTs on movement of inpatient services it had proved difficult to persuade some local politicians of the need to reorganise hospital services in order to improve quality and safety outcomes.

- The Welsh population was a significant user of Royal Shrewsbury Hospital services, and this was likely to be a continuing requirement in the future. Full consultation with the devolved administration responsible for Welsh health services had not taken place, (this was outside the remit of the CLF).

- There is a requirement to provide a network of urgent care services closer to people's homes. Emergency care and urgent care needs to work closely together to ensure that patients receive the right treatment first time. Systems need to be put in place to identify those patients attending emergency and urgent care centres who could be seen by primary care clinicians.

- There was a good case for bringing together neonatology with inpatient paediatric services. Firstly clinical, eg the case of a recently born small baby with infection brought to paediatric services who required neonatal ICU (it was accepted that this was a rare occurrence). Secondly it would help solve workforce problems, ie provide acceptable rotas at consultant and middle grade trainee level conforming to EWTD.

- Since the two hospitals had been brought together under a single trust, there had been effective team building with most clinicians understanding they are working within single services. However, when questioned, some clinicians clearly retained a strong loyalty to their own hospital and did not always see that they were part of a team working across both PCTs. (This potentially could lead to a confused model of care and different service delivery).

- Shrewsbury & Telford Hospitals NHS Trust had developed an excellent obstetric service working across 2 sites with a midwife led service at Telford working together with a consultant led service at Shrewsbury

- The eight clinical pathways were at different stages of development, some more highly developed than others, and there was a requirement to continue working hard on these, in particular specific clinical pathways need to be developed in established areas such as stroke, acute coronary intervention etc.

- There was a pressing need to reorganise acute surgical services onto a single site so that specialist surgeons such as the breast surgeons could be

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

- The consequence of this is that accident and emergency services on the two sites would be designated as either level 2 or level 3. This would depend on whether acute surgery was on site. If only one site had acute surgery it would need to be clear how the site without surgery was supported and how patients might be moved from one site to the other if appropriate. Additionally it would require effective working with the ambulance service to ensure that the sites were used appropriately. Neither site would fulfil the requirements of a trauma centre, thus complex injury, in particular patients requiring neurosurgery, would be transferred to Birmingham or Stoke-on-Trent in the usual way.

- Paediatric surgery would continue to be provided elsewhere, in particular Birmingham Children's Hospital. Local services needed to cope with simple acute problems in children such as appendicitis rather than transfer patients unnecessarily to Birmingham. This was in keeping with parents' desires, which was made clear by the patient representative. It would mean that the surgeons and anaesthetists involved with children's care would need to be trained appropriately and would need to maintain their continuing professional development in liaison with a provider of children's surgery.

Conclusions

1. We accept the Clinical Leaders Forum's conclusion that there is an urgent requirement to change the configuration of acute clinical services to improve patient safety, allow better alignment of workforce to aid compliant rotas (meeting the requirements of the European Working Time Directive), to improve training, and lastly to allow the development of sub-specialisation (breast surgery, vascular surgery).

2. We strongly support the development of a single acute services site to provide for the population of 450-500,000 for Shropshire, Telford and Wrekin. This would enable the development of safe effective specialist services led and delivered by consultants. A feasibility study should proceed as soon as possible with a view to full public consultation. This should become the main strategic objective of Shrewsbury & Telford Hospital Trust which we hope will enable those working across the two PCTs to work together more effectively. Whilst the development of an acute single site is important, it should be remembered that it is only one component of an integrated health service which extends from the community through to secondary care. Nevertheless we recognise that this type of reconfiguration will be contentious. The local populations of Telford, Shrewsbury and Wrekin will need to recognise that Shrewsbury & Telford Hospital Trust will provide services for all the population in an equitable manner with the goal of providing high quality modern services. Whilst we cannot prejudge the result of any feasibility study, or options for a single site service, it was clear to us that a single acute hospital would need to be closest to the larger population base with the greatest clinical need not only for issues of ease of access, but to improve health and employment chances within that community.

3. We accept that, whilst this is a long term vision, there is an urgent need to reorganise acute surgery and paediatric services. Our view is that, wherever

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

4. Specialist and out of hours general surgery needs planning across both hospitals to create an appropriate out of hours general acute surgical service and to release specialist surgeons (eg breast and vascular surgeons) from the on call rota. Specialist surgical services such as vascular surgery need a dedicated out of hours services.

5. The needs of the Welsh population served by the RSH need to be firmly established to enable proper planning for the future. Whilst it may be difficult to identify any other providers able to meet these needs, this will need to be established with the Welsh health services and may need to involve consultation with the Mid Wales population.

6. Services provided by Shrewsbury & Telford Hospital Trust should be seen as single services provided across both PCTs. There needs to be a strong message that the Trust is responsible for providing high quality, equitable services for all the population.

7. The planning of urgent care centres needs to be carefully considered. Protocols need to be in place to ensure the right treatment is delivered at the right time within the urgent care centres and that, where necessary, patients are referred to the Accident & Emergency Departments at RSH and PRH as appropriate. This will become even more important when there is a single A&E service for the whole population. Whilst it is conceivable that an urgent care service co-located with an A&E Department might reduce attendance within the A&E Department, there is little evidence that this is possible, or is a cost effective model. Removing easy to treat simple cases to urgent care centres inevitably increases the cost per case within the A&E department, thus the financial consequences of shifting care needs to be considered carefully. We strongly support the motivation to provide services closer to patients' homes. Inevitably it needs to be recognised that smaller services, delivered closer to patients' homes, may well cost more. Other models should be considered, for instance co-locating and jointly commissioning primary care services within the A&E department, which would mean that a single triage can take place more efficiently, and those patients who attend A&E departments who could use primary care services are appropriately identified. Urgent care centres/minor injury units are more profitably used to deliver care to distant or rural populations.

8. The work on the eight clinical pathways needs to continue with appropriate stakeholder involvement. We considered that some of the plans currently presented are not clear and lack sufficient detail. We do not intend to comment further on the clinical pathways at this stage.

9. Continuing dialogue with the ambulance services is important. Our expectation is that the ambulance services are developing a strategy for pre-hospital care. This will become all the more important as Shrewsbury & Telford Hospital Trust moves to a single acute site as it will be argued by those populations with longer travel times that this will impinge on clinical outcomes. Presently there is little evidence that small increments in travel times adversely affect clinical outcomes, but there is good evidence that one of the better ways to improve acute care is to ensure that patients are treated appropriately at the scene of the accident, or within their own homes when there are acute medical problems, prior to transfer to hospital. It is important that the ambulance services have appropriate plans to develop the critical care practitioner role and work with the acute sector – emergency medicine services and acute medical services – to ensure that there are protocols in place for all acute clinical care pathways.

10. The development of clinical pathways is an appropriate way forward to resolve strategic issues and the four Trusts are to be congratulated on bringing together the appropriate stakeholders and clinical workforce to do this piece of work. We would encourage the pathway development teams to be bold and consider new ways of working to meet the stated strategic goals. Inevitably much of the emphasis on the strategy so far has focused on the acute care setting because of the political considerations. However the true gains for improving the health of the local population are to be had elsewhere, thus attention to preventative medicine is crucial, but also looking at ways of dealing with the real problems of the future, eg long term conditions. Here there may be an opportunity to consider the development of strong community based services, which reach into hospitals and acute care providers, rather than the traditional model. Many specialties which are presently provided by secondary care providers might more reasonably be commissioned within the community but reach into hospitals; for instance diabetes and endocrinology, elderly care, rheumatology, neurology and new models of children's care provision.

11. Thus far there has been little discussion about mental health care, in particular child and adolescent mental health services. Further work needs to be done here. Additionally transitional services in general between child health to adult services are an important topic which needs specific plans.

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

Recommendations

1. The Shrewsbury and Telford Executive Group (STEG) commission a feasibility study for a single site acute hospital as soon as possible, and consult on this along with plans for interim changes to the services.

2. A small number of options need to be presented to the population for consultation. The interim arrangements should bring together acute surgery on one site with the other acute services supporting emergency medicine services. These include inpatient paediatrics, obstetrics and gynaecology services and neonatology.

3. Further work needs to be done to emphasise to the population that Shrewsbury & Telford Hospital Trust is providing single services across two PCTs. Clinical leaders in both hospitals need to champion the proposed service model. Further team building should continue so that clinicians on both sites feel part of a single service.

4. The needs of the population of Powys and Mid Wales should not be neglected when considering service reconfiguration. We suggest that urgent consultation takes place with NHS Wales.

5. Further discussions are required with the ambulance services to ensure that the impact of service reconfiguration is fully understood, and that the ambulance service is making all appropriate plans to develop pre-hospital care. This must include Welsh ambulance services as well as more local services.

6. Further work is required on all the clinical pathways, which need to be across primary and secondary care, involve patient groups and other key stakeholders.

7. The acute general surgical rota should be staffed by surgeons with the appropriate expertise, that is general surgeons and/or upper gastrointestinal and colorectal surgeons. This may mean that specialist surgeons eg breast surgeons and vascular surgeons are no longer on the acute rota.

8. Vascular surgeons should create their own dedicated service and out of hours provision (NB this may require a collaboration between Shrewsbury & Telford Hospital Trust and adjacent trusts so that there are enough surgeons with an appropriate population base to generate sufficient activity.

Dr Chris Clough, Dr Marion Waters and Dr Steve Ryan

National Clinical Advisory Team

12 February 2009

AGENDA ITEM 4
APPENDIX B

Health Gateway Review 0: Strategic Assessment (DH444)

Developing Health and Healthcare in Shropshire, Telford and Wrekin

Date of issue to SRO:	20 February 2009
SRO:	Jo Chambers and Simon Conolly
Organisation:	Shropshire County PCT and Telford and Wrekin PCT

1. Recommendations of the Gateway Review

1. We recommend that a programme initiation document is developed for the programme stating the objectives, scope, timescale, constraints, budget, structure, governance, etc. Note: The programme initiation document should determine the scope and timescale of the whole programme, rather than a single phase of the programme. (By end March).

2. We recommend that the Programme Board membership be extended to include key stakeholders and key disciplines. The membership should, ideally, not exceed twelve persons and, as a minimum should include the SROs, SaTH, SHA and WMAS. Revised terms of reference should be drafted to reflect the role of the new Programme Board. (Agree at March Programme Board and implement in April)

3. We recommend that elements of the programme are specified as projects or activities and that the lines of reporting and accountability are established for each element. Projects should be structured and managed formally. (By end March)

4. We recommend that a suitably experienced or qualified, full time Programme Manager is appointed to:
   - Implement effective risk identification and management in the programme and its constituent projects;
   - Develop a programme plan for the whole programme (ie beyond this phase);
   - Provide confidence to the Programme Board, through the Programme Director, that the programme is running to time, budget and purpose;
   - Develop, at the appropriate time, key programme documents such as a Benefits Realisation Plan and a Post Programme Review;
   - Ensure that appropriate reports on the projects and programme are delivered to the Programme Board in a timely fashion. (Implement recruitment or appointment immediately)

5. We recommend that the communications plan is developed further to identify the desired outcomes for specific stakeholder groups or individuals and to put in place activities designed to deliver those outcomes. (In time for March Programme Board meeting)

6. We recommend that the consultation is based on a longer term solution to the location of acute hospital services (probably a single site) and that the current 2012/13 options are consulted upon, to the extent required by law, as interim stages in the delivery of a long term solution. (By End April)

The next Health Gateway Review is expected in August, prior to any consultation process commencing but after the current phase is completed.

2. Outline Action Plan

Recommendation 1 (Programme Initiation Document)

Key Activity	Responsibility	By when
Confirm Project Leads Phase 3	Project Director/SROs	25th February
Define scope of programme and projects for whole programme	Project Director/SROs	20th March
Agree overall programme timetable, constraints and projects and agree with project leads and West Midlands SHA	Project Director	20th March
Review Governance arrangements and discuss with West Midlands SHA	SROs	20th March
Prepare draft programme initiation document	Project Director	31st March
Agree timetable for development of overall detailed programme plan to be prepared by Programme Manager	SROs	31st March
Review draft programme initiation document	Programme Board members and project leads	10th April
Final programme initiation document to Programme Board	Project Director	22nd April

Recommendation 2 (Programme Board)

Key Activity	Responsibility	By when
Review Programme Terms of Reference	SROs	To Programme Board 25th March

Recommendation 3 (Project Plans)

Key Activity	Responsibility	By when
Project leads to develop detailed project plans with activities, reporting and accountability arrangements for Phase 3	Project leads	9th March
Project leads to review risk identification (Phase 3) and how risk will be managed	Project Leads	9th March
Phase 3 project plans reviewed	Project Director/SROs	16th March
Phase 3 Updated Programme of Work to Programme Board	Project Director	25th March
Agree timetable for development of detailed project plans within overall programme under coordination of Programme Manager	SROs	31st March

Recommendation 4 (Programme Management)

Key Activity	Responsibility	By when
Agree Interim support Phase 3 until Programme Manager in post (proposals approved at 28.01.09 Programme Board and reviewed at 25.02.09 Programme Board)	Project Director/SROs	27th February
Agree funding for Programme Manager	SROs	27th February
Prepare Job Description for Programme Manager	Project Director	6th March
Advertise and appoint	SROs	Advertise 13th March, appoint mid April
Risk management plan to Programme Board as part of Updated Phase 3 Programme of Work	Project Director	25th March
Continue to provide Programme Board with progress reports in format taken to February Board until Programme Manager reviewed reporting arrangements	Project Director and relevant leads	ongoing
Develop and implement effective risk identification and management in the programme and its constituent projects; Develop a programme plan for the whole programme (ie beyond this phase); Develop, at the appropriate time, key programme documents such as a Benefits Realisation Plan and a Post Programme Review; Review projects and programme monitoring arrangements and implement changes	Programme Manager	Timescale to be finalised when end March

Recommendation 5

Key Activity	Responsibility	By when
Develop communications plan	Communications leads (SCPCT and T&WPCT)	To 25th March Programme Board
Develop stakeholder management plan	Communications leads (SCPCT and T&WPCT) and SROs	25th March

Recommendation 6

Key Activity	Responsibility	By when
Agree basis of consultation in light of interim pre-feasibility report and discussions with West Midlands SHA	SROs	End April

3. Proposed Projects and Project Leads, Phase 3

Project	Lead	Key Support
2012/13 Service Plans	Dr Steve Evans	Debbie Vogler – technical and financial support Zena Dalton Project Manager Financial analyst (tba) Richard Brough (Children's)
Single Site Option Appraisal	Debbie Vogler	Zena Dalton Project Manager Sub contract pre feasibility study
Models of Care - 10 sub projects managed through the CLF (further discussions needed to agree remit for each of the sub projects and project management arrangements based on review currently underway)	Dr. Jane Povey Dr. Catherine Woodward	Leads for each of Models of Care Project Manager (tba)
Capacity in Primary Care	Dr. Andy Inglis Dr. Jane Povey	Project Manager (tba) John Snell, Workforce PCT directors for information and estate
Equality and Diversity Impact Study	Julie Thornby Pam Bickley	Sub contract study
Communications and Engagement	Julie Thornby Pam Bickley	Simon Horrocks
Governance and External Assessment	SROs	John MacDonald