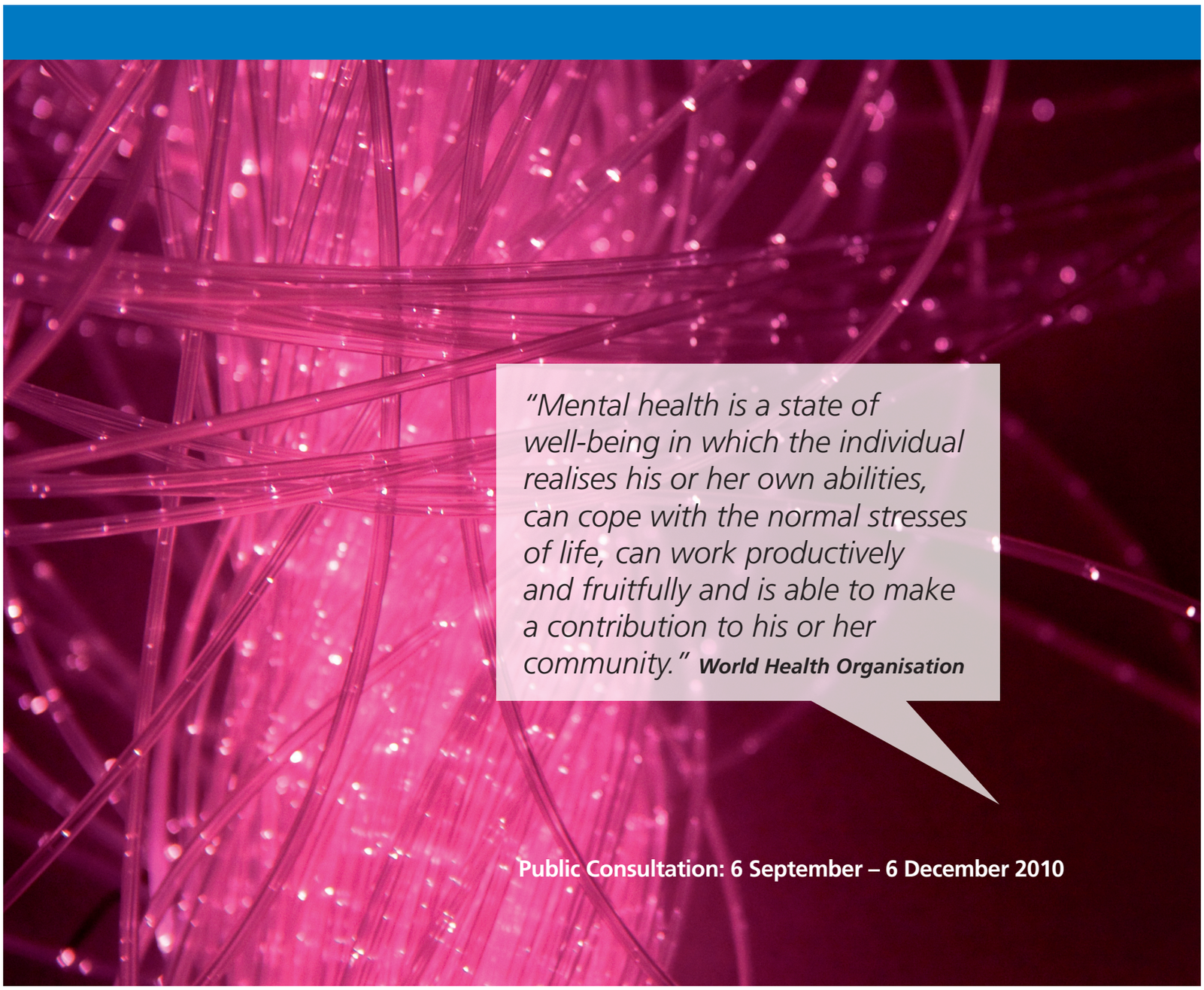
Shropshire County NHS
Primary Care Trust

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

NHS
Telford and Wrekin

Next steps for mental health care in Shropshire, Telford and Wrekin

Public consultation document on proposals to strengthen community care and redesign inpatient services



Contents

Picture on front cover: A fibre optic light in the sensory room for older people with mental health problems at St. Georges Hospital.

Section 1: What this consultation is about

This consultation document is about the future direction of mental health services in Shropshire, Telford and Wrekin. It seeks views on how people would like to see local services developed over the next three to five years, given that the NHS bodies responsible are committed to strengthening mental health care delivered in the community and to replacing the 157-year old Shelton Hospital in Shrewsbury with modern, purpose-designed facilities on an adjacent site.

The document does not cover all the individual specialist areas of mental health services, but we will be happy to discuss those over the forthcoming months. It is important that we see people as a whole, with a range of needs and views. We know that people with learning disabilities or those who need help with substance misuse will also use mental health services, so when this document refers to "mental health" it includes everyone and takes this into account.

Building on Previous Discussions

The proposals outlined here are the result of extensive discussions about mental health service priorities that have already taken place over the past 10 years, including a major consultation exercise in 2004.

Between 2007 and 2009, as part of a national review of care pathways across all NHS services, a possible mental health strategy for Shropshire, Telford and Wrekin was widely debated and consulted on. During 2009, there was also consultation on an outline planning application for new inpatient facilities to be built next to the Shelton hospital site in Shrewsbury.

This document, published on 6 September 2010, seeks to bring all this work together. It reflects the feedback received and conclusions drawn from all the previous views and ideas.

Leading the Consultation

This consultation is being undertaken by Shropshire County Primary Care Trust and NHS Telford and Wrekin, the two statutory bodies responsible for assessing people's health needs in their respective areas and for entering into contracts with service providers to meet those needs.

To find out local views on these proposals, both organisations are working with South Staffordshire and Shropshire Healthcare NHS Foundation Trust, which runs the majority of the hospital and community-based mental health services currently available in Shropshire, Telford and Wrekin.

Your views matter

We want to hear the views of service users, carers, residents, staff, and the different organisations we work with in the NHS, local government and the voluntary and independent sectors.

Essentially, we want you to tell us how you think our proposals will best meet local mental health needs within the resources available to us.

We would like you to tell us what factors you think we most need to take into account in strengthening community mental health services across Shropshire, Telford and Wrekin, and in replacing Shelton Hospital with brand-new facilities that reflect modern mental health care. It is important that the way in which we implement these changes contributes to improved mental health and well-being for people from all sections of our population.

Period of public consultation

This consultation will run from 6 September to 6 December 2010. Full details of how and where you can respond are given on page 22. Thank you for reading this document and for telling us your views.

Section 2: Why our mental health services need to change

How good mental health care is vital to all of us

Mental health impacts on everything we do as individuals. It affects our ability to think, to work, to maintain personal relationships, to take part in social activities and generally to enjoy what life has to offer.

One in four of us will experience a mental health problem of some kind during our lives. Around half of all women and a quarter of men will be affected by depression at some point. People with a physical illness have twice the rate of mental health problems compared to the general population. People who have been abused, or have been victims of domestic violence, are also especially vulnerable.

Good mental health services are therefore vital to ensuring that those of us who are affected receive the care and support we need.

Good services and partnerships are also essential to support people with employment, housing, leisure and other aspects of life. This consultation will be an opportunity to ask for views on how we can best work in partnership to promote well-being and mental health as well as support people with difficulties.

A broad review of healthcare strategy in our areas

Over the past years, mental health services across Shropshire, Telford and Wrekin have been part of the general review of NHS care pathways initiated by Lord Darzi and as part of our local Joint Strategic Needs Assessment, which is a report identifying the specific health needs of our population. Key questions asked include:

* How well are local needs being met by the existing pattern of care?
* Where, when and how should services be enhanced and improved to better meet those needs in the future?

Extensive previous discussions on these issues have involved a wide range of organisations and individuals: NHS, voluntary and independent providers of existing services; local authorities and other providers of social care; service users; carers, GPs and other clinicians with an interest in mental health, and the two local primary care trusts. The proposals contained in this consultation document reflect their views and aims.

Guiding principles that have emerged from our review

We know from the feedback we received that there is a consensus in favour of rebalancing the way services are provided, so that fewer people with mental health problems need to be admitted to hospital and more of them are treated in the community.

A number of key principles for building a stronger mental health service for our communities have emerged, including:

* greater emphasis on promoting positive mental health as an important part of people's overall health and well-being;
* a shift towards providing more mental health services in primary care (e.g. in local GP practices) and community settings;
* early identification of signs that individuals are suffering from mental distress, so that the necessary support can be put in place to help prevent the need for them to be admitted to hospital;
* easier and more equal access to mental health services for people throughout Shropshire, Telford and Wrekin, with greater consistency in the way services are provided to local communities and a wider range of options for patients that will better meet their specific needs;
* a greater focus on the 'recovery model' of mental health care, which emphasises the importance of getting people back into education, training and work, where appropriate, so that they maintain their sense of self-esteem and live their lives to the full;
* a step by step pathway for ensuring easier access to psychological and 'talking' therapies;
* all referrals to specialist mental health services to be dealt with efficiently and consistently so that, no matter how individual patients come into the system, they receive the most appropriate care for their needs;
* improved services for older people experiencing mental health problems, especially dementia;
* better co-ordination of services and better liaison between GPs, primary care teams and specialist mental health services;
* increased involvement and support for family and carers, particularly where they are providing significant levels of support.

Working towards a more community-focused model of care

By today's standards, the balance of mental health services in Shropshire, Telford and Wrekin is tilted too far towards hospital care. Over the past 50 years in Britain there has been a significant shift from the idea of treating large numbers of people in 'institutions' towards treating the vast majority of people in the community. The emphasis has moved very much away from keeping people with mental health problems isolated from the rest of society towards trying to ensure that, as far as possible, they remain fully functioning members of that society.

A number of documents published over recent years have contained strategies for the NHS and its partner organisations to move towards this new way of working. They include, for example, the National Service Framework for Mental Health published in 1999. More recently, in 2009, the Department of Health issued its New Horizons strategy designed to improve the mental health and well-being of the whole population and the

services provided to those with poor mental health.

Why services in Shropshire, Telford and Wrekin have not moved as far and as fast as elsewhere

Mental health services in Shropshire, Telford and Wrekin have been moving in this direction of travel, but not as far and as fast, and perhaps not as consistently, as in many other parts of the country. This does not mean that mental health care in our area is poor. But it does mean that community services are not as highly developed as we would like them to be.

One local GP practice manager summed this up well during the reviews of services that have been taking place:

"We need flexible mental health care that can respond to local demand and a shorter length of hospital stay with improved access to community support at a local level."

A mental health service user, who is clearly able to speak from personal experience of how services have been provided in the past, also pinpointed the need for change:

"You get used to the service that you have got and think that this is how it has to be – you feel that there is no option for change. But, through crisis support and home treatment at a local level you can re-integrate with your community, which helps to reduce long stays in hospital."

Commenting on some of our earlier ideas for moving the focus more from hospital into the community, a carer told us:

"This proposed way of working helps to fulfil a dream on the parts of carers and service users. There is a stigma attached to hospital admission. It creates fear for people who use services, as they think that they will be judged as a result of being in hospital. But if services worked more as one and services were delivered at more of a local level, the 'carousel of care' across 24 hours would feel more co-ordinated and would respond better to individual circumstances with more personalised care."

We believe that the proposals presented here are designed to address the points made by the GP practice manager, service user and carer quoted above.

Releasing resources tied up in one of the last Victorian-built mental health hospitals in England

Too many resources devoted to NHS mental health services in our area are locked up in the running of Shelton Hospital in Shrewsbury, one of the last – if not the last – of the old Victorian mental health asylums still being used in England to deliver inpatient services to people with mental health problems. As a result, compared with many other parts of the country there has been under-investment in the full range of community services that are widely considered to be the bedrock of modern mental health care.

Nor are our Shelton patients receiving their hospital care in a purpose-built facility that reflects modern thinking about the most appropriate and effective therapeutic environments. Although changes to the fabric of the hospital have been made over the years, it is virtually impossible to turn a building opened only six years after Queen Victoria came to the throne into the kind of psychiatric unit expected in the 21st century.

How well-developed community care networks help to reduce hospital admissions and lengths of stay in hospital

In practical terms, the current imbalance in mental health services means that there may not be enough services in some parts of our area to help ensure early identification of mental health problems, and not enough community-based solutions to help support patients in their own homes as well as we would like.

We know that the right support delivered at the right time in the right way can help prevent a problem from getting worse, thus making hospital treatment unnecessary.

It can also reduce the length of time that individuals have to spend in hospital, as stronger community services make it possible for them to be discharged earlier than they would otherwise have been. It also helps people to stay in or return to work, take up housing and other services and make the most of opportunities such as leisure and community life.

There are particular issues in the more isolated, rural parts of Shropshire, where it is often more difficult for people to access services, especially if they are reliant on public transport. Tackling the problems of rural isolation is something that must be addressed as part of our strategy.

We are also aware that support for each person identified as a carer needs strengthening, not least because the ability of families and friends of people with mental health problems to support them in the community is critically important to long-term recovery (please see page 15 for how we propose to improve support for carers.)

How we compare for hospital admissions with the rest of the country

Statistics published in June 2010 by the Audit Commission show that the rate of admission to inpatient mental health units varies significantly between the country's PCTs, with even more variation for the average length of stay per patient in different areas.

An analysis by the Association of Public Health Observatories of mental health hospital admissions of adults of working age between 2001 and 2006 shows an admission rate of 0.40 per 100,000 residents for Shropshire and 0.16 for Telford and Wrekin. These compare, for example, with 0.04 for Northamptonshire, 0.06 for Buckinghamshire, 0.07 for Surrey and 0.08 for Warwickshire. Only 13 local authority areas in England had higher hospital admissions rates than Shropshire. It is likely that because our area has fewer community services for mental health than elsewhere, more people have to be admitted to hospital.

Proposals for improving local services

In the next section we explain in greater detail how we propose to tackle these challenges, and how you can comment on our proposals.

Section 3: How we propose to strengthen community mental health services

The vast majority of people with mental health problems across all age groups in our local population can and should be treated in the community, not in hospital.

In some respects, this is no different from addressing physical illness. Only those with the most severe problems need to spend time receiving treatment in hospital. There is therefore a spectrum of care ranging from information on improving and maintaining mental health and well-being, counselling and psychological therapies through to contact with specialist community mental health teams and, in some cases, admission to hospital for the most intensive level of care.

How, then, do we propose to improve the model of mental health care currently provided? A key step would be to expand the range and extent of support available through primary care, whether in GP surgeries, health centres or community clinics.

Making information on mental health more readily available

We will improve information for people with mental health problems, including information on managing long term conditions and information for carers. This is crucial for those who, whilst not needing face to face counselling, nevertheless need pointing in the right direction, through advice over the telephone or information that enables them to find support group in their local community.

The crucial role of GPs and primary care in mental health services

Around 91% of people with mental health problems are treated by GPs and their teams in primary care, with less than 10% of all cases being referred to specialist services. GPs, therefore, play a key role.

Previous feedback has told us the ability of GPs and primary care teams to refer appropriate patients to counselling and psychological therapies is important, but that access to such therapies across the area is variable.

We believe it is important to ensure earlier and more consistent access to these 'talking therapies' which, can help people suffering from anxiety, phobias and depression by preventing their condition from getting worse and often by enabling them to stay at work and carry on with their normal lives. The intensity of therapy required depends, of course, on the type and severity of an individual's condition.

Over recent years some local GP practices have introduced practice-based counsellors. Other counsellors linked to the Improving Access to Psychological Therapies (IAPT) scheme have also started working with GPs and their teams. Experience suggests that some surgeries lack space to accommodate these services and waiting times for access to them are too long. There may also be confusion about the different types of counselling

available and who they are most appropriate for.

We propose to make it easier and simpler for Shropshire, Telford and Wrekin residents to access NHS-funded counselling and psychological therapies, whether they are referred to those therapies through their own GPs or by other means. What matters is that people who need such help should not have to wait a long time for it. An early and appropriate response is important to good clinical outcomes.

We intend to achieve improvements by reducing duplication, improving co-ordination of counselling and psychological services in the community, reducing waiting times and introducing measures to monitor their clinical effectiveness over time. Better communication between the different organisations involved will be essential.

Strengthening community mental health teams

We plan to strengthen the whole range of mental health services provided outside hospital. It starts with our multi-disciplinary community mental health teams who form the hub around which so much of the support provided to patients revolves.

The teams include specially trained mental health nurses, psychologists, occupational therapists, social workers and others whose individual and collective expertise enables personalised solutions to be provided to people with mental health problems, whether in their own homes or at centres as close as possible to where they live.

Currently, there are six community mental health teams working in Shropshire County based in Market Drayton, Oswestry, Bridgnorth, Ludlow and two teams in Shrewsbury; and three teams in Telford and Wrekin based in Wellington, Oakengates and Madeley.

The teams strive to help and support people with mental health problems, to prevent the need for admission, or re-admission to hospital. Importantly, the teams are able to intervene early during an episode of mental ill health which, if not addressed, could result in the individual needing to go into hospital.

The Early Intervention Team also provides intensive support to those who have a first episode of severe mental illness. This is intended to reduce the need for very long term community support or hospital care.

This 'crisis resolution' approach is a key part of the service offered in the community. 'Crisis resolution' means identifying when someone's health is deteriorating, and putting support in place to stop problems getting worse, and prevent hospital admission. In some cases it could involve a change in medication, in others, the team may implement more frequent visits to support the service user at home, or introduce additional therapies to complement and reinforce those already in place.

Under the proposals now being consulted on, by 2012 we would expect there to be 90 additional staff working differently across the nine geographical areas covered by the teams (35 in Telford and Wrekin and 55 in Shropshire County.) Most would be in the nine community teams, but with some more specialist community staff working across more than one team. They would include some of the existing hospital staff from Shelton and other mental health wards in our area who, after training, would be able to transfer

into community-based roles. Others would be existing community staff whose roles are changed or extended in order to provide a more flexible service to patients. The teams would provide services to both adults and older people, including people with dementia. Overall, the changes are intended to improve access to mental health care, and ensure that services are provided for individuals in the most appropriate setting.

A single point of contact 24 hours a day

A key element of the plan is that GPs would have a single point of contact with specialist mental health services through the community mental health team that covers their practice area. As these teams comprise both NHS and local authority staff, they are well placed to 'navigate' the available services and to ensure that patients are referred to the service that is right for them. We also want the 'single point of contact' system to work 24 hours a day, seven days a week. This means that someone contacting any part of the service at any time would receive a single assessment and plan to meet their needs. This may involve one or more teams.

It is important that once a GP's patient has been referred, their needs are assessed and the most appropriate form of treatment is provided. GPs have told us clearly that they want to avoid the risk of patients being 'bounced back' to them by one part of the mental health system and, as a consequence, having to start again by referring their patient to another part of the same system. GPs want a system that works smoothly and efficiently in the best interests of their patients, without delays.

Many patients tell us that they value their contact with community mental health teams in their own areas. They also value the continuity of care that can be provided in this way, as one service user explains:

"It is nice to know that the 'team' is there. The familiarity is important to me. I do not like to travel here, there and everywhere and to see lots of different people. Care should not be all split up."

Integrating home treatment within the local community mental health teams

We also propose to strengthen our home treatment teams. These are vitally important elements of a comprehensive modern mental health service because they exist to deliver the right level of care and support at the right time to the right person.

Home treatment may be especially important for some service users who have previously come through a phase of mental illness – possibly including a period in hospital – and who, with the necessary support, are now recovering at home. Carers and families have a crucial role in the success of home treatment for many and we will support and work with carers as part of the recovery process.

Currently, there is a home treatment team based at Shelton Hospital in Shrewsbury and another based at Castle Lodge in Telford. We want to strengthen the existing arrangements so that more service users have access to home treatment and that more intensive home treatment is available more consistently.

To achieve this, we envisage some home treatment staff being placed within the geographically based community mental health teams rather than, as now, being centralised at two locations. This would enable the staff providing the service to have greater contact with service users, to be more accessible to them, and to work in a more

integrated way with community mental health teams. It would also address the point made to us by service users themselves that 'care should not be all split up'.

As part of the enhanced home treatment service, the Foundation Trust plans to introduce 'nurse prescribers'. The aim is to reduce the current reliance on consultant psychiatrists for prescribing medication to patients living at home and, in this way, to enable specialist medical staff to spend more time supporting and advising GPs.

Integrating 'assertive outreach' within the local community mental health teams

Similarly, we plan to strengthen 'assertive outreach' teams. 'Assertive outreach' means working to stay in touch with and support people with severe mental illness who might otherwise lose contact with health services. The teams comprise community-based staff assigned to deliver ongoing help and support to individuals with a history of severe and enduring mental illness who, despite their level of need, might not otherwise stay in contact with specialist mental health services. Currently, our assertive outreach teams are based in Oswestry, Bridgnorth, Shrewsbury and Wellington.

Under the proposals, it is intended to integrate assertive outreach teams within the community mental health teams. This will achieve a more co-ordinated approach and greater flexibility in delivering care. As a result, it will help service users by ensuring that they have faster and more consistent access to specialist community mental health staff and are less likely to need admission to hospital.

Being flexible enough to respond to the specific needs of all the people we serve

We recognise that no single approach to providing care will meet the needs of all the people and all the areas we serve. We know that emotional and social support are also important and that this is often provided by voluntary and community groups, carers and families. To the greatest possible extent, we need to be adaptable and flexible. To enable us to do this, we welcome views of how specialist mental health services can best work for you.

The importance of effective partnership between health, social care and other key services

We recognise that an effective mental health service depends on well developed NHS community mental health services and good liaison between the NHS, social services and other organisations.

What is especially important is the ability of these organisations to work together in providing the full range of help and support that people with mental health problems need if they are to be able to continue, as far as possible, with their normal lives.

Such support includes, for example, housing, training and education and access to local leisure facilities. All these key services are vital. If people with mental health problems are to be able to live in the community, they need to be part of that community.

Over the next five years we will aim to improve sharing of information between different organisations, this includes with the independent and voluntary sectors which provide excellent support for users of services and others who choose not to use specialist services. We will explore ways of increasing the availability of affordable, better-supported residential accommodation for people with mental health problems in the community.

There will be improved communication with acute hospital services to ensure that people receiving acute hospital care, but who also have mental health needs, are supported. This will include Mental Health Liaison services or Crisis Resolution/ Home Treatment working together more closely or improving access to psychological therapies to help with anxiety or depression.

We will also continue to work with our Local Involvement Networks (LINks) which aim to give citizens a stronger voice in how their health and social care services are delivered. Run by local individuals and groups and independently supported - the role of LINks is to find out what people want, monitor local services and to use their powers to hold them to account.

The key role that the voluntary and community sectors can play in mental health care

We know that some people prefer not to go to the NHS about their mental health problems, possibly fearing the stigma which, they believe, is associated with the 'mental health system'. Instead, they may turn for help, advice and support to a wide range of voluntary and community organisations that are not part of that formal system.

A wide variety of support is provided by the voluntary and community sector including helping to prevent mental illness, supporting carers and offering specialist help and advice about particular conditions, such as Alzheimers.

We welcome feedback from these voluntary and community organisations and the people who use their services, about the role they can best play in improving mental health.

We will continue to build strong partnerships across health and care, and with community and voluntary groups, to make the services work best for people and fit around people's lives, jobs and leisure, rather than the other way round.

Reviewing our approach to dementia care

Our review of services over the past few years has identified a particular need to strengthen services for older people with mental health problems, including dementia.

Current estimates suggest that the number of people aged 65 and over with dementia-related illness will have risen by over 20% between 2008 and 2013. With an ageing population we can expect the numbers to rise even higher by 2020 and beyond. Providing good dementia care is therefore a necessity for our mental health services, not an optional extra.

Significantly, we calculate that the number of people on GP registers with a diagnosis of dementia is lower than we would have expected for our population. We believe, therefore, that efforts to improve diagnosis of dementia must be stepped up, both among older people with the condition and among those under 65 years of age who are displaying early symptoms.

Both as part of our review of services, and as part of a specific dementia exercise, we have identified a number of key improvements we intend to make over the next five years to ensure that we are in line with best practice recommendations in the National Dementia Strategy and the new NICE Quality Standards for Dementia.

Improvements we have identified for local dementia care services

The specific improvements we have identified include:

* making health professionals and the public more aware of the symptoms of dementia so that the condition is diagnosed as early as possible, the stigma associated with dementia is reduced, and appropriate action is taken to slow down the progress of the disease and reduce its effects on the individual;
* developing a single point of referral and strengthening local 'memory services' to ensure accurate assessment and diagnosis of dementia and the start of appropriate treatment and support that will help patients to remain independent for as long as possible;
* enhanced support for carers to help them do everything they can to ensure that their loved ones enjoy a good quality of life for as long as possible, and to reduce their sense of isolation;
* improved information and on-going support for carers of dementia patients;
* improved advice for dementia patients and their families immediately following diagnosis and on an ongoing basis;
* enhanced support for local care homes that look after people with dementia;
* enhanced support for general staff working in acute and community hospitals and other community settings to help them deliver good care to people with dementia;
* reduction in the inappropriate use of anti-psychotic medication for the management of dementia;
* improved end of life care, including symptom control and nursing support, for dementia patients.

Incrementally there will be new members of the team who specialise in supporting older people with mental health problems and dementia, including increased access to Memory Services resources and staff who respond to avoid admissions where there is a crisis. There will also be additional resources to support primary care in identifying those with dementia and supporting the independent and voluntary sectors in their role.

The importance of caring for people in familiar surroundings wherever possible

One of our nurse specialists who supports younger people with dementia in their own homes stresses the importance of this service. She said:

"People need more care in their community and to be in familiar surroundings. They need to be looked after by familiar workers who provide consistent levels of support."

Ensuring that older people have access to the full range of support and services currently provided to younger people

As part of our proposed changes to the way in which community mental health teams work, it is intended to merge the currently separate teams responsible for adults of working age and those aged 65 and over. There will continue to be members of the team who specialise in supporting older people with mental health problems. However, a single team will help to ensure that older people have access to the full range of

services and support that is provided to younger people.

Support for carers

People's carers have a vital part to play in their recovery from mental ill health. Carers may be family members, close friends, neighbours, or members of a local support group. In some instances, they may be paid carers. In our consultations and discussions with carers and carers' groups over the past three years, they have identified the same overall priorities as service users themselves and we will also take the priorities of the Carers' Strategies for Shropshire, Telford and Wrekin into account.

Those priorities include:

* overcoming the stigma associated with mental ill health;
* personalising services so they are based on individuals' needs;
* easy access to information and advice about mental health, available services and support, welfare benefits and housing;
* preventing suicide;
* involving service users and carers in decisions that will affect them;
* showing that service users' and carers' involvement in consultations leads to tangible changes that reflect their input;
* supporting carers to stay mentally and physically well and treating them with dignity;
* enabling carers to have lives of their own alongside caring;
* assisting carers not to be forced into financial hardship due to their caring responsibilities;
* respecting carers as expert care partners;
* protecting young carers from inappropriate caring or harmful caring roles.

Staff will provide increased support to carers and enhance their involvement during planning care and recovery. This will include considerations of how to give carers a break from caring while their loved one is having care and support from services, and improving carers' assessments so that suitable plans are in place to meet their needs while carrying out their caring role.

The difference our proposed changes to community mental health services would make

If all of our goals for improved community services are achieved over the next five years, it will mean more of the people affected by mental health problems being able to continue to live in their own homes and lead their own lives. However, a minority of the people affected by mental illness – though fewer than now – will need hospital treatment at some point. The next section explains the plans for modernising inpatient mental health care.

Section 4: How we propose to modernise inpatient mental health services

In the previous section of this consultation document, we explained how we propose to strengthen community mental health services and reduce the need for admission to hospital. This 'tilting of the balance' would bring Shropshire, Telford and Wrekin more into line with modern mental health practice and address many of the concerns that have been expressed to us by service users, carers, GPs and others.

This section addresses the fact that the majority of people with mental health problems who require the more intensive treatment which can only be provided in an inpatient setting, are currently looked after in buildings constructed in the mid 1800s. It explains the options considered for improving the current facilities.

Existing inpatient facilities

Currently, the principal facilities into which Shropshire, Telford and Wrekin patients are admitted for mental health treatment are:

* Shelton Hospital in Shrewsbury, which currently has 56 beds used for Shropshire patients and 29 beds used for Telford and Wrekin patients
* Castle Lodge in Telford, which currently has 9 funded beds that provide a short-term 'step down' facility for patients with acute mental health problems who may previously have been in Shelton Hospital and who now need less intensive care than that provided by our teams at Shelton. There are no plans to replace Castle Lodge and the number of beds would increase to 12. It serves a useful purpose for patients from the Telford and Wrekin area and will continue to do so for the foreseeable future.
* Beech Ward at Whitchurch Community Hospital which currently has 16 places for older people in Shropshire with mental health problems, usually admitted currently because insufficient community support means that care packages at home have broken down. Plans to provide this care in a better way are described on page 19.

The major change envisaged is to replace Shelton Hospital with brand-new facilities. This follows detailed consideration of a number of scenarios. These scenarios are explained below and highlight why Shelton's replacement by a different model of inpatient care is vital for the improvement of mental health services in the area.

Scenario 1 for Shelton Hospital: leave it as it is

One option would be to leave the facilities at Shelton exactly as they are. On the plus side, there would be minimal disruption. However, the disadvantages of such an approach massively outweigh any small advantages which may be perceived.

Shelton Hospital was originally constructed and opened in the 1800's. As with all very old

structures, it is difficult and expensive to maintain. The current backlog of work needed to bring it up to standard is estimated at over £10 million, and spending this would prevent us from investing in better community care and in improved hospital facilities.

Besides cost, Shelton is a huge building that despite attempts to improve it, simply does not provide the type of environment which we know most helps people recover from mental illness.

Whilst we have considered the option of retaining the building and trying to do our best with it, we have rejected it. We would prefer to invest the resources in services for people rather than maintaining old buildings that are no longer fit for purpose.

Scenario 2 for Shelton Hospital – update the existing facilities

A second option that we have considered was to update inpatient facilities within the existing Shelton building. This option was rejected as being too expensive in relation to the gains achieved. Furthermore, it would not release staff and resources for redeployment in the community.

Scenario 3 for Shelton Hospital – rebuild facilities on the same site with the same number of beds as now

A further option we considered was to rebuild brand new facilities on the Shelton site with approximately the same number of beds as the existing hospital. This, in principle, would have allowed the same number of people to be treated in hospital as are treated now. Whilst that would have maintained our inpatient capacity at current levels, we believe it would be a mistake. To provide a genuinely modern service to meet today's needs and standards, we need to strengthen our community services and to rely less on hospital-based care.

Scenario 4 for Shelton Hospital – replace the existing facilities with a new mental health 'village'

The fourth and preferred option is to stop using the existing Shelton buildings and to build new, but smaller facilities on an adjacent site. By 'smaller', we mean that the current very large Victorian building would be replaced with facilities based on an entirely different and much more appropriate philosophy. Instead of constructing a single new building to replace the old one, we believe that we should deliver facilities on a more 'human' scale. We have therefore embraced a new vision for the site with a collection of much smaller, more residential-style facilities which, together, make up what might best be described as a 'village'.

What the proposed new 'village' would comprise

Five separate units of accommodation would be built in the new village adjacent to the current site. They include:

* two 16-bedded acute units;
* one 16-bedded unit to deliver complex care for vulnerable adults;
* one 16-bedded unit for older people with dementia-related mental health problems;
* one 16-bedded unit for younger people with dementia-related illnesses.

That means a total of 58 beds would be available for local residents from our area, made up of 36 beds for Shropshire patients and 22 for Telford and Wrekin patients. Other beds are for patients from Powys and other areas. Apart from the existing New House at the Shelton site, which would be retained as a facility for substance misuse patients, the rest of the hospital complex would be sold commercially. Enough land would be kept in NHS control to enable the new 'village' to be landscaped.

The balance of need between community and inpatient beds will be kept under review.

Creating a better environment for those who need inpatient care

In the design of new facilities in our proposed 'village', considerable emphasis would be placed on the creation of a therapeutic environment where interaction between staff and patients contributes to the quickest possible recovery. We envisage that the new buildings would be much better suited to providing modern mental health care and rehabilitation. This, coupled with the simultaneous strengthening of community mental health services, would mean shorter lengths of stay in hospital and enable patients to return sooner to their homes and communities.

All inpatient accommodation in the new buildings would be provided at ground floor level to allow immediate access to outside space and maximise patient safety. Opportunities would be taken to ensure that the buildings are as energy efficient as possible, with a significantly reduced carbon footprint than the existing Shelton facilities.

The significance of this new approach to delivering inpatient care was highlighted in an article written for a Shelton Redevelopment Project newsletter by service user Jenny Brazier. She wrote:

"Shelton's redevelopment is going to be more than just new buildings. The focus is on modernising services."

Stressing that the latest plans have been heavily influenced by service users themselves, Jenny also emphasised just how long discussions about Shelton's redevelopment have been going on. As she explained, planning for a new hospital to replace Shelton has been in place since 1956.

A plan based on earlier consultations on the kind of facilities that would best meet inpatient needs

We believe the opportunity is here to make that possibility a reality, and to give Shropshire, Telford and Wrekin the kind of inpatient facilities that reflect best practice in mental health care today.

South Staffordshire and Shropshire Healthcare Foundation NHS Trust has already undertaken extensive consultations on the proposals for new facilities to replace the existing Shelton Hospital. These formed part of its submissions with an outline planning application for the scheme in 2009, when the Trust held 16 events to consult on the proposals. A total of 543 people attended the events to express their views, including service users, mental health staff, members of the public, elected representatives and representatives of organisations including Mind and the Campaign to Protect Rural England.

Anticipated reductions in hospital admissions and average length of stay

We estimate that, if we go down the route we have described in this document, there will be a reduction in hospital admissions for mental health problems in the order of 15% on current levels. That means about 160 fewer admissions a year. We also estimate a potential reduction in average length of stay from 44 days to around 27 days.

In practice, it means fewer people in hospital at any one time, fewer people admitted during the course of a year, and less time being spent in hospital by those who are admitted. A result is that more patients will remain at home and more of them will be supported by one or more of our community-based services, avoiding the need for unnecessary residential care.

Beech Ward at Whitchurch Hospital

Beech Ward at Whitchurch Hospital currently provides 16 places for older people with mental health problems including dementia. It is not a long-stay facility. People are often admitted because with limited community support available currently, care at home has broken down and there are delays in arranging long term solutions such as more care at home or, depending on an individuals' needs, transfer to a residential or nursing home of their choice. Hospital admission is therefore needed as an emergency 'stop gap'.

However, in our view, the environment of Beech Ward is not well-suited to the delivery of modern therapeutic care, even in the short-term. It is isolated from community-based services for people with dementia and, as a result, staff are not able to call upon a broad enough range of resources. In line with the staff arrangements described later in this document, the strengthening of community services will provide opportunities for inpatient staff to retrain for community settings.

Improving community-based services for dementia patients in this part of Shropshire

We believe it is possible to deliver a better service for these patients by strengthening and improving co-ordination of dementia care services in this part of Shropshire and, in appropriate cases, providing more intensive help from the community mental health team. The improved community services in these proposals will support this approach.

The aim should be to enable individuals, with the right support, to live independently for as long as they possibly can and to support their carers and families. If, however, their condition reaches a point where staying at home is no longer possible for them and their carers, their transfer to residential or nursing home care should be facilitated as smoothly and efficiently as possible, with an emphasis on helping them and their family to choose an environment that best meets their needs and preferences.

Our proposal is to close Beech Ward by the summer of 2011. In making these changes, we shall ensure that individuals receive early assessment of their needs and the type and level of support that will best enable them to remain in their local community.

This will help them benefit from continuing contact with the people they know and from being in familiar surroundings. We recognise that the home support and treatment provided to them needs to be accessible seven days a week, 24 hours a day in order to address possible changes in their condition and well-being and, where necessary, to respond to their carer's concerns.

We do not expect these new arrangements to result in increased demand for residential care places funded by the local authority. Rather, we expect to see a shift within NHS-funded services from care provided in hospital to care provided in the community. This will include enhanced community mental health teams and, where necessary, access to residential and nursing home care, including a new facility that has recently opened in the Whitchurch area. Flexibility and choice for individuals will be a priority.

Elms House in Shrewsbury

We have also been looking at future alternatives for Elms House in Shrewsbury, which currently has 14 places for people recovering from mental illness. As in the case of Beech Ward, we believe this service could be provided better elsewhere. We are proposing, therefore, to progressively reduce the number of places in Elms House until, by February 2012, it is closed and patients who would previously have been admitted to the unit are supported instead by intensive home treatment.

West Bank in Telford

We have also been looking at future alternatives for West Bank in Telford, which currently has 12 places for people recovering from mental illness. As it is now considered best to provide rehabilitation where someone is living, by giving intensive home support in their home we need to understand the future need for rehabilitation in a more hospital type-setting. There are a small number who are very disabled by their condition who need this type of care and support before they are able to live more independently. However, we want to develop more community or home-based rehabilitation where users have settled accommodation and where they can have support to live independently. The review will consider this and develop a future plan.

Implications for staff arising from all the proposed changes

The changes we have described will have staffing implications. More staff would be needed to strengthen community services. Many will be existing staff employed in inpatient services who undergo training for new roles in a range of community settings. Some will be new staff appointed through the normal recruitment process. Where existing hospital-based staff express an interest in making the transition into a community-based role within our new model, South Staffordshire and Shropshire Healthcare Foundation NHS Trust will provide the necessary training.

Estimated costs of replacing Shelton Hospital

Current estimates indicate that to build new inpatient facilities on the Shelton site would work out at approximately £50 million when all building work, professional fees and associated costs are taken into account. There are sources of funding that South Staffordshire and Shropshire Healthcare Foundation NHS Trust can access to cover this, both from its own capital reserves and through the NHS Bank.

The changes in the investment profile in the new facilities would form part of the contracts entered into by the Foundation Trust with Shropshire County PCT, NHS Telford and Wrekin and GP consortia when they take over from the PCTs.

How some resources would be switched from inpatient services to community care

It should be stressed that changes to mental health services in Shropshire, Telford and

Wrekin are not intended to deliver net savings for the NHS.

In other words, no resources will be removed from mental health under these proposals. However, the way the resources are used would change in order to reflect a greater focus on community-based care delivered to the majority of patients and, at the same, to create a different environment for the minority of patients who need the more intensive treatment that only an inpatient facility can provide to them.

Moving towards greater equality of access to mental health services

An important factor to consider is how these proposals could achieve greater equality of access to mental health services across the area. Earlier consultations have suggested that older people with mental health problems are less well served than adults of working age. The steps planned will help to improve the availability and quality of care for older people, including those affected by dementia.

We recognise that the rurality of much of Shropshire poses particular problems for the delivery of services, not least because of the distances involved and the difficulties faced by people who have no transport of their own. Furthermore, for those who live a long way from Shelton, admission for inpatient care means a degree of isolation from their home community.

By strengthening community services in the ways described, we believe that access to specialist mental health support should be enhanced, even in the more rural parts of the county.

Better community services should also reduce the need for admission to an inpatient unit many miles from people's homes.

Finally, we believe that the emphasis within our new model on 'personalised' solutions to mental health needs would ensure that people from all social backgrounds and ethnic groups receive packages of care that are specifically tailored to their individual needs. Our aim is to ensure, wherever possible, that service users themselves have a major contribution to make to the design of their own care packages.

A phased approach to ensure a smooth transition

Subject to the outcome of this consultation and to approval of a final business case for the new inpatient facilities on the Shelton site, we envisage that the strengthening of community services would start immediately. Indeed some increased staffing is already being taken forward. Additional staff will also be in place at the time of starting the building work. Construction work at the Shelton site might start early in 2011 with completion scheduled for the autumn of 2012.

The existing wards will continue to function as usual throughout the construction. During that period, there would be a phased increase in community staff followed by a gradual reduction in the number of available beds in the existing Shelton Hospital as they stop being used. This will also enable inpatient staff to be progressively redeployed for the strengthening of community services.

We believe that a phased approach is the best way of ensuring a smooth transition of mental health services in Shropshire, Telford and Wrekin towards a more community-focused model, with a reduced dependence on inpatient beds to deliver the care people need.

Section 5: Having your say

We want to hear from as many people as possible about our proposals for developing community mental health services in Shropshire, Telford and Wrekin and replacing Shelton Hospital with a new mental health village constructed at a different location within the Shelton site. The consultation feedback will be considered by the Boards of both NHS Telford and Wrekin and Shropshire County PCT in deciding how to take forward the strategy, and by the Foundation Trust in its work on the full business case for the Shelton development.

How you can respond to this consultation

You can have your say in a number of different ways:

We would prefer you to complete the feedback form enclosed with this document (if it is not enclosed please call **01952 580473** or **0800 032 1107**) or visit one of the following websites where you can also complete the questionnaire online:

www.telford.nhs.uk/consultations

www.shropshire.nhs.uk/consultations

www.southstaffshealthcare.nhs.uk

This helps us analyse the consultation results more consistently. Return the feedback form to:

FREEPOST RRZR-SZAA-BUBZ, Next Steps for Mental Health in Shropshire, Telford and Wrekin, Oak Lodge, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL

* You can also write a letter setting out your views to the same address above
* You can email your views to: **consultation@telfordpct.nhs.uk** or **consultation@shropshirepct.nhs.uk**

Aspects of the document on which we would especially welcome your comments

(please use the separate feedback form covering these questions if possible)

1. What factors do you think are most important in delivering good **community** mental health services in future?
2. Is there anything that you think we should look at again or have not got quite right in the proposed new arrangements for **community** mental health services?
3. What future role do you think the voluntary and independent sectors can play in delivering mental health services to the people of Shropshire, Telford and Wrekin?
4. What factors do you think are most important in delivering good **inpatient** (hospital) mental health services in future?

5. Is there anything that you think we should look at again or have not got quite right in the proposed new arrangements for **inpatient** (hospital) mental health services?
6. How far do you agree with the proposals in the consultation document?

Whilst we would especially welcome your views on these specific points, you are welcome to comment on or ask questions about any part of this consultation document.

Obtaining further copies of this document

Further copies of this consultation document are available on request. Please call **01952 580473** or **0800 032 1107**. Alternatively, you can download a copy by going on to the following websites:

www.telford.nhs.uk/consultations

www.shropshire.nhs.uk/consultations

www.southstaffshealthcare.nhs.uk

Different formats of this document

We can provide different formats of this document for example large print, Braille or a different language. A summary document is also available in Easy Read, again please call **01952 580473** or **0800 032 1107**, or go online.

Arranging to talk to someone from the Primary Care Trusts or Foundation Trust

If you want to talk to someone from Shropshire County PCT, NHS Telford and Wrekin, or South Staffordshire and Shropshire Healthcare Foundation NHS Trust about these proposals, please phone **01952 580473** or **0800 032 1107** or email **consultation@telfordpct.nhs.uk or consultation@shropshirepct.nhs.uk**.

The public events below are planned to take place during the consultation period. These are drop-in sessions and anyone can come along, chat to staff and find out more or get answers to any questions they may have.

* 21 September, 3.30pm – 6.30pm, Meeting Point House, Telford
* 27 September, 10am – 1pm, The Cedars, Shelton Hospital, Shrewsbury
* 6 October, 12noon – 3pm, Civic Centre, Whitchurch
* 15 October, 1pm – 4pm, Community Centre, Craven Arms

Date by which all responses need to be made

All responses to this consultation need to be made by **6 December 2010**.

Shropshire County NHS
Primary Care Trust

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

NHS
Telford and Wrekin

01952 580473 or **0800 032 1107**

consultation@telfordpct.nhs.uk or **consultation@shropshirepct.nhs.uk**

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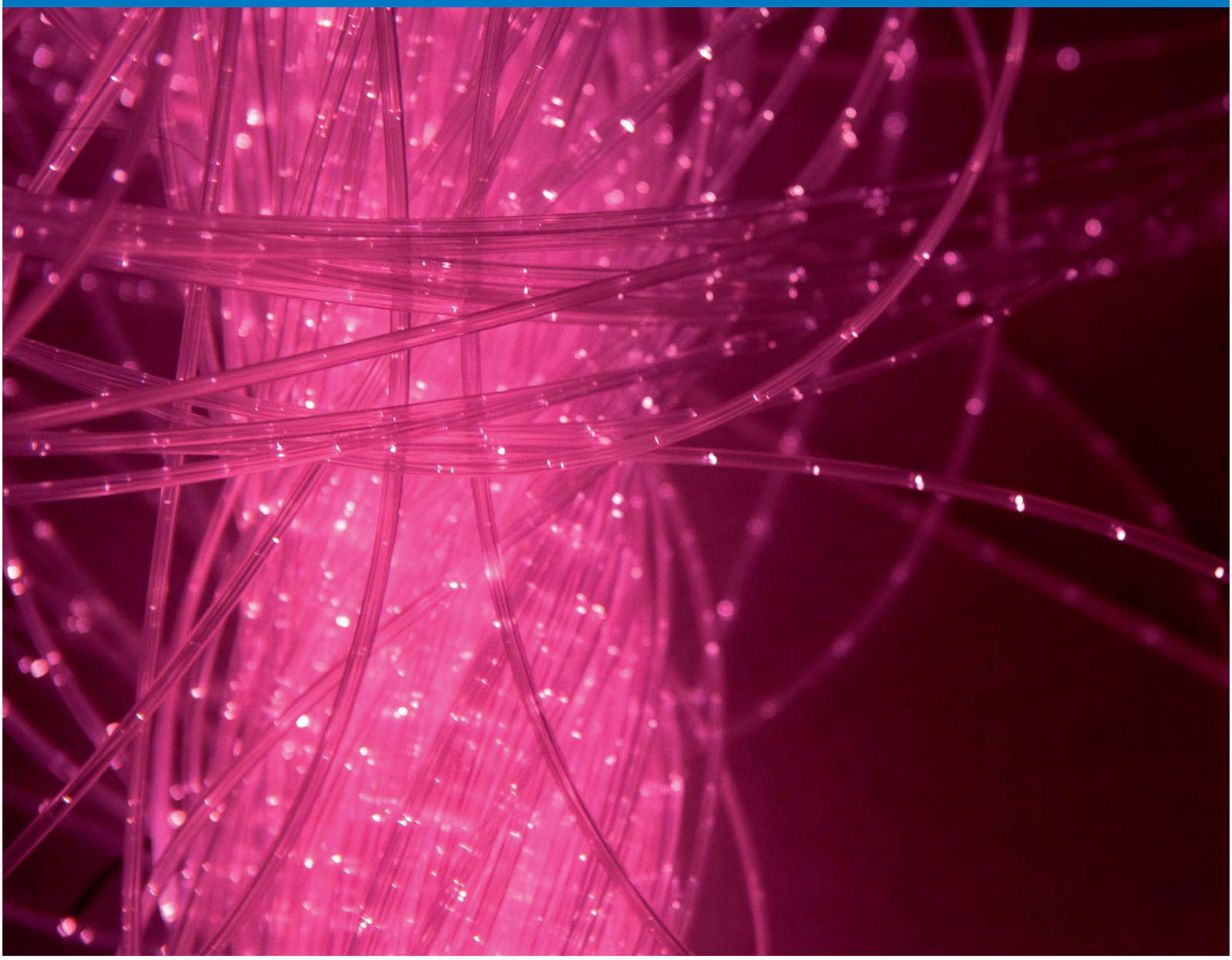

The Shrewsbury and Telford Hospital NHS
NHS Trust

Shropshire County NHS
Primary Care Trust

NHS
Telford and Wrekin

Notes from a Clinical Problem Solving Workshop on Tuesday 10 August 2010

31 August 2010

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1. Introduction

We are aiming to begin a new conversation about how best to respond to some serious emerging quality and safety concerns within the Hospitals in Shrewsbury and in Telford.

There has of course been a long history of debate about these issues over many years. Many people might wonder why it is necessary to continue to look for ways of dealing with these problems. Why can't services be left as they are?

Our problem is that it is getting increasingly hard to make sure all of the right people with the right skills are always in the right place to deal with the needs of patients. This problem is getting more difficult because:

See Section 4 for more information about the challenges.

- The training programme of doctors who become specialists (consultants) is now shorter that it used to be. Historically for example, a general surgeon might have carried out large volumes of abdominal, breast and vascular surgery whilst in training. Today consultants will have specialised in one of these branches of surgery much sooner and will therefore not have the skills to perform techniques they have not been trained to deliver. This could lead to a situation for instance where a surgeon who does not operate on the abdomen in the day time has to perform such surgery at night.
- The number of doctors who we can recruit to work in the Shrewsbury and Telford Hospitals fluctuates a great deal. This could lead to occasions when there are not enough doctors to cover all the departments in the hospitals. This is happening partly because doctors can choose where to work and some are deciding not to come to our hospitals because of the problems described above. We have also experienced a reduction in the availability of some doctors from overseas who have in the past been able to help with these difficulties. The consequence of this could be that too few doctors are left trying to look after too many patients.

We believe there is much to be proud of about the standards of health care in our two hospitals. We are worried that without some changes, standards will start to slip. We will also face questions about whether it is right to provide such services if we cannot do so safely into the future. We are confident that with the right configuration we can continue to build for the future rather than feel concerned about which services might be lost from our hospitals.

See Section 5 for more information about what we aim to achieve.

We are clear that there are some fixed points. These include:

- Ensuring that we have two vibrant, well balanced and successful hospitals, with both hospitals playing a full role.
- We are committed to an A&E Department on both sites: we will strive to make these level 2 A&E.
- We will ensure there is access to emergency general surgery from both sites.

Everyone recognises that all of the commitments will need to be tested for affordability and deliverability.

In order to test and shape this, the following work is taking place during 2010/11:

- Clinical Problem Solving Workshop (August 2010): This discussion document includes a report from that workshop.
- Discussion Phase (August to December 2010): This discussion document launches the Discussion Phase.
- Assurance Process (December 2010): A panel of clinical and patient representatives, with an independent chair, will test the proposals that emerge from the Discussion Phase.
- Formal Consultation (from 2011): A period of consultation to share the proposals that have emerged from the process and invite comment from all interested parties.

See Sections 6 to 9 for more information about the Clinical Problem Solving Workshop.

See Section 12 for more information about the stages of this process.

The government has set out four tests which any proposals for service reconfiguration will need to meet. These are:

- Support from GP commissioners.
- Strengthened public and patient engagement.
- Clarity on the clinical evidence base.
- Consistency with current and prospective patient choice.

See Section 10 for more information about the four tests for service reconfiguration.

We will need to keep these tests firmly in mind as we proceed with this important work on the future configuration of hospitals services in Shropshire, Telford and Wrekin.

This is intentionally an early discussion document, to prompt a broad debate about the best way to address the challenges we face. We encourage you to share this widely, so that people and organisations across Shropshire, Telford & Wrekin and mid Wales can help to shape the way forward.

See Section 11 for information about making your views known.

Your views are vital to help us achieve our goals of vibrant, well balanced and successful hospitals in both Shrewsbury and Telford.

Yours sincerely,

Adam Cairns
Chief Executive
The Shrewsbury and Telford Hospital NHS Trust

Jo Chambers
Chief Executive
Shropshire County PCT

Simon Conolly
Chief Executive
NHS Telford & Wrekin

2. Contents

3. Preface from Dr David Colin-Thomé

The new government's White Paper - 'Equity and excellence: Liberating the NHS' - sets out proposals to allow the NHS more freedom to innovate and deliver health outcomes among the best in the world.

The White Paper is currently out for general consultation and whilst its proposals are radical, there is much proposed that should please many clinicians given the central role offered to in particular doctors. The aim is to empower clinicians to deliver results – setting them free to make decisions for their patients, for example GPs commissioning services for their local communities.

The White Paper paves the way for the NHS to become a truly world class service: a service that is easy to access, treats people as individuals, and offers care that is safe and of the highest quality. The vision is for a service where patients have real power and are able to say 'no decision should be taken about me, without me'. This means patients having real choice in where they are treated and, where appropriate, in the type of treatment they receive. It means that patients must have the information they need to be able to exercise choice in an informed way.

It also means that clinical staff will be empowered to work with patients to determine the best treatment for them, rather than focusing on top-down process targets. Groups of clinicians will work through GP commissioning consortia, alongside their local communities, to shape health services to meet the needs of patients. Hospital doctors will be given more power and responsibility to work with patients to drive changes in the NHS, and achieving health outcomes among the best in the world

Alongside this, we must ensure greater accountability for the NHS to justify how it spends public money and how it uses this to improve the health of its patients. And, we must continue to build on the efforts of staff across the service to improve the quality of patient care whilst also achieving efficiency savings of £15-20 billion over the next four years to reinvest in frontline health services.

It is vital that the NHS continues to modernise and improve, and to meet the challenges of improving quality and productivity, but this must go hand-in-hand with an NHS where improvements are driven by local clinicians, patients and their representatives from the ground up. Local NHS clinicians will need to find innovative, safe and sustainable ways to provide more care closer to home, driven by the needs of patients and communities. They must also ensure that they are listening to staff, particularly their concerns about the risks to patient safety now and in the future. In some cases this may lead to changes to acute and specialist services in order to maintain and improve health outcomes.

Joining the workshop on 10 August, I was very pleased to see the high levels of commitment, energy and creativity to tackle the very real challenges faced by local clinicians to sustain quality and standards in the services they provide. I heard clinicians talking open and passionately about their aspirations to offer the best possible outcomes for patients in Shropshire, Telford & Wrekin and mid Wales. I also heard their concerns about the challenges facing those services, and an acknowledgment that things cannot continue as they are.

Importantly, I heard a shared commitment to see a lasting solution that delivers quality care and that has patients at its heart. I have also given my own commitment to continue to work with local clinicians to help them develop workable options up to the point of consultation.

Dr David Colin-Thomé
National Director for Primary Care, Department of Health

4. Why did we hold a Clinical Problem Solving Workshop?

During 2008 and 2009, the NHS began to review the shape of local health services, aiming to offer patients and communities:

- Better quality and outcomes
- More opportunity to improve your own health
- More support if you, or the people you are caring for, are living with long term conditions
- More services close to where you live wherever possible, and
- Safe and sustainable hospital services.

We recognise that we did not get this process right, and we have learned a lot from learn from the valuable feedback we have received from patients, the public and other key partners on the work that took place last year.

Now, with a change in government, and details of the coalition government's health policy now becoming progressively clear, it is essential that we agree a way forward to resolve the challenges facing a number of clinical specialties in the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury.

The discussions during 2009/10 focused on services like A&E, acute (emergency) surgery and inpatient children's services. However, the immediate future requires us all to think beyond these services and consider how we can re-shape services to fit with patient expectations, safety and the need to meet regulatory requirements.

The way we resolve these challenges, and the eventual solutions, must be genuinely centred on patients and carers.

It is also vital that the challenges we face and the solutions that address them are owned by clinicians in primary care and local hospitals. In our view, it is imperative that local clinicians from primary care and secondary care have the opportunity to lead the development of the way forward as it will be local clinicians who will have to work with whatever arrangements are finally agreed. They will need to be confident that services allow them to offer safe, sustainable, accessible care for their patients.

This is why we have begun this process with a workshop of clinical representatives from the two hospitals and from GP practices. The two PCTs and the Trust wrote to clinicians at the beginning of July proposing the following representation and inviting comment:

- 8 clinicians from The Shrewsbury and Telford Hospital NHS Trust nominated by Divisional Directors, Clinical Directors and the Medical Director
- 8 clinicians from Telford and Wrekin, nominated by the 3 GP Commissioning Consortia
- 8 clinicians from Shropshire, nominated by the PEC Chair following consultation with PBC Chairs and the LMC
- 2 Clinicians from Powys nominated by Powys Teaching Health Board, and
- 1 other GP from outside Shropshire, Telford & Wrekin and Powys (Dr David Colin-Thomé, the national clinical director for primary care).

A list of the people attending the workshop can be found in Section 13.

The workshop is only the first part of a process that will engage patients and patient groups, clinical staff, wider NHS staff, local representatives and other key partners into proposals for formal consultation that are based on contributions from as many perspectives as possible. More information about "What Happens Next" can be found in Section 12.

What are the challenges facing local health services?

As a reminder, these challenges are predominately to do with achieving a safe level of service for patients, bearing in mind the binding legal framework that governs the training of doctors, the skill sets and availability of key medical and surgical specialists and the need to achieve a financially sustainable model of service delivery.

These challenges will have to be considered within the context of nil or minimal capital resources (i.e. money for buildings or major equipment), and within the context of the health policy of the new government.

The key areas we need to address include[1]:

What is the government's vision for the NHS?	What are the challenges for local health services?
Genuinely centred on patients and carers	We recognise that we did not get the process right last year. And, if we don't get the process right then we cannot reach the best possible solution that will ensure safe and sustainable services whilst commanding the confidence of patients, and of the clinicians who provide their care. Decisions about the shape of NHS services must be made through an open and transparent process that engages patients and patient representatives, clinicians, local authorities and other key partners. Importantly, the government has set four tests that must be met when any decisions are made about changes to heath services (see Section 10). We welcome your thoughts and comments about how we can ensure that these tests are met in a process that delivers the best solution for local communities.
Achieving quality and outcomes that are among the best in the world	Many people receive a truly excellent service from the local NHS, but we recognise that this is not always the case. Sometimes this is because the way NHS services are delivered is rooted in the past, rather than looking to the future. We need to think carefully about where, when and how we provide your services – so that the right person provides you with the right care in the right place at the right time, to high quality standards that give you the best outcomes for your care. Also, we are seeing rising levels of obesity, and there is still more work to do to help people to quit smoking. We need to support people to make positive choices about their lifestyle that will have a big impact on their health. Eating well, being more active and giving up smoking can all help to tackle life-threatening illnesses such as cancer, type 2 diabetes and heart disease.
Refusing to tolerate unsafe and substandard care	24 hour health services need enough specialists to keep them running round the clock. Meanwhile, there are legal limits on how many hours NHS staff can work. This helps to ensure that staff are fit and alert to provide specialist care. Also, doctors and nurses need to see enough different patients to keep their skills up to date. This applies when people are qualified but also whilst they are in training. Doctors in training provide a vital part of the workforce to support 24-hour care. If hospitals only see a small number of patients, they may not be accredited to train doctors.

[1] Drawn from on "Equity and excellence: Liberating the NHS" (Department of Health, 2010) – the coalition government's White Paper setting out their plans and proposals for the NHS

	We also want to introduce best practice from elsewhere in the NHS, and internationally. This may not be possible if services remain in their current configuration. This means that we need to make plans now that will address the challenges we will face in the future. You can find out more about current staffing levels and the challenges in **Section 3 of the "Supporting Information"** produced for the Clinical Problem Solving Workshop. This is available from our website at www.ournhsinshropshireandtelford.nhs.uk
Eliminating discrimination and reducing inequalities in care	There is considerable diversity in the communities across Shropshire, Telford & Wrekin and mid Wales. For example, Telford & Wrekin has a younger and growing population, areas with high levels of income deprivation and low levels of car ownership. Shropshire and mid Wales both face the challenges of rural access and deprivation for an ageing population. Across the area, more people are living longer with long term conditions such as diabetes, dementia and cancer. We need to support people to live with long term conditions by providing more services close to people's homes to help them remain independent. More information about health status and health improvement priorities can be found in **Section 7 of the "Supporting Information"** produced for the Clinical Problem Solving Workshop. This is available from our website at www.ournhsinshropshireandtelford.nhs.uk
Putting clinicians in the driving seat and setting hospitals and providers free to innovate, with stronger incentives to adopt best practice	New equipment and treatments offer patients a better chance of recovery from illness and injury. Some new equipment and treatments need specialist staff and can only be offered in larger specialist centres. They cannot be offered in every district general hospital across the country. Where issues of safety and sustainability mean that some services need to be centralised, then we need to work with patients to understand how this impacts on them and support them to access the services they need. Other clinical equipment and treatments are getting cheaper and easier to use, so they can be offered in smaller local hospitals (including community hospitals) and GP practices. We need to find ways to bring more treatments and technologies into local settings. This will make services more convenient for local people and reduce travel. We also need to take opportunities to use technologies such as telehealthcare so that patients need to visit hospital less often.
More transparent with clearer accountabilities for quality and results **Giving citizens a greater say in how the NHS is run**	We want to make sure that this process during 2010 and 2011 is open and engaging. It should deliver safe and sustainable solutions based on the needs and expectations of patients and patient representatives, clinical staff, wider NHS staff, local authorities and other key partners. This includes meeting the four tests set out in Section 10.
Less insular and fragmented, working better across boundaries including with local authorities and between hospitals and practices	The way we deliver safe and sustainable services must be centred on the needs of patients and carers, not the convenience of organisations, clinicians or managers. The solutions delivered by this process must help patients and carers to navigate their way through the system. Health and care organisations need to work together in ways that make services seamless for the people receiving them.

More efficient and dynamic, with a radically smaller national, regional and local bureaucracy	We must all find ways to ensure that NHS resources reach frontline clinical care rather than being spent on bureaucracy and administration. In their White Paper, Liberating the NHS, the coalition government has signalled major changes in the way the NHS is run to "*free staff from excessive bureaucracy and top-down control*." The White Paper also reminds us of the major financial challenges facing the public purse, stating that "*our massive deficit and growing debt means that there are some difficult decisions to make. The NHS is not immune from those challenges. But far from being the reason to abandon reform, it demands that we accelerate it. Only by putting patients first and trusting professionals will we drive up standards, deliver better value for money and create a healthier nation.*"
On a more stable and sustainable footing, free from frequent and arbitrary political meddling.	We will do no favours to patients if we spend beyond our means. Instead, we must find innovative and creative ways to deliver safe and sustainable health services within the financial resources available to us. The commitments described in this document, and the solutions that emerge from this process, will therefore need to be carefully tested to ensure that they are affordable to the public purse and can be delivered.

What do you think are the main challenges facing local health services, and for local communities, and how can we address these?

5. What do we aim to achieve?

All parts of the local NHS are agreed about what we are aiming to achieve.

We expect to see two vibrant, well balanced and successful hospitals in Shrewsbury and Telford, with both hospitals playing a full role.

While the focus of discussions has tended in the past to be on services like A&E and acute (emergency) surgery, the immediate future requires us all to think beyond these services and consider how we can re-shape services to fit with patient expectations, safety and the need to meet regulatory requirements.

To be clear, everyone agrees on the need to ensure there are A&E services on both hospital sites, and our shared commitment is to strive to provide a level 2 facility at both hospitals. With respect to emergency general surgery, we are also all committed to achieving access to emergency general surgery on both sites.

Our guiding principles for this work are:

- We are approaching this latest iteration of the work with an open mind. This is because previous attempts to secure a solution have not worked.
- We have a responsibility as the local NHS to ensure that the services we provide are both safe and sustainable for the future.
- Our services are provided to meet the needs of our patients, and the communities they live in – and in particular to address the needs of the most vulnerable and disadvantaged people that we serve. All parts of the NHS have a responsibility to ensure and encourage proper patient participation in this work.
- We believe that it is right that clinical staff from secondary and primary care need to own both the current problems and challenges and the problems and challenges of any new option that's created. This is why we relaunched this process with a workshop for consultants and GPs to come together and look at the situation together and identify potential options.
- The outcome of the process will need to be a well balanced solution that ensures we have vibrant and successful hospitals on both sites.
- There will be 2 A&Es, and we will strive to deliver them both at level 2.
- There will be access to acute surgery on both sites. We cannot say at this stage how this will be achieved as this needs to be decided through a process of clinical and patient engagement.
- We need to make the best use of the hospital estate at both PRH and RSH, recognising that there is unlikely to be sufficient capital to make large changes to buildings.
- We will work hard on enabling strategies such as improving tele-health solutions, transport and transfers.
- We believe that the solution should be determined based on appraisal of the relevant facts. The financial consideration is simply that there will not be any more money than there already is. So, options need to be grounded in this reality.
- We are all clear that the recommendations of the clinical problem solving workshop will need to be tested with patients and communities. They will also need to be tested to ensure they are safe, sustainable, deliverable and financially viable, and demonstrate that they meet the government's tests for reconfiguration proposals (see Section 10).

What are your views on these guiding principles?

6. Overview of the Clinical Problem Solving Workshop

The main features of the day were as follows:

- Dr David Colin-Thomé, national clinical director for primary care at the Department of Health, provided his reflections on the current climate for the NHS, and in particular how health services can work with patients and key partners to deliver the vision set out in the new government's White Paper.
- Dr Richard Brough and Mr Tony Fox set out some of the clinical challenges facing local hospital services.
- Professor Beverly Alimo-Metcalfe set participants the challenge of leading the process of creating a vision for future health services through engagement with clinical colleagues, the local community and partners. She outlined the research evidence around clinical leadership, including her own research with Real World Group, and has provided the following summary:
    - *"In order to deliver healthcare services that are of the highest quality, and that are safe for the patients and community of Shrewsbury & Telford, in a challenging economic environment, the Trust must create a culture which enables all of its staff to give of their best, every day, and in a way which does not damage their morale or well-being, so as to ensure that the results are sustainable.*
    - *"This will require the highest levels of leadership at all levels, and particularly by local clinicians in primary care and those in hospitals modelling an 'engaging approach' by working in respectful, strong and transparent partnerships, on a shared vision of high quality and safe services, to which their colleagues, by their involvement, also become committed.*
    - *"Leadership cannot be sustained unless there is a culture of engagement throughout the Trust, which is embodied in relationships with patients, their representatives, local authorities and other key partners.*
    - *"Our recent longitudinal research in the NHS has proved that by exhibiting the values and behaviours of engaging leadership, on a daily basis, and in every kind of relationship, produces the highest levels of performance, as well as high levels of motivation, and an openness for change and constant improvement; it also sustains well-being.*
    - *"At all times, engaging leadership strives to connect people and their ideas and efforts through creating genuine partnerships in which colleagues work as co-designers and co-owners in developing and implementing a shared vision."*
- Dr Mike Roddis supported clinicians to work in groups to identify options for moving forward to address the clinical challenges. One group focused on acute surgery and the other on children's services.
- During the final session, participants shared the discussions from their working groups. The options they presented are summarised in Sections 7 and 8. Other options discussed in the groups but not presented back during this final session are outlined in Section 9.
- The final closing also provided an opportunity to take these ideas further and consider other options. A further model for services was suggested, and is also summarised in Section 9.

7. What picture of services was presented by the Acute Surgery Focus Group?

This section describes the picture of services that was presented by the Acute Surgery Focus Group during the feedback session at the end of the workshop. The picture of services presented by the Children's Services Focus Group is described in Section 8. Other models that were discussed during the day are described in Section 9.

A. Who was involved in this focus group?

- Mr Chris Beacock
- Dr Steve Evans
- Mr Chris Hinton
- Dr Jim Hudson
- Dr Michael Matthee
- Mr Mark Prescott
- Mr Bruce Summers

B. What were the main parameters and constraints we considered?

- In an emergency situation patients need to be able to access appropriate specialty surgical services so that clinical outcomes are the best possible.
- It is necessary to establish and maintain a consultant vascular surgery rota. Vascular surgery will need to have inpatient facilities on one site only. Linkages to interventional radiology are critical to providing an acute aortic aneurysm service.
- The viability of the current model for acute surgical provision is questionable because of:
  - Increased sub-specialisation of surgeons
  - Impact of implementing the European Working Time Directive
  - Reduced availability of adequately trained non-consultant surgeons
  - High financial cost of maintaining duplicate surgical takes on each of the two sites.
- There is a need to provide a balance of services across the two sites.
- Facilities for emergency and elective paediatric surgery will need to be focused on one site.
- Acute surgery has clear critical clinical linkages with acute medicine, paediatrics, gynaecology and trauma.
- The principles of 'stabilise and transfer' are already applied to a number of patients that move between the two hospitals or out of county. There is likely to be a small increase in transfers between RSH & PRH in order to ensure that patients are managed by the appropriate specialty team.
- Only a small proportion of surgical patients present as emergencies. The majority are investigated and treated as day cases or outpatients and these services will continue on both sites.
- Specialities that are not represented on a particular site out-of-hours will normally have a presence in that hospital during the normal working week (e.g. for outpatient, daycase).

C. What options did we identify?

- No change.
- Bringing acute surgery together in a new hospital between Shrewsbury and Telford.

- Focusing acute surgery on one of the two existing sites.

D. What did we think about these options?

- No change – this is not an option because of the parameters and constraints described in section 4.
- Bringing acute surgery together in a new hospital between Shrewsbury and Telford – this is not an option as building a new hospital would cost many hundreds of millions of pounds, which is not affordable in the current economic climate or the foreseeable future.
- Focusing acute surgery on one of the two existing sites – this is a feasible scenario as long as:
  - The Trust works together as a single organisation with all clinical departments integrated across the two hospital sites
  - Commissioners recognise SaTH as the provider rather than individual hospital sites
  - Issues of transportation are addressed – emergency, clinical & patient transport, public/visitor, staff, resources
  - The infrastructure of each hospital can support the proposed changes with minimal capital investment.

E. What could it look like?

PRH		RSH
Breast surgery Urological surgery Vascular surgery Orthopaedic Surgery (elective and emergency), e.g. fractured neck of femur Major (non life threatening) trauma and minor trauma Medicine		Acute surgical take Colorectal surgery Upper Gastro-intestinal surgery Orthopaedic surgery (mainly emergency including multiple injuries), including fractured neck of femur Major (life threatening) trauma and minor trauma Medicine
	ENT	

F. What would be the expected consequences, positive and negative?

- Two well-balanced sites providing a wide range of surgical services and A&E services at both sites.
- A safer service.
- Unnecessary duplication of services is ended, leading to a more efficient and sustainable service.
- More travel for staff and for some patients.
- Keep these services in the county, rather than seeing them drift to specialist centres outside Shropshire and Telford & Wrekin – including keeping a local paediatric surgical service.
- Acute abdominal emergencies, mainly colorectal and upper GI, would be taken to RSH. Vascular emergencies would be taken to PRH.
- PRH would have a non-resident (off site) surgical rota. This may provide for an on-site presence extended outside normal 9-5 hours to reflect when the majority of activity takes place.
- RSH would have a resident (on site) surgical rota 24/7.
- Major trauma would be taken to the RSH site.
- Rotation of medical staff between the two sites would help to maintain skills and interest and equalise workloads.

- There is likely to be an increase in the number of acute patients transferred between sites after stabilisation.
- Political/market effect of siting vascular surgery at PRH needs to be assessed.
- Risk losing some patients from the east of the county if Wolverhampton is closer for some services.
- Potential clinical links between Wolverhampton and SaTH in urology and head and neck surgery are facilitated.
- Multiple major trauma (e.g. life-threatening) would go to the RSH site, otherwise services for orthopaedic trauma and emergencies would remain the same.

G. What led us to draw this picture?

- This creates a balance of specialties, allowing surgery to continue at both sites and providing surgical support to A&E and general medicine, allowing a credible A&E service to continue at both hospitals.
- Most trauma could be taken to either site. Only a small proportion would need to be taken to the site with the main acute surgical take (RSH).

PRH

- The majority of the breast surgery currently takes place at PRH and would continue there.
- Urological surgery currently takes place at both sites but could be located at either site.
- Vascular surgery currently takes place at both sites but must be located on a single site. Either site could be possible.
- Urology and vascular surgery are ideally located together as they both need access to interventional radiology.
- Having three surgical specialties at PRH would ensure that there are sufficient junior doctors to enable a non-resident junior surgical rota to support vascular surgery, A&E and the acute medical take.
- An elective paediatric surgical unit at PRH might run as a five day ward with some overnight paediatric cover. More robust arrangements for emergency paediatric anaesthesia and surgery would be a desirable co-product.
- Possible co-location of ENT inpatient services to make best use of the hospital estate and infrastructure at PRH.

RSH

- The majority of inpatient colorectal surgery currently takes place at RSH and would continue there.
- The majority of the acute non-orthopaedic surgical take relates to colorectal and GI.

H. Are there any particular constraints that mean certain services need to be on specific sites?

- Linkages between acute surgery, trauma and paediatrics (which in turn has links to neonatology and therefore obstetrics) mean that these services need to be co-located. This could be accommodated within the existing facilities at RSH. A new build would be required to accommodate neonatology and obstetrics at PRH.

What do you think about the issues discussed above? These ideas will raise lots of questions. Some of these are included as a guide in Section 11.

8. What picture of services was presented by the Children's Services Focus Group?

This section describes the picture of services that was presented by the Children's Services Focus Group during the feedback session at the end of the workshop. The picture of services presented by the Acute Surgery Focus Group is described in Section 7. Other models that were discussed during the day are described in Section 9.

A. Who was involved in this focus group?

- Dr Shalindra Allen
- Dr. Richard Brough
- Dr David Colin-Thomé
- Dr Peter Clowes
- Dr. Frank Hinde
- Mr. Alan Leaman
- Dr Michael Lewis
- Dr Maher Moselhi
- Dr. Chris Pearson
- Dr. Adam Pringle
- Dr Ian Rummens
- Dr Karen Stringer
- Dr. Wendy Jane Walton

B. What were the main parameters and constraints we considered?

- Ensuring links between children's services and other specialties, including ENT, Surgery, Orthopaedics, Anaesthetics and Neonates.
- The issue of rota cover – depending on the choice of site this may affect the ability to cover paediatrics, neonates and community whilst also maintaining clinical skills.

C. What options did we identify? and

D. What did we think about these options?

- No change – this is not an option because it would not ensure safe and sustainable local children's inpatient services.
- A model that would see paediatric inpatient services focused on one site, with the other providing a paediatric assessment unit accepting patients between 8am and 10pm. Potentially this could also include a nurse-led overnight ward alongside the paediatric assessment unit, which would need to be explored further. This is the model that was presented during the feedback session at the end of the workshop, and is described below.
- A model that would see paediatric inpatient services retained on both sites, with a consultant-led overnight service on one site and a 6-8 bed unit for non-acute overnight stays with middle-grade overnight cover on the other site. This model was not presented during the feedback session and is discussed in Section 9.

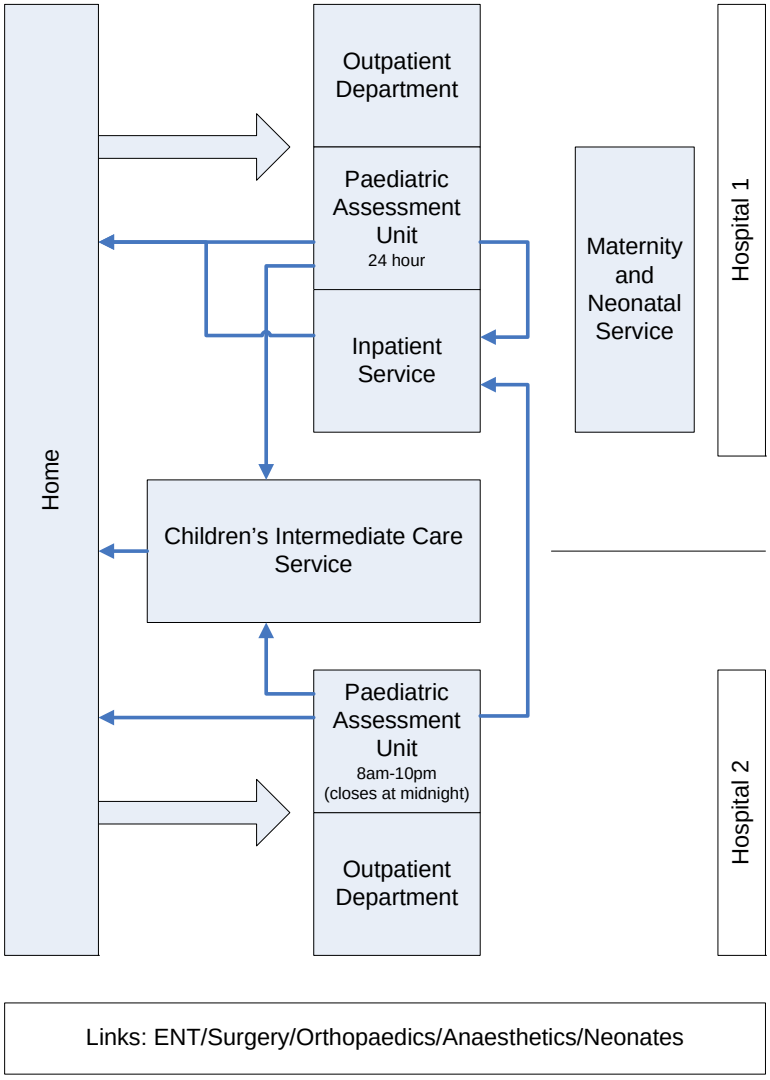
E. What could it look like?

Both hospitals have a paediatric assessment unit, able to assess children, provide immediate care and discharge to home and/or with support from a Children's Intermediate Care Service.

One hospital would provide a children's inpatient service and would have a 24-hour paediatric assessment unit. The second hospital would refer children requiring overnight stay and the paediatric assessment unit would accept referrals between 8am to 10pm (closing at midnight).

Hospital 1		**Hospital 2**
Children's Outpatient Services 24hr Paediatric Assessment Area Inpatient Beds Special Care Baby Unit Consultant-led maternity services with co-located midwife-led maternity services		Children's Outpatient Services 8am to 10pm Paediatric Assessment Area Midwife-led maternity services
Children's Intermediate Care Service		
Home		

The care pathway for children attending hospital can be summarised as follows:



Opportunities for considering a low-intensity nurse-led overnight ward at Hospital 2 should also be explored.

F. What would be the expected consequences, positive and negative?

- Retains paediatrics on both sites – outpatients, paediatric assessment and day case surgery provided on both sites; inpatient paediatrics provided on one site.
- During “open” hours, more than half of children do not need to be admitted and are sent home. Many children attending the paediatric assessment unit at Hospital 2 (without inpatient beds) will therefore be discharged to home or with intermediate care support. Those requiring inpatient stay would need to be transferred to the inpatient unit. If a low-intensity nurse-led overnight ward could be established then children requiring low-intensity support (such as fractures requiring traction) may not need to transfer. This needs to be explored further.
- Overnight, the majority of children arrive by GP referral or ambulance and would therefore be directed to the hospital offering overnight assessment, and would be admitted if appropriate. Based on current statistics this is likely to affect one patient per night.
- Compared to the current service, the same care in the same place will be available for the majority of children, as few children require overnight admission to a local district general hospital. The main difference will be for families whose child is admitted.

G. What led us to draw these pictures?

- This model presents an option for maintaining safe and sustainable inpatient children’s services, linked to the wider clinical challenges facing the county.

H. Are there any particular constraints that mean certain services need to be on specific sites?

- There are vital clinical links between inpatient children’s services and the neonatal service. The neonatal service needs to be located with the consultant maternity unit.
- Consultant maternity services and the Neonatal Unit are currently based at RSH. Space and facilities would therefore need to be found at PRH, either through a new build or by relocating other services from PRH to RSH.

What do you think about the issues discussed above? These ideas will raise lots of questions. Some of these are included as a guide in Section 11.

9. What other ideas were brought up in the workshop?

The workshop offered an opportunity for wide-ranging discussion about ways to address the clinical challenges faced by NHS services in the county.

The following model was discussed in the Children's Services Focus Group:

This model would see paediatric inpatient services retained on both sites, with a consultant-led overnight service on one site and a 6-8 bed unit for non-acute overnight stays with middle-grade overnight cover on the other site.

PRH	RSH
A&E department Continues to take significant limb trauma, acute medicine, etc.	Level 2 trauma centre Takes any major trauma not flown out
Vascular surgery and urology On site surgical middle grade doctor only overnight. Supported by H@N nurses Middle grade doctor covers vascular and urology inpatients and provides opinions in A&E and for the physicians	Acute general surgery + surgical trainees
Paediatric unit with 6-8 beds for non acute overnight stayers. On site paediatric middle grade doctor only overnight. Supported by nurse practitioners Middle grade doctor covers paediatric beds and provides support to A&E	Paediatrics + paediatric trainees
General medicine	General medicine
Trauma and orthopaedics	Trauma and orthopaedics
ITU	ITU

The possible consequences of this model would include:

- Paediatric medical overnight beds are maintained at both sites, with paediatrician support to both A&E departments.
- Continue to need two middle grade rotas, which does not address current pressures on rotas. May not address risks to maintaining role in education of doctors in training, which will impact on available workforce.
- From an emergency surgery perspective, this would support us to addresses surgical staffing problems.
- Focuses major trauma on one site (addressing the challenges of covering two trauma centres) – this is not specifically relevant to paediatrics, but helps to address the wider clinical challenges in the county.
- Maximises use of ITU and in-patient bed capacity – again, this is not specifically relevant to paediatrics, but helps to address the wider clinical challenges in the county.

The following model was discussed in the closing stages of the workshop:

A further idea was discussed during the closing stages of the workshop, and there was not time to develop it further. However, we welcome thoughts from clinicians and patients about a scenario where we develop the two hospitals as parallel centres of excellence:

PRH	RSH
Centre of excellence for Women and Children's Services, including the consultant maternity unit, neonatal unit and inpatient children's services.	Centre of excellence for Acute Surgery, including major trauma.
Relocation of surgical inpatient services to RSH would help to provide physical space for relocation of women's services to PRH.	Relocation of women's services to PRH would help to provide physical space for relocation of inpatient surgical services to RSH.
Care pathways would need to be in place for children requiring acute surgery and inpatient stay.	
Continues to provide outpatients, day surgery and diagnostic services, so the majority of patients continue to receive their care locally.	
Both hospitals continue to provide medical assessment and inpatient general medicine.	
Both hospitals provide midwife-led maternity units (at PRH this would be co-located with the consultant maternity unit).	

This report is intentionally a rough draft, drawn together from flipchart notes and feedback from participants. The ideas described in Sections 7, 8 and 9 are intended to prompt discussion and debate, rather than to define the way forward. We welcome other models and options that will help us to address the clinical challenges faced by local health services.

What do you think about the issues discussed above? What other ideas and suggestions do you have?

10. What tests has the Government set for service reconfigurations?

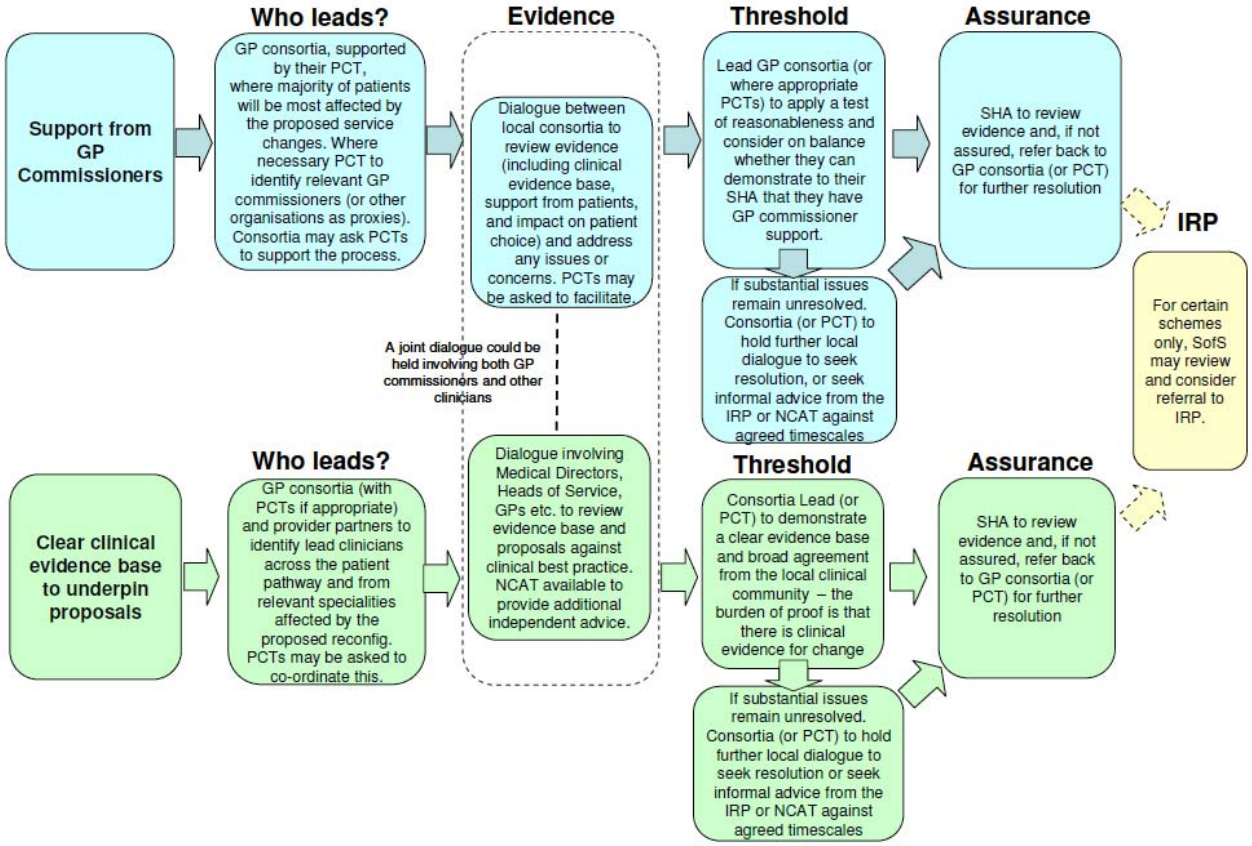
The Secretary of State for Health has identified four key tests for service change in the NHS in England, which are designed to build confidence within the service, and with patients and communities. The tests require existing and future reconfiguration proposals to demonstrate:

- Support from GP Commissioners
- Strengthened public and patient engagement
- Clarity on the clinical evidence base
- Consistency with current and prospective patient choice.

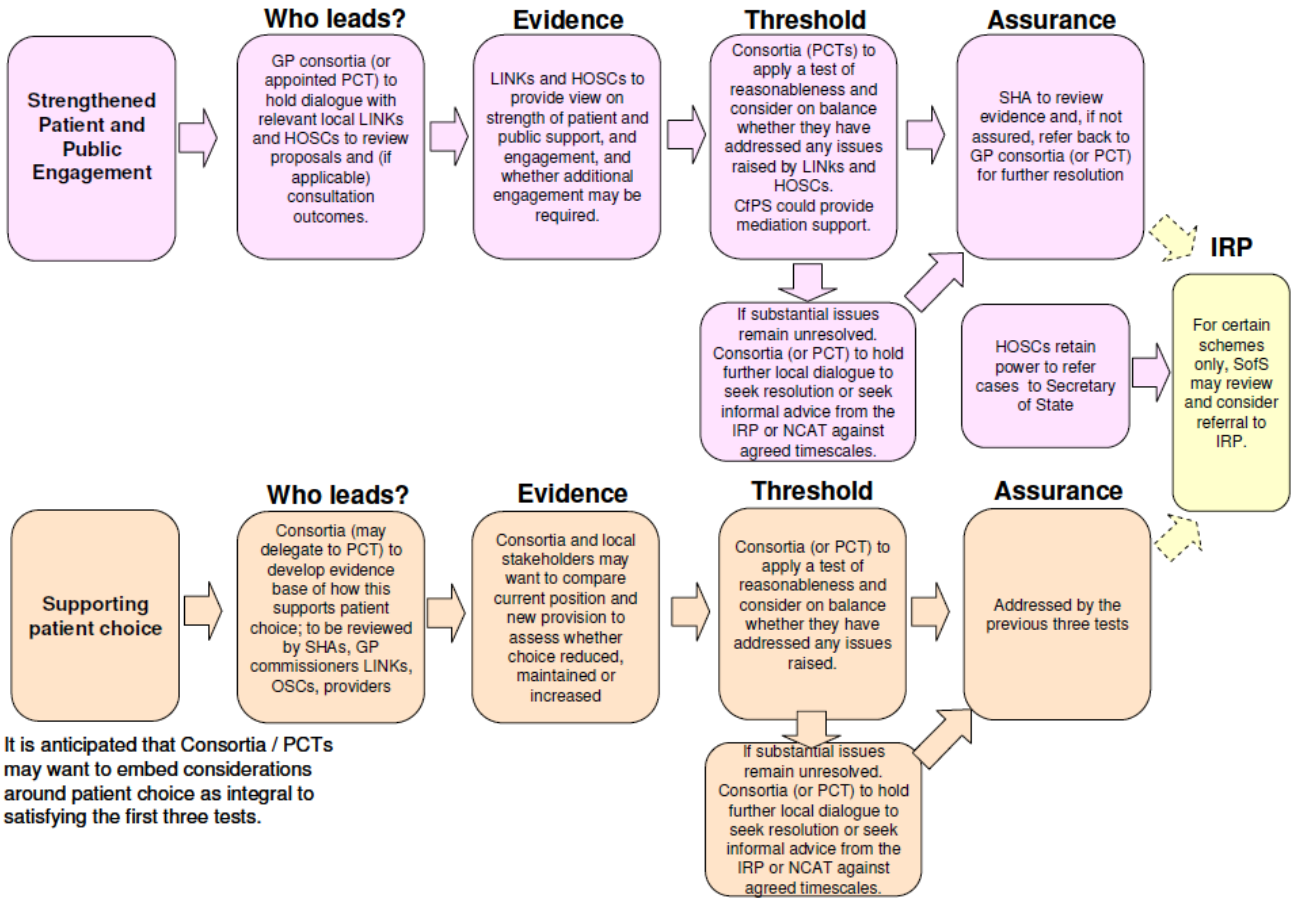
The government has chosen not to set specific thresholds for any of the tests, as the process should be locally led and designed. The process of gathering evidence for the four tests will be led by GP-led commissioning organisations or by GPs supported by PCTs.

The four tests are summarised below, or more detailed information about the tests is available from our website at **www.ournhsinshropshireandtelford.nhs.uk** or from the Department of Health website at **www.dh.gov.uk**

An outline process for applying the GP commissioner and clinical evidence tests is illustrated in the following diagram:



An outline process for applying the public engagement and patient choice tests is illustrated in the following diagram:



These tests are intended as a useful guide to help the NHS work with patients and patient representatives, clinicians, wider NHS staff, local authorities and other local representatives and other key partners to review challenges to health services.

How should we use these four tests as part of this review of local health services?

11. Making Your Views Known

It is essential that patients and patient representatives, clinicians, wider NHS staff, local authorities and other local representatives and other key partners are fully involved in shaping the future of local hospital services.

This is why we have shared these ideas at such an early stage. They are not fully worked through. They are not formal options. There are certainly no decisions.

Instead, we need you to think about the issues discussed in these papers, talk about them with your friends and colleagues and tell us what you think.

These ideas will raise lots of questions, some of which are set out in the previous sections. Here are a few more ideas, but please feel free to comment beyond these questions:

- How do we ensure that patients and carers know where to go in an emergency to access the best care as quickly as possible?
- How do we ensure that as much planned care continues to be provided in both hospitals – or even closer to home if possible?
- What is the impact on patients and carers? How many would need to attend a different hospital compared with now? What extra support would patients and carers need if the shape of services changed?
- How do we make sure that the specific needs of circumstances of the different communities we serve – in Telford & Wrekin, in Shropshire and in mid Wales - are taken into account when deciding the best way forward? This could include issues such as demographics, urban and rural deprivation, public health issues, travel times and other factors affecting local people's access to and need for health services.
- What is the impact on the working lives of the staff on each site? Can we successfully manage the change processes required?
- What additional travel arrangements would need to be put in place for patients, visitors, staff, resources?
- Does this address the challenges to safety and sustainability discussed in section 4?
- How much will it cost? In revenue terms (staffing, clinical supplies)? In capital terms (building costs, major equipment)? Can the local NHS afford this?

Please send us your thoughts and ideas by 12 November 2010:

By email **ournhsinsat@nhs.net**

By post **Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust**

Princess Royal Hospital, Grainger Drive, Apley Castle, Telford TF1 6TF, or
Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ

A comment form is provided at the back of this document.

We would like to be able to share all of the comments that we receive, so please let us know if you would like your comments to be kept anonymous.

12. What Happens Next?

We hope that as many people as possible will take the opportunity to comment on this discussion paper, and we will ensure there are wide opportunities for patient and public engagement to help make this happen.

We expect that this discussion phase will take place between the end of August and the end of November. This will allow us to build the views and suggestions of patients and patient groups, clinical staff, wider NHS staff, local representatives and other key partners into proposals for formal consultation that are based on contributions from as many perspectives as possible.

We believe that this will enable us to develop a set of proposals that take into account the key issues that are important to the people we provide services for, and the people that deliver those services. The table below outlines the suggested timetable.

Period	Phase	Purpose
August 2010	Clinical Problem Solving Workshop	A clinical problem solving workshop took place on 10 August 2010. This involved GPs from Telford & Wrekin, Shropshire County and Powys alongside hospital consultants from The Shrewsbury and Telford Hospital NHS Trust. Building on the extensive work done to date, this workshop explored the clinical challenges and options available for a sustainable solution. In our view, it is imperative that local clinicians from primary care and secondary care have the opportunity to lead the development of the way forward as it will be local clinicians who will have to work with whatever arrangements are finally agreed. It is also essential that their proposals are tested widely with clinical colleagues and with patients and communities (see below).
End of August to December 2010	Discussion Phase	Between August and November we are sharing the emerging thinking from our workshop of local hospital doctors and GPs about the range of ways of resolving the configuration issues – including this report. We expect this phase to help us to develop a well thought through set of proposals based on a very inclusive discussion. We want to hear from patients and patient groups, clinical staff, wider NHS staff, local representatives and all our key partners.
December 2010	Assurance Process	During December 2010 there will be a process of assurance led by the two PCTs (NHS Telford & Wrekin and Shropshire County PCT). This will involve the testing of the proposals from the Discussion Phase by a group involving clinical and non clinical officers of the PCTs, patient representatives (through the local LINKs and Montgomeryshire CHC), with observer rights for the local Health Overview Scrutiny Committees. This group will have an independent chair.
New Year to March/April 2011	Formal Consultation	Following the Assurance Process, there will be a period of consultation to share the proposals that have emerged from this process and invite comment from all interested parties.

13. Participants in the Clinical Problem Solving Workshop

Clinical Representatives

Dr Shalindra Allen	GP	NHS Telford & Wrekin
Mr Chris Beacock	Consultant	The Shrewsbury and Telford Hospital NHS Trust
Dr Richard Brough	Consultant	The Shrewsbury and Telford Hospital NHS Trust
Dr Peter Clowes	GP	Shropshire County PCT
Dr David Colin-Thomé	National Director for Primary Care, Department of Health	
Dr Steve Evans	Medical Director	The Shrewsbury and Telford Hospital NHS Trust
Mr Tony Fox	Consultant	The Shrewsbury and Telford Hospital NHS Trust *(am only)*
Dr Frank Hinde	Consultant	The Shrewsbury and Telford Hospital NHS Trust
Mr Chris Hinton	Consultant	The Shrewsbury and Telford Hospital NHS Trust
Dr Jim Hudson	GP	NHS Telford & Wrekin
Mr Alan Leaman	Consultant	The Shrewsbury and Telford Hospital NHS Trust
Dr Michael Lewis	GP	Powys Teaching Health Board
Dr Michael Matthee	GP	Shropshire County PCT *(am and early afternoon)*
Dr Maher Moselhi	GP	Shropshire County PCT
Dr Chris Pearson	GP	NHS Telford & Wrekin
Mr Mark Prescott	Consultant	The Shrewsbury and Telford Hospital NHS Trust
Dr Adam Pringle	GP	NHS Telford & Wrekin
Dr Ian Rummens	GP	Shropshire County PCT
Dr Karen Stringer	GP	NHS Telford & Wrekin
Mr Bruce Summers	Consultant	The Shrewsbury and Telford Hospital NHS Trust
Dr Wendy Jane Walton	GP	NHS Telford & Wrekin

Management Representatives

Jo Chambers	Chief Executive	Shropshire County PCT
Clare Old	Director of Commissioning and Service Improvement, NHS Telford & Wrekin on behalf of Simon Conolly, Chief Executive, NHS Telford & Wrekin	
Adam Cairns	Chief Executive	The Shrewsbury and Telford Hospital NHS Trust

Facilitators

Professor Beverly Alimo-Metcalfe PhD MBA MSc CPsychol FBPsS

Beverly has an international reputation in the field of leadership studies - an area of interest for over 20 years. She is passionate about embedding ethical leadership throughout organisations, and in supporting individuals and organisations in strengthening their capacity. As a result of her reputation she has undertaken numerous advisory roles, including membership of the expert advisory panel of QIPP, Academic Advisory Panel of the Chartered Management Institute (CMI) and the Government's advisory group at the Department for Business, Enterprise & Regulatory Reform in relation to the Macleod Review on Employee Engagement. She has been working closely with local government and the NHS in research, postgraduate teaching, and in developing leaders and leadership capacity since 1984. She is Professor of Leadership at Bradford University School of Management and Chief Executive of Real World Group (www.realworld-group.com).

Dr Mike Roddis BSc MB ChB MBA FRCPath

Mike qualified as a doctor in 1978 and became a consultant chemical pathologist in 1985. He became clinical director in 1988, gaining his MBA in 1990. In 1994 he moved to the Homerton hospital as clinical director for surgery and clinical support services and became medical director of The Princess Alexandra Hospital in Essex in 1996. He left the NHS in 2002 to become an independent medical management consultant. He is a Director of Healthcare Performance Ltd. (www.healthcareperformance.co.uk).

Dr David Colin-Thomé OBE

As well as providing independent clinical input to the workshop, Dr David Colin-Thomé also supported the facilitation of the event. David Colin-Thomé was appointed as National Clinical Director for Primary Care in May 2001 and as National Director for Primary Care and medical adviser to the commissioning and system management director at the Department of Health in 2007. He was a GP from 1971 at Castlefields Health Centre Runcorn, retiring in March 2007. His practice has been leading-edge nationally over the last 10 years or so, pioneering systematic management of long-term conditions employing managed care techniques. David has considerable experience in the public sector having spent eleven years as a councillor and formerly senior medical officer at the Scottish Office and Director of Primary care at North West and London Regional offices. He publishes regularly on primary care reform, and has also recent published "Mid Staffordshire NHS Foundation Trust: A review of lessons for commissioners and performance managers" (2009) and "Review of GP Out-of-Hours Services" (with Professor Steve Field, 2010).

Comment Form

We welcome your comments about the issues discussed in this document.

We would like this process to be as open and transparent as possible, so we would like to be able to share or publish the comments we receive. Please indicate below if you would prefer your comments to be anonymous.

<table>
<tr><td colspan="6">Please put a cross (X) in the box below if you would like your name and/or organisation to be kept anonymous if we share or publish the responses we receive.
Your contact details will not be published.</td></tr>
<tr><td>Name</td><td colspan="4"></td><td></td></tr>
<tr><td>Organisation (if applicable)</td><td colspan="4"></td><td></td></tr>
<tr><td rowspan="3">Contact Details (e.g. email address, postal address)</td><td colspan="4"></td><td>X</td></tr>
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<tr><td rowspan="2">Individuals: Which area do you live in?
Organisations: Which area(s) does your organisation cover?
Please tick all that apply</td><td>Telford & Wrekin</td><td>Shropshire</td><td>Mid Wales</td><td colspan="2">Other (please state)</td></tr>
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<tr><td colspan="6">Please let us know your comments about the issues discussed in this report
We have included some questions on page 22 as a guide. Please feel free to continue on additional pages.</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="5">Would you like to be invited to events and activities to discuss these proposals?
Please tick the box if you would like to be kept informed – and make sure you have included contact details above.</td><td></td></tr>
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Please return your comments to the Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust at Princess Royal Hospital, Grainger Drive, Apley Castle, Telford TF1 6TF, or
Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ
You can also respond by email to ournhsinsat@nhs.net