TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Friday, 11 February 2011 at 10.00 am at AFC Telford Learning Centre, Wellington, Telford

PRESENT – Councillor V Fletcher (TWC Health Scrutiny Chair) (Chairman), Councillor G Dakin (SC Health Scrutiny Chair), Councillor K Calder (SC), Councillor R Chaplin (TWC), Ms D Davis (TWC), Councillor T. Huffer (SC), Ms J Gulliver (TWC), Councillor A. McClements (TWC), Ms P Paradise (SC) and Mr D Saunders (TWC)

Also Present - Councillor J Seymour (TWC Cabinet Member: Adult Care & Support), Councillor S Jones (SC Portfolio Holder for Adult Services)

Officers – F Bottrill (Scrutiny Manager, TWC), D. Dorrell (Scrutiny Officer, SC), P. Smith (Senior Democratic Services Officer, TWC)

JHOSC-17 APOLOGIES FOR ABSENCE

Ms R Manger (SC) and Ms H Thompson (SC)

JHOSC-18 DECLARATIONS OF INTEREST/PARTY WHIP

None

JHOSC-19 MINUTES

RESOLVED – that the minutes of the meeting held on 13 December 2010 be confirmed as a correct record, subject to the inclusion of Cllr R Chaplin (TWC) in the list of those Members present at the meeting.

As the Chief Executive of the Shrewsbury & Telford Hospital NHS Trust was delayed in getting to the meeting, the Chairman proposed that the order of business as set out on the agenda be varied. It was therefore agreed that Agenda item 6 be brought forward on the agenda.

JHOSC-20 NEXT STEPS FOR MENTAL HEALTH CARE IN SHROPSHIRE, TELFORD & WREKIN

This item was presented by Michael Bennett (Lead Joint Commissioning & Contracting Manager). A paper providing an update on the proposals for the modernisation of mental health services and feedback on the formal public consultation had been circulated to the Committee.

Following formal public consultation between September and December 2010 (which the Joint Committee had considered and taken part in), South

Staffordshire & Shropshire Healthcare had produced a Full Business Case (FBC), working closely with commissioners to appraise options and affordability. The FBC was fully aligned with local Mental Health Strategies, and was also consistent with the vision set out in the new national mental health strategy – 'No Health Without Mental Health'. The FBC had been forwarded to Monitor, who regulated Foundation Trusts, for their approval.

Documents on the proposals were available throughout the consultation period, and a series of more than 40 public events had taken place across the county. People broadly supported the need to modernise services through strengthening community-based support and replacing Shelton with a new modern in-patient facility. 137 responses to the questionnaire were received – 69.4% of respondents strongly or mostly agreed with the proposals; 14.5% were not sure or neutral; and 16.1% strongly or mostly disagreed. The report also set out the factors that respondents saw as most important for both community services and in-patient services, as well as some of the other feedback from the events and consultation meetings. The strongest concerns voiced during the consultation focused on the proposal to close Beech Ward at Whitchurch Community Hospital. As a result, the FBC included a commitment that community teams were in place and working effectively prior to any reduction in capacity of inpatient services. This included a specific commitment to establish a review group for the Whitchurch area to oversee the community developments before any change to Beech Ward. Statements of support for the modernisation proposals had been received from partner organisations and stakeholders.

In terms of governance arrangements, the implementation of the proposals would be taken forward by a Sub-Committee established with delegated powers by the PCT Boards. The Sub-Committee would monitor performance and quality of service provision under the modernisation plan, and would formally agree any bed closures once assurance had been received that the community services were in place and the bed reductions could be safely made. The Foundation Trust had already started to make service improvements in line with commissioning intentions, and since Christmas there had been a significant reduction in the number of beds being used, mainly through earlier and better interventions in the care process.

Members asked a number of questions about the proposals contained in the FBC, and the feedback received from the consultation exercise, including:
- what arrangements were there currently at Shelton for patients needing intensive care, and how would this be provided in the new in-patient facility?
Response – at present, there was a small area just off the main ward. However, this was quite a confined space, and sometimes patients had to be sent to a specialist unit at Stafford or elsewhere. In the new facility, one of the wards would be designed to allow a higher dependency level of care (including greater staffing provision). In some circumstances, there might still be a need to use specialist facilities elsewhere.

- how many beds would be provided in the new facility, and what would be the likely turnover on length of stay?

Response – 58 of the 74 acute and organic beds would be commissioned by the respective PCTs. Based on current usage, this would equate to 36 beds for SCPCT patients and 22 beds for T&W patients. Patients from Powys would not be going to use the new in-patient facility, so there would be some additional capacity if needed. In terms of length of stay, this was currently high for older people (around 60 days). Through using community alternatives (eg: support for people to return to their own living environments as soon as possible) and better psychological interventions in wards, it was proposed to reduce length of stay to an average of under 30 days.

- was the financial viability of the FBC affected by the decision of Powys not to use the new in-patient facility as well as the likely implications of the Comprehensive Spending Review on health and care?
Response – The PCT Boards had looked at the proposals and were satisfied that they were viable in terms of their financial commitment. However, it was recognised that the modernisation programme had to be delivered against a backdrop of a difficult economic climate, and that some modifications might have to be made in order to ensure its delivery. The financial case would have to be approved by Monitor – the external regulator.

- who would be involved in the monitoring of the transition from inpatient to community based services?
the Sub-Committee of the PCT Boards would oversee the process. The Sub-Committee was chaired by one of the non-executive members of the SCPCT, and they were looking at the possibility of including Council Members/Officers on the group. The Chairman added that the Joint Committee would continue to monitor the situation.

- would there still be a consultant in Whitchurch?
Response – there would still be a consultant for the Whitchurch area, but they would not necessarily be based at the Community Hospital.

What assurances could be given that there were enough trained people available to meet the need for 88 additional staff working in community teams?
Response – a number of staff would move from in-patient settings to community services as part of the re-modelling of services. There were other trained people coming into the area, and the South Staffs & Shropshire Healthcare Trust had not indicated any concerns about potential recruitment problems.

The Chairman reminded Members that the Joint Committee would continue to monitor the modernisation programme. It was also suggested that the minutes of the PCTs' Sub-Committee meetings could be circulated to members of the JHOSC for information.

JHOSC-21 **<u>KEEPING IT IN THE COUNTY – CONSULTATION ON SECURING THE FUTURE OF HOSPITAL SERVICES IN SHROPSHIRE, TELFORD & WREKIN</u>**

Adam Cairns (Chief Executive, Shrewsbury & Telford Hospital NHS Trust), Leigh Griffin (Interim Chief Executive, NHS Telford & Wrekin), Julie Thornby (Shropshire County PCT) and Tim Porter (West Midlands Ambulance Service) were in attendance for this item.

The Chairman reminded the Committee of their role in the consultation process, which was due to end on 14 March 2011, and the duty they then had to examine any final proposals that were agreed by the Trust Boards, including applying the "Lansley tests" that had been set out by the Secretary of State for Health. There was therefore likely to be the need for two further meetings – one to finalise the Committee's response to the consultation document and one to scrutinise any final proposals. The Scrutiny Manager – T&W advised that a briefing note about the process would be circulated to Members.

Adam Cairns then responded to the issues and questions that had been circulated in advance of the meeting. These reflected comments from Members at previous meetings and questions that had been submitted by members of the public.

<u>Maternity and Paediatric Services</u>

There were a number of issues that had arisen during the consultation:

i) the risk to patients resulting from an increase in travel time from a midwifery unit to the proposed consultant-led unit at Princess Royal Hospital (PRH).
Robust plans were in place to manage these situations, and ways were being explored to shorten the time for an ambulance to arrive and get the patient to the PRH. There was a level of risk in the current model of service provision. The safest place for birth was as obstetrics unit, but many women chose to give birth at the midwife-led units. The existing service managed the risk, which could involve travel from the midwife-led units to the consultant-led unit if complications arose during labour. The Trust had experience of managing these risks, and managed them well. One alternative would be not to provide a midwife-led service.

ii) the ability of the proposed paediatric assessment unit at Royal Shrewsbury Hospital (RSH) to deal with cases referred from A&E.
This was currently being tested, and information was being sought from hospitals that already had such arrangements.

iii) provision of acute paediatric surgery at PRH
It was proposed to have a team of four surgeons based at PRH who would carry out the most common procedures (eg appendix). This would be enhanced by having 3 teams of surgeons on call, one of whom would be able

to operate on the acutely ill child. Some reassurance had been provided on this model, which was being considered by the clinical assurance group. The Trust was confident about the proposed transfer arrangement from Shrewsbury to Telford. In the most serious cases, patients were already transferred to Birmingham Children's Hospital.

iv) management of change in paediatric oncology services
While it was proposed to relocate this service to the PRH, it was recognised that local people had contributed to the existing facility at RSH. Service users and staff at the current facility would be asked to help design the new facility.

In terms of the numbers of paediatric beds, there would be no reduction in the number of beds currently provided.

Stroke Services

Views had been expressed during the consultation for a 24-7 service to be provided at both hospital sites. It was hoped that this could be delivered by mid May, through the co-operation of staff and discussions with neighbouring Trusts for the provision of a telecare service.

Vascular Surgery

Considerable efforts had been made to retain the screening programme for aortic aneurysms in Shropshire, and there was a commitment from the Department of Health that the Trust would be in phase 3 of the roll-out of the national screening programme.

In terms of angioplasty procedures and surgery for widening the arteries around the heart, discussions were being held with specialist commissioners about SaTH being able to carry out any planned surgical treatment following an angioplasty procedure. At present, patients had to go to Wolverhampton or Stoke for such treatment.

Development of Clinical Pathways

Work was progressing really well, and clinicians were saying that they had found the exercise valuable in terms of identifying things that could be enhanced now or in the future, irrespective of the outcome of the consultation proposals.

Car Parking and Public Transport

Options were being looked at, and the feasibility of providing a shuttle bus service between the two hospital sites was currently being explored. It was projected that around 200 parking spaces would be lost at the RSH, and around 30 at the PRH, although the latter could probably be replaced.

Adam Cairns also confirmed that the Trust had responded to e-mails/letters received by the Chairmen of the Committee and forwarded to the Hospital Trust.

Members then questioned Mr Cairns on a number of issues :

- What were the capital costs for new maternity provision at either site, and was any additional money available from the Strategic Health Authority (SHA)?
Response – at the PRH site, use could be made of some existing space, and the cost of a package to deliver the provision would be in the region of £25-28m. At the RSH site, the existing maternity building was no longer 'fit for purpose' and would need to be replaced. The cost of this would be around £62m, which was not affordable at the current time. The maternity building at the RSH was a big liability for the Trust, because it was unlikely to meet new Quality standards and could compromise the Trust's move to Foundation status – as the Trust would need to demonstrate that its services were safe and sustainable. There was confidence that the money would be available for the capital works arising from the proposals, although it would be at the outer edge of what could be achieved. The costings for building work had been calculated in line with Department of Health guidelines. It was confirmed that the Trust was confident that the funding from the SHA would be available to support the proposed developments.

- Was "hospital at home" still being considered as part of the paediatric care pathway?
Response – no changes were proposed to the "hospital at home" service, and all of the outpatient services would be provided locally. The average length of stay of a child in hospital was one day.

- What was the timescale for the implementation of the national screening programme for aortic aneurysm screening?
Response – if the Trust was able to proceed, the Phase 3 timeline was October 2012. If it couldn't meet that target, it could go into Phase 4 (which was the final phase of the roll out)

- What opportunities did the West Midlands Regional Trauma Strategy present for SaTH?
Response – Shropshire would not be a regional specialist trauma centre, but it was hoped that the RSH would be designated as a "trauma unit". The PRH would continue to perform as a trauma hospital, but more complex, life-threatening cases would be taken to the RSH.

- what were the risks if these proposals did not go ahead?
Response – The risks had been described in the consultation document. If a solution could not be agreed locally, then the Trust was unlikely to achieve Foundation Trust status on its own, and might have to become part of another Foundation Trust which could then make decisions about services in Shropshire and Telford & Wrekin. Under new arrangements, if the Trust did not get a licence from Monitor (the regulator) to perform certain services, then

these services would cease in the area. The Trust would also have to find efficiencies of 4-5% as part of the £20billion that the NHS had to save nationally.

- what work was being done to ensure there were effective clinical adjacencies under the proposed arrangements?
Response – further work was being undertaken by the clinical pathway groups to ensure that clinical adjacencies were as effective as possible.

- Do the Ambulance Service or Primary Care Trusts have any significant concerns over any elements of the proposals?
Response – Tim Porter advised that WMAS was working closely with the Steering Group on the proposals. There were no significant concerns at this stage. There was likely to be long-term commissioning of ambulance services, so that any requirements would be future-proofed. Leigh Griffin (NHS Telford & Wrekin) and Julie Thornaby (Shropshire County PCT) stated that the PCTs needed to be assured that these proposals were safe and sustainable, and that the consultation process had been robust. Work was continuing with SaTH on minimising any risks, and the most recent work would be considered by the Assurance Panel on 28 February.

The Scrutiny Manager also clarified that if the proposals went ahead, the implementation would take place in different phases. Some services would move location relatively quickly, while others would require further work, eg: outline and full business cases which might need further approval from the relevant Boards.

The Chairman thanked Adam Cairns and Tim Porter for their attendance.

Members then discussed potential dates for their next meetings. The Chairman requested that Committee Members be provided with the Assurance Panel's report before the Committee met to finalise its response to the consultation. It was suggested that Officers, in consultation with the joint Chairmen, prepare a draft response based on the comments and views expressed by members so far. This could then be brought to the next meeting as the starting point for agreeing a final response.

RESOLVED -

(a) that the following meeting dates/times be approved:
- the morning of Friday 11 March 2011, in Shrewsbury – to agree the final response to the consultation proposals;
- the afternoon of Friday 25 March 2011, in Telford – to consider the final proposals for hospital services in Shropshire, Telford & Wrekin (if agreed by the Trust Boards)

(b) that the Scrutiny Officers be authorised, in consultation with the joint Chairmen, to draft a response to the consultation proposals for consideration at the next meeting on 11 March.

JHOSC-22 TRANSFORMING COMMUNITY SERVICES – PROPOSALS FOR A NEW NHS TRUST TO PROVIDE COMMUNITY HEALTH SERVICES FOR SHROPSHIRE, TELFORD & WREKIN

This item was presented by Fran Beck and Julie Thornby (Shropshire County PCT) and Leigh Griffin (NHS Telford & Wrekin), who provided an update on the consultative proposals, which the Committee had broadly supported at their last meeting.

Julie Thornby reported on the outcomes of the public consultation exercise which ran up until Christmas 2010. From the responses and comments received, there was a strong level of support for the proposals to form a new Community Health Trust. The priorities for most people were maintaining access to local services, maintaining the quality of services, ensuring patients' views were heard, and that the services to be provided by the Trust would be "joined-up" with other health and care services/agencies. Dag Saunders (TWC co-opted member) advised that both patient LINks had been involved in the consultation process, and that it was considered that the consultation had targeted the right groups.

Julie Thornby added that Mike Ridley (who had a strong NHS background) had been appointed as the Interim Chair of the new Community Trust for a 12 month period until January 2012.

In terms of next steps, Fran Beck reported that the Business Plan was being revised and updated for submission to the respective PCT Boards and the Strategic Health Authority before going to the Department of Health on 14 March 2011 for final approval. If approved, it was aimed to have the new Trust in place by July 2011. There would be a lot of work to do in the interim, in terms of merging the two current organisations and devising new organisational structures. Leigh Griffin added that they were working closely with the local authorities in terms of effective re-enablement services for people coming out of hospital. In response to a question, it was confirmed that the new Trust would be subject to financial monitoring by the Department of Health.

The Chairman thanked the NHS representatives for their attendance.

RESOLVED - that the position be noted.

The meeting closed at 12.50 pm

Chairman……………………………………

Date……………………………………………

Committee and Date	Item/Paper
Joint Health Overview and Scrutiny Committee 11 March 2011 10:00 am	**5b** Public

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DEVELOPING HEALTH AND HEALTH CARE: RESPONSE TO CONSULTATION

1.0 Summary

1.1 To consider and agree response to the consultation *'Keeping it in the County – Securing the Future of Hospital Services in Shropshire, Telford and Wrekin'* which has been undertaken by Shropshire County Primary Care Trust, Telford and Wrekin NHS and the Shrewsbury and Telford Hospital NHS Trust.

2.0 Recommendation

Members consider and agree final response to consultation attached in draft at Appendix E *to follow*.

REPORT

3.0 Background

3.1 The Joint Health Overview and Scrutiny Committee (JHOSC) met on 8 October 2010 to consider proposals to consult on initial ideas to help to determine the future configuration of hospital services following a clinical problem-solving workshop held on 10 August 2010. After further work, including a second clinical workshop and assessment by an Assurance Panel (attended by the Joint Chairmen as observers) set up by Shropshire Primary Care Trust and NHS Telford & Wrekin, options on which to consult were considered by the JHOSC on 13 December. The interim response of the JHOSC following that meeting is set out at Appendix A.

4.0 Developments to Date

4.1 Since January, the Joint Chairmen have received, considered and responded to a number of communications from the public with regard to loss of Maternity and Paediatric Services at the Royal Shrewsbury Hospital (RSH). Questions and issues raised were forwarded on to SaTH for answers.

4.2 The Joint Chairmen have attended a number of the SaTH and PCT public events, and a seminar for Councillors at Shropshire Council. They have visited both the Maternity Unit at the RSH and the proposed area for Women's and Children's Services at the Princess Royal Hospital (PRH) (notes of the visits are attached at Appendix B). During these visits, they have talked to staff and received information on A&E attendances for children under 16 indicating there was little attendance between 11 pm and 7 am. There have also been discussions with West Midlands Ambulance Service (WMAS) on the 'Make Ready' system. In addition, they have attended seminars and listened to discussions to hear of positive plans for the future in Shropshire of Trauma Care, Vascular Surgery and AAA Screening. Information and evidence was also produced on progress with development of clinical pathways.

5. Assurance Panel

5.1 The Joint Chairmen attended a further meeting of the Assurance Panel on 28 February to observe and assess whether the assurance process has been sufficiently transparent and robust. The report of the Assurance Panel will be made available to the JHOSC.

6 Further Information Requested

6.1 Having assessed all the information that has been made available, a summary of issues identified through the JHOSC process to date is set out at Appendix C. Further clarification and evidence has been requested from SaTH, the PCT, WMAS and the SHA and this is set out in the table at Appendix D.

7. Next Steps

7.1 The Trust Boards will meet during the daytime on Thursday 24 March to consider the outcome of the consultation and proposals put forward. There then follows a meeting of the JHOSC on the evening of 24 March to consider the Trust Boards final decisions and it is at this stage the JHOSC will consider those decisions and whether or not proposals approved by the Trust Boards should be referred to the Secretary of State.

7.2 If the proposals are agreed, the JHOSC have requested plans for implementation and will be monitoring developments and progress.

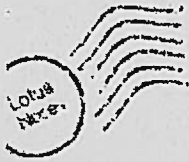
8. Response to Consultation

8.1 In light of information contained in this report and further information to be made available at the meeting, the Joint Committee is asked to consider the draft response to the consultation set out at Appendix E.

8.2 Members may wish to delegate to the Scrutiny Officers, in consultation with the Joint Chairmen, completion of the final response for submission, copied to all Members of the Joint Committee.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) Consultation document *Keeping it in the County*
Human Rights Act Appraisal The recommendations contained in this report are compatible with the provisions of the Human Rights act 1998.
Environmental Appraisal N/A
Risk Management Appraisal Risks associated with proposals have been identified by the Trusts and further work to mitigate is ongoing.
Community / Consultations Appraisal A series of public consultation meetings on he proposals has been held by Shropshire County NHS PCT, Telford and Wrekin NHS and The Shrewsbury and Telford Hospital NHS Trust
Cabinet Member: N/A
Local Member: All Shropshire and Telford and Wrekin Councillors
Appendix Appendix A: Interim response of the Committee - 13 December 2010 Appendix B: Notes of Hospital Visits Appendix C: Summary of Issues identified by the JHOSC process Appendix D: Further information requested. Appendix E: Draft Response to Consultation *to follow*

APPENDIX A



Dianne Dorrell/EXTERNAL/SHROPSHIRE-CC
22/12/2010 11:44

To adam.cairns@sath.nhs.uk, jo.Chambers@shropshirepct.nhs.uk, pam.bickley@telfordpct.nhs.uk
cc fiona.bottrill@telford.gov.uk, Val Beint/COMSER/SHROPSHIRE-CC@SHROPSHIRE-CC, Tom
bcc
Subject Developing Health and Health Care Consultation

Dear Adam, Jo and Pam

Many thanks for your time in joining us at the Joint Health Overview & Scrutiny Committee a week last Monday and on previous occasions with regard to developing health and health care.

The Joint Committee broadly welcome proposals aimed at securing the future of hospital services in Shropshire, Telford and Wrekin and recognise the proposals have been clinically led, and these are not being put forward for financial reasons but are based upon achieving services that are safe, high quality and sustainable long term.

However, the Joint Committee also note that with the proposals, there are new risks to be addressed and that some ideas need to be further worked upon before further assurance can be given. The Joint Committee will therefore be meeting again to consider its final response later in the consultation period when it is hoped that such assurance will be available.

With regard to the consultation, Members were in support of the process subject to comments and suggestions made at the meeting.

Should there be a move to make changes with regard to acute surgery for safety reasons, as discussed at the meeting, before the end of the consultation period, the Joint Committee request that they be notified immediately any such changes are known.

Kind regards

Dianne Dorrell
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APPENDIX B

NOTES OF HOSPITAL VISITS

Notes of Visit to Maternity Unit, RSH – 4 February 2011 (9 am to 12 noon)

Councillors attended:- Gerald Dakin (Shropshire Council), Veronica Fletcher (Telford & Wrekin Council) and Liz Parsons (Shropshire Council)

Also attended: Dianne Dorrell (Scrutiny Officer, Shropshire Council)

The Group met with Adrian Osborne, Head of Communications and Business Development and Sue Ellis, Senior Midwife for a tour of the Maternity Unit at the RSH which was built in 1969.

Neonatal Unit:

- Little space to store of Incubators (stored in one of the parent 'flats', otherwise stored out in corridors) and no onsite cleansing facility for incubators
- Have to have enough cots and incubators but no room to store them
- Staff share one toilet with 4/5 parents
- No neonatal unit currently at PRH, so unwell babies come to the RSH where there are neonatal consultants (There are about 2 or 3 a year)
- Unit was 70% full
- Neonatal Unit important to be retained in Shropshire, otherwise babies sent out of county
- RSH has expertise for very sick babies, using nitric oxide therapy
- 'Hot room' for first assessments was overcrowded with 6 cots
- Doctor was writing up notes outside on a trolley as not enough room in the ward
- 'Treatment Room' cluttered with stored equipment and difficulty to get round
- Has to be a self-sufficient unit as cannot borrow from other hospitals, so much was stored in large cardboard boxes in a storage area at the end of the ward where it was difficult to open up the boxes due to lack of space
- Linen was stored out in the corridor, and the baby clothes cupboard was in cluttered with piles of clothing
- Desk area was full with many using this area
- Cupboards in the Resource Room looked cluttered and this room was also used as a counselling room
- There was a small 'play area' at one end of the corridor that was just a small 'pen' with toys
- Feedback from patients indicates that they were pleased with the service and staffing expertise but the fabric of the building attracts negative comments
- In response to a question "If the unit transfers to the PRH would they have the expertise?" Recruitment and retention is difficult in city areas. Shropshire

differs with a mix of staff from across the county and so it is anticipated there would be no change if the unit moved to the PRH.

- Dr Alison Moore met with the group and expressed concern on the overall proposals for moving paediatric services to the PRH in that the RSH presented a geographical hub covering the north, south and Powys. Midwife-led units in Oswestry, Bridgnorth and Welshpool were only for low-risk deliveries and it was a concern of the RSH paediatricians if the service was moved to PRH
- Overall impression was the cramped conditions and shortage of space
- The Group noted there were triplets born in Liverpool that had transferred back to the unit but twins born in Cambridge could not come back as there was insufficient room which was distressing for the parents

Paediatric Unit

- A CPAP (Continuous Positive Airways Pressure) specialist respiratory machine had been installed 3 years ago, to save children with special respiratory problems going out of county for treatment
- The ward had been fully occupied all winter
- Dr Martin Rees met with the group who spoke of divided views amongst the clinicians, stating there had been a lack of openness and clarity on costings for the move whereby cost dictated acceptance of risks involved and he was concerned for patient safety. His concern was around the impact on babies being transferred by ambulance with a midwife out of hours when there would no longer be a service at the RSH available to assess and stabilize them. He added that Dr Andrew Tapp did not feel that a flying squad arrangement would work.
- There were3 cubicles for oncology. This normally worked well but when full children were treated out in corridors.
- The Rainbow Centre had been added to the Paediatric Ward 4 years ago, via the Lingen Davies charity. There were 2 family units for end of life care
- 25 patients were currently being treated and this number would accumulate as long term follow up care was extended over the next 3 to 5 years
- There were 3 oncology units and when there was an overspill patients were transferred back to paediatric cubicles
- Patients also came from Powys and Hereford
- There was a concern of the staff regarding the need for speed in administering anti-biotics, once diagnosed. Patients admitted in an emergency would need to be assessed and stabilised in a dedicated unit before being transferred on to the PRH, and without this at the RSH, there was concern for patient safety
- There was a multi-disciplinary consulting room which was cramped with lack of privacy
- In the paediatric assessment bay patient notes were being prepared on a bed
- There was one single operating theatre and when full, one of the 12
- delivery rooms was used which clearly provided insufficient space for operating

- There were 3 midwife-led delivery rooms at the end of the corridor
- There were insufficient post natal beds and the midwife-led units could be used if necessary

Basement

- This area flooded during heavy rainfall, flooding up through the drains caused by difficulties with the plumbing systems
- The area was used as a storage holding bay
- If a child needed to go to surgery, there was a 7 – 9 minute journey from the basement along a grimly 'decorated' and dimly lit corridor with exposed ceiling pipe-work and ducting, with water dripping and where flooding and deterioration was evidenced with walls showing water damage.
- Critically ill women were also transported to the main hospital along this corridor where they would pass the mortuary
- There was a storage area for files with a warning on how to protect and store against water damage in plastic crates
- The building did not meet building standards and even with some 'patching' would not last beyond 2020 and there was asbestos in the roof

Meeting with Head of Midwifery

- The Group retired to a 'meeting room' in the basement (where furniture also showed signs of water damage) to meet the Head of Midwifery at Shrewsbury, Cathy Smith who answered a number of questions:-
- 2% of women in Shrewsbury chose to have home births, 10% in Shropshire, and Oswestry was low at around .5% as women preferred the RJAH
- There should be no change in how the proposals will support home births. Women from the Oswestry in the north may prefer to go to Wrexham where there is a consultant obstetric to have Welsh births
- The additional travel time to the PRH will mostly affect those travelling from Oswestry and Ludlow
- There is a need for more midwifes for the welsh catchment area
- There will be 15 additional midwives recruited, 5 now and another 5 in April
- Some neonatal nurses did not want to work at Telford and so there would be a national recruitment programme with risk assessments being put in place should there be a sudden loss of staff
- The Hub and spoke model would continue with the hub moving to Telford and would be a mirror image of what was currently in place, accepting there were complex issues for those patients travelling from further afield. Further details discussions were needed with the Ambulance Service.
- The point was made that many sick children are already sent out of county for treatment but these proposals represented internal moves within county

- Additional Information: Sath had been invited to a meeting in April to join in the next phase of a national AAA screening programme as it was considered a suitable site but only if inpatient vascular surgery was on a single site

Notes from Visit to Princess Royal Hospital 14th February 2011 (2 – 5pm)

Present:
Cllrs. Veronica Fletcher, (Telford and Wrekin) Gerald Dakin part, (Shropshire Council Rosemary Chaplin part (Telford and Wrekin)

Officers: Adrian Osborne (SaTH, Head of Communication and business Development) Frank Hinde part (SaTH Consultant Paediatrician), Jo McMellon part (Children's Ward Manager) Cathy Smith part (Head of Midwifery) Jackie Copson part (Midwife) Chris Needham part (Head of Estates) Dianne Dorrell (Shropshire Council Scrutiny Officer) Fiona Bottrill part (Telford and Wrekin Scrutiny Manager)

Members met Frank Hinde, Jo Mcmellon and Adrian Osborne and were shown offices and consulting rooms in the pre-fabricated building. It was noted that this could be relocated which would create space for new build.

Members were shown the paediatric ward. This is located near accident and emergency and the x-ray department. It was reported that this is important when children are sedated so that the X-ray or scan can be taken before the child starts to 'come round'. It is also important that the ward is close to the theatres located on the floor above – there is good access to this floor from several lifts.

Members were shown a working document that illustrated a model to locate services. This would include a new build on to the maternity unit that would include neonatal services.

It was commented that gynaecology could move as this did not need to be located adjacent to midwifery services.

Paediatric oncology would be relocated on to the PRH site. A commitment has been made to provide services that are as good or better that the facilities at RSH. The ward at PRH would have an outside entrance and play area.

Currently a teacher spends time at both paediatric wards at RSH and PRH. Bringing the inpatient units on to one site would mean that better use can be made of this time. Better use could also be made of the play specialists. It was also commented that it would be good to have an adolescent unit – teenagers who are 16 or 17 can present with complex issues e.g. pregnancy, overdoses and alcohol. The ward currently has an adolescent room with a pool table which is very popular.

On the ward there are 2 bays with 6 beds each. This allows children over 8 to be in a separate bay in the majority of cases. There is a separate treatment room.

There is one high dependency cubical and second can be can. A third high dependency cubical can be made available but staff cover becomes an issue and the number of monitors available.

The ward has been designed and built to recent specifications – there was good storage space and working space for clinicians.

On there ward there are patient toilets and an assisted bathroom with a hoist. Children have access to television from 7am – 7pm free of charge. Parents can pay for the child to have television later but in the evening they use head phones so it does not disturb other patients.

All the cubicles have fold out beds that parents can use.

The larger cubicles at the end of the ward can be used to isolate patients. Children under one are usually isolated or children with infections that may spread. The room can be used to accommodate twins or siblings that both need care.

In total there are 26 bed spaces. Occupancy is labile it can range from 100% to 5%. The number of patients does not always determine how busy the ward is – it is also dependent on the case mix and the staffing cover this requires. PRH paediatrics rarely closes to patients and has been 'on take' for Wolverhampton and Hereford. The issues children and young people present with varies with the seasons. Most children present before 10pm. Figures for the number of resuscitations after 10pm were provided.

It was reported that there is a flexible approach for day patients on the ward but availability of a bed cannot often be confirmed until near the date. It takes less than 5 minutes from the ward to get to the theatres.

If there is an emergency for a child in A&E then a paediatrician can be 'bleeped'

It was confirmed that paramedics can give antibiotics. The paramedics are skilled as stabilising and transporting sick or injured children. It was recognised that the role of the WMAS is crucial in getting children to hospital quickly – the time waiting for an ambulance can be more critical that the travel time in the ambulance. This issue was reflected in the discussions at the recent public meetings on the proposed reconfiguration.

The children's ward does provide opportunities for paediatric training for paramedics – but this has to be balanced with the training needs of nursing staff.

A separate counselling room was available on the ward.

There was some discussion about the hospital at home programme for children. It was recognised that this services is limited and that there are about 35 children receiving this service. The nurse providing this service also does shifts on the ward. The expansion of this service is dependent on funding.

Neonates do not come to the children's ward at PRH – babies under 10 days currently go directly to RSH. Mothers that give birth prematurely are transferred to Shrewsbury before the birth.

Frank Hind and Jo McMellon left and the Members were joined by Chris Needham who showed the options for accommodating the services that would move to PRH under the proposed reconfiguration.

It was explained that the amount of space required was calculated based on the number of beds required and the square meter space this would need. At this stage the plans are still developing and focus on the space and co-location.

It was explained that because of the modern design of the building the some of the services that would be moved could be accommodated in existing buildings. E.g. the Medical Assessment unit if moved could provide 800 square meters of space for paediatric services. There would also be new build which could include neonatology, delivery suites and theatres and the children's oncology. It was explained that the 2 ward currently used for surgery at PRH could be used to accommodate the head and neck services.

Frank Hinde produced a chart for the group on AE attendances for children under 16 which indicated nothing between midnight and 7 am and very little before 9 am

Site Overview

- The Group were conducted to the second floor to give an over view where the planned 2 storey new-build would be sited at the back of the hospital. Existing modular buildings would be re-used/repositioned. The cruciform design would join into other nearby units to maintain all the right flows (theatre, obstetrics, neonates, delivery suite, labour ward and possibly an extra theatre) (a review of theatre scheduling may provide more efficiencies)
- The proposed new design had been costed within the £28M assured budget with a team of healthcare planners under DOH Guidelines on formulae costings for new build
- Procurement 21 Contractors registered nationally for hospital building work would be used with costs guaranteed

Wrekin Midwife Led Maternity Unit

- Situated at the opposite end of building from proposed new build
- Well designed in 2000 to create a feeling of bright open space (was the former laundry)

- There was a large outpatient area to the side
- The Unit had the WANDA Assessment Unit so that mums to be didn't need to travel to RSH
- The Unit included 4 Delivery rooms which were spacious and designed to provide dignity and the Hodnet Post Natal Ward
- There was flexibility in that Labour Ward Delivery Rooms were currently used for check ups but there were closed wards which could reopen to take on extra capacity
- There was much office space for midwives and a utility room
- If faced with the need for urgent caesarean operation, mothers in Telford faced travel time issues in travelling to RSH
- There were around 5000 births in Shropshire and around 1/5 of these were at MLU's, the largest being Telford at around 500 (where half of the MLU births were) closely followed by Shrewsbury. Births at Ludlow and Bridgnorth varied, and Oswestry was the quietest unit. There could be a lot more at Telford but many women preferred to give birth in the consultant led unit at RSH.
- 4/5 of births took place in consultant led units
- Around 20% of mums needed to go to a consultant led unit
- Some premature babies at PRH go out of county as there were no neonatal cots
- A shuttle bus service was being costed up between sites and there was much support from staff for this
- Discussions would be taking place to improve signage to the PRH

The Joint Chairmen wish to thank Adrian Osborne, Sue Ellis, Penny Taylor, Jackie Hyne, Cathy Smith, Martin Rees, Alison Moore, Frank Hinde, Jo McMellon, Jackie Copson, Chris Needham and other staff they spoke to at both hospitals for their time.

APPENDIX C

Issues Identified by Joint HOSC on 'CURRENT' Model Service Provision

Issue identified	Risk Type (Current or anticipated)					Evidence received
	Clinical	Patient Access	Finance	Estate	Sustainability of services	
Condition of maternity building at RSH	✓			✓	✓	Joint HOSC meeting 08.10.10 Consultation document Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Joint HOSC 11.02.11
One obstetric theatre at RHS	✓				✓	Consultation document Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Joint HOSC 11.02.11
Acute surgery work	✓				✓	Joint HOSC meeting 08.10.10 Consultation document Joint HOSC meeting 11.02.11
Covering rotas at 2 sites	✓				✓	Joint HOSC meeting 08.10.10 Consultation document Joint HOSC meeting 13.12.10
Early specialist training for doctors	✓				✓	Joint HOSC meeting 08.10.10 Consultation document
Achieving Foundation Trust Status	✓	✓	✓	✓	✓	Joint HOSC meeting 08.10.10 Consultation document

						Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Joint HOSC 11.02.11
Maintaining provision of services within the County	✓	✓	✓	✓	✓	Joint HOSC meeting 08.10.10 Consultation document Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Joint HOSC meeting 11.02.11
Difficulty in recruiting doctors	✓				✓	Joint HOSC meeting 08.10.10 Joint HOSC meeting 13.12.10

APPENDIX C

Issues Identified by Joint HOSC on 'PROPOSED' Model Service Provision

Issue identified	Risk Type or Opportunity (Current or anticipated)					Evidence received
	Clinical	Patient Access	Finance	Estate	Sustainability of services	
Guidance from Royal college of Surgeons on surgery and paediatrics	✓	✓			✓	Requested
Increased travel time from west and south for consultant led maternity services	✓	✓				Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Visit to PRH maternity and paediatric service Joint HOSC 11.02.11
Increased travel time from south and west for paediatric services	✓	✓				Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Visit to PRH maternity and paediatric service Joint HOSC 11.02.11
Transfer of sick or ill children between sites (paediatrics and neonates)	✓					Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Visit to PRH maternity and paediatric service Joint HOSC meeting 11.02.11
Development of robust clinical pathways	✓	✓			✓	Joint HOSC meeting 13.12.10 Visit to RHS maternity and paediatric service Visit to PRH maternity and paediatric service Joint HOSC 11.02.11

						Information requested following Assurance Panel
Maintaining paediatric beds in proposed reconfiguration	✓					Joint HOSC 11.02.11
Future of the Rainbow Unit / children's oncology	✓	✓	✓			Joint HOSC 11.02.11 Visit to RHS maternity and paediatric service Visit to PRH maternity and paediatric service
How have the concerns of clinicians been taken into account	✓					Joint HOSC 11.02.11
Why building a new hospital has been rules out as an option			✓	✓		Information attached as Response to Question 2
Cost of rebuild at RSH compared to PRH			✓	✓		Information requested
Ensuring the proposed reconfiguration is sustainable along site the development of the Community Foundation Trust					✓	Information requested
Role of the WMAS in reducing time to get to hospital and transfers between sites	✓	✓	✓			Joint HOSC 11.02.11 Additional information requested on Make Ready system
Additional cost of transfers			✓			Information requested
Securing finance for new build and revenue costs			✓			Joint HOSC meeting 13.12.10 Joint HOSC meeting 11.02.11

APPENDIX C

Access to PRH by public transport		✓				Joint HOSC meeting 11.02.11 Additional information requested
Car parking at PRH		✓	✓	✓		Joint HOSC meeting 11.02.11 Additional information requested
Information on phases of implementation	✓					Information requested
Informing public and patients about change to services		✓				Information requested
Delivery of AAA screening	✓	✓				Joint HOSC meeting 11.02.11
Improved stroke services on both sites	✓	✓				Joint HOSC meeting 11.02.11
Improved opportunities for training and recruitment					✓	Joint HOSC meeting 08.10.10 Joint HOSC meeting 13.12.10 Joint HOSC meeting 11.02.11

APPENDIX D

Information Requested by the Joint HOSC for Meeting on March 11th 2011

	Evidence requested	Evidence from
1) Clarification on the Royal College of Surgeon's guidance 'children's surgery a first class service' (2006) which sets out that trauma and pediatric services should be on the same site. What status does this guidance have?	Copy of the recent correspondence from the Royal College of Surgeons on this matter and Tony Fox's view on this	SaTH Strategic Health Authority
2) Clarification on why selling both sites and building a new hospital is not an option.	Written response prior to meeting	Strategic Health Authority PCTs SaTH
3) Details of the costings for the building work options to develop the sites at RSH and PRH. What documents were used to support the calculations for the facilities needed and the cost for this work? Have these been applied equally to both sites?	Written response prior to meeting	SaTH
4) Ensuring that the role of primary and community services are taken into account in the proposed reconfiguration - e.g. the development of hospital at home for children.	Written response prior to meeting	PCTs Community Trust
5) If agreed, how will the implementation of this proposal support ongoing work to support PCTs and GP commissioners to avoid unnecessary hospital admissions?	Written response prior to meeting	PCTs SaTH Community Trust
6) Can the PCT, SaTH and Community Trust assure the Committee that the proposed reconfiguration of services will be sustainable at both sites if more	Written response prior to meeting	PCT SaTH

patients are treated in the community? Does the calculations take account of demographic changes?		Community Trust
7) What proportion of women who start their labour at a midwife led unit are transferred to a consultant led unit for the birth?	Written response prior to meeting	SaTH
8) How many of the 326 births in the Consultant led unit to women in the Powys Health Board area were elective or emergency?	Written response prior to meeting	SaTH
9) What discussions are taking place with other acute trusts outside Shropshire to develop care pathways to access services in emergency situations?	Written response prior to meeting	SaTH WMAS PCTs
10) Information on the care pathways and assurance of the clinical safety for maternity, acute surgery and pediatric services.	Written response prior to meeting	SaTH WMAS
11) How will the WMAS plans for the Make Ready system support the implementation of these proposals?	Presentation at meeting 11th March	WMAS
12) Clarification of any additional costs identified by the WMAS in relation to increased demand for transfers and increased journey times. This should include the cost and time required to train additional paramedics required.	Written response prior to meeting	WMAS
13) Are there any other options to mitigate risks that have been identified during the consultation process? Do these options involve additional costs and if so how will these costs be covered?	Written response prior to meeting	SaTH PCTs
14) Confirmation that transport arrangements between sites for patients, visitors and staff will be established as soon as services move between sites. What are the proposals to improve transport e.g. working with public transport providers,	Written response prior to meeting	SaTH Local Authorities

developing existing volunteer driver schemes.		
15) Do the proposals include increasing the number of car parking spaces at PRH and if so have these costs been included?	Written response prior to meeting	SaTH
16) Has the Trust come to a view on feasibility of the ideas set out in the consultation documents for: • Shuttle bus • Maternity flying squad • Night air ambulance • Telemedicine	Written response prior to meeting	SaTH
17) Clarification on the stages in which the proposed changes would be implemented and commitment to give regular updates and ongoing engagement with the Joint HOSC and other stakeholders.	Written response prior to meeting	SaTH
18) Information on how the changes if agreed will be communicated to the public, patients and other service providers.	Written response prior to meeting	SaTH PCTs

Shropshire County Primary Care Trust NHS

NHS Telford and Wrekin

LOCAL ASSURANCE PANEL

28th FEBRUARY 2011

FINAL REPORT:

Assessment of 'Keeping It In The County' proposals from The Shrewsbury and Telford Hospitals NHS Trust to reconfigure acute services

Introduction

The establishment of a local Assurance Process was agreed by the Boards of three local NHS organisations (both PCTs and The Shrewsbury and Telford Hospitals NHS Trust) in order to enable the PCTs, advised by independent experts, to test the clinical proposals put forward for acute hospital reconfiguration by local clinicians. In particular the local Assurance Panel was convened to assure the two PCT Boards for Shropshire County and NHS Telford and Wrekin and key stakeholders, that the proposals put forward by The Shrewsbury and Telford Hospitals NHS Trust, to reconfigure acute services across two hospital sites, met the four "Lansley tests" set by the Secretary of State:

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

National guidance on the 'Lansley tests' requires NHS commissioners to apply a 'test of reasonableness' when assessing whether the tests have been met, which considers a balance of evidence and stakeholder views in support of a substantial service change. (Source: Department of Health Gateway Reference 14543)

In addition the Panel was also tasked with providing assurance that four additional local criteria, agreed by the Boards of Shropshire County PCT and NHS Telford and Wrekin were also met:

- The proposals need to be clinically safe
- The proposals need to be robust and sustainable
- The proposals need to be financially viable and affordable
- They also need to meet the requirements of the "Lansley tests" – as set out above

The proposals that have been formally consulted upon, and which the Assurance Panel assessed, are:

- The establishment of a Women's and Children's Centre of Excellence on the Princess Royal Hospital (PRH) site:
    - The Obstetric Unit would move from the Royal Shrewsbury Hospital (RSH) to the Princess Royal Hospital (PRH). Midwifery Led Units would remain on both sites
    - All women would receive their antenatal and postnatal care at the same location as now
    - The Neonatal Intensive Care Unit would move from RSH to PRH and be co-located within the Women's and Children's Centre
    - Consolidation of inpatient gynaecology onto a single site at PRH
    - Consolidation of inpatient paediatrics onto a single site at PRH
    - Consolidation of inpatient paediatrics onto a single site at PRH with enhanced assessment units at both sites

- The maintenance of breast surgery at the PRH site
- Head and neck services transferred from RSH to PRH due to the high level of paediatric activity
- The consolidation of acute inpatient general surgery onto the RSH site
- The maintenance of an Accident and Emergency (A&E) service on both sites. Major trauma would continue to be seen at RSH. Long bone trauma would be seen in both A&Es
- All urgent medical cases (e.g. strokes, heart attacks and serious chest infections) would continue to be supported on the same hospital sites as present
- Most outpatients would continue to be seen at the same hospital as now
- Most patients being treated as day cases would go to the same hospital as now.

Background

The re-launch of work to secure high quality, safe and sustainable hospital services for Shropshire, Telford and Wrekin began on 10 August 2010 with a clinical problem-solving workshop. This event was attended by primary and secondary care clinicians, from Shropshire, Telford and Wrekin and Montgomeryshire and generated initial ideas to help determine the future configuration of hospital services.

A report on this workshop was produced, made available at:
http://www.ournhsinshropshireandtelford.nhs.uk/Library/Documents/Publications/Clinical%20Problem%20Solving%20Workshop%2010%2008%2010.pdf
and circulated to staff and other key stakeholders. Feedback was requested on the suggestions in the document by 12 November 2010.

Following the first workshop, various discussions also took place with staff and other stakeholders and any feedback given was incorporated into the proposals going forward. In addition to NHS organisations, the key stakeholders involved included clinical staff, the public and patients, local councils and politicians.

Two public workshops took place on 5 and 10 November 2010. Members of the public and patients who had been involved with the project previously or who had expressed an interest in being involved were invited to consider the proposals from the first clinical problem-solving workshop and the subsequent feedback received.

A second clinical problem-solving workshop took place on 17 November, with the same clinicians invited as to the first clinical problem-solving workshop. The purpose of this second meeting was to review the initial proposals and any new ones, based on the feedback received from clinical staff, members of the public and patients and other stakeholders following the first meeting and to formulate a more robust proposal to go forward to the next stage of the process – the Assurance Panel and then public consultation.

The two day Assurance Panel was held on 22/23 November. The Panel supported the proposals in principle, and found all of the Lansley tests were met except for part of one test, which reflected the Panel’s wish to have further information about clinical pathways and risks. A presentation of the Panel’s findings from the 22/23 November

event, including the areas on which the Panel requested further assurance for its meeting in February 2011, is available at:
http://www.sath.nhs.uk/Library/Documents/News/Presentations/101202-Assurance%20Presentation.pdf

As a consequence a second Assurance Panel was convened on 28 February 2011 to consider further information with a view to providing full assurance to the Boards of the two PCTs and key stakeholders.

Assurance Panel Composition

The composition of the Assurance Panel event held in February 2011 included:

Paul Beard, OBE - external independent chair
Caron Morton - Shropshire County GP, Chair of Shropshire County PCT Professional Executive Committee and Chair of the Transition Board of Shropshire County PCT (developing Shropshire County GP Commissioning Consortium)
Liz Fennelly – Shropshire County GP
Mike Innes - Telford and Wrekin GP, Chair of NHS Telford and Wrekin Professional Executive Committee
Matthew Whitcombe – Telford and Wrekin GP
Andrew Raynsford - Powys GP
Tony Wilson - Patient/public representative from CInCH – The Shropshire Local Involvement Network (LINk)
David Supple - Patient/public representative from Telford & Wrekin LINk
Derek Smith - Representative of Montgomery Community Health Council
William Hutton - Non-Executive Director of Shropshire County PCT
John Snell - Non-Executive Director of NHS Telford and Wrekin
Paul Tulley - Director of Commissioning of Shropshire County PCT
Steven Jarman Davies - Director of Commissioning Intelligence of NHS Telford and Wrekin
Rod Thomson - Director of Public Health of Shropshire County PCT
Jo Leahy - Acting Medical Director of NHS Telford and Wrekin
Nick Henry - Representative from West Midlands Ambulance Service (WMAS)

External Clinicians:

Lisa Kauffmann - Consultant Paediatrician, Clinical Director Children's Services Manchester PCT
Moya Sutton – Executive Nurse, Alder Hey Children's NHS Foundation Trust
Helen Scholefield - Consultant Obstetrician and a member of the Royal College of Obstetricians and Gynaecologists Committee for Quality and Safety and Chair of The Royal College of Anaesthetists Maternal Critical Care Committee

A representative of the Powys Local Health Board (LHB) was also invited to take part as a Panel member at both the November and February meetings, but unfortunately no one was available to attend either event.

In addition to the Panel, and to add transparency to the Panel process, two representatives from the Joint Health Overview and Scrutiny Committee (made up of backbench councillors from Shropshire Council and Telford and Wrekin Council) were invited to observe the process:

Councillor Tracy Huffer (Shropshire Council)
Councillor Veronica Fletcher (Telford and Wrekin Council)

In addition the Joint Health Overview and Scrutiny Committee's supporting officers were invited to attend to observe the process:

Dianne Dorrell – Shropshire Council
Fiona Bottrill – Telford and Wrekin Council
Stephanie Jones – Telford and Wrekin Council

Three members of the public, who had taken part in the patient workshops held prior to public consultation, were also invited as observers.

Assurance Panel Approach

At the Assurance Panel held on 22/23 November 2010, the Panel was unable to give full assurance and therefore requested further information to be provided by The Shrewsbury and Telford Hospital NHS Trust for consideration at an additional Panel day held on 28 February 2011. This further information included:

- Information about clinical risk mitigation for the proposed configuration
- Information on the paediatric pathway detailing the work of the Paediatric Assessment Unit and the nature of the cross site cover
- Information on arrangements for anaesthetics, Intensive Therapy Unit (ITU) and Ear Nose and Throat (ENT)
- Outcomes of discussions with hospital clinicians who have expressed concerns regarding the clinical and service risks associated with the proposals
- Information about mitigating concerns about increased travel time
- Information on the financial analysis underpinning the proposals
- Information on workforce planning

The Panel day on 28 February 2011 was structured to allow the Panel to discuss with invited attendees, information related to the areas that it had been unable to give full assurance on at the last event. In addition the Panel considered the main themes raised by individuals and organisations during the public consultation, so that Panel enquiries to seek assurance, would be informed by issues raised by the wider community of stakeholders. With this in mind, the Panel:

- Received information on responses sent to date through the public consultation, presented by the external company commissioned to analyse the consultation feedback and provide a report to local NHS Boards

- Received representations from individuals nominated by the local authorities for Shropshire, Telford and Wrekin and Powys respectively. The nominees comprised; elected members, council officers and a member of the public from the three areas, who set out the views and concerns of their respective populations about the proposals

Those attending to provide information to the Panel included:

- External contractor undertaking an independent external analysis of the public consultation responses on behalf the two PCTs
- Clinicians from The Shrewsbury and Telford Hospitals NHS Trust representing paediatrics, A&E, surgery, obstetrics and gynaecology, midwifery and neonatology
- Non clinical staff from The Shrewsbury and Telford Hospitals NHS Trust representing finance, workforce and estates
- Clinicians from Calderdale and Huddersfield NHS Foundation Trust, with particular experience in configuring paediatric and neonatology services between hospital sites

The Panel agreed that in providing assurance on the key tests they would take an evidence based approach, balancing the risks in the proposed model against the risks in the current model which the Panel had received information about and discussed at its November meeting.

Information and Evidence Heard by the Panel

Public Consultation Responses

The Assurance Panel received a presentation from the external company commissioned by the PCTs to provide a report of the consultation responses. The company provided some initial analysis of the consultation responses received to date. This information came with a warning that it was only a snapshot and that as the public consultation had not finished, this did not represent the final analysis. A summary of some of the main themes emerging so far was:

- There was a clear demarcation in responses to the consultation on the overall proposal, proposals on maternity services and inpatient paediatric services. Those responding from a Telford postcode were in the main supportive whilst those responding from Welsh, west Shropshire and Shrewsbury postcodes were generally opposed or strongly opposed. (The Panel noted that some of the respondents with Telford postcodes may be residents within the Shropshire County area).
- Those responding raised concerns about increased travel time for children and babies, resulting risks, and the impact it would have on other members of the

family and accessibility of services via public transport. Concerns were also raised about transfers during labour and after labour.

- Fewer respondents had expressed views on the proposed changes to acute surgery. The concerns raised in the responses around these services included travel time for those living in rural areas, concerns about surgeons not being available and capacity of the proposed site to support larger number of patients accessing services on one site.
- Fewer respondents had expressed views on the proposed changes to urology and stroke services. Concerns raised included the need for stroke services to be within travelling time of one hour and that rehabilitation services are accessible within the community.

Representations from Elected Members, Members of the Public and Council Officers

The following summarises some of the main concerns and issues raised on behalf of residents of Powys:

- The significant increase in travelling time for Powys residents if services are moved to Telford and the concerns that this will result in an increase in clinical risk
- The adequacy of the Welsh Ambulance Service to provide capacity to absorb extra travelling time in an already stretched service
- Powys is a large geographical area and there is no alternative District General Hospital in Powys that residents can access as an alternative to The Shrewsbury and Telford Hospital NHS Trust
- There appears to be a lack of consultation with the key stakeholders in Powys: Welsh Ambulance Trust, Powys Health Board and Powys County Council Cabinet Members. (It was clarified that The Shrewsbury and Telford Hospital NHS Trust had had discussions with these bodies and that the Powys Local Health Board had been invited to be part of the Assurance Panel on both occasions but had not been able to send a nominee)

The following summarises some of the main concerns and issues raised on behalf of residents of Shropshire**:**

- Recognise that the status quo is not sustainable
- Concerned about increased travel time for seriously ill children
- Need for provision of services to allow parents to stay overnight with admitted children
- Is capital funding secured and sufficient to fund proposals?
- Does moving services to Telford increase the risk of services being lost to existing foundation trusts outside the county?
- Parking capacity at PRH
- What is the sequencing of changes to surgical services?
- The loss of legacy of the Rainbow Unit to RSH site, for which substantial funds were raised by the public on the understanding that it would support a facility in Shrewsbury, and reduce the need for further travel

The following summarises some of the main concerns and issues raised on behalf of residents of Telford and Wrekin**:**

- Recognise that hospital services need to be kept in Shropshire
- The current proposals appear to provide an equitable split of services across both hospital sites and would allow the hospital to gain foundation trust status by 2014
- There is a danger that if proposals do not go ahead that services could be lost outside the county
- Concerns that the split of services being proposed is sustainable in the long term
- Assurance of the Royal College of Surgeons on changes to the services has been sought
- Concerns on travelling time for those living in the east of the county particularly in rural areas

Clinical Sustainability - Overview

The Assurance Panel received a presentation and a letter from the Chief Executive of The Shrewsbury and Telford Hospitals NHS Trust which was followed by a discussion to clarify some issues. The following evidence was noted by the Panel:

- National Clinical Advisory Team (NCAT) undertook a review of the proposals in December 2010, prior to public consultation beginning. The team's conclusion was that the proposal is logical and could deliver safer and more sustainable services in Shropshire and mid Wales. However, they did note that further work was required on defining pathways, identifying current risks and new ones associated with the proposals, developing solutions between clinicians stakeholders and patients, ensuring that travel plans are robust and that testing of procedures and training has been carried out. NCAT believe that all the four "Lansley Tests" were met.
- The results of a condition survey of the Maternity Department at the RSH site were shared with the Panel. The report was dated May 2007 and clearly illustrated the expected life span of the building to be five to ten years maximum, at which point the building would need to be decommissioned before patient safety was put at risk.
- A briefing by Capsticks solicitors on the impact of the new Health Bill on the NHS was shared with the Panel. This illustrated the challenge facing the Trust in the new regime that will require all NHS trusts to become foundation trusts by 2014. The regime will remove the support the NHS has historically provided to trusts that do not have a balanced financial position so they will be treated as any other private provider i.e. if not financially viable they will be allowed to fail. Without a solution to the liability for rebuilding cost for the maternity unit at Shrewsbury, it is unlikely that the Trust would become a Foundation Trust. Potentially this could mean that if the Trust does not become a Foundation Trust by 2014, services would be transferred to other Foundation Trusts to deliver, thus services could be provided by out of county providers.

- A high level financial assessment of the proposals has been completed, but the more detailed information appropriate for an outline business case could only be determined by the final decision on the pattern of services. It was clear that while a £62m capital scheme could not be afforded, one at £28m could be.
- A concern raised by local Shrewsbury-based consultant paediatricians was about the availability of surgeons to deal effectively with children at PRH, where the Inpatient Paediatric Unit would be based, when the base for most surgery would predominantly be RSH. In fact, the types of surgery carried out on children locally were relatively limited, with more complex surgical cases already being treated out of county. Also the local consultant surgeons had developed a robust proposal whereby the breast surgeons at PRH would provide an on call surgery service for children at PRH. Dual expertise for surgeons in breast and children's surgery was not uncommon, given the tendency for women's and children's services to be co-located.
- The Trust's view was that there was no evidence of the need for significant numbers of additional consultants to staff the proposed configuration in paediatrics.

As part of the presentation, the Medical Director and Director for Nursing from Calderdale and Huddersfield NHS Foundation Trust presented their experience of a very similar reconfiguration of paediatric and neonatology services they undertook two years ago. The following evidence was noted by the Panel:

- Two district general hospitals 5.5 miles apart, although road congestion means travel time is relatively much longer than the distance would suggest
- The Trust faced similar drivers for change to those stated by SaTH (The Shrewsbury and Telford Hospitals NHS Trust), in terms of; unsustainable clinical safety due to two sites duplicating two sets of rotas for maternity, neonatal units and paediatric units, and also experiencing difficulties in recruitment of clinical staff
- Proposals to change services caused public outcry and significant clinical opposition
- Following reconfiguration, there is now one maternity unit providing 78 hours of continuous consultant cover per week plus on call support, one neonatal unit with consultant neonatologists available 45 hours a week and always on call, two midwife led units and the ability to provide outreach work for women who would not normally access maternity services prior to birth
- Following reconfiguration there is one paediatric unit with a minimum of 45 hours cover, and one paediatric assessment unit which is nurse led. They have not experienced recruitment problems since reconfiguration, there are always two consultants available and they have been able to develop sub-speciality services across the Trust
- Evidence that changes have resulted in improvements in safety of care in relation to reductions in still births, caesarean rates and neonatal mortality
- Despite reductions in trainee consultant numbers expected in the future the reconfiguration has helped to future proof the Trust from this impact

In discussion with the Panel, the following points were clarified by the Chief Executive of SaTH:

- In terms of readiness to have in place nurse practitioners suitable to staff a Paediatric Assessment Unit, there would be a year of planning/development time to achieve this if the proposals go ahead

- Transfers of sick children from one hospital to another take place regularly when they are moved to Birmingham etc. The Trust was clear on the arrangements needed to manage transfers including specific protocols, staff training, and risk assessment of each case, with the paediatrician moving to the patient if transfer of the patient was not appropriate at that time.

In discussion with the Panel, the following points were clarified with the clinicians from Calderdale and Huddersfield NHS Foundation Trust:

- Acute surgery and inpatient paediatrics are not on the same hospital sites in Calderdale

In addition to the evidence presented by the Chief Executive of SaTH and clinicians from Calderdale and Huddersfield NHS Foundation Trust, the Panel also received documented clinical pathways, together with commentary on the risk mitigation, for the changes in services that will affect particular groups of patients:

- Maternity and Gynaecology
- Midwifery
- Neonatology
- Children's services
- Surgery

The Panel invited clinicians from SaTH to attend the event to provide clarity on points arising from the evidence above and also on issues raised in letters circulated to the Panel from GPs and clinicians within SaTH that had been received by Panel members. These points of clarity are documented for each pathway below.

The Panel noted that the clinical pathways presented to the Panel have all been agreed and signed off by three clinical working groups, involving clinicians who are supportive of the changes and those that have significant concerns. The clinical pathways have all been developed to minimise, as far as possible, the negative impact a change would have on patients. This involves on-call and cross site cover, clear demarcation of who should do what and when and the routes which ambulances should take in an emergency.

<u>Clinical Sustainability – Maternity Including Neonates</u>

- The Panel noted that the Maternity pathway had been agreed and signed off by consultant obstetric and gynaecologists and consultant neonatologists. (Note also the final point under this heading.)

- In relation to the concerns which National Clinical Advisory Team (NCAT) identified and had been flagged by the SaTH consultants as needing to be addressed, about a sick newborn presenting at RSH or other sites and the mother in labour and in difficulty at remote locations from the obstetric unit including RSH, the Panel noted the following:
  - The midwifery pathways have been agreed by clinical staff and these pathways currently exist now for women and babies at the Telford, Oswestry, Ludlow and Bridgnorth Midwife Led Units
  - Further training in advanced life support for midwives in the Midwife Led Units is planned irrespective of reconfiguration
  - The transfer incubator and equipment currently at PRH would move to RSH
  - WMAS have been part of all pathway discussions and the Trust reported to the Panel that WMAS support the proposed pathways. Both WMAS and WAS have identified the need for further discussions regarding the challenge on their resources should the Neonatal Unit move to PRH due to increased turnaround time
  - Further training will be required for midwives in Powys. Discussions regarding the maternity service in Wales would need to reflect current work led by the Welsh Assembly for maternity and neonatal care. SaTH officers are in discussions with Welsh colleagues to understand the links, interdependencies and issues as this develops
- In relation to the concerns which NCAT identified had been flagged by SaTH consultants as needing to be addressed, about women with undifferentiated lower abdominal pain, the Panel noted the following:
  - The pathway has been agreed and has the support of surgeons. Women will access services at both sites. A set of investigations will determine the nature of their abdominal pain. Women with gynaecological pathology will be cared for and treated at PRH. Women with surgical pathology will be cared for at RSH. GP triage and establishing whether a woman is pregnant or not have been identified as key elements to getting patients to the right hospital first time. Life saving interventions will be undertaken at both sites.
- In relation to the risk articulated through public consultation about distance and transport for some patients and their families especially for those from Wales and north and west Shropshire, the Panel noted the following:
  - Low risk pregnant women will still be able to have their babies at home or their nearest Midwife Led Unit. The elements of the pathway remain unchanged (except for location) in terms of what would happen if complications arose. Women who deliver at the Consultant Led Unit (due to being high risk or transferring in) would continue to be able to return to their nearest Midwife Led Unit for their postnatal care, as soon as they are able, as now. The new Women's and Children's Unit at PRH would have improved; fit for purpose facilities, for fathers and families with accommodation should this also be required
- In relation to the risk highlighted through public consultation on safety and impact of additional travel time in an emergency for mother and baby, the Panel noted the following:
  - The Panel were asked to note that the systems for managing longer travel times for women at all stages of pregnancy and birth than those proposed as part of this reconfiguration, are already in place. The early identification and management of risk is part of all clinicians' current practice and is documented

in the future pathways. The Trust stated that the Ambulance Services is committed to working with the Trust in exploring ways of reducing the overall pre-hospital journey. The Trust recognised and was committed to providing additional training, support and education required to help alleviate some of the anxieties that midwives have around increased travel time

- The Trust stated that the midwifery guidelines in place in Powys already anticipate transfer times greater than those proposed in the reconfiguration proposals
- The Trust has reviewed the literature available on this subject which is not extensive. The Clinical Director of Women's and Children's Services at the Trust, advised the Panel regarding a recent Dutch study (ACJ Ravelli et al 2011) that considered the potential impact of travel time for this group of patients. It was reported that whilst the Dutch and UK health systems were similar, maternity/obstetric services in the community and hospitals had significant differences. In his view this limited the transferability of its findings to the UK. However, the report did show that longer travel times for higher risk patients could be a factor in terms of adverse outcomes, and that travel times under 20 minutes are associated with fewer adverse outcomes.
- The authors of the study accept that the association between travel time and outcome may not be causal and feel that further research is needed and that travel time should be a factor looked at when adverse events happen. The authors also recognise that other studies have not come to the same conclusion that travel time itself is an independent risk for adverse pregnancy outcomes. However they do feel that their study can be used in health care planning particularly in the rural setting.
- The Trust has reviewed findings from the analysis of travel times, which suggests that when comparing the consultant deliveries population for 2008-2010, if all patients were to have travelled to RSH for delivery, 24.18% of patients would have arrived at RSH within 20 minutes and 98.67% would have arrived within 60 minutes. In comparison, if the delivery population had travelled to PRH, 37.06% would have arrived at PRH within 20 minutes and 93.71% would have arrived within 60 minutes. This means that an additional 12.88% of patients would benefit from a travel time shorter than 20 minutes, whereas an additional 4.96% would travel longer than 60 minutes. The exact nature and extent of this potential benefit of shorter travel times for the 12.88% of this group and the potential increased risk for the 4.96% are not known.
- The Trust believes, based upon clinical advice, that there is no evidence in the Dutch study that more patients could come to harm overall from the proposals.
- The Trust highlighted that total time travelled includes, not only the time in a vehicle, but also the time waiting for the ambulance etc. It is important therefore to look at how the waiting time for patients can be compressed and both the Trust and Ambulance Services are in discussions on how this may be achieved.
- The Ambulance Service also intends to increase paramedic skill mix from 50% to 70% which will result in a paramedic being deployed with every vehicle.
- The Ambulance Service is currently modelling the overall impact of service change on the numbers of transfers; however the Trust does not expect this to be material because patient flows already require a significant number of transfers between sites and reconfiguring services will simply redistribute these journeys on a more rational basis.

- o The Trust does acknowledge that for the Welsh Ambulance Service, the issue is about the small number of vehicles currently on station and that any additional journeys to PRH could cause further logistical issues for the delivery of their service. The Trust is supportive of discussions with the Welsh Assembly Government around improving access to the population of Powys which is taking place outside of discussions around reconfiguration of services.
- o The Trust has involved anaesthetists in all of the pathway design groups and plans to deploy anaesthetists across both sites under the reconfiguration proposals, providing training on maternity care for consultant anaesthetists with a three year window to allow this to take place.
- o All four consultant neonatologists based at SaTH have in their professional opinion serious concerns that the increased travel time may have significant detriment to neonatal cases transferred from the west of the county. Maternity services will be denuded of midwife cover while they are accompanying transfers. The numbers of neonates needing transfer from Midwife Led Units is relatively small, approximately 1-3%, but there are greater numbers of mothers who may need transfer whilst in labour. The consultant neonatologists believe that the Dutch study cited above, does not provide evidence specifically on the impact of travel on a neonate in difficulty, but they did not provide any alternative or additional studies or evidence on this.
- o The consultant neonatologists also believe, in their professional opinion, that a change of location to PRH will put the viability of the service at risk as geographically it will be nearer to other maternity centres like Wolverhampton which delivers the same services and weakens the ability of the Trust to attract trainees in the future. The Panel did not receive evidence to support this opinion. However, in discussions initiated by the Trust, the Director of Specialised Commissioning, which commissions the neonatology service, has emphatically stated that there are no plans to merge the Wolverhampton and Shropshire units.
- o The consultant neonatologist present at the Panel event recognised that the current state of the environment in the maternity building creates risks in the current services for patients, but did not know how this might be addressed.
- o The consultant neonatologists have stated that they believe that the proposal is the wrong solution, but have agreed the maternity and neonatology pathways if the model goes ahead.

Clinical Sustainability – Acute Surgery

- The Panel noted that the acute surgery pathways had been agreed and signed off by surgeons at both sites.
- In relation to concerns which NCAT identified that had been flagged by SaTH clinicians in relation to the child with an acute surgical problem, the Panel noted the following:
  - o Most specialised children's surgery is carried out in centres such as Birmingham and Liverpool.
  - o The majority of children with an acute surgical problem will be transferred from the Paediatric Assessment Units (PAU) at both sites to the inpatient unit at PRH. The vast majority of serious paediatric surgery cases are already transferred to Birmingham. It is proposed that the breast surgeons, who will be

based at PRH, will form an exclusive on-call rota for children's surgery. Increasing numbers of surgeons in training are specialising in both breast and paediatric surgery (as these services now tend to be co-located on the same hospital sites for women's and children's services) and it is hoped that a re-configured service would attract these specialists to Shropshire. The surgeons who currently focus on children's surgery do have the skills, training and experience to operate on children with good clinical outcomes and high quality care. This is a good opportunity to sustain the service and help keep routine children's surgery in Shropshire rather than going outside to regional centres.

- In relation to the inconvenience and risks identified through public consultation from distance and transport of patients and visitors from Telford and south-east Shropshire, the Panel noted the following:
    - The additional distance some patients will need to travel is acknowledged. Shuttle buses would operate between sites for both patients and visitors. Most day case procedures and outpatients appointments would continue on the same site as now. Work with WMAS and WAS would continue to ensure that patients are taken to the right hospital first time to reduce the numbers of transfers between sites.
- In relation to the issue raised through public consultation about supporting infrastructure at RSH e.g. ITU, theatres, beds etc. the Panel noted the following:
    - The ITU at RSH is already in the Trust's capital programme as it is acknowledged improvements to this facility need to be made irrespective of reconfiguration. A high level options paper has been developed for further discussion should the proposed reconfiguration go ahead. Discussions have started within the Surgical Clinical Working group regarding theatres, beds, staffing etc and this would continue into a planning phase. There are a number of productivity initiatives already underway within the organisation to improve patient flow, capacity and scheduling which would be a vital element in the required infrastructure plans.
- The Trust clarified that the ITU at PRH would not be scaled down under the proposals but remain the same but there would need to be an expansion of ITU at RSH.

<u>Clinical Sustainability – Paediatrics</u>

- The Panel noted that the children's services pathways had been agreed and signed off by consultant paediatricians at both sites.
- In relation to the concerns which NCAT identified that had been flagged by SaTH clinicians in relation to the child with trauma and major trauma (the latter acknowledged as uncommon) and the child presenting with critical illness presenting at any location including RSH, the Panel noted the following:
    - The pathway has been agreed. Children with trauma will attend A&E at either site and in the majority of cases, will simply be discharged home from A&E. If the child requires observation then they will be admitted to the same Paediatric Assessment Unit (PAU) at the hospital they are at. If a child requires an inpatient stay they will be transferred to, or remain at, PRH.
    - A child with major trauma will be taken to the RSH, as a designated trauma unit. Here they will be stabilised and then either transferred immediately to Birmingham Children's Hospital or transferred to the inpatient unit at PRH. If

their trauma is life or limb threatening then they will have their operation at RSH and once stable, transfer to either Birmingham Children's Hospital or PRH.

- The Panel noted the detail provided by SaTH on the workings of the PAUs at both RSH and PRH which are key to a reconfigured Children's Service within the county and forms an important part of each one of the new children's pathways. The detail can be summarised as follows:
  - PAUs have been a part of the inpatient wards at both sites for many years, although neither unit was established to be a stand-alone service or to operate 24 hours a day. Children accessing the PAUs do so for a number of reasons and are assessed, monitored, observed and treated in a planned or unplanned way. The majority of children are discharged home from the PAU. The small numbers who require an overnight stay following an unplanned visit to the PAU are transferred to the on-site inpatient ward.
  - In the proposed option for re-configuration of hospital services the PAU at the RSH site will be a stand-alone service as it will not have an on-site inpatient ward nearby. Early discussions within the Children's Clinical Working Group have suggested that the PAU should be open from 8.00-22.00 or to 00.00. Very few children access hospital services during the night and so the vast majority of patients who need to access PAU service would do so during these times. The PAU would "shut" to new patients two hours prior to closure to enable safe discharge home or transfer to the inpatient site. All attempts would be made to advertise the opening/closure time of the PAU at RSH and out of hours, ambulances and GP admissions would be directed straight to Telford.
  - The model of clinical staffing would be a mix of consultant, middle grades and children's nurses supported by health care assistants and ward clerks.
  - A visit has been made to Calderdale and Huddersfield NHS Foundation Trust by clinicians from SaTH, which has a similar configuration of services as that being proposed apart from the PAU on the non-inpatient site is open 24 hours, 7 days a week. The service is delivered by a team of Paediatric Nurse Practitioners (PNP). Paediatric registrars and registered children's nurses. The unit is supported by an on-call Paediatrician and patients with orthopaedic and surgical needs are managed by the relevant speciality medical team. The PNPs work from 21.00- 14.00. The Registrars work from 20.00 – 15.00 enabling an hour hand over at each shift change. Registered Children's Nurses work on the unit 24 hours, 7 days a week. They also have administrative support. The advantages of the PAU being open 24/7 includes management of children arriving at RSH as a "walk or carry in" in the middle of the night and also the care of children who require a "semi-elective" operation, for example orthopaedics.
  - Both PAUs should deliver a good quality child/family experience, provide care as close to home as possible, keep admissions as short in time as possible, provide reliable support for children with long term illnesses and minimise travelling, where possible, for medical care. The PAU should be located near A&E departments to facilitate the fast and safe transfer of patients. The units should also have safe and managed access due to the high volumes of people in these parts of the hospitals.
  - The current PAUs undertake both planned and unplanned/emergency activity. This would continue in a reconfigured service. The planned services would include investigations, reviews, procedures that require sedation and

  phlebotomy. The unplanned/emergency service would include assessment, treatment and observation of un-well children.
  - Whilst it is envisaged by the Trust that a large proportion of children attending the PAU would be discharged home, a number may require an over-night stay as part of their treatment and care. In the 24/7 model, these children would remain on the PAU and only be transferred if they require a longer stay in hospital. In the 08:00 – 22:00 model, children requiring an overnight stay of any length would be transferred to the inpatient unit.
- The Trust acknowledge that the PAU model requires further development and this will be influenced by ongoing discussions with staff and the Children's Services Clinical Working Group and by the feedback received from patients and the public as part of the public consultation.
- In relation to the concern NCAT identified that had been flagged by SaTH clinicians in relation to the child presenting with critical illness presenting at any location including RSH, the Panel noted the following:
  - This pathway has been agreed. However, it is based on the premise that the PAU (Paediatric Assessment Unit) at RSH will close overnight. Depending on the outcome of discussions regarding the opening times of the PAU this pathway may therefore change. Should the option be chosen to have the PAU open 24hours/7 days a week PAU, this would mean that some children would stay at the PAU at RSH overnight rather than being transferred to the inpatient unit at PRH.
- In relation to the concerns around the transfer of paediatric oncology from RSH to PRH, the Panel noted the following:
  - The Trust stated that they were very grateful for the hard work by parents and members of the community to raise money to create this important unit. However, because it is attached to the maternity unit it will need to transfer from its current location if the unit relocates. In addition, the oncology unit must be in the same location as the other inpatient children's services and so the move to PRH has been proposed. The new oncology unit would be provided to at least the same standards as now with the addition of a much needed filtration system and parents and families have been invited to help design the care environment.
  - The Panel noted that parents and patients have a very emotional attachment to the Rainbow Unit and it was understood that money had been raised on the understanding of the unit being at Shrewsbury, but that there would be no clinical reason that this had to been sited at the RSH site.
- In relation to the risks identified through public consultation on the lack of specific care/support for children out of hours at RSH, the Panel noted the following:
  - The vast majority of children access hospital care in-hours and into the early evening. This activity within the Trust significantly reduces around 22.00hrs. Work will continue with WMAS and WAS to ensure that patients are taken directly to the right hospital to be cared for by appropriate medical and nursing teams. For children who access the RSH out of hours via the A&E department, staff have the necessary skills and competencies in caring for children and their families. An on-call paediatrician would be available at RSH to be contacted for advice or to attend if required.
- In relation to the risks identified through public consultation about the distance and transport from Wales and north and west Shropshire for patients and their

families and the added stress and anxiety for parents if their child has to be admitted to PRH, the Panel noted the following:
    - The majority of children accessing the Trust do not need to stay in hospital overnight
    - When they do need to stay in, about 40% do so for less than 24 hours
    - The additional stress and pressure of travelling an additional 17 miles on top of their current journey for some parents is acknowledged by the Trust and all attempts will be made to make this as straight-forward and as short a stay as clinically appropriate. New facilities could include overnight accommodation for parents. The support which parents and families coming from outside of Shrewsbury and Telford receive now from the children's services teams would continue.
- The Panel noted that half of the consultant paediatricians i.e. those based at RSH have expressed serious concerns with the proposals. Their professional opinion is that it is inappropriate to base the children's inpatient service on the site that is not the designated trauma unit. They also believe that since the proposal also suggests that adult abdominal surgery is moved from PRH to RSH, in their view, there will be no suitably qualified surgeon available to operate on a child at PRH. However, the consultant paediatricians did not provide any evidence to the Panel in support of their professional opinion.
- The Trust have stated in response to the issue around trauma cases that the very small numbers of seriously ill and injured children are either sent directly to Birmingham Children's Hospital for treatment or they are stabilised within A&E and safely transferred. The future pathway has been agreed within the paediatric working group and is inline with the designation of the RSH as a trauma unit. It describes a process of stabilisation and transfer of children either to the regional trauma centre in Birmingham or to the PRH inpatient unit as clinically appropriate. There is currently protocol-based safe transfer of children, when clinically appropriate, into Birmingham. The Trust therefore has confidence that it can provide a similarly safe transfer of children between RSH and PRH for the small number of patients necessary. The Panel also noted that a trauma call for a child is not led by paediatricians but by an Emergency Department (ED) consultant. The model being proposed has been endorsed by the ED consultants, trauma surgeons, vascular surgeons, general surgeons and PRH paediatricians.
- The Trust have stated in response to the issue around Acute surgery on children that it is important to note that children under 2 years of age and children requiring more complex surgery are already safely transferred out of county to more specialist hospitals where the skills and expertise are available. For the paediatric surgery that remains within the Trust (mainly scrotal torsion and appendectomy) the trust plans to provide a separate surgical rota for the paediatric inpatient site which will provide an enhanced level of surgical support than is currently available at the PRH site. This will be led by four breast surgeons and they will be joined by two associate specialists. These senior and very experienced surgeons will be on call exclusively for children.
- The Panel considered the relevance of co-location of paediatrics and surgery and concluded that although this may be the ideal model, there are other viable options as demonstrated in other parts of the country.

Clinical Sustainability – Other Pathways

- In relation to the risk NCAT identified to sustaining high quality A&E services at PRH, the Panel noted the following:
  - o The Trust proposes that both hospitals will continue to have a 24 hour Accident and Emergency department. Patients arriving at accident and emergency departments will, as now, be assessed, monitored, treated, discharged, admitted and/or stabilised and transferred. Work would continue with WMAS and WAS to ensure that patients are taken directly to the right A&E department e.g. women with likely gynaecological pathology would be taken to PRH whilst those with surgical pathology would be taken to RSH.
- In relation to the risk NCAT identified on ensuring interventional radiology supports all care pathways, the Panel noted the following:
  - o Radiology consultants are members of all three clinical working groups and have begun to work through the implications reconfiguration of paediatrics, maternity/gynaecology, neonatology and surgery would have on their team, department and the service they provide. The consultants have confirmed that interventional radiology will support all care pathways and would be supported by a 24 hours 7 days a week rota.
- In relation to the concerns raised by the public that the Trust was not sufficiently linking with the ambulance services, the Panel noted the following:
  - o The West Midlands Ambulance Service and Welsh Ambulance Service have been involved in the work to date and would continue to participate in pathway discussions. They are also members of the Clinical Assurance Group. Specific discussions have been held between the Trust and WMAS and Trust and WAS to understand the impact the proposed changes would have on their service provision. Both WMAS and WAS have been invited to formally respond to the consultation.
- In relation to the risk of possible confusion about which hospital patients should go to that was raised during public consultation, the Panel noted:
  - o Information for the public regarding any change to service provision would be planned and implemented using NHS guidance and learning form elsewhere. Pathways have been designed and would be shared with GPs, the ambulance service, out of hours etc. with guidance on referral routes and processes. In a planned attendance, clear site information is provided as part of the booking process. If a patient attended the “wrong” hospital in an emergency, all care would be given by the staff at that site before safe transfer was arranged.
- The Panel noted the information the Trust provided on arrangements for anaesthetics, ITU (Intensive Therapy Unit) and the pathways for ENT(Ear, Nose and Throat), particularly the following:
  - o It is acknowledged that in relation to ENT, further work will be required in developing the A&E service at PRH to enable the safe transfer of the Acute Referral Clinic currently provided at RSH. Training will also be required within the RSH A&E to enable staff to care for patients presenting at Shrewsbury. This would be progressed as part of the planning and implementation phase of reconfiguration.
  - o Currently all ENT surgery (inpatient and day case) is undertaken at RSH with an occasional day case list at PRH. It is proposed that with reconfiguration a complete reversal of the present service will be necessary i.e. all future surgery at PRH with occasional day list at RSH. Day cases at RSH will be

confined to patients where there is no prospect of in-patient conversion being required.
- If the acute surgical take moves to RSH and the obstetric and neonatal service moves to PRH it is anticipated that there will be a need to increase critical care beds to support acute surgical services move to RSH.
- The capacity and capability of anaesthetists has been discussed in relation to the need for rotation of staff across two sites to ensure appropriate obstetric skills and experience is maintained. The Trust will need to confirm these requirements following the development of a more detailed workforce model.
- The infrastructure of the RSH critical care facility is currently poor and needs both renewal and increased capacity even in the absence of reconfiguration between the two sites. The upgrade of the RSH ITU/HDU (High Dependency Unit) facility is already identified as a scheme needing to be scheduled within a five year capital programme.
- Initial bed modelling for ITU suggests that the current 9 ITU/HDU beds at RSH is inadequate if the PRH surgical take is moved to RSH and up to 14 ITU beds may be required. Further work is required to finally validate this figure.

Workforce Planning

The Panel were presented with an update on the workforce planning that has been undertaken to date. The Panel noted that as part of the development of the reconfiguration plans, senior representatives from the HR team have been active members of the clinical working groups. In addition they have also been central to the three sub groups established to understand the issues in greater detail and develop the workforce plans for surgery, children's services and the maternity, gynaecology and neonatology.

Each sub group is using the regional workforce planning methodology. The common themes identified are:
- Change of working patterns
- Skill mix changes
- Workforce supply
- Training needs
- Use of extended roles
- Retaining teaching hospital status
- Travelling expenses/excess travel
- Relocation

The Panel noted that discussions have started to take place on workforce planning, however more work is planned to feed into development of the financial model.

Financial Sustainability Including Estate

The Panel received a high level overview of the revenue consequences of the reconfiguration of services and the implications for estates. The Panel felt that at this stage, insufficient work had been completed on workforce plans to enable a detailed financial model to be provided. Consequently, the Panel did not feel it was able to

either assure or not assure the Boards of the PCTs on the financial sustainability of the proposal.

However the Panel did wish to note the following:

- That there is a clear process for SaTH to work up an outline business plan for the proposals if they ultimately are supported to go ahead, in agreement with commissioners once the consultation process finishes and the shape of services has been agreed. This will then be followed by detailed business plans being developed that are informed by workforce development plans.
- The Trust have clarified that the figures quoted in the consultation document of £28 million for relocation of maternity, neonates and paediatrics on the PRH site and £62 million for a new build of maternity services are based upon Department of Health guidance which is an established methodology using a financial model by an external surveyor. The difference in the figures has been challenged in pubic meetings and the Panel sought clarification on the disparity of the figures quoted. The Trust stated that the figure for relocation to PRH is significantly lower due to the ability to reuse space within the current footprint of PRH, and because support services are shared within the PRH site rather than stand alone for each clinical department at the RSH site, the space saved from not having to replicate space for support services, allows more clinical space to be made available at PRH.

Panel Assurance

The Panel has judged the evidence presented to it and weighed the current risks as a result of services being delivered across two sites against the potential risks in the new model of services if the proposal goes ahead.

<u>The conclusions and assurance of the Panel is as follows:</u>

The Panel reviewed all of the “Lansley Tests”, which it had agreed at its November meeting had almost all been met.

The Panel agreed all the “Lansley Tests” had been met:

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

In terms of the three local criteria, the Panel’s assurance is as follows:

<u>Maternity</u>

Patient pathways have been developed and agreed. Overall, the pathway appears to offer better outcomes for a greater number of the population. Although the additional travel time for some is acknowledged, the Panel were assured on the robustness of

the assessment of risk for midwifery as this model is already operating. The pathways are reasonable; however, there are still ongoing discussions on mitigating some risks, particularly in the community, which need to be resolved.

The Panel were assured on the majority of the pathway, and that full assurance can be given provided the following issues are addressed:

- **Formal pathway risk assessment carried out**
- **Confirmation of detailed arrangements for transfers from Midwife Led Units**
- **Engagement with Powys LHB on issues for Wales**
- **Capacity and capability of WAS finalised**
- **Training for midwives in Wales**

Neonates

Patient pathways have been developed and agreed, albeit with serious reservations from the consultant neonatologists. Despite concerns raised by consultant neonatologists about increased travel time increasing risk, the only documented evidence provided was from the very recent study from Holland looking at perinatal issues, which suggested an increased benefit to a larger proportion of the population from the proposals through increasing those who could reach the consultant unit within 20 minutes. There also appeared to be no evidence of a threat to the service by relocating to PRH nearer other units. The Panel acknowledge the extra travel time for some patients and the possibility of risk for a small number, but this has to be balanced by the overall gain to the population of moving maternity/neonates to PRH.

The Panel were assured on the majority of the pathway, and that full assurance can be given provided the following issues are addressed:

- **Further discussions to take place with consultant neonatologists to identify the risks in the current service and solutions for providing the service in a clinically safe way, recognising that resolving the problem of the maternity building must be part of the solution.**
- **Workforce plans to be completed.**

Acute Surgery

Patient pathways have been developed and agreed and risk assessments have been carried out. Actions to mitigate the identified risks have also been identified and agreed. The Panel felt that the risks of the current model of service delivery were greater than those of the proposed model. Workforce plans have been developed, although some are still in progress, but skills gaps have been identified.

The Panel can give full assurance.

Paediatrics

Patient pathways have been developed and agreed, albeit with serious reservations from those consultant paediatricians now based at RSH. Despite concerns raised by consultant paediatricians regarding the need for linkages between the Paediatric Inpatient Unit and acute surgery and major trauma, the evidence provided on the ability to provide a dedicated paediatric out of hours surgical rota on the PRH site persuaded the Panel that this risk could be mitigated. Evidence also given from similar models working elsewhere in the country, showed that surgery and trauma cases can be safely managed in a model where these and paediatric inpatient services are on separate sites.

The Panel were concerned that there are suggestions that the PAU on the RSH site will be open 24 hours 7 days a week and questioned whether there would be enough patients accessing this unit to justify these opening times.

Workforce plans have been developed but not yet agreed and skills gaps have been identified.

The Panel agreed that in weighing the risk of the current model of service with the proposed model, the greater risk was in continuing with the status quo, because of the potential loss of services out of county this would lead to, with even greater travel time.

The Panel were assured on the majority of the pathway, and that full assurance can be given provided the following issues are addressed:

- **Clarity on PAU demand/capacity to define purpose, staffing and opening times**
- **Workforce modelling to be undertaken**
- **Virtual testing and formal risk assessment of pathways**
- **Risk mitigation needs further work**
- **The legacy of the Rainbow Unit needs to be addressed**
- **Communication strategy developed for parents accessing paediatric inpatients or PAU**

Financial Sustainability

The Panel, based on the evidence presented **was neither assured or not assured and refers this issue to the Shropshire County PCT and NHS Telford and Wrekin Boards for their consideration.**

TELFORD AND WREKIN AND SHROPSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE's - Draft Response to Consultation *Keeping it in the County – Securing the future of hospital services in Shropshire, Telford and Wrekin*

(Note: This response is purely in draft for the committee to consider and does not constitute the views of the Committee at this stage.)

1. What do you think about our overall proposals for Services at the Royal Shrewsbury Hospital and the Princess Royal Hospital?

Strongly support
Support
No opinion
Against
Strongly against

The Joint Committee believes that retaining the status quo is not an option if we are to maintain and protect valuable health services in Shropshire. It is essential that we secure the best possible Health Services for the County as a whole and give our support, subject to further reassurances that proposals put forward are safe, sustainable and affordable, as identified by both the Assurance Panel and in the Joint HOSC process.

2. CHILDREN'S SERVICES

2a. What do you think about our specific proposals for inpatient children's services?

Strongly support
Support
No opinion
Against
Strongly against

The Joint Committee is supportive subject to the assurances identified below.

2b. What do you like about our proposals for inpatient children's services?

Proposals have been clinician led with a focus on achieving improvements and consolidating services and resources on one site and not based around finance.

The PRH has the capacity to meet demand with paediatrics, neonatal, clinician led maternity, neonatal, oncology, operating theatres and family accommodation close together with specialist Paediatric teams available 24/7. DoH research and health needs assessment have been taken into account in the decision to base services at the PRH

No longer located, other than for purpose of stabilising with a possible overnight stay only at the RSH in a building, the condition of which is very poor, and cramped with only one operating theatre and which will be unsustainable into the future, and where there is a continual struggle to ensure that sufficient clinicians and support staff are available.

2c. What, if anything, worries you about our proposals for inpatient children's services?

Safety and outcome for children with trauma presenting at the RSH out of hours where there will be no in-house paediatrician and team other than on call arrangements.

Additional travel time to the PRH for children from the north west and south of the county with trauma, transported both by car and ambulance.

The availability of sufficient paediatric trained surgeons and associated staff at the PRH if proposals go ahead to ensure sustainable services in Shropshire.

Some paediatric clinicians have spoken against the proposals, albeit they have acknowledged the status quo is not an option and have agreed to work together to make the proposals workable.

The relocation of facilities that have been provided/funded with community support and investment at the RSH.

The proximity of the PRH to other Trusts leading to potential loss of services to Shropshire. However, it has been acknowledged that some premature babies at PRH have gone out of county as there were not enough neonatal cots.

2d. What would reassure you on any worries you may have?

All clinicians working together to ensure clinical pathways and arrangements are in place that mitigate risks to those having to travel the further distance to the

PRH for those requiring emergency treatment and arriving out of hours at the RSH including the transfer between hospitals

Reassurance from the WMAS that they are able to reach, stabilise and transport safely children with trauma from the north west, and south of the county the further distance to the PRH.

That the excellent paediatric oncology unit at the RSH is acknowledged and those involved in raising funds to build the unit at the RSH are involved in the design of the new unit at the PRH, with similar and hopefully improved standards at the PRH.

Further discussions with parents to listen and discuss their particular concerns and give reassurance.

Further work is undertaken with commissioners to develop hospital at home to avoid unnecessary hospital admission.

Detailed evidence of funding arrangements to support the proposals.

Detailed evidence of workforce planning and availability to support the proposals.

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3. MATERNITY SERVICES

3a. What do you think about our specific proposals for maternity services?

Strongly support
Support
No opinion
Against
Strongly against

The Joint Committee is supportive subject to the assurances identified below.

3b. What do you like about our proposals for maternity services?

The relocation of the consultant led maternity unit to the PRH will provide a modern, improved environment where there will be capacity to meet demand now and into the future with linked services, including operating theatres.

3c. What, if anything, worries you about our proposals for maternity services?

The loss of the clinical led unit at the RSH leading to extra travel time for emergencies arising from midwife led units from the northwest, and south of the county. Depending on the route taken, the time pathways must be explored and safe routes established. We acknowledge that some journey times may be reduced and others increased.

The potential loss of midwives who do not want to move to the PRH. However, it has been acknowledged that there is a mix of midwives and staff across the county and so it is anticipated that there would be no change if the unit moved to PRH.

3d. What would reassure you on any worries you may have?

Further development of the clinical pathways and arrangements to mitigate risks for those having to travel the further distance to the PRH.

Further work with GPs and Midwives to assess those considered at risk and appropriate action taken to ensure the safety of mothers and their unborn children.

4. SURGERY

4a. What do you think about our specific proposals for surgery?

Strongly support
Support
No opinion
Against
Strongly against

The Joint Committee is supportive subject to the assurances identified below.

4b. What do you like about our plans for surgery?

Proposals will attract high quality surgeons and support staff, thus maintaining and ensuring improved and strengthened services for Shropshire, leading to our hospitals becoming recognised and accredited centres of excellence.

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4c. What, if anything, worries you about our proposals for surgery?

The possible impact that new commissioning arrangements may have and the impact that any new DOH plans on service provision may have that could lead to some services ultimately going out of county. Service changes not meeting planned timescales putting patients at risk and impacting on the project as a whole. Availability of funding and key staff.

4d. What would reassure you about any worries you may have?

A detailed project plan with timescales and workforce planning

5. UROLOGY AND STROKE SERVICES

Are there any comments you would like to make about the location of urology or about the future pattern of local stroke services?

Taking account of the inpatient figures quoted on Page 19 of the consultation document, the location of urology with acute surgery at the RSH is sensible. With demographics relating to age of population, it would seem best to centre stroke services, with vascular surgery at the RSH, albeit preferable to retain some support at both sites, given that both hospitals will have A&E. The Joint Committee supports proposals for vascular service on one site which will result in the provision of AAA screening at the RSH. Progress is also noted in terms of angioplasty procedures and surgery for widening the arteries around the heart without the need for patients to travel out of county

6. OTHER COMMENTS

Are there any other comments you would like to make?

Members have been informed that the funding for the capital costs will be agreed. However, it is vital that the hospital Trust and PCTs have robust plans for all aspects of the financial planning to ensure that the proposals are financially sustainable.

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The role of the West Midlands Ambulance Service is key to the planning and the implementation of the proposals. It is important that any additional costs for transfer between hospital sites are taken into account when considering the cost of the proposals for the commissioning organisations.

A key concern that has been raised throughout the consultation has been ensuring that there is good transport to both hospital sites. The Committee want to ensure that arrangements are made so that staff, patients and visitors can move between sites as soon as services are relocated. It is also important that arrangements are made to ensure adequate parking at both hospital sites and that the cost of any new build parking at the PRH can be met.

Another concern relates to workforce and contingency planning to ensure that once the process of transferring services begins, to ensure patient safety is not compromised.

The Joint committee has welcomed the opportunity to be involved in the consultation process and have an opportunity to comment on the outcome of the clinical workshop in August 2010 that started the discussion around the current proposals. The Chairmen particularly welcomed the opportunity to visit both the PRH and RSH and also to observe the PCTs' Assurance Panel meetings in November 2010 and February 2011.

A final comment relates to those who still have oppose the proposals. The Joint Committee asks that the Trusts do all they can to alleviate those concerns. The Joint Committee particularly requests that ongoing discussion and work continues with our Welsh colleagues to address the concerns of those in Wales who will also be affected by the proposed change in services they access.

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