Committee and Date	Item
Joint Health Overview and Scrutiny Committee 12 April 2012 10.00 a.m.	3 Public

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 Thursday, 15 March 2012 at 10.00 am in the Reception Suite, Civic Offices, Telford

PRESENT – Councillor D. White (TWC Health Scrutiny Chair) (Chairman), Mr. D. Beechey (SC), Councillor K. Calder (SC), Councillor G. Dakin (SC Health Scrutiny Chair), Councillor V. Fletcher (TWC), Ms. J. Gulliver (TWC), Councillor T. Huffer (SC), Councillor J. Minor (TWC), Mr. R. Shaw (TWC) and Ms. A. Thorn (SC)

Also Present – Cllr. J. Seymour (TWC)
Officers – S. Jones (Scrutiny Group Specialist, TWC), F. Howe (Committee Officer, SC), P. Smith (Democratic Services Team Leader, TWC)

JHOSC-1 APOLOGIES FOR ABSENCE

Ms. D. Davis (TWC) and Councillor T. Huffer (SC)

JHOSC-2 DECLARATIONS OF INTEREST

Ms. A. Thorn declared a personal interest, as a director of Shropshire Partners in Care and a trustee of another company providing services to the NHS.

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JHOSC-3 MINUTES

RESOLVED – that the minutes of the meeting held on 19 December 2011 be confirmed as a correct record.

JHOSC-4 ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING

Dr. Catherine Woodward (Director of Public Health) and Mr. Tim Sykes (Vascular Surgeon and Clinical Director for AAA) gave a presentation on the local implementation of this Screening programme.

Dr. Woodward explained the benefits of screening for AAA among men aged 65 and over. A simple ultrasound scan of the abdomen was the easiest way to investigate whether a patient had an AAA, and research had demonstrated that screening of men over 65 reduced the mortality rate from a ruptured AAA by around 50%. The phased roll-out of the national programme began in 2009, with guidance that local programmes should be based on a minimum population size of 800,000. This presented a risk to the future of vascular services in particular in Shropshire, Telford & Wrekin, and so a business case for a local screening programme and retention of vascular surgery was developed in conjunction with the reconfiguration of clinical services provided by the Shrewsbury & Telford Hospital Trust (SaTH). The business case was approved, which was a very positive outcome for the population of Shropshire, Telford & Wrekin. All men in the programme area would be invited for screening in the year they turned 65 – in 2012, this would be 2,400 in Shropshire and 1,010 in Telford & Wrekin. Men already over 65 could self-refer, although this would need to be carefully managed.

Members were then able to view a demonstration of the ultrasound screening technique.

Small aneurysms (88% of all AAAs detected) were monitored along with counselling and support provided to patients. Large aneurysms (12% of all AAAs detected) were referred to the lead vascular surgeon in the local programme. Mr Sykes explained the surgical procedures that were used to treat the different types of AAA condition, and reported that mortality rates locally arising from both elective surgery and rupture/emergency surgery were at or better than the national average.

Members asked a number of questions about the screening programme and the surgical outcomes, including:

What happens to patients when a large aneurism is detected?
Response- they are referred to a vascular surgeon within a week, or immediately if the patient presents with pain.

How do you decide which treatment option to use?
Response- the options are an open procedure or the insertion of a stent using a non-invasive procedure. The choice depends on the condition and fitness of the patient.

How was the self referral process for those already over 65 going to be managed and publicised?
Response – there would be a communications plan as part of the roll-out, and GPs would be closely involved in any referral process. It was accepted that this would need to be managed carefully to avoid putting the programme under pressure.

Why wasn't there a programme for screening women?
Response – women did suffer from AAAs, but in much smaller numbers than men and so a universal screening programme was not justified.

Did the programme include provision for re-screening (after a certain period of time) of those who were initially screened as normal?
Response – no, if the diagnosis was normal at 65 then the individual was not likely to develop an AAA later in life.

RESOLVED - the Committee congratulated SaTH on achieving the AAA screening service for local people which is key to having vascular surgery available 24/7, to save lives and protect vascular services within the county.

JHOSC-5 THE FUTURE CONFIGURATION OF HOSPITAL SERVICES: FULL BUSINESS CASE

Adam Cairns (Chief Executive), Kate Shaw (Programme Manager) and Chris Needham (Director of Estates) from the Shrewsbury & Telford Hospital NHS Trust were in attendance for this item. An assurance grid updating the Committee on how concerns raised during the consultation on the reconfiguration were being addressed in the Full Business Case was attached to the agenda.

Adam Cairns gave a presentation to Members on the latest position regarding the development of the Full Business Case (FBC) for the proposals for the future configuration of hospital services in Shrewsbury and Telford. Planning applications for the new-build work at both hospital sites were progressing, and Balfour Beatty had been appointed to undertake all design and construction work. The Full Business Case was due to be submitted to the Trust Board and PCT Cluster for approval on 16 April, followed by the Strategic Health Authority on 17 April.

Further work had been continuing to provide assurances to patients, service users and staff on the re-configuration proposals. For example, in relation to paediatric oncology, there had been some further concerns expressed, and the Trust was working hard with parents and families on both the design and feel of the new unit at PRH, which would be a third bigger and have a dedicated outside space. Day treatment facilities would be available for the first time and there would be access to high dependency beds and the ability to separate off children's outpatients. Options for the future use of the current Rainbow Unit at RSH were being considered.

The PAU at RSH would be adjacent to A&E and space for an additional isolation cot had been designed into the neonatal unit. Neonatologists were working closely with Wolverhampton to look at training and development and the potential for shared posts.

The Transport and Travel Plan was due out in summer 2012 and it was felt this presented an opportunity to work with transport providers, and Local Authorities, to improve transport overall between population centres.

In terms of acute surgery, Mr Cairns reported that surgeons were of the view that the consolidation of abdominal surgery at RSH, and transfer of in-patient head and neck services to PRH should be accelerated in order to improve outcomes for patients. Therefore, discussions were taking place about bringing these proposals forward to July 2012. The status of Royal Shrewsbury Hospital as the designated Trauma Unit had been confirmed.

In financial terms, the Scheme remained affordable and within the capital budget of £35m for all the works required. However, since the Outline Business Case stage, the Department of Health had announced the availability of £300m public dividend capital nationally for hospital schemes and the Secretary of State had confirmed that £35m of this had been allocated to the SaTH scheme. However, it was emphasised that while this money was interest-free, a dividend would need to be paid back to the Department of Health each year. The Trust therefore had two funding options: to accept the investment from the Secretary of State and pay the annual dividend, or to borrow the capital and account for the cost of borrowing through the revenue budget. It was projected that the public dividend capital option would save the Trust almost £200k per year over the cost of loan repayments so was a much better option. It was not possible for the Trust to borrow additional capital because the cost of borrowing was not affordable.

Chris Needham then showed the site and floor plans for the new facilities at the Princess Royal Hospital, particularly the new Women and Children's Unit. There would be a re-designation of car parking at the PRH site to resolve some of the current issues, and to compensate for the loss of some of the staff car park due to the new-build. A plan was also shown of the relocation of services at the Royal Shrewsbury site.

Mr Cairns then responded to a number of questions which had been submitted by the Committee to SaTH prior to the meeting:

- SaTH had assumed that QUIPP savings of 5% would need to be achieved; however, the PCT had advised that it is more likely that savings of 8-9% are more realistic. What target had been assumed in the FBC?
  Response – 5% savings had been built into the plan, but the Trust would look for and expect to make additional savings. The planning assumption in the FBC was that costs would be released in-step with the ability to release costs and in step with any falls in income from reductions of in-patient numbers.

- Has SaTH taken account of the impact of savings pressures on the wider health economy in the FBC, and what impact will the reduction in PCT funding have on the business case and future services?
  Response - SaTH had agreed the cost assumptions and expected cost reductions for this and next year with the PCT. For following years, the level of costs would be kept in-step with the level of income and the PCT was working with SaTH to redesign services to enable this to happen. SaTH was looking at reducing costs by preventing admissions, moving people through the system more quickly, and earlier discharge. For

example, the service for frail and elderly patients was being redesigned. Once they are in a hospital bed, frail and elderly patients tend to lose their independence very quickly and are harder to return to independence. A pilot had been established so that frail and elderly patients are met "at the door" by a geriatrician for quicker diagnosis, treatment and discharge. In the pilot, 32% of patients had returned home within 72 hours. This had freed up beds and created efficiencies for SaTH, and had reduced pressure on Continuing Health Care and adult social care budgets post-discharge. SaTH was now working with the PCT and partners to see whether some of these services could be provided at home. Reshaping services in this way would help to balance income and cost.

- Who commissioned the current review being undertaken by Finnamore and has the review on identifying gaps in service provision across the wider health economy been considered in the development of the FBC?
  Response – the Chief Executives of all NHS Trusts in Shropshire and Telford and Wrekin had asked for this independent assessment of how the big challenges to the NHS (e.g. current and future funding, cost pressures of new drugs and surgical techniques, ageing population and obesity etc.) would impact on the Shropshire health economy, and to identify what work needed to be done with partners to develop a better service but for less money. The report had not been published yet, but it would help SaTH to understand how we sustain hospital services as the number of patients we treat falls due to the move to more community/preventative work. The implications of the report will be worked though once they are known.

- What do the £500k 'decanting' costs, as outlined in OBC table 72, relate to?
  Response – these were to cover such things as "double running" and provision of temporary accommodation during the transition period.

- PWC cost improvement schemes in OBC: Table 75 shows a total cost saving of £17m in 2012/13, whereas Table 77 shows net total savings of £14.063 in 2012/13. What is the explanation of these differences?
  Response – the total recurring saving was £17m - the net savings figure in Table 77 is after taking account of non-recurring expenditure needed in the first year to deliver the savings.

- Why are SaTH only planning to achieve a Monitor financial risk rating of 3, instead of a higher 4 or 5 rating?
  Response – SaTH was confident that it could plan its way through all the changes and still hit a 3 rating. This was a realistic assessment, and a 3 rating represented the minimum requirement for Foundation Trust status.

- If there was a pandemic, which required beds previously removed to be brought on-line, how would these emergency services be provided and staffed, and have the costs been factored in?
  Response – the Trust has a pandemic plan which could involve managing the elective programme, re-opening beds or providing temporary accommodation. The Community hospitals could be deployed with only

the sickest going to SaTH. The plan forms part of the wider Shropshire Health economy's response to any pandemic emergency. Telehealth offered the potential in future to connect to other hospitals to treat patients who would not normally be treated in the county.

The OBC referred to an assumption in the Trust's Long Term Financial Plan of an increase in "non-clinical" income of 2% per annum to 2105/16. Could you clarify what these relate to?
Response – this related to income from SaTH's role as a teaching hospital for undergraduates and for qualified doctors, plus income from car parking, restaurants etc.

- Does SaTH have a contingency plan if the FBC doesn't gain approval and funding?
  Response – the fact that Public Dividend capital funding had been offered by the DoH gave a good indication that the FBC would be approved. The contingency was the "do nothing" option as set out in the OBC but this would mean higher costs and would result in the loss of services.

- What are the risks around a reduction in income from out-of-county commissioned services in the medium/long term, and have they been factored into the FBC?
  Response – currently around 10% of income came from Wales and 10% from other areas outside the county. It was thought that the service changes that were being proposed would mean that we could regain some patients who were currently going out of the county. The reconfiguration created the potential to increase income, but increases had not been factored into the FBC.

- How will the risks around the commissioning priorities of the CCGs and competition from the private sector be managed?
  Response – we need to make sure that services are fit for purpose and stand up to scrutiny and competition. The Health & Social Care Bill has created a stronger relationship between GPs and clinicians which enables them to work together to design a system that is affordable and meets the needs of local people.

In addition to the questions tabled in advance, Members asked further questions arising from the presentation:

- What assurances can be given that the Telecare initiative will be taken forward when Adam Cairns leaves the Trust?
  Response – A number of deliverables have been agreed over the next 5-6 months including the green light for the FBC, the proposal to start cardiology services in Shropshire, and Telehealth. Work has been done on Telehealth to develop our understanding of how to use the technology and to find a partner in the field so we can achieve the benefits of scale. We are close to agreeing a specification with payments worked out over a number of years.

- What progress has been made on the transfer of patients' records between sites, and how does the Trust communicate back to GPs?
  Response – we need to improve from where we are. There are a lot of written records, and we are looking at what options there are for getting the records into an electronic form and what systems we would need to hold all medical records electronically. Further work also needs to be done on the administrative processes for the storage and management of records between the two sites. This forms part of the IT strategy. We have been developing a discharge summary form which is almost in place which will be transferred back to GPs. GPs need more information presented in a useful way, and further consideration is being given to the summary to make sure it is right. We hope to have this in place over the next 6 months.

- There is not much information in the OBC about cost improvement schemes for 2015/16. Could you give us some more detail?
  Response – the cost improvements have been worked out in detail for the next 3 years and in less detail for the following 2 years because it is more difficult to be precise so far ahead. Further details will be firmed up over 2012/13 and 2013/14 and can be brought to Scrutiny.

During the general discussion, some concerns were expressed about misleading information being published in the press about the capital funding for the scheme. Adam Cairns stated that SaTH was planning further publicity to counter what were seen as "myths", and Members agreed that, where possible, the Committee should seek to promote the positive messages about the changes.

RESOLVED

The Committee welcomed the news about the potential alternative capital funding for the hospital configuration which would reduce the revenue costs for the scheme, and acknowledges the hard work to date that SaTH had put into securing the funding.

JHOSC-6 CHAIRMAN'S UPDATE

The Chairman updated members on the items discussed at the Regional Health Scrutiny Chairs' network meeting on 13th March 2012.

The group had received a number of presentations:

- The roll out of the NHS 111 service. The PCT clusters and Clinical Commissioning Groups had agreed to take a West Midlands approach. There would be a period of consultation and engagement including with HOSCs leading up to the launch of the service in February 2014.

- An update on service wide reviews affecting the region. The key reviews were highlighted as:

- Stoke services – likely implementation 2013/14 with consultation where necessary
- Children's surgery – possibly looking at relieving pressure on Birmingham Children's hospital by moving surgery to smaller number of hospitals – intended to complete the work programme 2012/13.
- Reduction of acute beds – this was being done as part of reshaping hospital services.

- Regional PCT Cluster update, including a report on the development of the Clinical Commissioning Groups across the region, and the key ambitions, challenges and risks associated with the health reforms and budget pressures.

- An update on the role of the CfPS Regional Advocates. The DoH has made £4,000 available to each region for support/development and the group awaited further guidance.

- Feedback from the CfPS Health Accountability Forum held in London on 12th March 2012 which considered the regulations and guidance relating to Scrutiny from the Health & Social Care Bill. The comments agreed at the meeting were tabled, and individual authorities were asked to support the comments which would be submitted to the Department of Health and the CfPS as a joint West Midlands response. The comments would inform the development of the regulations and guidance which would go out for consultation in due course.

JHOSC-7 GYNAECOLOGICAL CANCER PATIENT PATHWAYS

Attached for information to the agenda was an update report of the Greater Midlands Cancer Network on the audit of patient pathways for gynaecological cancer. Ethical approval for the audit and survey questionnaire had been obtained, and the audit would commence shortly.

RESOLVED – that a further update be received once the audit has been completed.

JHOSC-8 DATE OF NEXT MEETING

It was reported that the next meeting would be held on 12th April 2012 at Shirehall, Shrewsbury to consider the final draft Final Business Case for the Future Configuration of Hospital Services prior to its submission to the Trust and SHA Boards.

The meeting closed at 12.35 pm

Chairman……

Date……

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
	Service / Issue identified	Information to be monitored	Evidence from	
1	**Paediatric Services**			
1.1	Safety and outcomes for children with trauma presenting at RSH out of hours when there is no in house paediatric support other than an on call team	Details of clinical pathway and role of WMAS	SaTH WMAS	The paediatric clinical care pathways developed during the consultation and assurance phase of the programme have been reviewed. The pathways reflect the availability of paediatric staff for the majority of the time when children are accessing the service due to the co-location of the Paediatric Assessment Unit (PAU). Staff will be in the PAU from 09.00 to 22.00 and will support their A&E colleagues if required. Out of hours, the on-call Paediatrician for RSH will be called in to support the trauma team if required. The Paediatric Triage and Transport Group (chaired by Dr Frank Hinde) continues to meet. This group includes Trust staff (including the new trained Advanced Paediatric Nurse Practitioner), Shropdoc and both West Midlands Ambulance Service (WMAS) and the Welsh Ambulance Service (WAS). The group has developed the process and draft guidelines for the safe transfer of patients both within county and out of thecounty; the triage pathway for patients being brought in by their parents/carers, patients referred urgently by their GP and those being brought in by ambulance; and also the principles for time limited transfers. This work is now being widely shared for comment and sign-off. The workforce requirements, including training, submitted as part of the Outline Business Case have also been reviewed and will be included in the Full Business Case.
1.2	Provision of the PAU at RSH is based on clinical need	Evidence of clinical need for paediatric services	SaTH PCTs*	The service model for the Paediatric Assessment Unit at RSH was agreed by the paediatric consultant and nursing teams and was reflected in the Outline Business Case. The opening times are based on detailed analysis of the times of admissions to the Trust (either via A&E or GPs). This showed that the

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
				numbers of children admitted into the Trust during the night are very low, equating to less than 3 children across both sites. Admissions at both sites peak at midday and again at 18.00. The PAU will be staffed for 13 hours per day and it is proposed that it will be open to the public from 09.00 to 21.00. Children likely to require an overnight stay in hospital will be triaged straight to the PRH site. When the PAU at RSH is closed, all ambulances and GP admissions will be routed straight to PRH. In the rare and extreme case of the paramedics transferring a child believing they could not get to the PRH safely (airway obstruction for example), they will adhere to their nearest hospital protocol (the Trust and WMAS will work together to review all supporting protocols, polices and operational guides prior to the implementation of these changes). The Trust has recruited one trained Advanced Paediatric Nurse Practitioner and is currently recruiting a second. In addition, there are two nurses currently being trained. The Royal College of Paediatrics and Child Health (RCPCH) who visited the Trust in May last year were involved in the discussions around the future service model, including the delivery of the Paediatric Assessment Units (PAU) and the workforce requirements. They support the view of having a 13 hour PAU at the RSH site; the development of Paediatric Advanced Nurse Practitioners; and a Short Stay PAU (SSPAU) open 24 hours alongside the inpatient unit at the PRH site.
1.3	Additional travel time to PRH for some children transported by car and ambulance	Mitigation of risks and role of WMAS in reducing response and transport times	SaTH WMAS	This issue will continue to be addressed through the working groups described above as the Trust moves forward with the implementation of change. The parents and public focus groups are helping the Trust understand what would help them when they are bringing a child to the hospitals in an emergency. This includes dedicated drop-off/short stay parking, being able to call ahead and discuss their needs with a clinician and clear routes into the relevant department. In terms of ambulance transfer times the Transfers and Transport

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
				Group, chaired by Adam Cairns and comprising WMAS and WAS representatives, PCT and GP Commissioners, local Councillors and Trust representatives continues to meet. The cross-border agreement between WMAS and WAS has been formally in place since December 2011 and is reported to be working well. This means the nearest ambulance will respond to a patient, irrespective of which side of the border they are on. Both WMAS and WAS continue to work through their skill-mix changes and develop the role and coverage of Community First Responders. In addition, clinicians within the Trust are working to reduce the impact of additional journey times by improving the system and processes when patients come in through the door, for example reducing the 'door to needle time' from 60 to 45 minutes for children with cancer who urgently need intravenous antibiotics. The work undertaken to understand and improve the emergency transfer needs will form part of the Trust's Travel and Transport Plan. This plan will also describe the non-urgent travel and transport needs patients, carers and the public have in accessing the Trust's services. Patients and the public are currently invited to take part in a Travel and Transport Survey until 28 March 2011 which can be accessed via the Trust's reconfiguration web pages www.sath.nhs.uk/future. We propose to present the draft Travel and Transport Plan to the JHOSC in July/August 2012.
1.4	Development of clinical pathways and mitigation of risks when transferring children between hospital sites	Reassurance from the WMAS that they are able to reach, stabilise and transport children safely	WMAS	The Paediatric Triage and Transport Group has developed the process and draft guidelines for the safe transfer of patients between hospital sites. These guidelines are being shared widely for comment prior to sign off by the Clinical Working Group. The detail will be included in the Reconfiguration Travel and Transport Plan.
1.5	Paediatric staff work together to make proposals workable	Evidence of clinical engagement	SaTH	There have been numerous formal and informal meetings with paediatric staff since the approval of the Outline Business Case in

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
				September 2011. These meetings have focussed on the design and lay-out of the paediatric departments at both RSH and PRH. Paediatric staff are also involved in the Clinical Working Groups for Women and Children's as well as actively participating in the Head and Neck and Surgery Clinical Working Group meetings and discussions. This has included reviewing the proposed care pathways across all areas, discussing workforce and training requirements and identifying implementation needs.
1.6	Capacity of neonatal service to provide, where possible, services for premature babies in County	Service planning and commissioning intentions	SaTH PCTs *	Clarity was sought from the West Midlands Specialised Commissioning Team on the designation level of neonatal units for the Outline Business Case. They confirmed that there are no plans at this stage to alter the current designations across the West Midlands. The capacity assumptions for the neonatal unit are such that the number of 'cots' will remain the same within the Full Business Case as detailed within the Outline Business Case. We are considering a proposal for the addition of an isolation cot. Representatives of the West Midlands Neonatal Network have welcomed the clinicians' aspirations to increase their joint working with Wolverhampton following the reconfiguration with joint training and developments and potentially shared consultant posts in the future.
1.7	Development of paediatric oncology service at PRH with facilities at same standard or better than rainbow unit	Service design, estate and facilities	SaTH	The clinicians delivering the current oncology service have been extensively involved in the discussions and meetings about the requirements for the relocated service. This has included the need to have access to high dependency beds, access to a garden from all rooms and the ability to isolate outpatient services for oncology patients away from general children's outpatients. This will be described in the Full Business Case. We have held and are continuing to hold regular focus groups with patients, parents and families of the Rainbow Unit to involve them in the planning of the new unit.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
				As part of these focus groups, we have listened and responded to ideas and concerns, for example about the outside play areas, clinical spaces and facilities. We have also held a focus group specifically to explore issues, ideas and concerns around transport and access. We have set up a task group which will meet in April 2012 to decide on an appropriate legacy for the Rainbow Unit. We also invited patients/ former patients and their siblings to take part in a home-based activity to come up with ideas on the look and feel of the interior and exterior of the new unit. We have received some great feedback from this activity and these are currently displayed on the ward for people to see. Ideas from this will be incorporated in the next phase of the plans. The ongoing communications and engagement is described within the Full Business Case.
1.8	Those involved in fundraising for the rainbow unit to be invited to be involved in the design of the new paediatric oncology unit	Evidence of patient / public engagement and feedback on how this has influenced service design	SaTH	All parents, families and fundraisers of the Rainbow Unit have been invited to attend our focus groups. We have listened to their feedback around the new unit and their ideas and suggestions have been reflected in the design. This includes providing larger parents and families' accommodation, better facilities for parents and families, being able to access the outside space from families' facilities, having a day case area and single bedrooms, a cooker in the kitchen and a dedicated drop-off parking area for parents arriving in an emergency. The last meeting was held on 20th February, which was chaired by our Chief Executive. At that meeting it was agreed that we would establish a task group focusing on the legacy of the Rainbow Unit. This will look at the future use of the unit and also about providing a lasting legacy, such as piece of artwork. We are currently asking for volunteers to be a part of this, including anyone who was involved in the fundraising for the existing unit.
1.9	Further work with Commissioners to develop hospital at home service for children to avoid unnecessary hospital admissions	Commissioning intentions of PCTs and joint work with Community Trust	SaTH PCTs* Community Trust	The Trust remains keen to progress with the development of robust out of hospital care services for children. An initial discussion with Trust and Community Trust clinicians and local PCT commissioners is due to be held this month.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
1.10	Evidence of work force planning and availability to support the proposals	Details of national guidance for work force planning mapped against demand / need and commissioning intentions	SaTH PCTs*	The workforce plan submitted with the Outline Business Case has been reviewed, updated and amended. A revised plan will be submitted with the Full Business Case. We have continued to use the Trust's strategic workforce planning methodology, which is based on the Skills for Health 6 Steps model. Planning of the workforce has been done based on future clinical service models. A firm of external consultants have been working through the medical workforce issues with Head and Neck to develop a jointly owned and workable future plan. The nursing workforce numbers have been formulated taking Royal College of Nursing standards into account, using the Trust's agreed skill mix templates. The Full Business Case will be shared with the staff side at the TNCC (Trust negotiating and Consultative Committee – the formal committee for engaging with Staff Side Representatives) on 21 March 2012. From that point work will commence jointly with staff side to develop the implementation programme and its associated consultation mechanism. Representatives from the TNCC have been part of the programme and the development of the Full Business Case and will continue to be closely involved in the implementation phase. The workforce section of the Full Business Case includes a detailed section on the Transformational Change Programme which will enable the Trust to implement the necessary workforce changes.
2	**Maternity Services**			
2.1	Development of clinical pathways to mitigate risks for mothers who will have to travel further to services at PRH	Engagement, support and training with obstetrics team, community midwives, GPs and WMAS	SaTH GPs WMAS	The Women and Children's Clinical Working Group has met and reviewed all pathways developed and submitted as part of the Outline Business Case. These pathways were used as the basis for planning the workforce requirements for both the Outline Business Case and the Full Business Case and will now be used to plan the implementation of change. This will include the enhancement of the skills and techniques currently used by clinicians delivering services to the rural population rather than a major re-training programme. 'Skills Drills' currently used within the maternity service for the

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
				resuscitation of babies in the Midwifery-Led Units (MLUs) will be broadened to include a Skills Drill for the risk assessment, process and practice of transferring a woman in labour from the MLUs to the Consultant Unit to accommodate additional (or less) time needed for travel. This will include close liaison and working with both ambulance Trusts to ensure their involvement and amendment to their ways of working, if required. The Trust continues to have discussions and with commissioners and providers regarding plans for the reconfiguration and development of services (which includes maternity and neonatology) across Shropshire, Telford and Wrekin and mid and north Wales. One of the aims of this Strategic Forum is to ensure that plans, as far as possible, are aligned and take account of organisational changes across boundaries and the impact this may have on the rural populations of Shropshire and Wales (please also see Public Engagement section below).
2.2	Further work with GPs and midwives to assess those considered at risk and action taken to ensure the safety of mothers and their unborn children.	Engagement, support and training with obstetrics team, community midwives, GPs and WMAS	SaTH GPs WMAS	Women accessing maternity services in the county and in Powys are currently assessed to determine their level of risk. This assessment determines their pathway of care. These pathways were reviewed and amended earlier in the programme to reflect the new models of care and the future location of the consultant obstetric unit and neonatology services. The policies and processes that are currently in place to assess a woman's level of risk are being reviewed to ensure clinical risks are appropriately assessed and managed in the future. This includes the introduction of the Skills Drill described above. Irrespective of the plans to reconfigure maternity services, a training programme for all midwives in the stabilisation and transfer of newborn babies has been developed and is underway. An update of the training and support of GPs and midwives will be presented to the HOSC in the summer of 2012.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 06 March 2012
2.3	Continued engagement of the WMAS in the development of clinical pathways	Improved response times and details for routes to PRH from rural areas	WMAS	
2.4	Potential loss of midwives who do not want to move to PRH	Ongoing engagement with staff and work force planning	SaTH	The issue of a potential loss of midwives who do not want to move to the PRH will be dealt with as part of staff engagement within the management of change process. All midwives currently rotate around the units provided by the Trust and so a loss of midwives due to moving the consultant-led service to PRH is not envisaged. An update will be provided as part of the presentation described above in the summer of 2012.
3	**Acute Surgery**			
3.1	Provision of AAA screening	Implementation timescales	SaTH	The provision of AAA screening will commence in April 2012. Mr Tim Sykes (Vascular Surgeon) is the Clinical Lead for the AAA Screening programme and will present progress to the Joint HOSC, along with Dr Catherine Woodward (Director of Public Health) and Chair of the AAA Screening Programme Steering Group on 15 March 2012.
3.2	Maintaining existing services in the County and SaTH becoming a Centre of Excellence	Joint HOSC to be informed of any changes to services prior to implementation	SaTH	Discussions on the implementation time frames for surgery and other challenged services continue. During the consultation and assurance phase of the programme the need to consolidate inpatient surgery as soon as practically possible, and ahead of 2014, was widely discussed. Following discussion at the Hospital Executive Committee in both January and February and the Trust Board in February, the Centre for Surgery are beginning to plan the consolidation of the inpatient surgical service (excluding gynaecology; head and neck; and breast surgery) at RSH in July 2012, ahead of the new intake of junior medical staff in August. This will be discussed further in the presentation by the Chief Executive on 15 March 2012.
3.3	Wider changes in NHS e.g. changes in commissioning resulting in services	Implications of Health and Social	SaTH PCTs*	The Future Configuration of Hospital Services proposals have been developed through engagement with GPs and commissioners, and to

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	going out of County	Care Bill		address the reconfiguration principles set out by NHS Telford & Wrekin and Shropshire County PCT which included keeping two vibrant, well balanced, successful hospitals in the county with access to acute surgery from both sites. One of the key drivers for making these changes has been to reduce the risk of further services leaving the county and the Trust looks forward to continued support from Health Overview and Scrutiny Committees to maintain safe, sustainable local services for people in Shropshire and Telford & Wrekin. We continue to engage with the GP Commissioners in Shropshire and Telford and Wrekin and they remain members of key groups within the reconfiguration programme (Clinical Assurance Group; Transport and Transfers Group).
3.4	Service changes not meeting planned timescales putting patients at risk and impacting on the project as a whole	Update on target and milestones to achieve implementation Risk management	SaTH	The management of risk continues within the operational surgical services according to the Trust's policies. The Trust's Risk Management Group meets monthly where the issues are discussed and actions agreed. The Future Configuration of Hospital Services programme has a robust risk management system in place. The programme's Steering Group (chaired by the Chief executive) meets monthly weeks where risks and issues are discussed and action agreed. The key milestones and timescales for actual service change will be reflected in the detailed implementation plan as part of the Full Business Case.
3.5	Detailed workforce planning	Workforce planning against demand / need and national recommended guidelines	SaTH	As described above, detailed workforce planning has been carried out and will be reflected in the workforce section of the Full Business Case.
3.6	Patients who cannot be stabilised and transferred to be operated on at PRH	To be included in development of clinical pathways	SaTH	The Clinical Working Group for Surgery is continuing to meet and has reviewed the surgical care pathways. It has been reconfirmed that patients admitted to the PRH who cannot be stabilised and transferred

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				to the RSH for their operation will have their operation at PRH. Day case surgery; inpatient breast, gynaecology and head and neck surgery; and paediatric surgery will all take place at PRH thus maintaining a strong and robust surgical presence in Telford.
4	**Stroke Services / Urology**			
4.1	Provision of thrombolysis on both sites	Implementation timescales	SaTH	Thrombolysis continues to be available at both sites 24 hours a day, seven days a week. With the service now running 24/7 across both sites and with the support of the Network Thrombolysis Rota we have increased the number of patients receiving thrombolysis from 23 (4% of patients) in 2010-2011 to 61 (almost 8% YTD) 2011-2012. From October 2011, the Trust has had a Network Thrombolysis Rota network in place to support the local delivery and long term sustainability of this service. Telemedicine carts will be installed within the thrombolysis rooms at RSH and PRH which will enable a clinical network of consultants (from SaTH; University Hospital North Staffordshire; and Burton Hospital) to actually see and examine the patient remotely. It is anticipated that the date for Telemedicine going live will be June 2012. This has been revised to reflect the delays that were experienced in final procurement processes. We will be celebrating the 100th patient to receive Thrombolysis at the same time as the launch. Dr Rob Campbell is the networks clinical lead for this work. This will also be the Trust's first tele health care project being supported by Mr Mark Prescott and Dr Darren Warner Tele Health Care Lead.
4.2	Evaluation of current provision against the National Stroke Strategy with indication from SaTH and Commissioners on how gaps will be met	Update report on issues identified	SaTH PCTs*	The health economy wide Stroke Strategy Group meets regularly to discuss and agree delivery of the stroke strategy locally. This group involves all stakeholders and includes: clinicians and stroke leads from primary, secondary care and the Community Trust; commissioners; and representatives from the Heart and Stroke network. An action plan is in place to address identified gaps and progress against this plan is

monitored at each meeting. The group also assesses progress against the recommendations of the West Midlands Quality Review.

Performance is good against the key stroke targets within the Trust:
% of patients spending 90% of time on a stoke unit –
target 80%: Jan = 83.5%, YTD = 87.5%
% of patients having a swallow screen within 24 hours of admission –
target 70%: Jan = 91.1%, YTD = 85%
% of patients with high risk TIA scanned and treated within 24 hours –
target 60%: Jan = 93.75%, YTD = 89.4%

Dr Suzy Thompson is the new Clinical Lead for Stroke and Care of the Elderly who will be working with Dr Campbell to develop services. Dr Meena Srinivasan is now based at Telford to particularly focus on Stroke services at PRH.

The specific areas or gaps within the service they are currently being discussed within the Stroke Strategy Group are:

- Psychological support – this is provided in 3 levels. We are meeting the requirements for Level 1, "assessing sub-threshold problems, common to many or most people with stroke". A business case is to be put together to meet the requirements for Level 2 and 3, to provide a Clinical Psychologist as part of the Stroke team. A focus group for patient and public involvement is also being set-up. The Occupational Therapists are designing a flowchart to be incorporated in the Stroke Care Pathway to identify which patients would benefit from which assessments. A Stroke Patient and Carer group is being set up which is hoped will extend into a "befriending" service.
- Early Supported Discharge – this service has been extended and is awaiting a long term commissioning decision
- Stroke therapy assessment is now available at the weekend, with access to stroke therapy specialist provision under discussion within the Medicine Centre with Dr John Jones
- TIA service at weekends (this service is currently provided 5 days a week). We have undertaken a demand and capacity review looking

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				to provide this later this year with ongoing support from the Heart & Stroke Network, TIA Leads meeting, and inter-departmental working.
4.3	Provision of coronary angioplasty procedures	Implementation timescales	SaTH	The provision of coronary angioplasty remains a longer term aspiration of the Trust. A further update will be given in the summer of 2012.
5	**Public & Staff Engagement**			
5.1	Further discussions with patients, public and parents to listen to them and discuss their concerns and give further reassurance	Communication and Engagement strategy Feedback from public engagement and how this has informed service development	SaTH	Throughout autumn/ winter 2011, senior clinicians and lead executives went back out to various community groups and council meetings that were visited as part of the Keeping It In The County consultation across Shropshire, Telford and Wrekin and mid Wales. This was primarily to ask people to share their ideas and concerns and to ask for their help in shaping the future of women's, children's, head and neck and surgical services. From March 2012 onwards, senior clinicians and lead executives have begun to go back out to these communities again. This will continue throughout 2012. The Trust has established four focus groups for the following areas: • Surgical services • Children's services • Children's cancer and haematology services • Women's services (including gynaecology and maternity) These groups have had several meetings and have provided some valuable feedback - the notes and presentations are available on our website www.sath.nhs.uk/future Since summer 2011, we have produced quarterly issues of our special newsletter 'Looking to the Future'. Included in these newsletters are updates on the latest plans, frequently asked questions, feedback from the focus groups, myth busters, interviews with clinicians, case studies and information about upcoming events and how people can get involved. These have been sent to all our hospital members, distributed around our hospital sites and sent to all GP practices for patients and public to pick up. They are also published on our website. We have also

| | | | | published three special issues of the newsletter which have focussed on the initial designs for the new women and children's unit, women's services and children's services. These have been distributed around our hospitals, are handed out at events and meetings and are available on our website. Our next issue of Looking to the Future will be incorporated as part of the Trust's wider newsletter 'A Healthier Future' which will be published in April 2012.

The Trust has set up dedicated web pages – www.sath.nhs.uk/future - which are regularly updated to include the latest news, FAQs, blogs and events. We also invite comments and suggestions from public and patients via our email address future@sath.nhs.uk

We have also taken out advertisements in the free local newspapers across Shropshire, Telford & Wrekin and mid Wales in October 2011 and January 2012 to explain the changes that are planned to our hospital services and what it will mean to patients and the public. The adverts also included myth busters, upcoming events and information about how people can get more involved. The next advert will appear in April 2012 and will include an update on the latest news across the Trust.

The ongoing communication and engagement will be detailed in the Full Business Case. |
| 5.2 | SaTH does all it can to alleviate the concerns of those who have been opposed to the proposals | Communication and Engagement strategy
Feedback from public engagement | SaTH | Meetings and correspondence with local MPs, journalists and individuals who have been opposed to the proposals have continued into this phase of the programme. They have also been involved in the meetings listed above and as part of our focus groups. We are also responding to people's concerns via email and through Freedom of Information requests.

The Trust is committed to working closely with patients and with parents and families of young children, who have very specific health needs, to alleviate their concerns and to ensure that clear pathways are in place. Similarly, the Trust is working closely with members of staff who also have raised their concerns. |

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5.3	Address concerns of Welsh colleagues who will be affected by the changes	Feedback from WAS, Powys Health Board and Welsh Assembly	SaTH	As detailed above, senior clinicians and members of the executive team revisited communities across mid Wales in autumn/ winter 2011 to talk to them, listen to their views about the proposed changes and encourage people to get more involved. The Trust has started to go back out to these communities, including town council meetings and health information events. We are also arranging to visit mother and baby groups across mid Wales in the spring. The Welsh Ambulance Service and Councillors from Powys are represented at the Trust's Transfers and Transport Group and have been working closely with WMAS on cross border working and solutions to covering such a large rural area. WAS are also members of the Strategic Forum along with representatives from the Trust, local PCTs, WMAS, Powys Local Health Board and Betsi Cadwaladr Teaching Health Board. The focus of this group is to share plans for reconfiguration and development of services across Powys, North Wales and Shropshire, Telford and Wrekin. The group met again in November 2011 where an update was given on the emerging work in North Wales for changes to acute services (in particular for surgery; maternity; neonatology; and paediatrics). Trust officers are in contact with colleagues in North Wales to share pathways and learning. All organisations have committed to continue to share proposals and plans as they develop.
5.4	Public are kept informed and patients informed of the implications for changes before they take place	Communication and Engagement strategy Feedback from public engagement	SaTH LINkS	The Communication and Engagement Strategy continues to be implemented. The strategy describes a variety of regular communication, including: community meetings; 'Looking to the Future' newsletter; articles in the local media; interviews on local radio; and the website. As the plans and timings for implementation get nearer, a large scale communication campaign will be launched to ensure that all patients and public know what is happening, when and where and what this means to them if they access the Trust's services. This will include posters, door-to-door mailings, articles in the local press, TV and radio and targeted advertising.

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				The detailed plans for implementing the changes will be presented to the HOSC in the summer of 2012.
6	**Workforce planning**			
6.1	Planning to ensure that once the process of transferring services begins patient safety is not compromised	Capacity planning and risk management for implementation	SaTH	Workforce planning is key to the reconfiguration programme and much detailed work has been undertaken to understand the staff affected, the management of change process and to link this to the emerging implementation plans. This will be described in detail in the Full Business Case. Each Centre has undertaken a Quality Impact Assessment on the proposed changes and what this means for patients and the services they receive. The Quality Impact Assessments will also be included in the appendices of the Full Business Case, as will the programme risk registers.
6.2	Recruitment and training of paramedics by WMAS to support transport between sites	Details of recruitment and training of paramedics	WMAS	
6.3	New Issue: Report in press of reduction in staff numbers to make savings	Linking workforce planning with budget and savings targets	SaTH	The issues of bed reductions and any associated staffing reductions are separate from the FCHS programme. However of necessity the bed reduction programme does impact on some of the services affected by the FCHS programme, and is referenced within the workforce planning section of the Full Business Case. As the reconfiguration progresses, workforce plans will be kept under review within the context of the Trusts wider financial and workforce plans. As part of the Outline Business Case, a wider bed capacity modelling exercise was completed. This takes into account the efficiencies that can be made when we work differently. It also considers the longer term demographic changes within Shropshire and Telford and Wrekin and the impact these will have on the future shape of hospital services. This work is also incorporated into the Full Business Case.

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7	**Finance and Estates**			
7.1	Robust plans for all aspects of financial planning to ensure financial sustainability	Confirmation of loans to finance reconfiguration Details of costs to implement reconfiguration Details of ongoing running costs for reconfigured services Commissioning intentions of PCTs	SaTH PCTs*	A detailed costing schedule of the preferred capital options at both RSH and PRH has been supplied our contractors, Balfour Beatty, and validated by our external cost advisors. This will continue to be updated as the market testing for the works at PRH undertaken by the Trust's construction partner continues to define their supply chain costs. The final capital costings will be included in the Full Business Case. The revenue implications of the service changes, the non-service led revenue impact and the revenue and capital spend profiles are also being finalised. This work will be detailed within the financial case within the Full Business Case.
7.2	Additional cost of transfer between sites is taken into account	Cost of transfer arrangement for SaTH Cost of increased travel times for WMAS and implications for cost to commissioners	SaTH WMAS PCTs*	Analysis by WMAS on the current activity flows and the impact the proposed changes has been completed. WMAS report an immaterial impact. Both WMAS and PCT Commissioners are members of the Transfers and Transport Group. More detail on the Trust's plans for inter-site travel will form part of the Trust's Reconfiguration Travel and Transport Plan in the summer of 2012.
7.3	Adequate parking at both sites	Plans for parking facilities	SaTH	Specialist transport advisors have analysed the quantum of journeys by patients, staff and visitors. This work has provided a view of the need to provide car parking spaces alongside the need to further develop alternative travel options. This will be included with the Travel and Transport Plan. The provision of extra car park spaces at PRH is reflected within the Outline Business Case and initial feedback from the planning authority will require the Trust to include a number of transport and travel mitigation targets that will influence the final number of spaces that should and can be provided. Therefore when the planning consent is made the final number will be identified although the Trust has identified an aspirational target of an additional 200 spaces.

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8	**Transport**			
8.1	Good transport to both sites	Feedback from discussions with Local Authorities and transport providers	SaTH	Discussions with local authorities has highlighted the pressures on public transport provision but has also focussed the attention of the transport planners to explore opportunities that arise from a joint working approach i.e. volumes of those travelling may support new routes or enhance existing routes. In addition, a travel and transport survey is underway (to conclude at the end of March) to determine people's experiences, views and ideas on the current and future travel and transport options for the future. The output of this work will be included within the Travel and Transport Plan and presented to the HOSC in the summer of 2012.
8.2	Arrangements are made so staff, patients and visitors can move between sites as soon as services are relocated	Timescales for implementation	SaTH	The Travel and Transport Plan will include the options and arrangements for cross site transport and will be presented to the HOSC in the summer of 2012.
9	**Implementation**			
9.1	Joint HOSC request details of any changes prior to implementation	Update to Joint HOSC meetings	SaTH	The Trust proposes to provide an update to the HOSC in May 2012.

*PCT indicated the Commissioning body and includes the developing GP Commissioning arrangements