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.

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.

<u>Clinical Sustainability – Acute Surgery</u>

- 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:
  - Most specialised children's surgery is carried out in centres such as Birmingham and Liverpool.
  - 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:
  - 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:
  - 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:
  - 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:
  - 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:
  - 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.
  - 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.**