Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 14 March 2014
My Ref:
Your Ref:

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Monday, 24 March 2014**
Time: **4.00 pm**
Venue: **Council Chamber. Shirehall, Abbey Foregate, Shrewsbury, SY2 6ND**

You are requested to attend the above meeting.
The Agenda is attached

Claire Porter
Corporate Head of Legal and Democratic Services (Monitoring Officer)

Members of Joint Health Overview and Scrutiny Committee

Gerald Dakin (Co-Chair)	David Beechey (Co-Optee)
Derek White (Co-Chair)	Ian Hulme (Co-Optee)
Tracey Huffer	Mandy Thorn (Co-Optee)
Simon Jones	Dilys Davis (Co-Optee)
Veronica Fletcher	Jean Gulliver (Co-Optee)
John Minor	Richard Shaw (Co-Optee)

Your Scrutiny Officers are

Martin Stevens
Tel: 01743 252722
Email: martin.stevens@shropshire.gov.uk

Fiona Bottril
Tel: 01952 383113
Email: Fiona.bottrill@telford.gov.uk

AGENDA

1 Apologies for Absence

Contact: Martin Stevens (01743) 252722

2 Disclosable Pecuniary Interests

Members are reminded that they must not participate in the discussion or voting on any matter in which they have a Disclosable Pecuniary Interest and should leave the room prior to the commencement of the debate.

3 Minutes (Pages 1 - 6)

To confirm the notes of the meeting held on 13 December 2013 as a correct record.

Report of Democratic Services Team Leader is attached.
Contact Phil Smith (01952) 383211

4 Mental Health Services (Pages 7 - 14)

To update Members on the reconfiguration of mental health services in Shropshire and Telford & Wrekin, including Castle Lodge. Reported is marked to follow. The following people will be in attendance:-

Fran Beck (Executive Lead Commissioning Telford CCG)

Paul Cooper (Commissioning and Service Redesign Lead -
Mental Health and Learning Disabilities)

Helen Swindlehurst (Head of Commissioning – Mental Health & Children
NHS Telford & Wrekin CCG)

Lesley Crawford (Director of Mental health Services – South Staffordshire and Shropshire Healthcare NHS Foundation Trust)

5 Provision of Stroke Services (Pages 15 - 32)

To review the recommendation that hyper acute stroke services should remain in Telford for the medium term (2014) with the longer term vision (from 2015) agreed through the NHS Future Fit Clinical Services Review. Report attached.

Representatives from the Shrewsbury and Telford Hospital NHS Trust will be in attendance.

6 Future Configuration of Hospital Services (Pages 33 - 48)

To consider the future configuration of hospital services, items to be addressed will include Women and Children's Services and the Travel & Transport Plan. Report attached.

Representatives from the Shrewsbury and Telford Hospital NHS Trust will be in attendance.

This page is intentionally left blank

TELFORD & WREKIN COUNCIL/SHROPSHIRE COUNCIL

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of a meeting of the Joint Health Overview and Scrutiny Committee held on Friday, 13 December 2013 at 1.00 pm at the Business Development Centre, Stafford Park 4, Telford

PRESENT – Councillor D White (TWC Health Scrutiny Chair) (Chairman), Councillor G Dakin (SC Health Scrutiny Chair), Mr D Beechey (SC Health Scrutiny Co-optee), Ms D Davis (TWC Health Scrutiny Co-optee), Cllr S Jones (SC), Cllr J Minor (TWC) and Mr R Shaw (TWC Health Scrutiny Co-optee)

Also Present –

Shrewsbury & Telford Hospital NHS Trust
Mr P Herring – Chief Executive
Dr E Borman - Medical Director

Telford & Wrekin Clinical Commissioning Group
Mr D Evans – Chief Officer
Ms F Beck – Executive Lead Commissioning

Shropshire Clinical Commissioning Group
Mr P Tulley - Chief Operating Officer

Shropshire Community Health NHS Trust
Ms J Thornby – Director of Governance & Strategy

NHS Commissioning Board (Shropshire & Staffordshire)
Ms D Wickham

Mrs F. Bottrill (Scrutiny Group Specialist, TWC)
Ms F Howe (Committee Officer, SC)
Mr P Smith (Democratic Services Team Leader, TWC)

JHOSC-13 APOLOGIES FOR ABSENCE

Cllr V Fletcher (TWC), Mrs J Gulliver (TWC Health Scrutiny Co-optee), Mr I Hulme (SC Health Scrutiny Co-optee), Cllr T Huffer (SC), Mrs M Thorn (SC Health Scrutiny Co-optee)

. .

JHOSC-14 DECLARATIONS OF INTEREST

None

JHOSC-15 MINUTES

RESOLVED – that the minutes of the meeting held on 23 September 2013 be confirmed as a correct record.

JHOSC-16 CALL TO ACTION

David Evans (Telford & Wrekin CCG) presented a report which updated the Committee on the local response to the national NHS 'Call to Action'.

An engagement pack had been developed by the Clinical Commissioning Groups (CCGs), which was available on-line (with a feedback form) and was used at a series of face-to-face presentations to key strategic local groups and stakeholders across the county. There was also a You Tube video; use of conventional and social media; and a number of roadshows in town centres or supermarkets. A full list of all the engagement activity was appended to the report. Also appended to the report was a summary of the feedback that had been received from the on-line Call to Action Survey (approximately 3000 responses had been received to date) and from a similar survey among clinicians across the care sectors. There was a correlation between issues raised in both surveys in terms of positives, negatives and opportunities. In order to provide an opportunity for the survey feedback to be shared with the public, and for further discussion and debate to take place, the CCGs arranged a whole day event at Telford International Centre on 25 November 2013. This was attended by over 300 delegates, and there was a clear message coming out of the discussions that there was a need for change within the local NHS and for the planning of long-term safe and sustainable health services. Edwin Borman (SaTH) added that this also reflected the view of clinicians about planning for the next 10-20 years.

The Committee then asked a number of questions and put forward comments on the response to 'Call to Action' within Shropshire and Telford & Wrekin:

If reform of primary health care was done well, this would have a positive benefit on acute hospital services. In particular, a lot more could be done at GP level, and it was essential that people saw real improvements at a local level before any further reform was attempted. It is also necessary to look at how we use Community Hospitals. This was borne out by responses in the on-line survey, which showed that access to primary care services was a concern for the public.
Response – David Evans advised that both CCGs were working on a strategy to deliver more services locally through various parties/agencies. One approach might be to build teams around GP practices in order to ensure that good quality acute care was available at a local level. Edwin Borman said that when people talk about access to health care they are usually talking about primary care, they have less concerns about access to secondary care. Dawn Wickham added that NHS England was rolling out a strategy for primary care, with further guidance likely in January 2014. This was a national approach that could be tailored to local circumstances and so would tie in with any initiatives in Shropshire and Telford & Wrekin. Julie Thornby stated that the

links between general and specialist community teams needed to be got right, and work was being undertaken to look at the options for ways in which people were treated in the community.

What lessons needed to be learned from previous NHS initiatives/re-structures?
Response – Dawn Wickham stated that 'Call to Action' was a good starting point. However, time was needed to work up proper solutions – experience had showed that rushing things did not lead to good outcomes. There also needed to be a strong clinical case for any changes to the way services were to be delivered. It was very important to have all partners involved to test out options to see if they will work in practice.

Were any proposals for future models of care that might arise from the 'Call to Action' going to be deliverable financially?
Response – David Evans stated that there would not be any extra funding, and that a solution needed to be delivered within the resources currently available. Not everything was going to be achievable resource-wise, and so dialogue needed to continue with local communities to identify priorities and find a sustainable solution.

What was the timescale for taking the Commissioning Strategy forward, and how would the JHOSC be involved?
Response – Paul Tulley advised that there were two main streams of work arising from 'Call to Action' – a clinical services review, and operational plans being produced by the CCGs by June 2014. These would include a shared plan and vision for the next 5 years. There would be discussions with partners before the plans went to the CCG Boards for consideration.

Members welcomed the amount of engagement that had already taken place as part of the 'Call to Action', and noted that the Committee would be kept informed of further progress on the Sustainable Clinical Services Strategy. It was commented that doing nothing is not an option. One co-optee expressed strong views at the impact on NHS staff of constant change, and questioned the need for further wholesale changes to services before previous re-configurations had had time to "bed down". There was also a need to educate the public about the implications of maintaining services on both hospital sites. The Chair added that hospital services were already highly scrutinised – it was important that money was spent on services not 'chasing awards'. He gave the example of the Mid Staffordshire hospital which had achieved Foundation Trust status but where patients had been neglected.

RESOLVED – that the report be noted.

JHOSC-17 CLINICAL SERVICES REVIEW

David Evans (Telford & Wrekin CCG) presented an update on the review of clinical services, and circulated a briefing paper.

The first meeting of the Programme Board overseeing the Review had recently taken place. A list of the organisations represented on the Programme Board was appended to the briefing paper. A number of work streams had been established to look at specific issues/services, with the aim of analysing in detail how services were currently used and comparing that with the best clinical practice. The Board had also agreed that there should be partnership working between clinicians and patients for more collaborative care. The aim was to put forward outline improvement plans by Autumn 2014. An outline timetable for the Programme was included in the briefing paper. It was a challenging timetable, but there was a clear aspiration to stick to it.

The Chair noted that the original timetable had slipped by six months, but that this was acceptable as long as it enabled a full and proper consultation exercise to be undertaken which gave people a clear rationale for the Review and the options available. Cllr Dakin added that any case for change in the way services were currently provided needed to be clearly spelt out to local people. Peter Herring (SaTH) stated that the Review was not a 'fait accompli'. The process would be transparent, and there needed to be a mature debate about the options and solutions available for providing long term high quality and sustainable patient care.

The NHS representatives were asked for reassurances that the current service was safe and 'fit for purpose' while the Review was taking place. Mr Evans replied that both CCGs were satisfied that hospital services were safe at the present time. It was possible some services might be jeopardised if the Review experienced a significant slippage in its timetable. In response to a question about why social care providers were not represented on the Programme Board, Mr Evans explained that the Board was already large and there was a risk of it becoming unwieldy if more representatives were added. However, other groups/organisations could be involved in some of the workstreams. A question was asked about how the Trust and CCGs respond to individual incidents for patients e.g. falls. Peter Herring responded that the the Clinical Service Review was a strategic review. However, when things do happen this would be looked into. Edwin Borman added that he would rather know when incidents happen and learn from them. If there was culpability this would be pursued. Members also wanted to know how the JHOSC would be kept informed of progress and involved in the process. Mr Evans advised that the Programme Board would be meeting regularly and there would be regular feedback directly to the JHOSC, and indirectly via newsletters etc.

The update and briefing paper were noted.

JHOSC-18 UPDATE ON STROKE SERVICE

Dr Edwin Borman (Medical Director, SaTH) provided an update on the performance of the hyper acute and acute stroke services following their temporary transfer to the Princess Royal Hospital (PRH), Telford in July 2013.

On most measures against both local targets and national performance standards, the service was now doing better, and was now above the national

average. From an analysis of patients coming from Powys, there did not appear to be any incidences of delays or missed treatment for thrombolosis. The experience over the last five months showed that this was potentially a model that demonstrated that better care for stroke patients could be provided by reconfiguring services.

The Chair remarked favourably on his visit to the stroke services unit at both hospital sites prior to the temporary transfer. In relation to patient admission, Dr Borman was asked whether they now go straight to the ward for scanning rather than being admitted through Accident & Emergency. Dr Borman advised that more patients were coming directly to the ward, although some were still coming in via A&E. There was still room for improvement in terms of the target for patients receiving a scan within one hour.

Cllr. Dakin asked if the improvement in service had been publicised through the press. Edwin Borman responded that the Trust had spoken to the press and a press release would be issued on Stroke Day.

JHOSC-19 NHS 111

Fran Beck (Telford & Wrekin CCG) presented a briefing paper on the current position regarding provision of the NHS 111 service to improve access to non-emergency urgent care.

Since West Midlands Ambulance Service had stepped in to run the Dudley Call Centre, the performance of the service had improved significantly. Assurance could be provided that the transition to the new provider had gone well, and that the Centre was now a very different place to before. Patient representatives on the CCG Board had visited the Call Centre, and were satisfied that it was now meeting demand. There had been no clinical incidents in the last 2-3 weeks. One or two technical issues had arisen, but had been dealt with through contingency planning. Capacity would be increased over the Christmas period to meet any additional demand.

NHS England had announced plans to re-procure 111 from 2015, and it was anticipated that there would be more focus on an integrated service between 111 and Out of Hours. In the meantime, there was a requirement to offer a 24/7 NHS 111 service that was fully compliant with national service specification. West Midlands Ambulance Service was the only provider able to deliver this at this time, and, after careful testing, the 111 divert from Dudley to Shropdoc was taken off on 26 November 2013. However, the Shropdoc number was still live, and so local callers could either call 111 or the Shropdoc number directly.

A pan-Shropshire project board, including both clinicians and patients, had been established to oversee the procurement of the new 111 service from 2015. In due course, the CCGs expected to report to the JHOSC on recommendations for a future model.

Members praised Shropdoc for the excellent job they had done in stepping in to the breach following the initial problems with 111. Fran Beck reassured the JHOSC that people could still ring Shropdoc directly. In response to a question about whether there was any difference in the response times between the Dudley 111 Call Centre and Shropdoc, Ms Beck stated that she did not have that detailed information. However, both providers were meeting targets and providing a very rapid response. Dawn Wickham (NHS England) added that the expertise of the Ambulance Service was now being applied to the 111 pathway, and the Call Centre was operating much better.

The Committee noted the report, and were satisfied that the 111 service was currently 'fit for purpose', and that contingencies were in place for any additional demand over the Christmas and winter period.

JHOSC-20 CHAIRS' UPDATE

Further to the item on Mental Health Services at the last meeting, the Chair reported on on-going concerns regarding the provision of mental health services, and the lack of consultation on apparent changes that were being made to the "blueprint" for the delivery of these services. Following a meeting with the Director of Commissioning at Telford & Wrekin CCG, it was agreed that the Telford & Wrekin Health & Adult Social Care Scrutiny Committee would be involved in a workshop to look at whether current services were 'fit for purpose', what needed to be improved and how this would be measured. There also needed to be an understanding of how this linked to the wider Clinical Services Review.

JHOSC-21 JOINT HOSC WORK PROGRAMME

The Chair reported on the items yet to be completed on the Committee's work programme. There was still some work to be done on monitoring of changes arising from the last re-configuration of hospital services, including the move of Women and Children's Services to the PRH and the Travel & Transport Plan. For the next meeting, it was agreed that there should be a "Holding to Account" session.

It was reported that this would be Fiona Howe's last meeting, as she was moving to a new position within Shropshire Council. Members thanked Fiona for the all the work she had done in supporting the JHOSC. Martin Stevens would be replacing Fiona as Shropshire Council's Committee Officer for health scrutiny.

The meeting closed at 2.17 pm

Chairman……..……

Date……..……

Health Overview & Scrutiny Committee

24th March 2014

Review of the Modernisation of Mental Health Services across

Shropshire, Telford & Wrekin

1.0 Background

1.1 In 1956 a promise was made to the people of Shropshire to build a new patient facility to replace the old asylum 'Shelton Hospital'. In September 2012, over 50 years later, the Redwoods Centre opened and Shelton finally closed. This was done in partnership between South Staffordshire & Shropshire Healthcare NHS Foundation Trust, Shropshire County and Telford & Wrekin PCTs and both local authorities.

1.2 The opening of the Redwoods Centre did not just represent the availability of better in-patient facilities, but a wider strategic approach to modernising mental health services. Partners recognised that without significant change, the way services were delivered would remain the same; and patients would not benefit from innovation. Consequently, in preparation for the closure of Shelton, all stakeholders involved committed to a wider 'modernisation programme', one which would challenge expectations and transform services.

1.3 Patient groups were engaged throughout the process and supported the concept of investing more in Home treatment, Crisis Resolution and Assertive Outreach services. The aim was to ensure these could become more responsive and accessible as the first line of support while increasing the numbers of staff in Community Mental Health Teams and in the Memory Service.

1.4 The proposals were in line with the extensive review recommendations and guidance at the time including:-

- New Horizons,
- Royal College of Psychiatry
- CQC requirements,
- The 'West London Review'
- 'Living Well with Dementia:
- The National Dementia Strategy' published by the Department of Health in 2009, which influenced the design of the healing environment of the new Redwoods Centre.
- Locally developed joint strategies between PCTs and the respective councils in Shropshire and Telford & Wrekin.

1.5 Since the local modernisation programme the Government has confirmed its commitment for the NHS to increase its focus on Mental Health services through the publishing of "Closing the Gap: Priorities for essential change in mental health" (Department of Health, 2014). This includes building on the objectives set out in the 2011 strategy "No health without mental health" and sets out the areas where people should see the fastest change e.g. high quality services with a focus on recovery, establishing clear waiting time limits, tackling inequalities in access.

1.6 NHS England has also focussed on *parity of esteem* to ensure that mental health services are given the same focus as physical health services. This is set out in the 2014/15 mandate from the Government to NHS England to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole" (Department of Health, November 2013) The government has also published the "Mental Health Crisis Concordat: Improving outcomes for people experiencing mental health crisis" (HM Government, 2014), the aim

of which is to ensure that local agencies work together to improve care provision for those experiencing a mental health crisis.

1.7 The future delivery of care provision has to be configured and delivered within the reality of the financial context where resources are finite; both Commissioners and Providers have financial targets to meet in the form of Cost Improvement Plans (CIP), Quality, Innovation, Prevention and Productivity plans (QIPP) and local government savings targets.

2.0 Current position

2.1 It is now 18 months since the new inpatient mental health provision, the Redwoods Centre was opened. Progress delivering the Modernisation Plan has been closely monitored by commissioners. At first this was through a joint sub group that reported to both PCT Boards in Shropshire and Telford & Wrekin. More recently it has been monitored by the joint CCG monthly contract and performance monitoring group with South Staffordshire & Shropshire Healthcare NHS Foundation Trust (SSSFT).

2.2 It is important that the assumptions in the original modernisation plan are revisited to establish whether they have been met and the model of care envisaged is still the most appropriate to meet the needs of our future populations. The original business case included an expectation that such a review should take place in the near future in two parts to consider a) the building project, and b) the wider expectations about better mental health services.

3.0 Castle Lodge beds

3.1 Castle Lodge is a nurse led unit with 12 beds developed prior to the Mental Health modernisation exercise as a step up/step down facility and before Crisis and Resolution teams and assertive outreach teams were expanded. It has effectively become 'redundant' in the new model of community based 'step up and step down teams'.

3.2 It was temporarily closed in September 2013 due to the reduction in use – keeping an empty unit open could not be justified financially. The development of crisis response and home treatment teams means that patients requiring this level of care can be better supported in their home environment rather than as in-patients. The monthly average bed occupancy level for the first 6 months of the year while it was open was 77.3%, whereas the average bed use by percent to Month 9 since it's closure has been 68.3%. There has been no increase in the numbers of out of area beds needed since September 2013.

3.3 There has also been a corresponding increase in activity by the Crisis Resolution/Home treatment teams. The beds at Castle Lodge were temporarily closed in September due to the reduction in use corresponding to the increase in support in the community. At that time only 50 % of the available beds had been occupied by residents of Telford and Wrekin over the previous 6 months in line with the general trend for overall bed occupancy for T&W reducing to well below contracted levels by around 30%.

4.0 Benefits realisation review process

4.1 HOSC members are already aware of the intention by both CCG boards and SSSFT that a review of the modernisation process should take place – as set out in the original business case. The first part of the review on the outcomes of the new build project plan has been completed and findings presented at the SSSFT board. This process is being managed directly by the SSSFT and is not within the scope of this review.

The scope of the review covers:

- Inpatient bed facilities provided by SSSFT for Shropshire and Telford & Wrekin patients
- Out of Area patient placements where the bed has been purchased due to a gap in local

capacity rather than the need for specialist placement
- Community Services provided by SSSFT for Shropshire and Telford & Wrekin patients

The review does not include:
- The provision of diagnosis/care for patient presenting with Autistic Spectrum Disorder (ASD). There is a separate piece of work being undertaken regarding this.
- The Redwoods building project plan – this work has already been undertaken by the SSSFT.

While the implications for future modernisation are potentially far reaching, the review is also focusing on the bed capacity needed across Shropshire and Telford & Wrekin to inform the decision about whether to make the 'temporary' closure of Castle Lodge Permanent.

4.2 The review is being led by CCG commissioning leads with support from a steering group with representation from SSSFT, both CCGs and both local authorities.

4.3 The review to assess the assumed service benefits of the modernisation programme is underway and is based on three components:-

Step 1 - A review of the modernisation exercise – have the anticipated benefits been realised?

Current/planned activities within this component include:
- Interrogation of the data to identify changes in activity between in-patient and community settings measured against the outcomes set out in the original business case.
- Completion of a case note audit of the use of psychiatric intensive care (PICU) to give assurances to CCGs about the levels of demand/need and appropriateness of use and length of stay in PICU; and to assess the usage of out of area beds for PICU and other acute care.
- To review the key assumption in the modernisation plan about the balance of inpatient and community based care – was the modelling right, and have workforce development and capacity building exercises been properly completed so the new model is working?

Step 2 - A review of current against best practice to help us understand what 'Good' Mental Health Services look like.

Current/planned activities within this component include:
- Undertake literature review of best practice and recent NHS guidance
- Complete benchmarking exercise of current provision against this information
- To check whether current provision offers safe arrangements

Step 3 - Engagement with stakeholders to ensure they inform both 1 & 2 above and subsequently decisions about best service design and best use of resources.

5.0 Progress to date

5.1 Key points to note from stage one of the review to date include the following:
- Initially, it took some time for the staff in the Crisis and Home treatment and community teams to be appointed, inducted, trained and developed, and indeed this work is still ongoing. The plan was ambitious as it involve retraining staff who had previously not had community experience, and for those who had to learn new skills.
- More recently the volume of community based activity has increased, and service users are being appropriately supported in community environments. This increase in community activity has been particularly notable in the Memory Service which includes the Memory Clinic and Dementia Home Treatment teams.
- While the need to access beds out of area for acute care or for psychiatric intensive care (PICU) continues there has been a reduction in the numbers of people cared for out of area

from 2012/13. Most 'out of area' admissions during 13/14 have been for either psychiatric intensive care or to acute beds within the Trust wider capacity but out of Shropshire or Telford. Psychiatric Intensive Care is commissioned on a cost and volume arrangement with SSSFT or other hospitals out of area – it is not in the block contract with SSSFT.

- The intention in the initial business case was to reduce the average length of stay for inpatients in acute beds. The modelling assumption was that the average length of stay would be 27.1 days. The current cumulative length of stay at Month 9 (2013/14) is 30.2 days although the trend based on month 9 (December 2013) (when there was an average length of stay of 27.5 days), suggests this will continue to reduce and the target could be achieved during 14/15.
- There are ongoing debates nationally about the need to further improve services for people suffering with Dementia, which can be considered a long term condition where hospital admission (in an unfamiliar environment) may not be the right place to offer care. In our patch we do not currently have a 7 day service; two thirds of admissions are out of hours; and community teams operate a caseload model which may not be the most responsive model. Team structures and models of care are inconsistent and much more needs to be done to understand the needs of carers.
- SSSFT Directors have used internal benchmarking to highlight differences in clinical effectiveness and productivity of local teams in Shropshire/Telford & Wrekin, (although for the trust these issues may apply across the whole of their area). While quality and performance measures for the trust are generally positive, there is scope for improvement in service models.

  For example:-
  - Some Community teams have twice as many referrals as others with the same population
  - Caseloads in one locality are 25% lower than another with the same population, but referrals are 15% higher
  - Length of stay on wards varies considerably
  - Delayed transfers of care are increasing year on year – which suggests some challenges with interface issues with partners, particularly Social Care and Housing.
  - Home treatment / crisis services – flexibility and treatments vary
  - Limited use of personal budgets

5.2 Key points to note from stage two of the review to date include the following:

- South Staffordshire & Shropshire NHS Foundation Trust (SSSFT) is part of the NHS Benchmarking Network. The mental health benchmarking report (2013) demonstrates that the number of occupied acute beds across the Trust is at the median level of bed provision and is at the lower percentile for acute adult admissions and occupied bed days per 100,000 population. It is also at the median level for length of stay. It is important to note that the 'occupied bed day' capacity (the term in the contract for bed capacity) includes Castle Lodge.
- The trust has embarked on an internal programme of improvements and is engaging staff, service users carers and wider stakeholders in that. Managers are reviewing the skill mix in each team to ensure the most expensive staff are being used more effectively, and are piloting new innovative approaches, for example increases rehabilitation support for Dementia patients.
- These changes are being steered in the context of needing to identify savings of circa £14m over the next 3 years on top of commissioner savings, so must deliver more cost effective approaches in addition to improving clinical outcomes.
- Mental Health Services are not without guidance on what 'Good' looks like. The evidence continues to point to a patient centred approach with a focus on 'recovery.
- A pathway approach whereby prevention, early intervention and support to avoid crisis, with a range of rapid interventions to manage unavoidable escalations immediately and sensitively – which may involve a period of in-patient care, followed by effective rehabilitation is still, in a

nutshell, the 'Gold Standard'.

- To achieve this requires an effective partnership model with service users, carers and all key agencies, and for Mental Health staff to be supported in developing a skillset so they can deliver evidence based interventions at the right time and place.

5.3 Key points to note from stage 3 of the review include the following:

- The review of the modernisation includes engagement with patients, carers and other stakeholders to determine their experiences as a result of the changes made to date. The questions asked through the period of engagement will be based on the assumptions set out in the initial business case, AND the outputs from steps one and two above.
- The engagement period will run for a six week period from the beginning of April to mid-May. This will be organised and all information collated by the Communications team, Staffordshire Commissioning Support Unit. The CCG Patient & Public Involvement leads and representatives from the Councils will also be involved in the process. The intention to engage has been presented at both CCG patient engagement groups. Local Authorities, Healthwatch, Carers groups, Voluntary sector forums and other appropriate groups will be involved.
- There will be CCG representation at the SSSFT patient engagement group on 18th March to discuss how best to engage with patients and carers and this will feed into a planning meeting to be held on 25th March. The engagement period will culminate in a large event in mid-May which will be professionally facilitated.
- As well as engagement events, information will also be collated from complaints departments, the Friends & Family initiative and the real time patient experience surveys that are on-going.
- The steering group would also ask members of the HOSC for comments on the findings to date, and the high level proposals for future modernisation.

Appendix A sets out how the engagement will be carried out.

6.0 Final Report

6.1 The final review report scheduled for June will provide recommendations for how we improve:-

- Needs assessment of mental health needs of our population
- Are current pathways 'fit for future' – do they provide clear integrated pathways?
- Agreeing on what "good" looks like – as above? Or what?
- What does the balance between inpatient and Home Treatment services need to be?
- Embedding the recovery model and having the user at the centre of care delivery
- Flexible use of beds - type and location
- Ensuring all services are clinically responsive and safe?
- Reducing variability in care provision between localities thus ensuring that there is consistency of care delivery across the health economy
- Ensuring timely access to care in the event of a crisis in line with the Concordat
- Access to support to prevent crises occurring and staying well to prevent further crises
- Wherever possible to avoid hospital admission by providing alternative care and support
- Working in close partnership with other agencies and stakeholders.

7.0 Next steps

7.1 The review team will bring a final report to the CCG Boards and HOSC in June as planned. This will include a complete set of recommendations based on the analysis and engagement underway.

7.2 The recommendations will inform strategic delivery plans to ensure that the local population has timely access to modern, high quality accessible and responsive mental health services that are amongst the best in the country, and offer best use of finite resources.

8.0 Recommendations

8.1 HOSC members are asked to:-

1. Note progress to date
2. Comment on the plans set out for the review of the Modernisation of Mental Health Services
3. Contribute to the county wide debate on ‘what do good mental health services look like?’

Appendix A

Modernisation of Mental Health Services across Shropshire and Telford

Proposals for Engagement

The modernisation of mental health services locally continues. Modernisation to date has included the opening of The Redwoods Centre, Shrewsbury, increases in community services and, more recently, the temporary closure of Castle Lodge, a bed based facility in Telford.

As mental health services across Telford and Shropshire enter a new phase, it is important to carry out meaningful engagement with patient groups and organisations in relation to these services. A six week programme of activities with various groups is planned, beginning in April, and this will culminate in a large public event during May.

Objectives

- To gain service user feedback regarding the expected benefits of the mental health modernisation programme
- To gather feedback from key stakeholder groups about what they want from a modern mental health service and how these services can best be delivered

Areas to address include:

1. **Improved access**
    - How accessible is crisis support when it's needed?
    - How do you access community mental health teams?
    - When referred for a bed – has it been available?
    - Has access to psychological therapy in hospital improved?
    - Has access to the Memory Service improved?

2. **Safety and minimising risk**
    - Patient experience in the hospital environment – does it feel like a safe and supported environment?
    - Does it feel different to Shelton? If so – how?
    - Staffing levels – do they feel appropriate?

3. **Better care/increased services in the community**
    - Does it feel as if there is more care in the community?
    - How accessible/responsive is it?

4. **Is the ward accommodation better than before?**
   16-bed wards /wifi/ ensuite now in place
    - Are better outcomes achieved?

5. **PLACE (formerly PEAT) ratings**
   - Are service users involved in the ward assessments?

6. How would you like to be engaged when being asked for your feedback in the future?

This page is intentionally left blank

The Shrewsbury and Telford Hospital NHS Trust

Reporting to:	**Joint Health Overview and Scrutiny Committee Meeting, 24 March 2014**
Title	Medium term configuration of Stroke Services provided by The Shrewsbury and Telford Hospital NHS Trust
Sponsoring Director	Dr Edwin Borman, Medical Director
Authors	Dr Edwin Borman, Medical Director Debbie Kadum, Chief Operating Officer Adrian Osborne, Communications Director
Previously considered by	The Shrewsbury and Telford Hospital NHS Trust - Hospital Executive Committee, 25 February 2014 Shropshire Clinical Commissioning Group Quality and Resources Committee, 26 February 2014 The Shrewsbury and Telford Hospital NHS Trust - Trust Board, 27 February 2014 Shropshire Clinical Commissioning Group Governing Board, 12 March 2014
Discussion and Summary	Joint HOSC Members will be aware that hyper-acute stroke services were consolidated on to the Princess Royal Hospital (PRH) site last summer, initially as a urgent short term measure, but then on a continuing interim basis – with the agreement of CCGs and the Joint Health Overview and Scrutiny Committee – when early review suggested that the single site service was providing measurable improvements in key service standards which are a proxy for patient outcomes. The Trust has understand a review of options for the medium term configuration of stroke services which has concluded that (a) the hyper-acute stroke service should continue to be unified in the medium term as this has the greatest scope for offering the best outcomes for patients (b) the clinical quality of the service at PRH and RSH is not a differentiating factor as the multi-disciplinary teams at both sites provide a high standard of service (c) the capacity of the hospitals to accommodate a single site service is a differentiating factor as there is not capacity at the RSH without adverse impact on either timely access or requiring significant changes to other services. The review has therefore recommended that the hyper-acute stroke service be maintained at the Princess Royal Hospital whilst the longer term shape of stroke services is agreed through the NHS Future Fit review. The attached paper provides more information about this review and the rationale for the recommendation on the medium term configuration. In addition to the information contained in this report: • Shropshire CCG has reached agreement with WMAS with regard to the impact on ambulance services of the consolidation on a non-recurrent block basis for 2014/15. This is to allow the full detailed modelling work on ambulance resources required for Shropshire to be undertaken locally to inform future contractual arrangements from 2015/16 onwards. • The Shrewsbury and Telford Hospital NHS Trust has set out a programme of work for implementation and transition in the context of NHS Future Fit, which is set out overleaf. This recommendation has been endorsed by the Board of The Shrewsbury and Telford Hospital NHS Trust and is presented for consideration by the Joint Health Overview and Scrutiny Committee for Shropshire and Telford & Wrekin

It is anticipated that the programme of implementation and ongoing review by the Trust will include:

Review of quality and outcomes	Continuation of the quality review programme which includes:		
	• Continued ongoing clinical review by the Trust	SATH	Ongoing
	• Continued robust incident reporting to identify and review any issues of concern	SATH, Ambulance Services, GPs/Commissioners	Ongoing
	• Continued monthly quality and performance indicator reports for review at commissioner level	SATH, Commissioners	Monthly
	• Ongoing patient experience monitoring	SATH	Quarterly
	• Continued quarterly review meetings	SATH, Ambulance Services, Commissioners	Quarterly
Workforce	Formalisation of the staffing model (medical, nursing, therapies, diagnostics) for the coming year to maintain and improve cross-site working and make further progress towards seven day working, in the context of wider plans across the Trust towards seven day working.	SATH	End March 2014
Vision for medical services	Development of the above in the context of the wider model for acute medical services in the medium term. Continued movement towards the standards set out in the Midlands and East Stroke Services Review will be incorporated into this, although there are significant interdependencies with progress on the NHS Future Fit Clinical Services Review.	SATH	End March 2014
Pathways	Formalisation of pathway for direct transfer of patients from PRH to Newtown Hospital (e.g. those assessed as ESD-viable)	SATH, Powys	End March 2014
	Continuing to work with Ward 22S/R at RSH to strengthen and reinforce the vital role of stroke rehabilitation within the stroke pathway	SATH	End March 2014
	Sustained access to TIA including development of plans for seven day working.	SATH	Ongoing
Engagement & Communication	Communication and engagement with our communities, including clarity on the clinical basis for this decision and reiterating to our communities and commissioners that the long term shape of the county's hyper-acute stroke services will be agreed through the NHS Future Fit review.	SATH, NHS Future Fit Programme	End January 2015
Patient and Carer Experience	Work with patient and community partners to continue to strengthen pastoral support for families and carers	SATH, Patient and Community Groups	End April 2014
Contracting	Reflect medium term model for hyper acute stroke services in contracting process	All	End March 2014

Stroke Services: Ensuring the best outcomes for patients and communities in the year ahead

Progress and Way Forward

Version 3.0, 3 March 2014

Summary

- The most important message for anyone with a suspected stroke is

  "When Stroke Strikes, Act F.A.S.T."

  - FACE: Has their face fallen on one side? Can they smile?
  - ARMS: Can they raise both arms and keep them there?
  - SPEECH: Is their speech slurred?
  - TIME: Time to call 999 if you see any one of these signs

- The way that people access stroke services in an emergency has not changed. As now:
  - If you dial 999 you will be taken straight to the best place to provide your care.
  - If you are referred urgently by your GP then you will be referred straight to the best place to provide your care.
  - If you walk in to A&E or another urgent care service you will be assessed and they will arrange treatment or transfer to the best place to provide your care. Both hospitals continue to be able to provide stroke thrombolysis and TIA services.

- Where people receive some of their stroke care has changed for a temporary period:
  - Hyper acute stroke services are currently provided at the Princess Royal Hospital in Telford.
  - Acute stroke services and stroke rehabilitation in an acute setting continue to be provided at both the Royal Shrewsbury Hospital and the Princess Royal Hospital.
  - A&E services continue to be provided at the Princess Royal Hospital and the Royal Shrewsbury Hospital.

- Following the temporary changes to stroke services introduced in summer 2013 (which saw the Princess Royal Hospital become the Trust's centre for hyper-acute stroke services on an interim basis) we have reviewed these changes on detail with a particular focus on quality and access for patients. This has identified a sustained improvement in overall access to definitive stroke care, which in turn is associated with improved outcomes for patients. There are longer travel times for some patients in the west of our catchment but significantly more patients are receiving CT scan within 1 hour of arrival and being admitted to an acute stroke unit within 4 hours of arrival at the unified PRH service compared with the RSH service for the same period the previous year.

- Whilst both sites have the skills and capabilities within the stroke team to be the unified site, the distinguishing factor is the capacity within the two hospitals to accommodate the unified hyper-acute stroke service. Specifically, RSH does not have the capacity to host this service in the medium term without significant changes to other hospital services. We therefore recommend that the unified service at PRH continues **until the longer term shape of the county's acute and community hospital services has been developed through the NHS Future Fit clinical services review**.

- The decision to continue to provide unified hyper acute stroke services at the Princess Royal Hospital pending the NHS Future Fit clinical services review would not and could not prejudge the outcome of that review.

- This recommendation is based on detailed and ongoing review of quality, safety, outcomes and experience for stroke patients across Shropshire, Telford & Wrekin and mid Wales. This process will continue so that the safety, outcomes, recovery and experience of our patients remains paramount.

Page 18

1. Current Position

Patients and communities across Shropshire, Telford & Wrekin and mid Wales expect and deserve the highest standards of safe, high quality, up-to-date clinical care for stroke that:

- increases survival rates
- improves quality by reducing disability and shortening recovery times, and
- improves patient experience.

The Shrewsbury and Telford Hospital NHS Trust strives for the highest standards of care, and working with patients and partner organisations we have already begun to develop a vision for the future of stroke services in the county.

In response to short term staffing challenges during summer 2013, the Trust acted promptly to secure safe, dignified stroke services for our patients and communities. This included the temporary unification of hyper acute and acute stroke services at the Princess Royal Hospital in Telford.

During this unification there has been clear evidence of improved performance against key stroke indicators that provide a proxy for improved patient outcomes (e.g. admission to specialist stroke unit within four hours of arrival, 90% of time spent in acute stroke unit, access to CT).

The table below compares (a) current performance during the temporary unification with (b) local standards, (c) national averages and (d) prior period performance.

Table 1: Comparison of Stroke Access - Single Site HASU at PRH (Jul to Dec 13) vs. Two Site HASU at PRH & RSH (Jul to Dec 12)

(a) Data for period 1 July 2013 to 31 December 2013			(b) Local Standard	(c) National Average (1Jul-30Sep 13)	(d) Data for period 1 July 2012 to 31 December 2012			
					PRH		RSH	
Number of stroke admissions to PRH		444				245		215
Number of discharges		435				232		214
% receiving thrombolysis	GREEN	**13%**	10%	11.8%	GREEN	11%	AMBER	7%
% admitted to Acute Stroke Unit within 4 hours of arrival	GREEN	**85%**	70%	58%	GREEN	85%	RED	48%
% receiving CT within 1 hr of arrival	AMBER	**47%**	50%	41%	AMBER	45%	RED	26%
% receiving CT within 24 hours of arrival	GREEN	**94%**	90%	93%	GREEN	91%	AMBER	81%
% spending 90% of their time on Acute Stroke Unit	GREEN	**89%**	80%	84%	GREEN	93%	AMBER	62%
Dysphagia Link Nurse (swallow) assessment within 4 hours	GREEN	**70%**	70%	57%	GREEN	78%	AMBER	65%

The table demonstrates that:

- Performance against stroke standards has significantly improved compared with the service at RSH for the equivalent period in 2012. This is not a reflection of the clinical care and treatment provided by the multi-disciplinary team but reflects the wider challenges for capacity and flow in the hospital.

- Performance against stroke standards has been maintained compared with the service at PRH during the equivalent period in 2012.

Note that these are access and time-to-treatment indicators that do not reflect the quality of care provided by doctors, nurses, therapists and wider hospital teams. A wider set of quality standards (e.g. relating to issues such as access to therapies) is also vital to the ongoing review and improvement of stroke services. We are clear that there are no clinical grounds to differentiate between the two sites, and patients can be reassured about the commitment, skills and competence of the multi-disciplinary team at both PRH and RSH.

But, based on these indicators and the wider experience of providing specialist stroke services from a single site, clinicians in the Trust asked for more time to review the service. Specifically, this included reviewing whether a return to two-site services, albeit only for the medium term pending decisions on the wider shape of acute and community hospital services through the NHS Future Fit review, may represent a retrograde step if this reduced our ability to offer our patients improved outcomes.

It was therefore agreed with commissioners that the unification should be extended for a further temporary period so that the benefits and disadvantages could be reviewed and a recommendation made for the provision of these services for the medium term (to 2014).

Improvements in access to stroke services during the temporary unification of hyper acute and acute stroke services at the Princess Royal Hospital in summer 2013 led to a request by hospital clinicians to review the potential benefits of continuing with a single site service for the medium term.

2. Longer Term Vision for Stroke Services

The recent review of stroke services across the Midlands and East of England recommended that hyper-acute stroke services should be provided by services seeing at least 600 stroke patient admissions each year, supported by a seven day a week specialist stroke workforce.

Locally, hyper-acute stroke services have been provided from two sites, each seeing in the region of 450 stroke patient admissions each year. There is a strong view amongst our clinical staff that moving to a single centre of excellence for hyper-acute and acute stroke services will create the conditions for improved clinical outcomes for stroke patients through increased survival, and increased quality by reducing disability and shortening recovery times. It will support the local NHS to develop and maintain a specialist 7-day workforce (currently 5-day) ensuring rapid and daily access to specialist expertise for stroke patients during a critical period of their treatment and recovery.

Providing services from two smaller sites reduces the ability of the local NHS to recruit and retain sufficient specialist workforce to develop and maintain a 7-day service. This has major implications for the capacity and resilience within the workforce to cover periods of short term vacancies and other leave. The recent short-term workforce challenges that faced our stroke services are a further indication of the potential benefits from moving to a single site service in the longer term.

However, any medium term changes do not and will not pre-judge the longer term decisions that will need to be made about a move to a permanent single site service (and the location of that service). Instead, the clinically-led recommendations developed with patient and community engagement following the Midlands and East Stroke Services Review need to be debated and tested more widely, and considered alongside wider challenges and opportunities for improving clinical outcomes, patient safety and patient experience in the county's acute and community hospital services and beyond.

It is therefore recommended that the vision for stroke services beyond 2014 should be developed through the NHS Future Fit review of community and acute hospital services in Shropshire and Telford & Wrekin (involving all communities served by these hospitals in Shropshire, Telford & Wrekin and mid Wales).

The agreed long term vision for stroke services is a single site for hyper acute and acute stroke services, the location of which should be decided as part of the NHS Future Fit review.

3. The main features of the stroke service at the Princess Royal Hospital and the Royal Shrewsbury Hospital

The main features of the Trust's stroke service are as follows:

- **Hyper Acute Stroke Units** (HASU) – Both the Princess Royal Hospital and the Royal Shrewsbury Hospital have facilities for a Hyper Acute Stroke Unit although currently this service is unified at the Princess Royal Hospital. These provide expert specialist clinical assessment, rapid imaging and the ability to deliver intravenous thrombolysis 24/7. Patients typically need this higher level of support for up to 72 hours after admission. During this period of their treatment, patients should typically receive an early multidisciplinary assessment, including screening of the ability to swallow and, for those that continue to need it, have prompt access to high-quality stroke care.
- **Acute Stroke Units** (ASU) - Both the Princess Royal Hospital and the Royal Shrewsbury Hospital have facilities for an Acute Stroke Unit although currently this service is only provided at the Princess Royal Hospital. These provide care immediately following the hyper-acute phase, usually after the first 72 hours following admission (the hyper-acute phase) for 3 to 7 days. Acute stroke care services provide continuing specialist and multidisciplinary care, continued access to stroke trained consultant care, access to physiological monitoring and access to urgent imaging as required. In-hospital rehabilitation continues or is initiated, with rehabilitation goals identified to support planning for discharge from the acute hospital setting.
- **Stroke Rehabilitation** – Stroke rehabilitation is provided at the Princess Royal Hospital and the Royal Shrewsbury Hospital. This provides specialist rehabilitation tailored to the needs of the individual, supporting them to leave acute hospital.

Stroke services are supported by a wide range of other care professions including radiography, dietetics, speech and language therapy, occupational therapy, physiotherapy and many other specialties depending on individual needs.

A model of stroke services with two HASUs and two ASUs in Shropshire is not consistent with the long term vision.

Before the current temporary unification of stroke services, HASU, ASU and stroke rehabilitation have been provided at both PRH and RSH. Stroke rehabilitation continues to be provided at both sites.

4. Options for the Medium Term

The options for the medium term (pending the outcome of the NHS Future Fit review) are set out below. The medium term configuration would be in place until longer term options are developed through NHS Future Fit review of acute and community hospital services (currently expected by the beginning of 2015).

Option	Assessment
(1) Maintain single site hyper acute and acute stroke services for the medium term. Acute-based stroke rehabilitation continuing at both PRH and RSH.	This is consistent with the longer term vision for stroke services, and there is a strong clinical preference for a single site HASU and ASU in order to create the conditions for improving outcomes for stroke patients through increased survival, and increased quality by reducing disability and shortening recovery times. There is greater scope for maintaining the improvements in key stroke indicators that have been observed during the temporary single site service during Summer 2013. There is greater scope for accelerating development towards 7-day consultant access which is not feasible with a two-site model. Feasibility should be tested for both (1a) PRH and (1b) RSH.
(2) Return to two site hyper acute and acute stroke service until longer term vision for stroke services is developed as part of wider strategy for acute and community hospital services.	Under this option the service would return to the configuration as at June 2013. This is counter to the clinical preference and the longer term vision for stroke services which is for unification of hyper acute and acute stroke services. The benefits in terms of improvement in key stroke indicators are not expected to be maintained. There is public voice in support of maintaining stroke services as locally as possible, and also anxiety that medium term changes will drive the long term shape of stroke services. We can provide assurance that the location in the medium term does not and will not influence the longer term location of stroke services. Development towards 7-day consultant-delivered service would be delayed until the longer term configuration of stroke services is implemented.

There are two main options (plus sub-options) for the medium term and both options should be considered.

5. Options for the Longer Term

The preferred option for the longer term (from 2015) is set out below. This would be tested and developed further, including decisions on the location of services, through the NHS Future Fit review.

Option	Assessment
Single site hyper acute and acute stroke services at a location to be agreed. Acute-based stroke rehabilitation continuing at both PRH and RSH.	The longer term vision for stroke services is for a single site HASU and ASU in order to create the conditions for improving outcomes for stroke patients through increased survival, and increased quality by reducing disability and shortening recovery times. This also provides greater scope to strengthen early access to senior clinical-decision makers through the development and maintenance of new models of 7-day working including 7-day consultant access. Feasibility should be tested for both (a) Princess Royal Hospital and (b) Royal Shrewsbury Hospital.

There is one option for the long term, with two sub-options which should be developed and tested through the wider review of acute and community hospital services in the year ahead.

Page 22

6. Consideration of Medium Term Options

The following factors have been considered in the review of options for stroke service configuration in the medium term:

	Criterion	Description	Factors
1	Clinical Outcomes and Access	A fast response to stroke, from onset of symptoms to definitive treatment, reduces the risk of mortality and disability. The identification of potential stroke patients and their timely admission to an appropriate stroke centre is a critical stage of the care pathway. Reduced door to needle time for stroke thrombolysis patients increases the chances of survival, recovery and reduced disability.	Reduced in-hospital delays to ensure prompt access to diagnosis and definitive treatment. Ambulance service transfer time from Shropshire, Telford & Wrekin and mid Wales to Hyper Acute Stroke Service. Ability to maintain clinical outcomes at current levels if not better.
2	Patient experience	Our aspiration is to provide high standards of dignified care for every patient and the people who care for them, which includes maximising opportunities for joined up care.	Accessibility for carers and relatives. Satisfaction of joined up care between home, hospital, community. Number of steps in the pathway (e.g. same or separate locations for HASU/ASU and rehabilitation).
3	Feasibility and deliverability	It must be feasible to deliver the service for the medium term, taking into account factors such as capacity (e.g. physical space), capability (e.g. specialist skills) and business continuity (e.g. maintaining service standards during any period of change).	Capacity to accommodate the service. Effectiveness of business continuity plans. Opportunity cost.
4	Wider impact	The wider impact on other services inside and outside hospital must also be considered (for example, if another service would need to move to accommodate a single site stroke service then this will have additional risks and benefits)	Impact on safety and sustainability of other services.

Assessment of medium term options will consider clinical outcomes & access, patient experience, feasibility & deliverability, and wider impact.

7. Assessment of Medium Term Options

The Trust has ensured that clinical audits and reviews have taken place in relation to key areas of patient outcomes and experience of the stroke service. These have included:

- Patient Experience
- Access to CT scan
- Missed opportunities to provide thrombolysis, and time from onset to symptoms definitive treatment including impact of additional travel time
- Access to acute stroke unit
- Impact on ambulance service deployment

7.1 Patient Experience

Ongoing review of patient experience has been a central aspect of the interim changes to stroke services, and the results are reviewed at quarterly quality and operational review meetings with commissioners and ambulance service partners[1]. Data for the period July to October 2013 is set out in the tables below, generally showing a positive patient experience with some key areas for improvement, including continuing to identify ways to strengthen pastoral care where patients and their family and carers are travelling further for specialist care that delivers the highest standards of safety and outcomes:

1. From the time you first arrived at hospital, how long did you wait before being examined by a doctor or nurse?		
I did not have to wait	44%	Nearly 90% of patients reported that they were examined by a doctor or nurse within 30 minutes of arrival at hospital. Two thirds of patients reported being examined within 15 minutes
Up to 15 minutes	22%	
16 – 30 minutes	22%	
31 – 60 minutes	11%	
More than 1 hour but no more than 2 hours	0%	
More than 2 hours	0%	
Don't know / Can't remember	n/a	

2. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?		
No	78%	Over three quarters of patients did not feel they had to wait a long time to get to a bed on a ward.
Yes, to some extent	22%	
Yes, definitely	0%	

[1] Note that the change to single site hyper-acute stroke services was implemented promptly to ensure safe stroke services in response to short term staffing challenges. The enhanced level of patient experience monitoring was introduced following this change and therefore comparable data for the previous service model is not available

3. Did you feel happy with the care and treatment you received during your stay at The Princess Royal Hospital, Telford?		
Yes, all of the time	78%	Over three quarters of patients reported that they were happy with their care all of the time.
Yes, some of the time	22%	
No	0%	
Don't know	0%	

4. (For patients who would previously have received their hyper acute care at RSH) How did you feel about being an inpatient at The Princess Royal if you thought you would normally access in-patient hospital services at The Royal Shrewsbury Hospital, Shrewsbury?		
Very happy	44%	Over 85% of patients who expressed a view said that they were very or mostly happy with being an inpatient at RSH.
Mostly happy	23%	
Not happy at all	11%	
Don't know	22%	

5. (For patients who would previously have received their hyper acute care at RSH) What was your experience of travelling and being admitted to The Princess Royal Hospital, Telford :		
Did not mind the extra distance	56%	14% of patients expressing a view felt that PRH was too far for relatives to visit. Further improvements to support relatives should be considered if a decision is made to retain single-site hyper-acute services at the Princess Royal Hospital.
Felt further, but didn't cause any problems to me or my relatives	11%	
Too far for my relatives to visit	11%	
Didn't mind once I realised I'd be transferred nearer to home if necessary, after 72 hours	0	
Don't know	22%	

6. Were you involved as much as you wanted to be in decisions about your care and treatment?		
Yes definitely	67%	11% of patients did not feel they were well enough involved in decision about their care. There is room for improvement, but this is higher than the overall score for the Trust.
Yes to some extent	22%	
No	0%	
I was not well enough to be involved in decisions about my care	11%	

7. Did hospital staff take your family or home situation into account when planning your transfer/discharge?		
Yes completely	44%	All patients who expressed a view reported that their home or family circumstances were taken into account completely or to some extent. No one reported that their circumstances were not taken into account.
Yes to some extent	22%	
No	0%	
It was not necessary	22%	
Don't know / can't remember	11%	

7.2 Access to CT scan

Receiving CT scan within 1 hour of arrival is an important process milestone for patients eligible for thrombolysis as it provides vital information to support the assessment of suitability of this treatment. A critical clinical question therefore is the proportion of patients eligible for thrombolysis who receive their CT scan within 1 hour.

The Trust has introduced a new performance measure to identify patients eligible for thrombolysis and record the number who received their CT scan within 1 hour of arrival. Since recording began in September 2013 up to the end of December 2013, 100% of patients eligible for thrombolysis have received their CT scan within 1 hour of arrival.

This indicates that the patients with the greatest clinical need for CT received this within one hour.

Additionally during the same period (1 September 2013 to 31 December 2013) nearly half of all patients (47%) received CT within 1 hour (broadly comparable with the national standard of 50% within 1 hour); and nearly all stroke patients (95%) received CT within 24 hours.

Challenges specific to PRH: There is a single CT scanner. Mitigation is provided through maintained access for urgent scans (e.g. stroke) during periods of planned maintenance, and through continued access to cross-site CT scan during unplanned maintenance.

Challenges specific to RSH: There are significant additional demands on CT scanning as the hospital is the main site for acute surgery. The presence of a second CT scanner provides some on-site resilience for planned maintenance. However, this scanner is designated for cancer services so reliance on this during unplanned maintenance can impact on other care pathways. There is also continued access to cross-site CT during unplanned maintenance.

7.3 Missed Opportunities to provide thrombolysis

Thrombolysis treatment for eligible patients is recommended up to 3 hours following onset of symptoms for individuals over 80 and up to 4.5 hours following onset of treatment for individuals under 80. Based on a review of patient notes, no missed opportunities to provide thrombolysis due to extended travel time have been identified during the temporary unification of hyper acute stroke services at the Princess Royal Hospital.

A review of patients where the time of onset of symptoms could be assessed has not identified any patients experiencing a pathway from onset to arrival greater than 3 hours (see overleaf). Note that individuals waking up with stroke symptoms are not included as the time of onset cannot be identified, and patients are therefore not normally eligible for thrombolysis.

Whilst some concerns have been expressed by members of the public about the potential impact of extended travel times on outcomes, no adverse outcomes or missed opportunities to provide thrombolysis have been identified and continued opportunities for reducing time from arrival to treatment can provide additional mitigation.

It is important to note that RSH has continued and will continue to maintain the facility and capability to deliver thrombolysis if required (e.g. a stroke identified in a patient already admitted with a different primary diagnosis)

Page 26

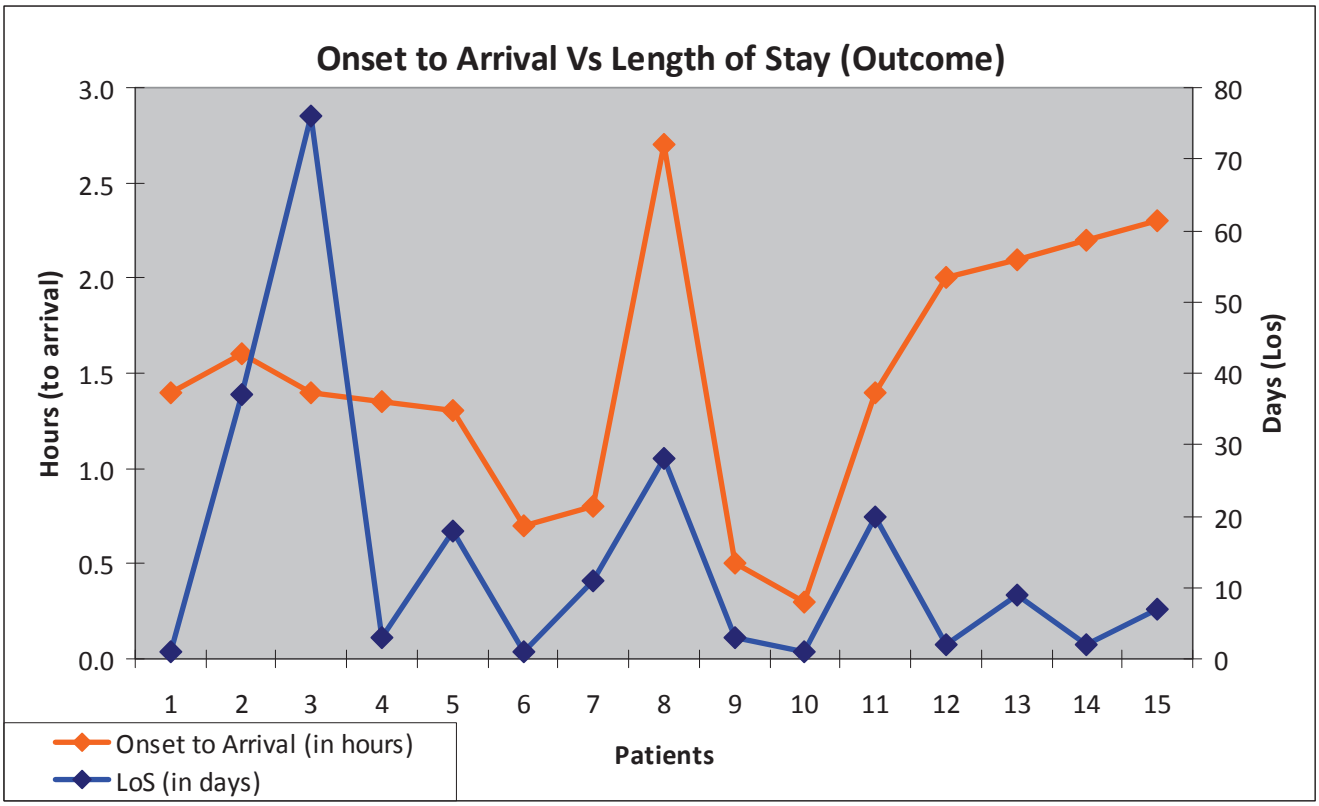


Figure 1: Onset to arrival time vs. Length of Stay (LoS) for a cohort of 15 stroke patients

7.4 Access to Acute Stroke Unit

Early access to a dedicated acute stroke unit supports continuity of specialist care which in turn contributes to improved outcomes.

The median time from arrival at hospital to admission to acute stroke unit has reduced from over 9 hours at RSH during the period April-June 2013 to around 100 minutes in the period July-September 2013 in the unified service at PRH. This compares with a national average for the same period of 215 minutes. The Trust also currently has a median time from arrival at hospital to assessment by a stroke trained nurse of 12 minutes, compared with a national median of 155 minutes from arrival to assessment. The rapid times in the Trust are mainly due to our specialist nurse-led service with pre-alert system from ambulance and switchboard.

The longer access times in April-June 2013 mainly relate to capacity challenges at the Royal Shrewsbury Hospital where some patients experienced extended periods in non-stroke wards before a specialist bed became available. During this time they will have received specialist hospital care but not with the additional benefits from accommodation in a dedicated stroke ward. However, as highlighted in Table 1 there have also been significant improvements in the proportion of patients reaching an acute stroke ward within 4 hours (with 48% of patients at RSH with the two-site HASU and 85% of patients at PRH with a single-site HASU).

Capacity at PRH: Demand for inpatient medical services does not normally experience the same peaks of high intensity at the Princess Royal Hospital. Consequently there are normally fewer challenges in protecting the designated bed base for stroke services. This winter the levels of demand on PRH have been higher than originally modelled in relation to the impact on unification of hyper acute stroke services, but despite this the levels of performance have been maintained at high levels.

Capacity at RSH: Significant additional work would be required in order to establish protected capacity at RSH to accommodate single site HASU and ASU at the hospital in the medium term. Returning to two site stroke services would also present some capacity challenges, and winter pressures have created some challenges in transferring patients to RSH for their ongoing care following the initial acute phase.

Whilst there is scope to re-accommodate two-site HASU and ASU at RSH this will lose the current and future benefits from providing a unified hyper acute service.

Capacity in the longer term: In the longer term, wider service redesign in the context of the review of acute and community hospital services would provide scope to accommodate single site HASU and ASU at either PRH or RSH.

7.5 Impact on ambulance service deployment

Alongside internal feasibility and service impact we are also working with ambulance services in Wales and West Midlands to understand impact along the emergency pathway. Further information is provided in the cover paper accompanying this report.

Page 28

8. Updated summary appraisal of options

The following table summarises the current interim appraisal of options:

Option	Assessment
(1a) Maintain single site hyper acute and acute stroke services for the medium term – service at PRH Acute-based stroke rehabilitation continuing at both PRH and RSH	• Based on ambulance journeys for suspected stroke patients between 1 July 2011 and 30 June 2012, 92% live within 1 hour of the Princess Royal Hospital. No missed opportunities to treat have been identified since the unification of hyper acute stroke services at the Princess Royal Hospital. • There is clear evidence of improved access performance since unification, which has continued into the winter months. • There is scope to maintain single site HASU and ASU at PRH, and the service could be accommodated here with minimal impact on delivery and continuity of other clinical services. • Multi-disciplinary teams at both RSH and PRH would provide good foundations for a unified service, so this is not a differentiating factor. • Maintaining a single site model provides scope to continue to deliver benefits for patients and move towards greater seven-day services with earlier and ongoing access to senior clinical decision-makers. **Option 1a is recommended as it will maintain the clinical benefits for patients across Shropshire, Telford & Wrekin and mid Wales and it is feasible.**
(1b) Maintain single site hyper acute and acute stroke services for the medium term – service at RSH Acute-based stroke rehabilitation continuing at both PRH and RSH	• Based on ambulance journeys for suspected stroke patients between 1 July 2011 and 30 June 2012, 99% live within 1 hour of the Royal Shrewsbury Hospital. • Stroke access performance was previously significantly lower at RSH, predominantly due to wider capacity and demand issues facing the hospital. There have been significant improvements in overall stroke access performance during the temporary single site hyper acute stroke service at the Princess Royal Hospital. • There are considerable feasibility challenges in accommodating a single site service at RSH, particularly without further clinical and/or financial impact on other services. It has not been possible to identify an alternative service to be relocated from the Royal Shrewsbury Hospital, nor to identify additional short term clinical accommodation on the site, in order to accommodate single site stroke services. • Multi-disciplinary teams at both RSH and PRH would provide good foundations for a unified service, so this is not a differentiating factor. • Maintaining a single site model provides scope to continue benefits realisation and move towards greater seven-day services. **Option 1b is not recommended as it is not feasible.**
(2) Return to two site hyper acute and acute stroke service until longer term vision for stroke services is developed as part of wider strategy for acute and community hospital services	• Under this option the service would return to the configuration as at June 2013. • This is counter to the clinical preference and the longer term vision for stroke services, which is for unification of hyper acute and acute stroke services. • The recent benefits in terms of improvement in key stroke indicators are not expected to be maintained. • There is public voice in support of maintaining stroke services as locally as possible, and anxiety that the medium term location will pre-judge the longer term shape of stroke services. We can provide assurance that medium term location does not and will not drive long term location of stroke services. **Option 2 is not recommended as it will not maintain the clinical benefits for patients across Shropshire, Telford & Wrekin and mid Wales.**

Option 1a (maintaining single site hyper acute stroke services at the Princess Royal Hospital pending the outcome of the NHS Future Fit clinical services review) is recommended as the preferred option

9. Implementation and Ongoing Review

If this recommendation is supported by the Trust and commissioners, the programme of implementation and ongoing review by the Trust will include:

Review of quality and outcomes	Continuation of the quality review programme which includes:		
	• Continued ongoing clinical review by the Trust	SATH	Ongoing
	• Continued robust incident reporting to identify and review any issues of concern	SATH, Ambulance Services, GPs/Commissioners	Ongoing
	• Continued monthly quality and performance indicator reports for review at commissioner level	SATH, Commissioners	Monthly
	• Ongoing patient experience monitoring	SATH	Quarterly
	• Continued quarterly review meetings	SATH, Ambulance Services, Commissioners	Quarterly
Workforce	Formalisation of the staffing model (medical, nursing, therapies, diagnostics) for the coming year to maintain and improve cross-site working and make further progress towards seven day working, in the context of wider plans across the Trust towards seven day working.	SATH	End March 2014
Vision for medical services	Development of the above in the context of the wider model for acute medical services in the medium term. Continued movement towards the standards set out in the Midlands and East Stroke Services Review will be incorporated into this, although there are significant interdependencies with progress on the NHS Future Fit Clinical Services Review.	SATH	End March 2014
Pathways	Formalisation of pathway for direct transfer of patients from PRH to Newtown Hospital (e.g. those assessed as ESD-viable)	SATH, Powys	End March 2014
	Continuing to work with Ward 22S/R at RSH to strengthen and reinforce the vital role of stroke rehabilitation within the stroke pathway	SATH	End March 2014
	Sustained access to TIA including development of plans for seven day working.	SATH	Ongoing
Engagement & Communication	Communication and engagement with our communities, including clarity on the clinical basis for this decision and reiterating to our communities and commissioners that the long term shape of the county's hyper-acute stroke services will be agreed through the NHS Future Fit review.	SATH, NHS Future Fit Programme	End January 2015
Patient and Carer Experience	Work with patient and community partners to continue to strengthen pastoral support for families and carers	SATH, Patient and Community Groups	End April 2014
Contracting	Reflect medium term model for hyper acute stroke services in contracting process	All	End March 2014

Page 30

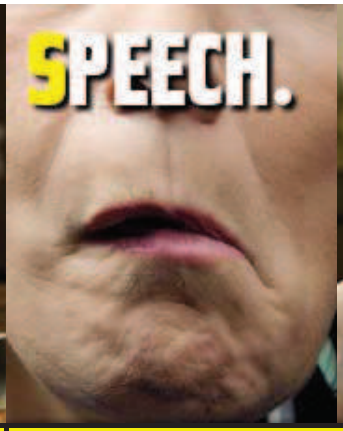
Contact details for feedback:

In writing: Dr Edwin Borman, Medical Director, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ

By email: consultation@sath.nhs.uk

Has their face fallen on one side?
Can they smile?

Can they raise both arms and keep them there?



Is their speech slurred?

Time to call 999 if you see any one of these signs

The Shrewsbury and Telford Hospital NHS Trust

Princess Royal Hospital
Apley Castle
Telford
TF1 6TF

Royal Shrewsbury Hospital
Mytton Oak Road
Shrewsbury
SY3 8XQ

www.sath.nhs.uk

Page 32 of 36

The Shrewsbury and Telford Hospital NHS
NHS Trust

Reporting to:	**Joint Health Overview and Scrutiny Committee Meeting, 24 March 2014**
Title	Update on Future Configuration of Hospital Services – Women and Children's Services, Travel and Transport Plan
Sponsoring Director	Debbie Vogler, Director of Business and Enterprise
Authors	Debbie Vogler, Director of Business and Enterprise Kate Shaw, Programme Manager John Kirk, Communications Officer
Previously considered by	Future Configuration of Hospital Services Programme Board Update to Trust Board scheduled for 27 March 2014
Discussion and Summary	The Keeping It In The County consultation, launched in November 2010, outlined the challenges facing acute surgery and inpatient children's services in the county, and set out proposals for addressing these specific challenges in ways that (a) recognised the condition of the hospital estate and (b) would not compromise the ability to continue to provide two well-balanced, successful hospitals with A&E departments. Following the conclusion of consultation in March 2011, then the development and approval of the Outline Business Case and Full Business Case, implementation of plans to maintain the safety and sustainability of acute surgery and women and children's service commenced. The county's acute surgery services were strengthened with the establishment of the Royal Shrewsbury Hospital as the county's main centre for these specialist services from summer 2012. Princess Royal Hospital also became the main centre for inpatient head and neck services at that time, in preparation for the opening of the new children's services in 2014. This is because of the important clinical links between head & neck and children's services. These services are now well established and construction work is under way to complete the new Shropshire Women and Children's Unit which is on schedule to open by October 2014. Children's inpatient services at PRH are due to relocate from their temporary location on Ward 14 to the new facilities next month (April) with the consolidation of the county's inpatient children's services (including oncology and haematology services) at the hospital in late September. Alongside this, inpatient women's services (non-maternity services, such as gynaecology) will transfer from RSH to PRH. This will be followed by the opening of new maternity and neonatal services later in September. This will complete the state-of-the-art, modern facilities for women and children across Shropshire, Telford & Wrekin and mid Wales. This paper provides an update against the lines of enquiry identified by the Joint HOSC following consultation and through subsequent review and scrutiny. In addition, a presentation will be provided to the Joint HOSC providing the latest information about the new facilities (including current pictures and artist impressions) and on the development of the Travel and Transport Plan. A visit for JHOSC representatives to the site is also being planned. Note that whilst the Keeping It In The County consultation sought to address specific challenges facing acute surgery and inpatient children's services without compromising the ability to provide A&E services, new challenges facing wider acute and community hospital services now mean that the broader shape of the county's hospital services needs to be reviewed. This work is under way through the NHS Future Fit review of acute and community hospital services, which will be discussed at a Joint Health Overview and Scrutiny Committee last this month.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
	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, updated and discussed and agreed with the West Midlands and Welsh Ambulance Services and Shropdoc and the Care Coordination Centre. 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. Detailed discussions are also underway to develop the Trust's own internal retrieval team to enable the safe and timely time limited transfers of ill and injured children from RSH to PRH. This will also include the transfer of neonates. A follow-up visit of the Royal College of Paediatrics and Child Health (RCPCH) took place in November 2013. The RCPCH formal report supported the workforce model for out of hours cover at RSH with the requirement of two additional two paediatricians. Recruitment is currently underway.
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 Children's Assessment Unit at RSH was also reviewed by the RCPCH with a recommendation that this continues to be discussed as part of the wider Clinical Services Review (Future Fit Programme) now underway. The service model for the RSH CAU will continue as proposed within the Full Business Case (described below). The longer term service model will form part of the wider health economy solutions for emergency and urgent hospital care as part of Future Fit.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
				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 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 CAU 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 CAU 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 are currently working together to review all supporting protocols, polices and operational guides prior to the implementation of these changes). The four Advanced Paediatric Nurse Practitioners described within the Full Business Case are now in post. Consideration is now being given to the possible recruitment of additional Advanced Paediatric Nurse Practitioners and Registered Nurses in joint rotational posts between Paediatrics and A&E.
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 continues to be addressed through the joint discussions with both WMAS and WAS. The Trust has responded to parents and public thoughts of 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. 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.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
				The work undertaken to understand and improve the emergency transfer needs has formed part of the Trust's Travel and Transport Plan. This plan also describes the non-urgent travel and transport needs patients, carers and the public have in accessing the Trust's services.
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	Clinical pathways have been agreed with WMAS, WAS, Shropdoc and the CCC. Implementation of these pathways and preparation for the service change is now well underway.
1.5	Paediatric staff work together to make proposals workable	Evidence of clinical engagement	SaTH	A great deal of progress has been made in terms of bringing the two paediatric departments together. From a nursing and ward perspective, this is being led by the new Nurse Managers: Emma Dodson and Rachel Triggs. All nurses are rotating between sites such that everyone will have worked together at some stage prior to the changes in September. Policies, protocols and ways of working have also been standardised. From a medical staff perspective this work is being led by the FCHS Medical Coordinators: Martyn Rees for Paediatrics and Bob Welch for Neonatology. This includes the merging of the previously separate consultant meetings; shared training and skills updates and again, rotation between sites. Detailed discussions with the paediatric clinical team continue with regards to everything from furniture and equipment and the layout of rooms to operational policies, risks and pathway implementation. Weekly Women and Children Project Team meetings have been taking place since February 2013 on a five week rolling programme through Maternity; Neonatology; Paediatrics; Gynaecology; and Admin and Support. All staff are invited to attend.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
1.6	Capacity of neonatal service to provide, where possible, services for premature babies in County	Service planning and commissioning intentions	SaTH PCTs *	Discussions are underway with commissioners and the Neonatal Network regarding the designation level of the Trust's current and future Neonatal Unit. The capacity assumptions for the neonatal unit form part of these discussions. Within the new Neonatal Unit there is capacity for 23 cots: 6 intensive care; 1 isolation/intensive care; 16 special care
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 continue to be extensively involved in the discussions and meetings about the requirements for the relocated service. The new Children's Haematology and Oncology Centre will have all elements described and agreed as part of the Full Business Case. Informal feedback from clinicians, parents and children is that the Trust will have achieved everyone's aspirations for a truly fantastic new centre including: • Single ensuite bedrooms with appropriate air filtration and access to purpose built outside space • 2 bed dedicated day case room with ensuite and access outside • Parents lounge and kitchen • Separate, yet integral, outpatient space • Playroom and waiting areas • All required clinical and non-clinical rooms (utilities; treatment, offices, reception etc) The focus groups with patients, parents and families of the Rainbow Unit have recently included art workshops to create tiles for the Rainbow Unit Legacy sculpture at RSH and the sign off of the look and feel of the new Women and Children's Centre including key colours, images and wayfinding.
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	SaTH	All parents, families and fundraisers of the Rainbow Unit continue to be invited to attend our focus groups. We listened to their feedback around the new unit and their ideas and suggestions have been reflected in the design.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
		service design		Three Rainbow Unit Legacy Art workshops have now been held with children and parents designing and creating their own glass tile. These have been held in Welshpool; Telford (including a tour of the new Centre) and within outpatients at RSH. A fourth and final workshop is now being planned with the artist and play leaders to maximise the numbers of children and families involved and to ensure that everyone has had the opportunity to be involved. Parents have also been involved in the work on the 'look and feel' and the naming of the new unit; Children's Haematology and Oncology Centre
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. Discussions with Trust and Community Trust clinicians and local CCG commissioners have resulted in the development of four key 'admission avoidance' pathways that went 'live' last December. Further discussions with commissioners on the development of a Trust Hospital at Home service would be welcomed.
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*	All workforce planning, within the Women and Children's Care Group and across the Trust has been completed and implementation is well underway. Detailed Workforce Implementation Logs track progress and are formally reviewed monthly within the Trusts Implementation Group chaired by Debbie Kadum, Chief Operating Officer. Formal staff consultation with over 650 Agenda for Change staff concluded at the end of November 2013. Formal consultation with non Agenda for Change staff is not required although all staff within this group have been formally notified of the changes ahead. Detailed work is now underway with staff who have a problem with the move in September. The Trust's intention is that solutions will be found for all staff before the end of April. For staff who state they can't transfer to PRH, job swaps and alternative roles are being explored as part of this formal process. Workforce issues form a large part of the Tuesday Women and

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
				Children Project Team meetings. The Future Project Team also attend ward and service team meetings and update the TNCC (Trust negotiating and Consultative Committee formally each month. Proactive staff involvement and engagement continues to be a focus of work for the Trust with tours of the new Centre, implementation and engagement workshops, training and familiarisation all planned and underway.
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	Clinical pathways have been agreed with WMAS, WAS, Shropdoc and the CCC. Implementation of these pathways and preparation for the service change is now well underway. 'Skills Drills' currently used within the maternity service for the resuscitation of babies in the Midwifery-Led Units (MLUs) have been 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. Both ambulance Trusts are keen to be part of Skills Drills to and within the new Women and Children's Centre once the building is handed over to the Trust at the end of May 2014. The Trust continues to have discussions with commissioners regarding developments associated with recommendations from the Maternity Services Review and in particular increasing the number of women accessing the MLUs.
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 have been reviewed and amended 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

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
				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.
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 has been dealt with as part of staff engagement within the management of change process. Whilst this can never be 100% accurate, as individual's circumstances and options do change, a loss of midwives due to moving the consultant-led service to PRH is not envisaged. All midwives currently rotate around the units provided by the Trust and this will continue.
3	**Acute Surgery**			
3.1	Provision of AAA screening	Implementation timescales	SaTH	The provision of AAA screening commenced as planned in April 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	Following discussions at the Hospital Executive Committee, the Trust Board and the Joint Health Overview and Scrutiny Committee, the Centre for Surgery was consolidated at RSH in July 2012..
3.3	Wider changes in NHS e.g. changes in commissioning resulting in services going out of County	Implications of Health and Social Care Bill	SaTH PCTs*	The Future Configuration of Hospital Services proposals were developed through engagement with GPs and commissioners, and to address the reconfiguration principles set out by the then NHS Telford & Wrekin and Shropshire County PCTs which included keeping two vibrant, well balanced, successful hospitals in the county with access to acute surgery from both sites. Ongoing discussions continue within the Future Fit Programme.
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	SaTH	All service changes to date have met amended timescales for implementation. Discussions going forward with regards to the impact of the Future Fit Programme on the development of services at RSH are now required.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
		Risk management		The management of risk continues within each the operational care group 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 FCHS Programme Board meets monthly where risks and issues are discussed and action agreed. The key milestones and timescales for actual service change form part of the FCHS Master Programme.
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 with implementation well underway.
3.6	Patients who cannot be stabilised and transferred to be operated on at PRH	To be included in development of clinical pathways	SaTH	Patients admitted to the PRH who cannot be stabilised and transferred to the RSH for their operation will continue to 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 from September 2104 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	In June 2013 the Trust Board approved the temporary unification of hyper acute and acute stroke services at the Princess Royal Hospital in response to short term staffing challenges. During this unification there has been clear evidence of improved performance against key stroke indicators that provide a proxy for improved patient outcomes (e.g. admission to specialist stroke unit within four hours of arrival, 90% of time spent in acute stroke unit, access to CT). It was therefore agreed with commissioners that the temporary unification should be extended for a further period so that the benefits and disadvantages of a unified hyper acute and acute stroke service could be reviewed further and a recommendation made for the

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
				provision of these services for the medium term (2014). This review has concluded and this paper recommends that PRH continues to provide unified hyper acute stroke services during 2014, and that the longer term shape of stroke services (from 2015) should be agreed through the NHS Future Fit clinical services review of community and acute hospital services.
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*	In June 2013 the Trust Board approved the temporary unification of hyper acute and acute stroke services at the Princess Royal Hospital in response to short term staffing challenges. During this unification there has been clear evidence of improved performance against key stroke indicators that provide a proxy for improved patient outcomes (e.g. admission to specialist stroke unit within four hours of arrival, 90% of time spent in acute stroke unit, access to CT). It was therefore agreed with commissioners that the temporary unification should be extended for a further period so that the benefits and disadvantages of a unified hyper acute and acute stroke service could be reviewed further and a recommendation made for the provision of these services for the medium term (2014). This review has concluded and this paper recommends that PRH continues to provide unified hyper acute stroke services during 2014, and that the longer term shape of stroke services (from 2015) should be agreed through the NHS Future Fit clinical services review of community and acute hospital services.
4.3	Provision of coronary angioplasty procedures	Implementation timescales	SaTH	The provision of coronary angioplasty remains a longer term aspiration of the Trust. We expect that this will be considered further as part of the Future Fit review.
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	SaTH	In addition to the actions outlined in the statement on 6 March 2012, a variety of further work has taken place. Focus groups and workshops have been held with members of the local community, as well as with partner agencies and staff to ensure they are engaged and to listen to concerns and aspirations. These will

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
		informed service development		continue to take place as we get closer to the opening of the Women and Children's Unit in September. Numerous advertisements and press articles have been carried in the local media explaining that the service is changing and providing updates on key milestones. There have also been news items and features on local radio promoting the move. Press releases have also been included on the Trust's website, and some of the items have been included in the GP Connect newsletter which is sent to GP practices. Following on from the two-sided Looking to the Future newsletter updates about the changes, regular updates have been included in the Trust's public-facing newsletter (issued to Trust members and available on the Trust's website) reminded people of the changes and providing an update on developments. Updates have been provided on the Trust's external website and, as well as social media. The Trust attended public meetings such as the Local Joint Committees in Shropshire last summer to provide an update on the changes and answer questions from members of the public. The Trust has created a working 'Plan on a Page' document outlining some of the work that has already taken place and some of the plans for the coming months.
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

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
				in place and that the current system of open-access and calling the Children's Ward direct, will continue. Similarly, the Trust is working closely with members of staff who also have raised their concerns.
5.3	Address concerns of Welsh colleagues who will be affected by the changes	Feedback from WAS, Powys Health Board and Welsh Assembly	SaTH	Representatives from the Welsh Ambulance Service continue to be an integral part of detailed pathway and implementation discussions. The Trust's Head of Midwifery and the Head of Midwifery for Powys, also meet and discuss the reconfiguration regularly. Colleagues from Wales are members of the Future Fit Programme Board and remain an important partner of the Trust and the wider health economy as we shape our future healthcare services.
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. Some of this is already underway, as outlined in 5.1 and the attached 'Plan on a Page'.
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 remains key to the reconfiguration programme and much detailed work has been undertaken to understand and work with the staff affected, deliver a management of change process and to ensure a robust link with service implementation plans. Live Quality Impact Assessments for each specialty within the Women and Children's Care Group (including Administration and Support) form an important element of the implementation process. The latest QIAs are submitted every month to the Medical Director, Chief Nurse and

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
				Chief Operating Officer for review.
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	This is no longer an issue. The Trust is undertaken a widely reported process for the recruitment of staff.
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*	Detailed cost and finance discussions continue. This work is validated by the Trust's external cost advisors, Holbrow Brookes. Regular updates, including a formal written report, are provided to the Trust's Finance Committee. The revenue implications of the service changes, the non-service led revenue impact and the revenue and capital spend profiles are continuously reviewed and formally reported to the FCHS Programme Board.
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. Future and wider service changes and their impact on transfers between sites will form part of the Future Fit Programme.
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 has been included with the Travel and Transport Plan. The provision of extra car park spaces at PRH was reflected within the Full Business Case and these are now built.

	Reconfiguration of Services at PRH and RSH			Position statement from The Shrewsbury and Telford Hospital NHS Trust, 24 March 2014
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. A jointly funded post has led to the appointment of a Travel Coordinator whose role is to work with both Local Authorities to progress this work.
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 be presented to the HOSCs at their March 2014 meeting.
9	**Implementation**			
9	Joint HOSC request details of any changes prior to implementation	Update to Joint HOSC meetings	SaTH	A full update and presentation will be provided at the 24 March 2014 meeting. The Trust welcome the opportunity to provide an update and tour of the new Women and Children's Centre at PRH following hand-over of the building at the end of May 2014.

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

Note that some references within this document refer to NHS arrangements prior to 2012 and therefore relate to the documents that were in place at that time (e.g. Primary Care Trusts have been dissolved and new GP-led Clinical Commissioning Groups are now in place to lead and shape the commissioning of local health services; locally there is a Clinical Commissioning Group for Shropshire and a Clinical Commissioning Group for Telford & Wrekin).

Planning for the Women and Children's Unit, PRH
Communications and Engagement Plan - Version 0.2, 13 March 2014

The Shrewsbury and Telford Hospital NHS
NHS Trust

Stakeholder Groups

A. Staff
Staff will need to be aware of the overall project — timescale, key messages, how it affects them and how it affects their patients. Regular updates at team meetings — ensuring information is passed to all staff, newsletter articles (particularly PPF Quarterly with payslips), intranet news items outlining key messages and dates, Ward Managers ensuring all staff (inc. those not with computer access) have the messages, switchboard/ CSMs/other key Trust staff will need to know dates and details.

B. Patients, families and visitors
This will be a major audience for the project as it will be imperative that all patients know exactly how it will affect them. Leaflet for Maternity to be included in Antenatal Booking Packs for those due to give birth from August onwards, discussions at appointments for those attending from February onwards and due to give birth around the time of the unit, regularly updated information on our website, regular contact near the time of the unit completion, media promotion, regular articles in our public facing A Healthier Future newsletter, posters around the units, use of social media near time of completion, promotion through GP Liaison to GP Surgeries, promotion through local user groups.

C. Partner organisations
All will need to be aware of key dates, but some will have a need for specific information: Ambulance Services and Transport Services will need updating with where to send women and children, Critical Care Organisers will need to know which site to send women and children to. Keep local and regional networks and Leagues of Friends updated and use their support where possible to promote the move.

D. Planners and Commissioners
Will need to be kept updated throughout the entire process with regular updates.

E. Media
We will need to plan for regular updates in the local media, including news articles and radio interviews promoting the key detail. Advertising nearer the date of opening will also need to be considered. We will need to be aware of potential adverse media nearer the time of opening if there are any teething problems and from mums/general public/staff unhappy with the further distance they may have to travel.

Programme Arrangements

Executive Lead: Debbie Vogler
Project Director: Chris Needham
Programme Manager: Kate Shaw
Communications Lead: John Kirk

Messages

- From September 2014, women who need a consultant-led delivery will give birth at the new Women and Children's Unit at the Princess Royal Hospital in Telford. This includes women who are expecting twins, women with diabetes, women who have previously had caesareans, women whose babies are in a breech position and women whose babies are premature.
- Women having a low-risk pregnancy will still be able to choose to have their baby at home; at one of the community midwife-led units at Bridgnorth, Ludlow and Oswestry; at the midwife led unit at PRH or the Royal Shrewsbury Hospital (which will be refurbished and relocated in 2014); at one of the midwife led units run by Powys Teaching Health Board.
- Antenatal appointments and scans will continue to take place as they do now.
- If a woman develops complications during labour at home or at one of our midwife led units, they will be quickly and safely transferred to the consultant-led unit at PRH, just as women are transferred to RSH now.
- The inpatient gynaecology service (where you have to stay in hospital overnight) will also be based in the new Women and Children's Unit at PRH in 2014. Gynaecology outpatients and day cases will continue to take place at both our hospitals.
- Children's inpatient services (where children have to stay in hospital overnight) will be based at a new Women and Children's Unit at PRH, which will open in 2014. This will also include a brand new Children's Cancer and Haematology Unit. The main reason for this change is that our children's doctors (paediatricians) believe that creating a single children's inpatient unit is the only way we can provide this service in the future and ensure that we continue to provide children's services within the county.
- The majority of children who use our hospital services will continue to go to the same hospital as now. This includes children who have to go out of the county for care at Birmingham Children's Hospital or Liverpool's Alder Hey Hospital. All outpatient and day case appointments will continue to take place at both hospitals.
- A Children's Assessment Unit will be available at RSH to assess and treat children who do not require overnight stay. We anticipate that this will be open approximately 13 hours during the day. A short-stay children's assessment unit will be available at the PRH alongside the children's inpatient ward.
- The A&E departments at both hospitals will continue to be able to assess and treat children in an emergency. If a child arrives at the RSH and needs emergency surgery they will be quickly and safely transported to the PRH. [Confirm message]
- The main reason for these changes is that the existing maternity building at RSH is in a poor state and cannot be the base for maternity and children's services in the long term. We have looked at a number of options and decided that transferring consultant-led maternity services to Telford is the only way we can secure safe and sustainable maternity services for Shropshire, Telford and Wrekin and mid Wales.

Outcomes

- Patients are aware of the dates of the changes and where their treatment and care will take place once the new unit opens, leading to a seamless transition.
- Partner organisations are fully aware of the changes, the key dates and how this affects them to prevent any issues when the new unit opens (e.g. ambulances know which hospital to take patients to).
- Staff are kept fully in the loop with dates and times and how they will be affected when the new unit opens, meaning they not only feel part of the process and that they are fully in the picture, but also that they can provide the best, most up-to-date, information for women, parents and their children.
- Communication with all involved works smoothly helping the bedding in process, and reducing the time staff need to take to answer questions from people who don't know where they should be.

Key Risks	L	C	LxC	Mitigation
Ensuring staff are kept informed and happy, to avoid staff stress, sickness or leaving which could place further pressures on the service.				Regular briefings within the Women and Children's Unit, particularly as we get closer to the opening date. Frequent updates to staff in internal communications.
Service users are not engaged and therefore there is confusion about where they need to go.				Frequent promotion of the changes in the media, Trust publications and on website. Mums and patients informed through their appointments, website and promotional materials kept up-to-date.
Partner organisations unsure of what to do leading to confusion, ambulances going to wrong hospital etc.				Regular engagement with partner organisations, particularly closer to the opening date, providing the latest information for them.

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Promote and Engage	**Communication in early-2014**	**Pre-launch**	**Launch period**	**Review and moving forward**
Planning for the move and engagement to firm up plans and timescales following approval of the Full Business Case Focus groups with local community and staff to ensure they are engaged and to listen to concerns and aspirations. Regular advertisements in the local media explaining that the service is changing. Two-sided Looking to the Future newsletter updates about the changes. Regular news items and radio interviews at key milestones of the build. Frequent newsletter articles, both internally and externally, providing key updates. Updates on the Trust's external website and internal intranet, as well as social media. Regular reconfiguration groups to keep staff informed. Roller banners promoting the move at key locations. Updates at local authority meetings, Local Joint Committees etc. IT systems updated to ensure correct coding from February onwards.	***Increase the level of communication from January 2014 as we approach a time when women will be considering their place of birth for the time of the move*** Communications Workshop with staff, members of the public and partner organisations to plan for the next 9-10 months. Leaflet for Maternity to be included in Antenatal Booking Packs for those due to give birth from August onwards, and planning to take place for more general leaflets for other parts of the Care Group. Discussions at appointments for those attending from February onwards and due to give birth around the time of the unit, as well as regularly updated information on our website. Regular articles in our public-facing A Healthier Future newsletter and internal newsletters. Posters around the units and wards promoting the move, what people should do etc. Promotion through GP Liaison to GP Surgeries, and promotion through local user groups. Relaunch of Maternity Services Liaison Committee (MSLC), which will include regular updates about the move. Further workshops with staff. Countdown clock on the intranet.	***This will be a busy period to ensure all staff and service users are fully prepared for what they will need to do from the launch date*** New health records and pregnancy information booklet, updated with details of the new unit. Frequent press releases/radio interviews about aspects of the project, which drum home the opening date, key contact numbers and what people need to do once it is open. Regular updates to staff through meetings to keep them fully included and updated. Regular articles in our public-facing A Healthier Future newsletter and internal newsletters. Posters around the units and wards promoting the move, what people should do etc, as well as key areas in the community such as GP Surgeries and Children's Centres. Promotion through GP Liaison to GP Surgeries, and promotion through local user groups and the MSLC. Consider setting up a hotline for people to call if they are unsure of where they need to go. Ensure all key groups also know what to do (i.e. CSMs, Critical Care Outreach, Ambulance Services etc).	***A lot of work will need to take place around the launch to ensure staff, users, members of the public and partner organisations are engaged*** All of phase 3 actions will either take place or be built on. Mail-shot in August to all relevant current patients (e.g. women or children on long-term care, pregnant women etc) reminding them of the moves and ensuring they have the up-to-date opening date and what they should do. Ensuring signposting is in place in other parts of our hospitals (e.g. A&E and main entrances directing people both where to go and what to do if they need to use Women and Children's Services after the unit opens). Consider running open days in the final weeks before the launch which will help engagement and community involvement. Involve former Mayor of Telford & Wrekin due to fundraising. Local transport information updated?	***Review how the project has gone from a Communications and Engagement perspective and plan the continued support*** What has worked well and can be built on (e.g. updating leaflets and booklets and posters etc)? Are there any outstanding areas that weren't a priority but that should be focused on now? Ensure website and intranet information continues to be kept up-to-date. Official opening with dignitary including further media promotion/ photo call etc.
2012-January 2014	**January-April 2014**	**May-July 2014**	**August-October 2014**	**November onwards**

This page is intentionally left blank