The Shrewsbury and Telford Hospital NHS
NHS Trust

Shropshire County NHS
Primary Care Trust

NHS
Telford and Wrekin

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

31 August 2010

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1. Introduction

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

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

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

See Section 4 for more information about the challenges.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

See Section 11 for information about making your views known.

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

Yours sincerely,

Adam Cairns
Chief Executive
The Shrewsbury and Telford Hospital NHS Trust

Jo Chambers
Chief Executive
Shropshire County PCT

Simon Conolly
Chief Executive
NHS Telford & Wrekin

2. Contents

3. Preface from Dr David Colin-Thomé

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What are the challenges facing local health services?

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

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

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

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

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

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

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

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

5. What do we aim to achieve?

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

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

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

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

Our guiding principles for this work are:

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

What are your views on these guiding principles?

6. Overview of the Clinical Problem Solving Workshop

The main features of the day were as follows:

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

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

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

A. Who was involved in this focus group?

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

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

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

C. What options did we identify?

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

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

D. What did we think about these options?

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

E. What could it look like?

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

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

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

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

G. What led us to draw this picture?

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

PRH

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

RSH

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

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

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

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

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

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

A. Who was involved in this focus group?

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

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

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

C. What options did we identify? and

D. What did we think about these options?

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

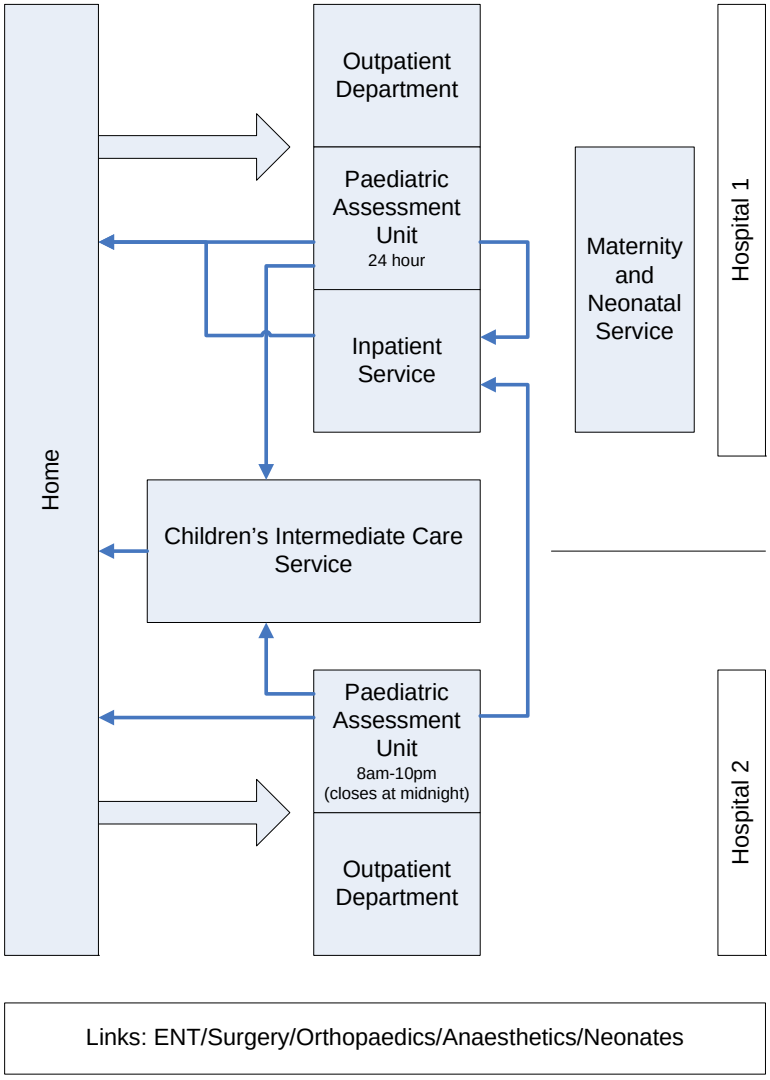
E. What could it look like?

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

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

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

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



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

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

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

G. What led us to draw these pictures?

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

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

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

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

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

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

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

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

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

The possible consequences of this model would include:

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

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

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

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

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

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

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

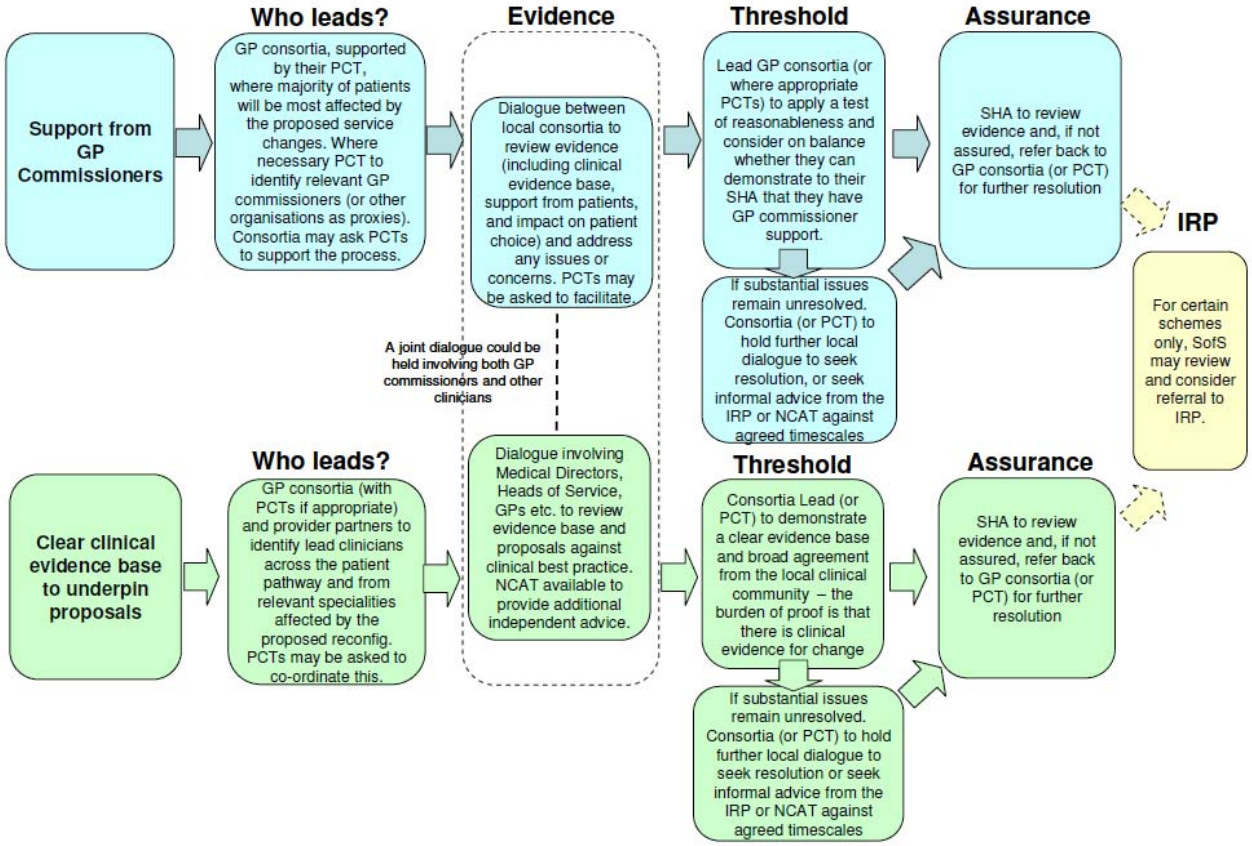
The Secretary of State for Health has identified four key tests for service change in the NHS in England, which are designed to build confidence within the service, and with patients and communities. The tests require existing and future reconfiguration proposals to demonstrate:

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

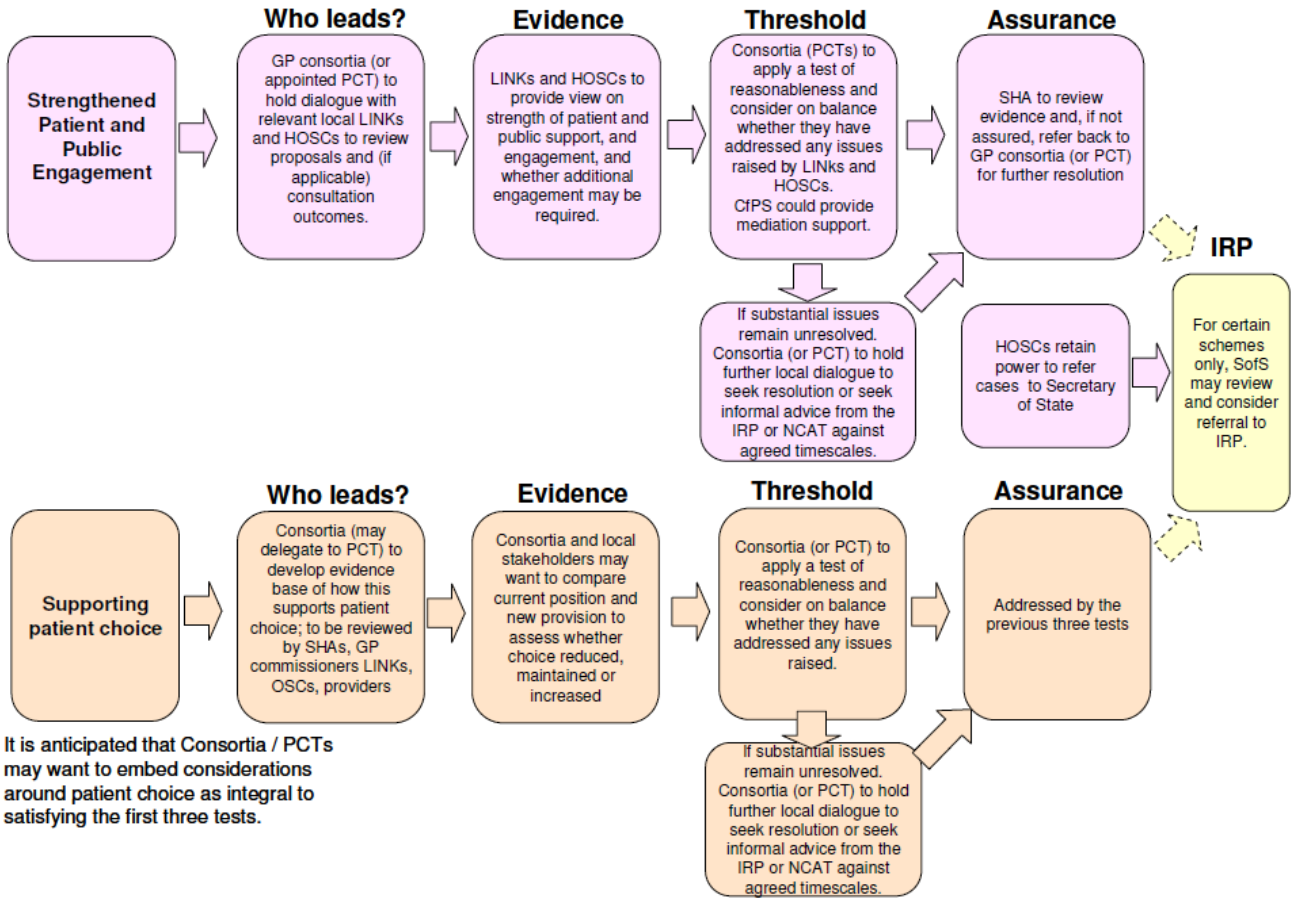
The government has chosen not to set specific thresholds for any of the tests, as the process should be locally led and designed. The process of gathering evidence for the four tests will be led by GP-led commissioning organisations or by GPs supported by PCTs.

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

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



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



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

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

11. Making Your Views Known

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

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

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

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

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

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

By email **ournhsinsat@nhs.net**

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

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

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

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

12. What Happens Next?

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

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

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

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

13. Participants in the Clinical Problem Solving Workshop

Clinical Representatives

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

Management Representatives

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

Facilitators

Professor Beverly Alimo-Metcalfe PhD MBA MSc CPsychol FBPsS

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

Dr Mike Roddis BSc MB ChB MBA FRCPath

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

Dr David Colin-Thomé OBE

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

Comment Form

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

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

<table>
<tr><td colspan="6">Please put a cross (X) in the box below if you would like your name and/or organisation to be kept anonymous if we share or publish the responses we receive.
Your contact details will not be published.</td></tr>
<tr><td>Name</td><td colspan="4"></td><td></td></tr>
<tr><td>Organisation (if applicable)</td><td colspan="4"></td><td></td></tr>
<tr><td rowspan="3">Contact Details (e.g. email address, postal address)</td><td colspan="4"></td><td>X</td></tr>
<tr><td colspan="4"></td><td>X</td></tr>
<tr><td colspan="4"></td><td>X</td></tr>
<tr><td rowspan="2">Individuals: Which area do you live in?
Organisations: Which area(s) does your organisation cover?
Please tick all that apply</td><td>Telford & Wrekin</td><td>Shropshire</td><td>Mid Wales</td><td colspan="2">Other (please state)</td></tr>
<tr><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td colspan="6">Please let us know your comments about the issues discussed in this report
We have included some questions on page 22 as a guide. Please feel free to continue on additional pages.</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="5">Would you like to be invited to events and activities to discuss these proposals?
Please tick the box if you would like to be kept informed – and make sure you have included contact details above.</td><td></td></tr>
</table>

Please return your comments to the Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust at Princess Royal Hospital, Grainger Drive, Apley Castle, Telford TF1 6TF, or
Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ
You can also respond by email to ournhsinsat@nhs.net