NHS
Transformation Unit

Shropshire Acute Services Review

1. Introduction

The NHS Transformation Unit was commissioned to help support the Strategy Unit of the Lancashire and Midlands CSU work with the Shropshire Future Fit programme. This small piece of commissioned work has been undertaken in August 2016.

Recognising the recent development of a Women and Children's Centre at Princess Royal Hospital, Telford (PRH), the Programme Board agreed at the longlisting stage (and confirmed in shortlisting) that the potential to locate consultant-led obstetrics either at the Emergency Centre (EC) or at PRH should be considered as a variant to options which do not locate the Emergency Centre at PRH. Option C2 is the sole remaining variant option.

This paper summarises the findings and conclusions of this initial commission.

We outline below:

1) The remit of the work;
2) What information we had access to;
3) The approach taken and whom we interviewed; and
4) Clinical Reference Group Panel key conclusions and recommendations.

2. Remit of the work

We were asked to:

1) Conduct an independent clinical review of Option C2 by considering both existing clinical stakeholders' views on the option and providing "critical friend" clinical advice on the feasibility of implementing such an option. In particular, commissioners wish to understand what would be required to make the variant option safe and sustainable, and what evidence there is of such configurations elsewhere.
2) Use a Clinical Reference Group Panel of Greater Manchester-based clinicians who have been involved in the development of service reconfiguration options around emergency/urgent care and women's and children's services to review the proposals and provide advice on this option and other options considered so far.
3) Conduct an interview programme of the key clinicians who have commented on the service change proposals to date.
4) Provide a summary report that could inform your current review process of the service options reconfiguration and what we would advise happens next.

3. Information reviewed

In undertaking the above brief, we have reviewed the following:

a) Business Case around the Future Fit programme prepared to date;
b) Option C2 high level option description; and
c) Option C2 Clinical Review Document prepared by senior clinicians at Shrewsbury and Telford NHS Hospitals Trust (SaTH) which sets out the impact that this option would have on women's and children's services, emergency services and other departments and specialities.

Further information was requested on current clinical workforce and activity levels across the two hospitals associated with emergency services and maternity and children services. Some of this was provided to our team on our site visits to both hospitals.

4. Our Approach

In the short time available, we have undertaken the following activities:

i. Convened a group of senior clinical experts from the Greater Manchester area with the professional credibility and independence from SaTH to review all the information and evidence.
ii. Convened a fact finding session to enable the Project Lead (Jeanette McMillan from the Transformation Unit) to meet key stakeholders and clinical leads and interrogate the brief further and establish key questions for the review panel to answer/address.
iii. Co-ordinated a half day workshop with the panel to review and discuss the information presented and develop the key conclusions.

We held a number of stakeholder interviews over a two day period as outlined in the table below:

Table 1 – Interviewees listing

Name	Title
Sanjeev Deshpande	Clinical Director for Neonatology, SaTH
Joe McCloud	Surgery Clinical Director and Deputy Scheduled Care Group Medical Director, SaTH
Louise Sykes	Anaesthetics, Theatres and Critical Care Clinical Director, SaTH
Kevin Eardley	Unscheduled Care Group Medical Director, SaTH
Adrian Marsh	Emergency Medicine Clinical Lead, SaTH
Jo Leahy	Clinical Chair, Telford & Wrekin CCG
Maggie Kennerley	Lead Midwife, SaTH
Andrew Tapp	Women and Children's Care Group Medical Director
Lynn Atkin	Lead Nurse for Women and Children's Care Group, SaTH
Shelia Fryer & Mike Taylor	Pathology Centre Manager, SaTH
Andrew Cowley	Clinical Director for Paediatrics, SaTH
Sheena Hodgett	Obstetrician, SaTH
Julian Povey	Shropshire CCG Clinical Chair
Debbie Vogler	Future Fit Programme Director

Note: Still to be interviewed - Dave Evans, SRO and Accountable Officer for Shropshire County CCG and Telford & Wrekin CCG who returns from leave on 5 September 2016

5. Findings from clinical staff and other stakeholder interviews

The interviews confirmed the overall local clinical assessment that Option C2 would be challenging to implement in its current description given the current location of specific services and concerns about staffing levels, rotas and future training implications. Consultants and clinical staff acknowledge the limitations of workforce, rotas and medical training impacting to varying

degrees, leading to differing opinions as to whether the other site in a concentration of emergency services should be 'warm' or 'cold' in service provision mix. The co–location of children's inpatient service capacity was raised by many as a key requirement for an emergency service option. The key reasons outlined by clinical staff supporting the co-location of women's and children's services with emergency services were articulated as:

- Reduction in clinical risk and improved patient outcomes;
- Clinical co dependencies and adjacencies to support timely care with the competencies to support good clinical outcomes;
- Stops duplication of services on both sites;
- More effective use of workforce and rotas;
- Enhanced recruitment prospects with the consolidation of higher acuity patients on one site;
- Paediatric anaesthetists available for A&E and surgery;
- Single neonatal and paediatric service retained;
- Supports 2013 RCPCH Review recommendation that there is only one A&E department;
- Ready access to intensivists for high acuity obstetric patients;
- Supports key elements of medical training for all specialties;
- Supports Keogh review requiring consultants to give 7 day consultant cover;
- Patients and general public will choose to attend where they understand services to be safest;
- Minimises the number of patient transfers and the need for consultant staff to attend another site in the case of an emergency (distance between PRH and RSH – 18 miles); and
- Will create more opportunities for integration between acute, primary and social care.

The CCG clinical leads expressed the following assessment at the interview:

a) All the previous options of hot and cold site models had raised financial resource challenges facing the health system;
b) Concerns around moving away from excellent modern facilities for women's and children's services and the wish not to lose the service benefits associated with modern facilities and consolidation of services;
c) Adjustments to Option C1 may be raised as part of the consultation process as part of providing a better solution for both populations;
d) All agreed that the configuration of services should be of high quality, minimise risk where possible, be evidence based and address the drivers for change to ensure that the future services are sustainable; and
e) Acknowledgement of the need to consider evidence that women's and children's services should be on a single "hot site" alongside lead emergency centre for the local population.

As a result of these interviews and site visits, a number of clarifications were sought re the clinical response to Option C2:

- Clarification on why critical care is required to be on both sites*;

- The feasibility of paediatrics covering two sites. Acknowledged there are significant challenges in neonatology covering both sites;
- Need to consider demographics as well as geography; and
- Clarification on why surgical specialities are required to be on the same site as women's and children's*.

*see section 8 which responds to these points

6. Clinical Reference Group Panel

We assembled a group of seven clinicians that reviewed your papers and several convened to formulate this response. All the clinicians have been involved in similar service reconfiguration options both with Greater Manchester work and through experience of other health systems. The group is summarised in the table below:

Table 2 – CRG Panel members

Name	Role	Organisation
Martin Smith (Chair)	Clinical Director for Emergency Medicine	Salford Royal NHS Foundation Trust
Steve Jones	Consultant in Emergency and Intensive Care Medicine and Clinical Director of Emergency Services	Central Manchester University Hospitals NHS Foundation Trust
Julie Flaherty	Children's Clinical Lead, Unscheduled Care	Salford Royal NHS Foundation Trust
Helen Howard	Interim Divisional Director of Midwifery	Pennine Acute Hospitals NHS Trust
Edwin Clark	Consultant General Surgeon	Stockport NHS Foundation Trust
Mark Robinson	Consultant Paediatrician and Clinical Director for Child Health	Wrightington, Wigan and Leigh NHS Foundation Trust
Christopher Cooper	Consultant Paediatrician and Clinical Lead for Paediatrics	Stockport NHS Foundation Trust
In attendance:		
Jeanette McMillan	Project Lead	NHS Transformation Unit
Paul Wood	Interim Director of Transformation	NHS Transformation Unit
Rachel Bevan	Project Manager	NHS Transformation Unit

7. CRG Panel key findings

The CRG Panel reviewed the Sustainable Service Programme (Final Strategic Outline Case) and 'Option C2 Clinical Review Document' produced by senior clinicians at SaTH. In reviewing what would be required to make the variant Option C2 safe and sustainable. The following issues were highlighted:

i. Clinical configuration and co locations – Both sites as a minimum would be required to have:
   - Level 3 adult ICU;

- Anaesthetics with capability in both adults and children (critical for ED where children are present);
- Imaging - plain x ray, USS, CT and MRI practitioners required on both sites but opportunity for diagnostic reporting to be centralised enabled by image transfer. Capability to provide interventional radiology on both sites (practitioners would need to travel between sites);
- Blood transfusion;
- Acute medicine;
- Access to surgery;
- Resuscitation services; and
- Paediatrics. NB - Neonates and Paediatrics will need to be sited together otherwise dual middle grade rotas or new ways of working with ANNP and ANPs are required. However, these new workforce models will only be achievable if they do not function in isolation.

From all these services, the critical co–locations were deemed to be paediatrics and ICU.

ii. Workforce development, sustainability and competencies required to deliver high quality care and clinical outcomes – There is a need to demonstrate a sustainable clinical workforce both in WTE and competencies. Having reviewed the current SaTH workforce challenges, the national position and the future availability of medical trainees, the evidence suggested that the probability of achieving and sustaining a clinical workforce to support Option C2 would be very challenging. Consideration should be given to new workforce roles such as associate physicians, assistant practitioners, ANNPs and ANPs. All of these roles would however, require a lengthy lead in time.

iii. Royal Colleges' Standards – Although the scope of work did not include a literature review, the expertise and experience of the Panel was employed to suggest that Option C2 would not meet the necessary standards of the Royal Colleges and CQC issues would be raised.

iv. Opportunities for integration and future proofing - Option C2 does not make reference to integration either with other health services, such as Primary Care services, or with social care services. In the modern health and social care system this is a missed opportunity to integrate services and through doing so improve patient experience and create a more contemporary service. Following on from this, the Panel felt that Option C2 would already be outdated by the time that it had been implemented, meaning that another service reconfiguration would then be needed to cope with future health demands

v. Evidence of similar configurations elsewhere – The evidence base from other health communities/systems indicates that a single emergency centre receiving undifferentiated case mix should ideally have all services including women's and children's services. This is more in line with Option C1 than the Option C2 configuration. The Panel suggested that some of the lessons learnt and service changes that have taken place in the East Lancashire service reconfiguration between Blackburn and Burnley would be useful to consider, including how they have implemented an urgent care service portfolio at the non-emergency centre site that incorporates a well-designed Paediatric Ambulatory Care service model with a supporting workforce model. In this particular case , this has prevented a significant flows of children to the emergency centre site . In addition , this has facilitated the concentration of staffing rotas on the areas of the highest workload.

8. CRG Panel conclusions

i. The Panel concluded that the need for service change was clearly evident given the current staffing levels across the two hospital sites' A&E services. Option C2 as outlined is, in the Panel's view, unlikely to be clinically deliverable in the next couple of years or foreseeable future. The critical service independencies that the system would need to address with consolidation of A&E services would be:
   - The co-location of paediatrics expertise;
   - Level 3 adult ICU; and
   - Training and accreditation standards.

ii. The Clinical Reference Group panel was unaware of any standalone women's and children's hospital service with an Emergency Department receiving just women and children. When women are part of a women and children's hospital you need to address their adult needs with a range of specialities. This is different to a standalone paediatric ED which is common but requires significant support from paediatric ED and inpatient paediatric specialists.

iii. The future clinical service design and delivery models should be innovative, address the forthcoming challenges and be designed to meet the future health standards of 2025 and beyond. Without this approach it is likely that there will be a need for a further service reconfiguration in the short to medium term. It is essential that services are developed collaboratively and are clinically supported.

iv. Current work on innovative workforce models is required to continue with pace to ensure a sustainable workforce capable of delivering the preferred option. But this is only part of the solution as it needs continued development and support in order to make it a sustainable model. As above this should include newer innovations such as associate physicians, assistant practitioners, ANNPs and ANPs, and recognition of lengthy lead in time for any of these roles to be implemented.

9. CRG Panel recommendations

1) We would recommend that your consultation on future options focuses on the hot and extended warmer service site configuration options that provide the opportunity to explore the scale and breath of urgent care services that could be provided on the non-emergency service centre site. As indicated, the Panel advise that you explore some of the East Lancashire service configuration model that achieves compliance with the Royal Colleges' standards and addresses staffing / services model required to minimise the level of patient journeys.
2) The Panel would advise exploring further more innovative clinical models of care underpinning a single emergency centre including women's & children's services ("hot site") and an innovative "warm site" with elective surgery, medicine, rehabilitation, ambulatory care, urgent care, community and primary care services.
3) Given your resource affordability challenges, we would suggest looking at how you could reduce your total system cost envelope around this option through the integration of those services in each locality, rather than viewing it through one organisation's perspective and the transfer of specific services from one organisation to another.
4) In addition, the scale of the emergency services that is considered affordable should be re-examined and it should be considered whether there are options for a shared workforce in certain specialties as part of a larger clinical service provision network.

5) All the options you consider should reflect evidence based standards and innovative models of care that are able to meet the challenges of health and social care in 2025 and beyond. In addition, consideration should be given as to what a sustainable and competent clinical workforce looks like for the future and that addresses and meets expected Royal Colleges' Standards, including training.

10. Next Steps

We would welcome the opportunity to discuss this paper further with you and al how we could support your clinical leaders in taking forward your option appraisal and Subsequent preparation for consultation on a range of options .