



Summary of individual responses to Future Fit consultation

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Introduction

The Future Fit public consultation ran from 30 May to 11 September 2018. This document provides information on the detailed evidence-based letters and emails we received from individuals on Shropshire and Telford & Wrekin CCGs' proposals to change the hospital services provided at the Royal Shrewsbury and Princess Royal hospitals.

The report aims to feed into the 'conscientious consideration' phase by providing the CCG boards with the following:

- Overview of feedback from individuals who have provided evidence to the consultation
- Main themes from the feedback
- A document to support a discussion on any potential material issues for consideration and any mitigation required

Overview of feedback from individuals

During the 15-week Future Fit consultation, we received evidence from eight individuals, several of whom have been very involved in the Future Fit programme over the last five years. Due to data protection reasons, the names of the individuals will remain anonymous in this document.

Main themes

The following 13 themes were identified within these individual responses:

1. Alternative model
2. Care closer to home/ services joined up
3. Clinical model
4. Planned care
5. Emergency care
6. Consultation Process
7. Equalities
8. Finance
9. Information technology
10. Patient safety
11. Population need
12. Staffing
13. Travel and transport

This section includes more detail on the feedback related to each theme and proposed actions.

1. Alternative model

There are several comments which suggest alternative models to the proposed Future Fit model of hospital care. One respondent suggests that the CCGs should think again about the model used in Northumbria, whilst another suggests learning from Yeovil District Hospital NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust. Other views suggest a 'central hub where you have all your inpatient beds, with day care and outpatients at both RSH and PRH and rehab and diagnostics at the community hospitals.'

A centralised acute hospital on the PRH campus would be better because: it would create a defence against 'usurpers from the east'. It would help SaTH keep specialist services as local as possible.

An alternative view is for SaTH, Shropcom and maybe Robert Jones to merge to become one integrated organisation. They believe this would develop 'safe effective integrated NHS provision in Shropshire'. Or to have a single site model, which would 'release at least £37 million pa from the acute sector for reinvestment in primary and community care services.'

2. Care closer to home/services joined up

There are comments around how the focus should be on ensuring that people can access healthcare as near to their homes as possible, therefore increasing the use of community hospitals. It is claimed that Future Fit is 'meaningless and dangerous' because of the 'absence of any context in relation to wider health economy or explanation of any plans to have integrated health and social care system.'

One person argues that planned care would be better served by having a facility somewhere like Welshpool, which would help with the problem of bed blocking. Another person suggests that the roll-out of diagnostics could facilitate first contact without the need for patients to go to a main centre. An alternative suggestion is that GPs could buy-in to the new system and take ownership of local hospitals where they could provide rehab beds and beds for minor admissions.

3. Clinical model

There are comments that the problem of a lack of beds has not been highlighted in Future Fit proposals and the argument that PRH was designed to cope with this future necessity. There is criticism that 'the proposals disregard anything other than binary choice of main hospital at either RSH or PRH' and that 'there is nothing about Future Fit that will make it fit for the future.'

One respondent also expressed concerns that older patients presenting at A&E may have multiple conditions requiring the intervention of specialist consultants based at the planned care site. This respondent proposed an alternative configuration whereby A&E, diagnostics and planned care would be co-located at RSH, with a UCC, cottage hospital, dialysis, cancer services, scans, x-rays and outpatients at PRH.

4. Planned Care

It was suggested that option 1 will be more disadvantageous to a majority of patients from Wales as 80-85% of patients and visitors would have to travel to PRH for planned care. Over a year planned treatments would vastly outnumber critical care treatments, making option 2 considerably more preferable to patients from the west of the catchment area. Another respondent commented that attending planned care at PRH would be particularly problematical for the larger ageing population relying on public transport.

One respondent also suggested that planned care would be better served by having a facility somewhere like Welshpool. The problem of bed blocking and inability to discharge a patient was highlighted, so a regional facility might alleviate this.

It was also suggested that CCGs should reconsider a different model that involves a central hub where you have all your inpatient beds, with day care and outpatients at RSH and PRH and rehab & diagnostics at the community hospitals

One respondent specifically suggested that SaTH is likely to lose market share of planned care as residents from Wales and NE Shropshire may choose to receive their planned care in Wales rather than travel to PRH. In addition a proportion of patients from the east of Shropshire receiving emergency treatment in Stoke or Wolverhampton will then continue to receive any further planned care at the same site.

5. Emergency Care

It has been suggested that the problems around maintaining a sustainable A&E service on two sites will be more or less eliminated by SaTH installing telehealth and creating a 'world first "cross site virtual all conditions A&E department" '.

One respondent also comments and cites evidence that whilst there is little likelihood of additional mortality being experienced under the proposed model (option 1 or 2) during episodes of serious emergency care over and above what is already experienced, there is also no evidence to suggest that current mortality performance in Shropshire will improve.

Under FF, demands on the ambulance service will increase and this part of the emergency system will see major shifts in operational requirements, including treatment at scene requirements. Additional ambulance service cost consequences are not yet understood.

6. Consultation process

Some comments are critical of the consultation process, which has 'ignored opinion of medical staff who provide secondary care, the drivers for providing excellent service, and geography.' There is also the claim that 'people who took part in both Keeping it in the County and Future Fit consultation are biased towards geographies in Shropshire and Powys.'

There is also criticism that Future Fit has used 'biased evaluation data' and that the non-financial assessment methodology is a 'badly flawed tool' to use when determining the deployment of public resources involving multiple communities who live in a large area.

7. Equalities

One person claims that 'there has yet to be any serious work identifying the risks posed to vulnerable groups, such as learning disabilities' and that 'this raises serious concerns'.

8. Finance

There are queries around the affordability of both options. There are claims that the current Future Fit plan will not work without a vibrant community/ primary care sector and that more investment (£35 million) is needed in the area.

One person comments that 'over investing capital in acute services is crazy and a self-defeating policy which runs against the need for funding more care closer to home'. Another person states that 'having a centralised acute hospital on the PRH campus would secure maximum value from recent past investment and would minimise future debt repayments'.

There is also a claim that the Future Fit plan 'takes no account of the loss in the market share that SaTH will experience, except to predict there is some repatriation of work back into the county'. For example, some people will choose a different hospital in which to have their planned care.

In addition, there are comments around how local government should be a key partner in 'developing and funding some of FF capital build' and 'potential sharing capital investment opportunities'.

9. Information technology

The benefits of telehealth are highlighted in the responses. One person comments that by installing telehealth, this eliminates the problems around maintaining a sustainable A&E service on two sites. This is echoed by another person who says that telemedicine would ensure there was always rapid contact available for specialist advice where necessary. It's also commented that patients should have a daily report card that goes with their hospital records.

10. Patient safety

There are two comments that have been categorised under the theme of 'patient safety'. One states the importance of keeping A&E at Shrewsbury while the other cites that there is no evidence that option 1 or 2 would improve current mortality performances in Shropshire.

11. Population need

Comments around population state that Option 2 is best as it would mean that 'the county's major hospital is closer to the majority of population it serves, which is a younger population that is expected to grow by about 5% over next 10 years'. It is also stated that 'the population from East Wales who use Shropshire services is 50,000 - less than one third of current population of Telford Town and one fifth of the PRH catchment area.'

12. Staffing

There are arguments that consolidating services will be best for clinical linkages and the recruitment and retention of medical staff. One person states that in order to make the FF proposals work financially, SaTH will have to reduce the cost of labour by circa £14m per year - a net reduction of 360 WTE. Staff to bed ratios will go from 5.73 staff per bed to 4.715 staff per bed.'

13. Travel and transport

Travel and transport is a key theme which several people comment on. It is stated that there is a need for a multi-storey car park, either at RSH or both hospitals in the future, with a suggestion that they are self-funding and revert to SaTH ownership after 10 years.

There are concerns around travel times, with a study by the University of Lancaster cited which found that siting services at Shrewsbury would place 2,000 people outside a 60 minute travel time, whereas if services were in Telford this would increase to over 11,000

There are also several reasons given as to why Option 2 is the better option. One comment suggests that Option 2 would mean that 'critical care services are based at a relatively modern hospital, which is designed to allow for coherent expansion and well-served by road, bus and rail links'. Another states that Option 2 would be preferable to patients from the west as 'over a year, planned treatments would vastly outnumber critical care treatments. This is echoed by another comment which states that 'option 1 will be more disadvantageous to majority of patients from Wales as 80-85% of patients and visitors would have to travel to PRH for planned care.'

There is also concern around ambulance delays in Powys and the increased demand that Future Fit would put on the ambulance service, with the suggestion that 'additional ambulance service cost consequences are not yet understood by the Future Fit programme or the West Midlands or Welsh Ambulance Service'.

Summary of responses from individuals

Response #1

Option preferred: neither

Comments:

- Proposals disregard anything other than binary choice of main hospital at either RSH or PRH
- There is nothing about Future Fit that will make it fit for the future
- We should be ensuring that people can access healthcare as near to their homes as possible and therefore should be increasing the use of community hospitals
- If GPs could buy-in to the new system and take ownership of local hospitals then we could provide rehab beds and beds for minor admissions at these facilities
- Roll-out of diagnostics could facilitate first contact without the need for patients to go to a main centre
- Telemedicine would ensure there was always rapid contact available for specialist advice where necessary
- CCGs should think again about the Northumbria model
- CCGs should reconsider a different model that involves a central hub where you have all your inpatient beds, with day care and outpatients at RSH and PRH and rehab & diagnostics at the community hospitals

Response #2

Option preferred: Option 1

Comments:

- The process has ignored opinion of medical staff who provide secondary care, drivers for providing excellent service and geography
Consolidating services will be best for clinical linkages and recruitment/ retention of medical staff
- Study by University of Lancaster showed that siting services at Shrewsbury would place 2,000 people outside a 60 minute travel time, whereas if services were in Telford this would increase to over 11,000
- 55% of our population live in smaller towns or a rural setting
- Current parking provision at both hospitals is woeful, especially at RSH. It will need three 3 level multi-storey car parks - two at RSH and one at PRH in order to accommodate extra 1,000 cars at RSH and 500 cars at PRH. This should be self-funding with car parks reverting to SaTH ownership after 10 years

Response #3

Option preferred: Option 2

Comments:

- Option 2 would mean that critical care services are based at a relatively modern hospital, designed to allow for coherent expansion and well-served by road, bus and rail links

- Option 2 would mean that the county's major hospital is closer to the majority of population it serves, a younger population that is expected to grow by about 5% over next 10 years
- Consideration has to be given to population from East Wales who use Shropshire services, however this is 50,000 - less than 1/3 of current population of Telford Town and 1/5 of PRH catchment area
- For accidents & less serious care, Welsh patients could still be treated at RSH and the few critical care cases could be treated at PRH or Wrexham
- Option 1 will be more disadvantageous to majority of patients from Wales as 80-85% of patients and visitors would have to travel to PRH for planned care
- Over a year planned treatments would vastly outnumber critical care treatments, making Option 2 considerably more preferable to patients from west of catchment area
- Problem of lack of beds has not been highlighted in Future Fit proposals. PRH was designed to cope with this future necessity

Response #4

Option preferred: Option 1

Comments:

- Agrees with Russell George that Shrewsbury should keep A&E in Shrewsbury
- Planned care would be better served by having a facility somewhere like Welshpool
- Problem is bed blocking and inability to discharge a patient so regional facility might alleviate this
- Multi storey car park at RSH is needed
- Patients should have a daily report card that goes with their hospital records

Response #5

Option preferred: Not stated

Comments:

- Concerns around ambulance delays in Powys

Response #6

Option preferred: Neither

Comments:

- Providing core hospital services on both sites and distributing specialist services on a different basis is an option and a twin site emergency care service should be considered as an option. Recommends learning from Yeovil District Hospital NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust
- SaTH is already creating a 'world first' cross site virtual all conditions A&E department" by installing telehealth and this more or less eliminates the problems around maintaining a sustainable A&E service on two sites

- Under options 1 and 2, while there is little likelihood of additional mortality being experienced during episodes of serious emergency care over and above what is already experienced, there is also no evidence to suggest that current mortality performance in Shropshire will improve (references "Closing five EDs in England between 2009 and 2011")
- Under FF, demands on the ambulance service will increase and this part of the emergency system will see major shifts in operational requirements, including treatment at scene requirements. Additional ambulance service cost consequences are not yet understood by the FFPB or WMAS or WAS.
- Insufficient attention has been given by the CCGs to predictable shifts in the market share which SaTH can expect under either Option 1 or Option 2. As such, the PCBC is flawed from an economic perspective. The economic impact of predictable changes in patient flow and revenue streams puts the viability of both options in very serious doubt unless the capital required for each option can be reduced by circa 50%.
- The current Future Fit plan will not work without a vibrant community/primary care sector. More investment is needed in this area (estimates it requires an additional £35million)
- Over investing capital in acute services as per current FF plans is crazy and is a self-defeating policy which runs against the need for funding more care closer to home
- A centralised acute hospital on the PRH campus would be better because: it would create a defence against 'usurpers from the east'. It would help SaTH keep specialist services as local as possible.
- Having a centralised acute hospital on the PRH campus would secure maximum value from recent past investment and would minimise future debt repayments.
- The capital cost of Option 1 was calculated in October 2016 by Rider Hunt on the basis of 765 overnight beds. The consultation doc says there will be 785. The cost of building an additional 20 overnight stay beds will be in the order of £7 million, plus interest, additional staffing charges and maintenance. This impacts on the predicted affordability of Option 1.
- The only risk/barrier associated with introducing a Northumbria-style service in Shropshire is a poor attitude towards providing integrated care and poor understanding of what a good integrated service looks like. The model is possible to adapt and implement in Shropshire.
- A merger of SaTH, Shropcom and maybe RJAH into one integrated organisation is possible. Details of a proposed eight-site hospital service are set out in his letter of 30/07/2018. There is enough money in our local system to develop a safe effective integrated NHS provision in Shropshire.
- A single site model would be the most efficient way to reconfigure services and would release at least £37 million pa from the acute sector for reinvestment in primary and community care services
- Proposed alternative plan: 1) close down RSH as venue for patient care 2) develop an ambulatory care (outpatient) facility in Shrewsbury town centre 3) provide hospital emergency facilities circa 400/450 beds on a site connected to the A5/M52 (sic) corridor on east of Shrews 4) open rehab beds on the same site as emergency beds but in accommodation owned and run by nursing care sector and adopt different contracting system for period patients spend in rehab phase; use PRH as site for planned case load as per option 2

- Local Government should be a key partner in developing and funding some of FF capital build. Equity investment approach can create income streams associated with various non-patient care activities, e.g. provision of parking, etc. Surplus can be reinvested in care services.
- A replacement hospital on eastern side of Shrewsbury would include 'franchise' space. With the exception of the outpatient department, it would have the same facilities as the FF option 1 proposal. Response includes suggested locations pinpointed on maps. RSH outpatient services should be central Shrews close to public transport.
- The FF plan takes no account of changes in SaTH market share except to predict there is some repatriation of work back into the county. There will be a loss of market share at SaTH. There will be a loss of market share at SaTH due to: a) Powys residents having more choice where to receive their planned care as a result of the PTHB strategy; residents from NE Shropshire will choose to use the hospital in Wrexham for planned surgery rather than travel to PRH and they may want all their hospital care - including emergency - from Wrexham, shifting their loyalty from SaTH to PTHB services; emergency cases on the east of Shropshire will receive their emergency care in Stoke or Wolverhampton - this will also impact on planned surgery since circa 16% of people attending A&E are referred to other hospital specialists for further treatment as planned care.
- In order to make the FF proposals work financially, SaTH will have to reduce the cost of labour by circa £14m pa - a net reduction of 360 WTE. Staff to bed ratios will go from 5.73 staff per bed now to 4.715 staff per bed under FF
- People who took part in both Keeping it in the County and Future Fit consultation are biased towards geographies in Shropshire and Powys
- The benefits points allocation is based on a biased sample of opinions which are no better than the random geography based biased views of the public. FF has used biased evaluation data
- KPMG consultants were not made aware of socio-geographic bias that exists
- The non-financial assessment methodology is a badly flawed tool to use when determining the deployment of public resources in the context of multiple communities spread over a large area

Response #7

Option preferred: Not stated

Comments:

- Ignoring the local authority as a potential partner in development of local health service infrastructure and potential sharing of capital investment opportunities is short sighted
- Absence of any context in relation to wider health economy or explanation of any plans to have integrated health and social care system renders Future Fit meaningless and dangerous
- There has yet to be any serious work identifying the risks posed to vulnerable groups, such as learning disabilities. This raises serious concerns

Response #8

Option preferred: Neither

Comments:

- Under option 1, the majority of people who would receive planned care at PRH would have to travel nearly an extra 40-mile round trip
- Vast majority of planned care patients would have a greatly extended travel element to their hospital visit
- Planned care at Telford would be problematic for the larger ageing population, many of whom have to rely on public transport
- Older people presenting at A&E have multiple conditions that may require attendance by a MDT whose specialist consultants would be based at PRH
- There is no clinical justification for either planned care or emergency care at Telford rather than Shrewsbury
- The best configuration would be to have UCC, cottage hospital, dialysis, cancer services, scans, x-rays and outpatients at PRH and A&E and all diagnostic & planned care at RSH

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